1 between July 1, 2009, and December 31, 2015, inclusive, that the
2 city was incorporated.
3 (d) For purposes of subdivision (b), the Controller may request
4 fiscal data from cities and counties in addition to data provided
5 pursuant to Section 2151, for the 2009–10, 2010–11, and 2011–12
6 fiscal years. Each city and county shall furnish the data to the
7 Controller not later than 120 days after receiving the request. The
8 Controller may withhold payment to cities and counties that do
9 not comply with the request for information or that provide
10 incomplete data.
11 (e) The Controller may perform audits to ensure compliance
12 with subdivision (b) when deemed necessary. Any city or county
13 that has not complied with subdivision (b) shall reimburse the state
14 for the funds it received during that fiscal year. Any funds withheld
15 or returned as a result of a failure to comply with subdivision (b)
16 shall be reapportioned to the other cities and counties whose
17 expenditures are in compliance.
18 (f) If a city or county fails to comply with the requirements of
19 subdivision (b) in a particular fiscal year, the city or county may
20 expend during that fiscal year and the following fiscal year a total
21 amount that is not less than the total amount required to be
22 expended for those fiscal years for purposes of complying with
23 subdivision (b).
24 2037. A city or county may spend its apportionment of funds
25 under the program on transportation priorities other than those
26 allowable pursuant to this chapter if the city's or county's average
27 Pavement Condition Index meets or exceeds 80.
28 2038. (a) The department and local agencies, as a condition
29 of receiving funds from the program, shall adopt and implement
30 a program designed to promote and advance construction
31 employment and training opportunities through preapprenticeship
32 opportunities, either by the public agency itself or through
33 contractors engaged by the public agencies to do work funded in
34 whole or in part by funds made available by the program.
35 (b) The department and local agencies, as a condition of
36 receiving funds from the program, shall ensure the involvement
37 of the California Conservation Corps and certified community
38 conservation corps in the delivery of projects and services funded
39 in whole or in part by funds made available by the program.

SEC. 26. Section 2103.1 is added to the Streets and Highways Code, to read:

2103.1. (a) Notwithstanding Section 2103, the revenues transferred to the Highway Users Tax Account pursuant to Sections 8352.4, 8352.5, and 8352.6 of the Revenue and Taxation Code shall be distributed pursuant to the formula in paragraph (3) of subdivision (a) of Section 2103.

(b) Notwithstanding subdivision (b) of Section 2103, the portion of revenues in the Highway Users Tax Account attributable to the increase in the motor vehicle fuel excise tax pursuant to subparagraph (B) of paragraph (1) of subdivision (a) of Section 7360 of the Revenue and Taxation Code, as adjusted pursuant to subdivision (c) of that section, shall be transferred to the Road Maintenance and Rehabilitation Account pursuant to Section 2031.

(c) Notwithstanding subdivision (b) of Section 2103, the portion of revenues in the Highway Users Tax Account attributable to the increase in the diesel fuel excise tax pursuant to subdivision (b) of Section 60050 of the Revenue and Taxation Code, as adjusted pursuant to subdivision (c) of that section, shall be transferred to the Trade Corridors Improvement Fund pursuant to Section 2192.4.

SEC. 27. Section 2192 of the Streets and Highways Code is amended to read:

2192. (a) *(1)* The Trade Corridors Improvement Fund, created pursuant to subdivision (c) of Section 8879.23 of the Government Code, is hereby continued in existence to receive revenues from *state* sources other than the Highway Safety, Traffic Reduction, Air Quality, and Port Security Bond Act of 2006. ~~This chapter shall govern expenditure of those other revenues.~~

(2) Revenues apportioned to the state under Section 167 of Title 23 of the United States Code from the national highway freight program, pursuant to the federal Fixing America's Surface Transportation Act ("FAST Act," Public Law 114-94) shall be allocated for projects approved pursuant to this chapter.

(b) This chapter shall govern the expenditure of those state and federal revenues described in subdivision (a).

~~(b)~~

(c) The ~~moneys~~ *funding described* in ~~the fund from those other sources~~ *subdivision (a)* shall be available upon appropriation for allocation by the California Transportation Commission for infrastructure improvements in this state on federally designated

Trade Corridors of National and Regional Significance, on the Primary Freight Network, and along other corridors that have a high volume of freight movement, as determined by the commission. In determining the projects eligible for funding, the commission shall consult the Transportation Agency's state freight plan as described in Section 13978.8 of the Government ~~Code, the State Air Resources Board's Sustainable Freight Strategy adopted by Resolution 14-2,~~ *Code* and the ~~trade infrastructure and goods movement plan submitted to the commission by the Secretary of Transportation and the Secretary for Environmental Protection.~~ *California Sustainable Freight Action Plan released in July 2016 pursuant to Executive Order B-32-15.* The commission shall also consult trade infrastructure and goods movement plans adopted by regional transportation planning agencies, adopted regional transportation plans required by state and federal law, and the ~~statewide~~ *applicable* port master plan ~~prepared by the California Marine and Intermodal Transportation System Advisory Council (Cal-MITSAC) pursuant to Section 1730 of the Harbors and Navigation Code,~~ when determining eligible projects for funding. Eligible projects for ~~these funds~~ *funding described in subdivision (a) shall further the state's economic, environmental, and public health objectives and goals for freight policy, as articulated in the plans to be consulted pursuant to this subdivision, and may* include, but are not limited to, all of the following:

(1) Highway capacity *improvements, rail landside access improvements, landside freight access* improvements *to airports,* and operational improvements to more efficiently accommodate the movement of freight, particularly for ingress and egress to and from the state's land ports of ~~entry~~ *entry, rail terminals,* and seaports, including navigable inland waterways used to transport freight between seaports, land ports of entry, and airports, and to relieve traffic congestion along major trade or goods movement corridors.

(2) Freight rail system improvements to enhance the ability to move goods from seaports, land ports of entry, and airports to warehousing and distribution centers throughout California, including projects that separate rail lines from highway or local road traffic, improve freight rail mobility through mountainous regions, relocate rail switching yards, and other projects that improve the efficiency and capacity of the rail freight system.

1 (3) Projects to enhance the capacity and efficiency of ports.
2 (4) Truck corridor *and capital and operational* improvements,
3 including dedicated truck facilities or truck toll facilities.
4 (5) Border ~~access~~ *capital and operational* improvements that
5 enhance goods movement between California and Mexico and that
6 maximize the state's ability to access ~~coordinated border~~
7 ~~infrastructure~~ funds made available to the state by federal law.
8 (6) Surface transportation and connector road improvements to
9 effectively facilitate the movement of goods, particularly for
10 ingress and egress to and from the state's land ports of entry,
11 airports, and seaports, to relieve traffic congestion along major
12 trade or goods movement corridors.
13 ~~(c)~~
14 *(d)* (1) ~~The~~ *In selecting projects for inclusion in the program*
15 *of projects to be funded with funds described in subdivision (a),*
16 *the* commission shall ~~allocate funds for trade infrastructure~~
17 ~~improvements from the fund~~ *evaluate the total potential costs and*
18 *total potential economic and noneconomic benefits of the program*
19 *to California's economy, environment, and public health. The*
20 *commission shall consult with the State Air Resources Board in*
21 *order to utilize the appropriate models, techniques, and methods*
22 *to develop the parameters for evaluation of projects. The*
23 *commission shall allocate the funding described in subdivision (a)*
24 *for trade infrastructure improvements* consistent with Section
25 8879.52 of the Government Code and the Trade Corridors
26 Improvement Fund (TCIF) Guidelines adopted by the commission
27 on November 27, 2007, or as amended by the commission, and in
28 a manner that (A) addresses the state's most urgent needs, (B)
29 balances the demands of various land ports of entry, seaports, and
30 airports, (C) provides reasonable geographic balance between the
31 state's regions, ~~and~~ (D) places emphasis on projects that improve
32 trade corridor mobility *and safety* while reducing emissions of
33 diesel ~~particulate~~ *particulates, greenhouse gases,* and other
34 ~~pollutant emissions.~~ *pollutants, and reducing other negative*
35 *community impacts, and (E) makes a significant contribution to*
36 *the state's economy.*
37 *(2) In adopting amended guidelines, and developing and*
38 *adopting the program of projects, the commission shall do all of*
39 *the following:*

(A) Accept nominations for projects to be included in the program of projects from regional and local transportation agencies and the Department of Transportation.

(B) Recognize the key role of the state in project identification and support integrating statewide goods movement priorities into the corridor approach.

(C) Make a finding that adoption and delivery of the program of projects is in the public interest.

~~(2)~~

(3) In addition, the commission shall also consider the following factors when allocating these funds:

(A) "Velocity," which means the speed by which large cargo would travel from the land port of entry or seaport through the distribution system.

(B) "Throughput," which means the volume of cargo that would move from the land port of entry or seaport through the distribution system.

(C) "Reliability," which means a reasonably consistent and predictable amount of time for cargo to travel from one point to another on any given day or at any given time in California.

(D) "Congestion reduction," which means the reduction in recurrent daily hours of delay to be achieved.

SEC. 28. Section 2192.1 of the Streets and Highways Code is amended to read:

2192.1. (a) To the extent moneys from the Greenhouse Gas Reduction Fund, attributable to the auction or sale of allowances as part of a market-based compliance mechanism relative to reduction of greenhouse gas emissions, are transferred to the Trade Corridors Improvement Fund, projects funded with those moneys shall be subject to all of the requirements of existing law applicable to the expenditure of moneys appropriated from the Greenhouse Gas Reduction Fund, including, but not limited to, ~~both~~ *all* of the following:

(1) Projects shall further the regulatory purposes of the California Global Warming Solutions Act of 2006 (Division 25.5 (commencing with Section 38500) of the Health and Safety Code), including reducing emissions from greenhouse gases in the state, directing public and private investment toward disadvantaged communities, increasing the diversity of energy sources, or creating opportunities for businesses, public agencies, nonprofits, and other

community institutions to participate in and benefit from statewide efforts to reduce emissions of greenhouse gases.

(2) Projects shall be consistent with the guidance developed by the State Air Resources Board pursuant to Section 39715 of the Health and Safety Code.

(3) Projects shall be consistent with the required benefits to disadvantaged communities pursuant to Section 39713 of the Health and Safety Code.

(b) All allocations of funds made by the commission pursuant to this section shall be made in a manner consistent with the criteria expressed in Section 39712 of the Health and Safety Code and with the investment plan developed by the Department of Finance pursuant to Section 39716 of the Health and Safety Code.

(c) For purposes of this section, "disadvantaged community" means a community with any of the following characteristics:

(1) An area with a median household income less than 80 percent of the statewide median household income based on the most current census tract-level data from the American Community Survey.

(2) An area identified by the California Environmental Protection Agency pursuant to Section 39711 of the Health and Safety Code.

(3) An area where at least 75 percent of public school students are eligible to receive free or reduced-price meals under the National School Lunch Program.

SEC. 29. Section 2192.2 of the Streets and Highways Code is amended to read:

2192.2. The commission shall allocate funds made available by this chapter to projects that have identified and committed supplemental funding from appropriate local, federal, or private sources. The commission shall determine the appropriate amount of supplemental funding each project should have to be eligible for moneys ~~from the fund~~ based on a project-by-project review and an assessment of the project's benefit to the state and the program. ~~Except for border access~~ *Funded* improvements ~~described in paragraph (5) of subdivision (b) of Section 2192, improvements funded with moneys from the fund~~ shall have supplemental funding that is at least equal to the amount of the contribution ~~from the fund.~~ *under this chapter.* The commission may give priority for

1 funding to projects with higher levels of committed supplemental
2 funding.
3 SEC. 30. Section 2192.4 is added to the Streets and Highways
4 Code, to read:
5 2192.4. The portion of the revenues in the Highway Users Tax
6 Account attributable to the increase in the diesel fuel excise tax
7 pursuant to subdivision (b) of Section 60050 of the Revenue and
8 Taxation Code, as adjusted pursuant to subdivision (c) of that
9 section, shall be transferred to the Trade Corridors Improvement
10 Fund.
11 SEC. 31. Section 9250.3 is added to the Vehicle Code, to read:
12 9250.3. (a) In addition to any other fees specified in this code
13 or the Revenue and Taxation Code, commencing July 1, 2017, a
14 registration fee of thirty-eight dollars ($38) shall be paid to the
15 department for registration or renewal of registration of every
16 vehicle subject to registration under this code, except those vehicles
17 that are expressly exempted under this code from payment of
18 registration fees.
19 (b) Beginning July 1, 2019, and every third year thereafter, the
20 Department of Motor Vehicles shall adjust the fee imposed under
21 this section for inflation in an amount equal to the change in the
22 California Consumer Price Index for the prior three-year period,
23 as calculated by the Department of Finance, with amounts equal
24 to or greater than fifty cents ($0.50) rounded to the next highest
25 whole dollar.
26 (c) Revenues from the fee, after the deduction of the
27 department's administrative costs related to this section, shall be
28 deposited in the Road Maintenance and Rehabilitation Account
29 created pursuant to Section 2031 of the Streets and Highways
30 Code.
31 SEC. 32. Section 9250.6 is added to the Vehicle Code, to read:
32 9250.6. (a) In addition to any other fees specified in this code,
33 or the Revenue and Taxation Code, commencing July 1, 2017, a
34 registration fee of one hundred and sixty-five dollars ($165) shall
35 be paid to the department for registration or renewal of registration
36 of every zero-emission motor vehicle subject to registration under
37 this code, except those motor vehicles that are expressly exempted
38 under this code from payment of registration fees.
39 (b) Beginning July 1, 2019, and every third year thereafter, the
40 Department of Motor Vehicles shall adjust the fee imposed under

1 this section for inflation in an amount equal to the change in the
2 California Consumer Price Index for the prior three-year period,
3 as calculated by the Department of Finance, with amounts equal
4 to or greater than fifty cents ($0.50) rounded to the next highest
5 whole dollar.
6 (c) Revenues from the fee, after deduction of the department's
7 administrative costs related to this section, shall be deposited in
8 the Road Maintenance and Rehabilitation Account created pursuant
9 to Section 2031 of the Streets and Highways Code.
10 (d) This section does not apply to a commercial motor vehicle
11 subject to Section 9400.1 or to a low-speed vehicle, as defined in
12 Section 385.5.
13 (e) The registration fee required pursuant to this section does
14 not apply to the initial registration after the purchase of a new
15 zero-emission motor vehicle.
16 (f) For purposes of this section, "zero-emission motor vehicle"
17 means a motor vehicle as described in subdivisions (c) and (d) of
18 Section 44258 of the Health and Safety Code.
19 SEC. 33. Section 9400.5 is added to the Vehicle Code, to read:
20 9400.5. (a) Notwithstanding Sections 9400.1, 9400.4, and
21 42205 of this code, Sections 16773 and 16965 of the Government
22 Code, Section 2103 of the Streets and Highways Code, or any
23 other law, weight fee revenues shall only be transferred consistent
24 with the schedule provided in subdivision (b) from the State
25 Highway Account to the Transportation Debt Service Fund, the
26 Transportation Bond Direct Payment Account, or any other fund
27 or account for the purpose of payment of the debt service on
28 transportation general obligation bonds and shall not be loaned to
29 the General Fund.
30 (b) (1) The transfer of weight fee revenues, after deduction of
31 collection costs, from the State Highway Account pursuant to
32 subdivision (a) shall not exceed:
33 (A) Nine hundred million dollars ($900,000,000) in the 2017–18
34 fiscal year.
35 (B) Eight hundred million dollars ($800,000,000) in the 2018–19
36 fiscal year.
37 (C) Seven hundred million dollars ($700,000,000) in the
38 2019–20 fiscal year.
39 (D) Six hundred million dollars ($600,000,000) in the 2020–21
40 fiscal year.

1 (E) Five hundred million dollars ($500,000,000) in the 2021-22
2 fiscal year and in every fiscal year thereafter.
3 SEC. 34. This act is an urgency statute necessary for the
4 immediate preservation of the public peace, health, or safety within
5 the meaning of Article IV of the Constitution and shall go into
6 immediate effect. The facts constituting the necessity are:
7 In order to provide additional funding for road maintenance and
8 rehabilitation purposes as quickly as possible, it is necessary for
9 this act to take effect immediately.

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AMENDED IN ASSEMBLY MAY 2, 2017

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, 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, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 205, as amended, Wood. Medi-Cal: Medi-Cal managed care plans.

(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, 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 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,~~ *plan,* 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~~ *being required to make* 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: yes. Fiscal committee: yes. State-mandated local program: no.

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

1 SECTION 1. It is the intent of the Legislature to implement
2 the revisions to federal regulations governing Medicaid managed
3 care plans at Parts 431, 433, 438, 440, 457, and 495 of Title 42 of
4 the Code of Federal Regulations, as amended May 6, 2016, as
5 published in the Federal Register (81 Fed. Reg. 27498).
6 SEC. 2. Section 10951 of the Welfare and Institutions Code is
7 amended to read:
8 10951. (a) (1) A person is not entitled to a hearing pursuant
9 to this chapter unless he or she files his or her request for the same
10 within 90 days after the order or action complained of.
11 (2) Notwithstanding paragraph (1), a person shall be entitled to
12 a hearing pursuant to this chapter if he or she files the request more
13 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~~ *Sections* 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.

1 (b) The department, in consultation with the Department of
2 Managed Health Care, shall develop all of the following:
3 (1) Time and distance standards for the following provider types,
4 as specified in Section 438.68(b)(1) of Title 42 of the Code of
5 Federal Regulations, to ensure that medically necessary covered
6 services are accessible to enrollees of Medi-Cal managed care
7 plans.
8 (A) Primary care, adult and pediatric.
9 (B) Obstetrics and gynecology.
10 (C) Behavioral health, including mental health and substance
11 use disorder, adult and pediatric.
12 (D) Specialist, adult and pediatric.
13 (E) Hospital.
14 (F) Pharmacy.
15 (G) Pediatric dental.
16 (H) Additional provider types when it promotes the objectives
17 of the Medicaid program, as determined by the federal Centers for
18 Medicare and Medicaid Services, for the provider type to be subject
19 to time and distance access standards.
20 (2) For those Medi-Cal managed care plans that cover long-term
21 services and supports (LTSS), both of the following:
22 (A) Time and distance standards for LTSS provider types in
23 which an enrollee must travel to the provider to receive services.
24 (B) Network adequacy standards other than time and distance
25 standards for LTSS provider types that travel to the enrollee to
26 deliver services.
27 (3) Standards to ensure that all services are available and
28 accessible to enrollees of Medi-Cal managed care plans in a timely
29 manner.
30 (c) The standards developed by the department pursuant to this
31 section shall, at a minimum, do both of the following:
32 (1) Meet or exceed existing time and distance standards
33 developed pursuant to Section 1367.03 of the Health and Safety
34 Code and the standards set forth in Medi-Cal managed care
35 contracts entered into with the department as of January 1, 2016.
36 (2) Meet or exceed the appointment time standards developed
37 pursuant to Section 1367.03 of the Health and Safety Code and
38 the standards set forth in contracts entered into between the
39 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~~ *into* at least five or more county ~~categories.~~ *categories, one of which is a rural county category.*

(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).

1 (D) Article 2.9 (commencing with Section 14088).
2 (E) Article 2.91 (commencing with Section 14089).
3 (F) Chapter 8 (commencing with Section 14200), including
4 dental managed care plans.
5 *(G) Chapter 8.9 (commencing with Section 14700).*
6 *(H) A county Drug Medi-Cal organized delivery system*
7 *authorized under the California Medi-Cal 2020 Demonstration,*
8 *Number 11-W-00193/9, as approved by the federal Centers for*
9 *Medicare and Medicaid Services and described in the Special*
10 *Terms and Conditions. For purposes of this subdivision, "Special*
11 *Terms and Conditions" shall have the same meaning as set forth*
12 *in subdivision (o) of Section 14184.10.*
13 (j) Notwithstanding Chapter 3.5 (commencing with Section
14 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
15 the department, without taking any further regulatory action, shall
16 implement, interpret, or make specific this section by means of
17 all-county letters, plan letters, plan or provider bulletins, or similar
18 instructions until the time regulations are adopted. The department
19 shall adopt regulations by July 1, 2019, in accordance with the
20 requirements of Chapter 3.5 (commencing with Section 11340) of
21 Part 1 of Division 3 of Title 2 of the Government Code.
22 Commencing July 1, 2018, the department shall provide a status
23 report to the Legislature on a semiannual basis, in compliance with
24 Section 9795 of the Government Code, until regulations are
25 adopted.
26 14197.1. (a) This section implements the state option in
27 subdivision (j) of Section 438.8 of Title 42 of the Code of Federal
28 Regulations.
29 (b) A Medi-Cal managed care plan shall comply with a
30 minimum 85 percent medical loss ratio (MLR) consistent with
31 Section 438.8 of Title 42 of the Code of Federal Regulations. The
32 ratio shall be calculated and reported for each MLR reporting year
33 by the Medi-Cal managed care plan consistent with Section 438.8
34 of Title 42 of the Code of Federal Regulations.
35 (c) A Medi-Cal managed care plan shall provide a remittance
36 for an MLR reporting year if the ratio for that MLR reporting year
37 does not meet the minimum MLR standard of 85 percent.
38 (d) For purposes of this section, the following definitions apply:

1 (1) "Medical loss ratio (MLR) reporting year" shall have the
2 same meaning as that term is defined in Section 438.8 of Title 42
3 of the Code of Federal Regulations.
4 (2) (A) "Medi-Cal managed care plan" means any individual,
5 organization, or entity that enters into a contract with the
6 department to provide services to enrolled Medi-Cal beneficiaries
7 pursuant to any of the following:
8 (i) Article 2.7 (commencing with Section 14087.3).
9 (ii) Article 2.8 (commencing with Section 14087.5).
10 (iii) Article 2.81 (commencing with Section 14087.96).
11 (iv) Article 2.9 (commencing with Section 14088).
12 (v) Article 2.91 (commencing with Section 14089).
13 (vi) Article 1 (commencing with Section 14200) of Chapter 8.
14 (vii) Article 7 (commencing with Section 14490) of Chapter 8.
15 (B) "Medi-Cal managed care plan" does not include dental
16 managed care plans that contract with the department pursuant to
17 this chapter or Chapter 8 (commencing with Section 14200).
18 (e) Notwithstanding Chapter 3.5 (commencing with Section
19 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
20 the department, without taking any further regulatory action, shall
21 implement, interpret, or make specific this section by means of
22 all-county letters, plan letters, plan or provider bulletins, or similar
23 instructions until the time any regulations are adopted. The
24 department shall adopt regulations by July 1, 2019, in accordance
25 with the requirements of Chapter 3.5 (commencing with Section
26 11340) of Part 1 of Division 3 of Title 2 of the Government Code.
27 Commencing July 1, 2018, the department shall provide a status
28 report to the Legislature on a semiannual basis, in compliance with
29 Section 9795 of the Government Code, until regulations are
30 adopted.
31 14197.2. (a) The Legislature finds and declares all of the
32 following:
33 (1) Designated public hospitals systems play an essential role
34 in the Medi-Cal program, providing high-quality care to a
35 disproportionate number of low-income Medi-Cal and uninsured
36 populations in the state. Because Medi-Cal covers approximately
37 one-third of the state's population, the strength of these essential
38 public health care systems is of critical importance to the health
39 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~~ *contract* services, including through fee-for-service, capitation, or other permissible manner. The rates of payment for ~~contracted~~ *contract* 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~~ *contract* 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

1 managed care plan is not in compliance with the requirements of
2 this subdivision, or is otherwise circumventing the purposes
3 thereof, to the material detriment of an applicable designated public
4 hospital system, and, independent of any remedy available to the
5 designated public hospital system, the department may reduce the
6 default assignment into the Medi-Cal managed care plan with
7 respect to all Medi-Cal managed care beneficiaries by up to 25
8 percent, so long as the other Medi-Cal managed care plan or
9 Medi-Cal managed care plans in the applicable county have the
10 capacity to receive the additional default membership. The
11 department's determination, whether to exercise discretion under
12 this paragraph, shall not be subject to judicial review. Nothing in
13 this paragraph shall be construed to preclude or otherwise limit
14 the right of any designated public hospital system to pursue a
15 breach of contract action in connection with the requirements of
16 this subdivision.
17 (6) Capitation rates paid by the department to a Medi-Cal
18 managed care plan shall account for the Medi-Cal managed care
19 plan's obligation to pay the directed payments to designated public
20 hospital systems in accordance with this subdivision. The
21 department may require Medi-Cal managed care plans and the
22 designated public hospital systems to submit information regarding
23 contract rates and expected utilization of services, at the times and
24 in the form and manner specified by the department. To the extent
25 consistent with federal law and actuarial standards of practice, the
26 department shall utilize the most recently available data, as
27 determined by the department, when accounting for the directed
28 payments required under this subdivision, and may account for
29 material adjustments, as appropriate and as determined by the
30 department, to contracts entered into between a Medi-Cal managed
31 care plan and a designated public hospital system.
32 (c) Commencing with the 2017–18 state fiscal year, and for
33 each state fiscal year thereafter, the department, in consultation
34 with the designated public hospital systems and each Medi-Cal
35 managed care plan, shall establish a program under which a
36 designated public hospital system may earn performance-based
37 quality incentive payments from the Medi-Cal managed care plan
38 they contract with in accordance with this subdivision.

1 (1) Payments shall be earned by each designated public hospital
2 system based on its performance in achieving identified targets
3 for quality of care.
4 (A) The department, in consultation with the designated public
5 hospital systems and each Medi-Cal managed care plan, shall
6 establish and provide a method for updating uniform performance
7 measures for the performance-based quality incentive payment
8 program and parameters for the designated public hospital systems
9 to select the applicable measures. The performance measures shall
10 advance at least one goal identified in the state's Medicaid quality
11 strategy. Measures shall not duplicate measures utilized in the
12 PRIME program established pursuant to Section 14184.50.
13 (B) Each designated public hospital system shall submit reports
14 to the department containing information required to evaluate its
15 performance on all applicable performance measures, at the times
16 and in the form and manner specified by the department. A
17 Medi-Cal managed care plan shall assist a designated public
18 hospital system in collecting information necessary for these
19 reports.
20 (2) The department, in consultation with each designated public
21 hospital system, shall determine a maximum amount that each
22 class *identified in paragraph (1) of subdivision (b)* may earn in
23 quality incentive payments for the state fiscal year.
24 (3) The department shall calculate the amount earned by each
25 designated public hospital system based on its performance score
26 established pursuant to paragraph (1).
27 (A) This amount shall be paid to the designated public hospital
28 system by each of its contracted Medi-Cal managed care ~~plan.~~
29 *plans.* If a designated public hospital system contracts with multiple
30 Medi-Cal managed care plans, the department shall identify each
31 Medi-Cal managed care plan's proportionate amount of the
32 designated public hospital system's payment. The timing and
33 amount of the distributions and any related reporting requirements
34 for interim payments shall be established and agreed to by the
35 designated public hospital system and each of the applicable
36 Medi-Cal managed care plans.
37 (B) A Medi-Cal managed care plan shall not terminate a contract
38 with a designated public hospital system for the purpose of
39 circumventing the payment obligations under this subdivision.

1 (C) Each Medi-Cal managed care plan shall be responsible for
2 payment of the quality incentive payments described in this
3 subdivision.
4 (4) Nothing in this subdivision shall be construed to replace or
5 otherwise prevent the continuation of prior quality incentive or
6 pay-for-performance payment mechanisms or the establishment
7 of new payment programs by any Medi-Cal managed care plan
8 and their contracted designated public hospital systems.
9 (5) The department shall provide appropriate funding to each
10 Medi-Cal managed care plan, to account for and to enable them
11 to make the quality incentive payments described in this
12 subdivision, through the incorporation into actuarially sound
13 capitation rates or any other federally permissible method. The
14 amounts designated by the department for the quality incentive
15 payments made pursuant to this subdivision shall be reserved for
16 the purposes of the performance-based quality incentive payment
17 program.
18 (d) In determining the uniform percentages described in
19 paragraph (2) of subdivision (b), and the aggregate size of the
20 quality incentive payment program described in paragraph (2) of
21 subdivision (c), the department shall consult with designated public
22 hospital systems to establish levels for these payments that, in
23 combination with one another, are projected to result in aggregate
24 payments that will advance the quality and access objectives
25 reflected in prior payment enhancement mechanisms for designated
26 public hospital systems. To the extent necessary to meet these
27 objectives or to comply with any federal requirements, the
28 department may, in consultation with the designated public hospital
29 systems, adjust or modify either or both the applicable percentages
30 or quality incentive payment program.
31 (e) The provisions of paragraphs (3) and (4) of subdivision (a),
32 and of subdivisions (b) and (c) shall be deemed incorporated into
33 each contract between a designated public hospital system and a
34 Medi-Cal managed care plan, and its subcontractor or designee,
35 as applicable, and any claim for breach of those provisions may
36 be brought directly in a court of competent jurisdiction.
37 (f) (1) The nonfederal share of the portion of the capitation
38 rates specifically associated with directed payments to designated
39 public hospital systems required under subdivision (b) and for the
40 quality incentive payments established pursuant to subdivision (c)

1 may consist of voluntary intergovernmental transfers of funds
2 provided by designated public hospitals and their affiliated
3 governmental entities, or other public entities, pursuant to Section
4 14164. Upon providing any intergovernmental transfer of funds,
5 each transferring entity shall certify that the transferred funds
6 qualify for federal financial participation pursuant to applicable
7 federal Medicaid laws, and in the form and manner specified by
8 the department. Any intergovernmental transfer of funds made
9 pursuant to this section shall be considered voluntary for purposes
10 of all federal laws. Notwithstanding any other law, the department
11 shall not assess the fee described in subdivision (d) of Section
12 14301.4 or any other similar fee.
13 (2) When applicable for voluntary intergovernmental transfers,
14 the department, in consultation with the designated public hospital
15 systems, shall develop and maintain a protocol to determine each
16 public entity's intergovernmental transfer amount in an applicable
17 state fiscal year for purposes of funding the nonfederal share
18 associated with payments pursuant to this section. The protocol
19 developed and maintained pursuant to this paragraph shall account
20 for any applicable contributions made by public entities to the
21 nonfederal share of Medi-Cal managed care expenditures,
22 including, but not limited to, contributions previously made
23 pursuant to Section 14182.15 or 14199.2. Nothing in this section
24 shall be construed to limit or otherwise alter any existing authority
25 of the department to accept intergovernmental transfers for
26 purposes of funding the nonfederal share of Medi-Cal managed
27 care expenditures.
28 (g) (1) This section shall be implemented only to the extent
29 that any necessary federal approvals are obtained and federal
30 financial participation is available and is not otherwise jeopardized.
31 (2) For any state fiscal year in which this section is implemented,
32 in whole or in part, and notwithstanding any other law, the
33 department shall not be required to make any payment to a
34 Medi-Cal managed care plan pursuant to Section 14182.15,
35 14199.2, or 14301.5.
36 (h) (1) The department shall seek any necessary federal
37 approvals for the directed payments and the quality incentive
38 payments set forth in this section.
39 (2) The department shall consult with the designated public
40 hospital systems with regard to the development and

1 implementation of the directed payment levels and the quality
2 incentive payments established pursuant to this section.
3 (3) The director, after consultation with the designated public
4 hospital systems, may modify the requirements set forth in this
5 section to the extent necessary to meet federal requirements or to
6 maximize available federal financial participation. In the event
7 federal approval is only available with significant limitations or
8 modifications, or in the event of changes to the federal Medicaid
9 program that result in a loss of funding currently available to the
10 designated public hospital systems, the department shall consult
11 with the designated public hospitals to consider alternative
12 methodologies.
13 (i) Notwithstanding Chapter 3.5 (commencing with Section
14 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
15 the department may implement, interpret, or make specific this
16 section by means of all-county letters, plan letters, provider
17 bulletins, or other similar instructions, without taking regulatory
18 action. The department shall make use of appropriate processes to
19 ensure that affected designated public hospital systems and
20 Medi-Cal managed care plans are timely informed of, and have
21 access to, applicable guidance issued pursuant to this authority,
22 and that this guidance remains publicly available until all payments
23 made pursuant to this section are finalized.
24 (j) For purposes of this section, the following definitions apply:
25 (1) "Contract services payments" means the amount paid or
26 payable to a designated public hospital system, including amounts
27 paid or payable under fee-for-service, capitation, prior to any
28 adjustments for service payment withholds or deductions, or other
29 basis, under a contract with a Medi-Cal managed care plan for
30 services, drugs, supplies or other items provided to a Medi-Cal
31 beneficiary enrolled in the Medi-Cal managed care plan. Contract
32 services includes all services, drugs, supplies, or other items the
33 designated public hospital system provides, or is responsible for
34 providing, or arranging or paying for, pursuant to a contract entered
35 into with a Medi-Cal managed care plan. In the event a Medi-Cal
36 managed care plan subcontracts or otherwise delegates
37 responsibility to a separate entity for either or both the arrangement
38 or payment of services, ~~"contracted~~ *"contract* services payments"
39 also include amounts paid or payable for the services provided by,
40 or otherwise the responsibility of, the designated public hospital

1 system that are within the scope of services of the subcontracted
2 or delegated arrangement so long as the designated public hospital
3 system holds a contract with the primary Medi-Cal managed care
4 plan.
5 (2) "Designated public hospital" shall have the *same* meaning
6 *as* set forth in subdivision (f) of Section 14184.10.
7 (3) "Designated public hospital system" means a designated
8 public hospital and its affiliated government entity clinics,
9 practices, and other health care providers, including the respective
10 affiliated hospital authority and county government entities
11 described in Chapter 5 (commencing with Section 101850) and
12 Chapter 5.5 (commencing with Section 101852), of Part 4 of
13 Division 101 of the Health and Safety Code.
14 (4) (A) "Medi-Cal managed care plan" means an applicable
15 organization or entity that enters into a contract with the department
16 pursuant to any of the following:
17 (i) Article 2.7 (commencing with Section 14087.3).
18 (ii) Article 2.8 (commencing with Section 14087.5).
19 (iii) Article 2.81 (commencing with Section 14087.96).
20 (iv) Article 2.91 (commencing with Section 14089).
21 (v) Chapter 8 (commencing with Section 14200).
22 (B) "Medi-cal managed care plan" does not include any of the
23 following:
24 (i) A mental health plan contracting to provide mental health
25 care for Medi-Cal beneficiaries pursuant to Chapter 8.9
26 (commencing with Section 14700).
27 (ii) A plan not covering inpatient services, such as primary care
28 case management plans, operating pursuant to Section 14088.85.
29 (iii) A Program of All-Inclusive Care for the Elderly
30 organization operating pursuant to Chapter 8.75 (commencing
31 with Section 14591).

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AMENDED IN ASSEMBLY APRIL 27, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

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.~~ *CalWORKs.*

LEGISLATIVE COUNSEL'S DIGEST

AB 227, as amended, 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 requires the State Department of Social Services to perform various administrative duties in connection with the CalWORKs program, including establishing rules and regulations*

ensuring the uniform statewide application of the schedule governing the payment of CalWORKs benefits.

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~~ *would, contingent upon the appropriation in the Budget Act of an amount sufficient to carry out the purposes of the bill, as determined by the department,* create the CalWORKs Educational Opportunity and Attainment ~~Program to~~ *Program. The bill would* 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~~ *equivalent as an ongoing adjustment to the recipient's monthly cash grant,* if the recipient meets certain eligibility criteria. *The bill would authorize a CalWORKs recipient to apply to receive education stipends totaling no more than $2,400 per year for enrollment in an education or training program leading to an associate's degree, career technical education program certificate, or bachelor's degree.* The bill would require a ~~recipient, when applying~~ *CalWORKs recipient who applies* for an education ~~bonus,~~ *incentive grant or stipend,* to submit evidence of completion of ~~the~~ *a high school* educational ~~program~~ *program, or enrollment in an education or training program, as applicable,* to the county. The bill would require the county, upon ~~verification of completion of the educational program,~~ *verification, as specified,* to certify that the recipient is eligible for ~~an education incentive grant and~~ *the grant or stipend and to* ensure that the recipient's monthly cash grant is ~~increased.~~ *increased, or that the recipient receives the stipend, as applicable.* 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~~ *would, contingent upon an appropriation of $20,000,000 in the annual Budget Act for this purpose, allocate* $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 bill would require that $10,000,000 of this amount be used specifically to support CalWORKs recipients in working toward completion of their high school diploma or its equivalent. The bill would require the board to submit a report to the Legislature, on or before March 31, 2019, regarding the additional services provided as a result of the appropriation, 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, 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.

Existing law continuously appropriates moneys from the General Fund to defray a portion of county costs under the CalWORKs program.

This bill would instead provide that the continuous appropriation would not be made for purposes of implementing the bill.

Vote: *2/3-majority*. Appropriation: ~~yes~~ *no*. Fiscal committee: yes. State-mandated local program: yes.

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) In California's high-skill economy, it is very difficult to get
4 a good, middle-class job without vocational education or a college
5 degree, let alone a high school diploma.
6 (b) This is a significant barrier to socioeconomic mobility for
7 California's highly vulnerable CalWORKs recipients, because as
8 many as 65 percent of CalWORKs recipients do not have a high
9 school education.
10 (c) Research has consistently shown that postsecondary
11 education boosts social mobility, particularly for those at the
12 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.~~

11341. (a) A CalWORKs recipient may apply to receive an education incentive grant in the amount of one hundred dollars ($100) per month for completion of a high school diploma or its equivalent, as an ongoing adjustment to the recipient's monthly cash grant.

(b) (1) A CalWORKs recipient may apply to receive education stipends totaling no more than two thousand four hundred dollars ($2,400) per year for enrollment in an education or training

program leading to a career technical education program certificate, an associate's degree, or a bachelor's degree.

(2) The stipend described in paragraph (1) shall be paid to a CalWORKs recipient at the outset of each term for which he or she is registered and shall be prorated according to the number of units or courses he or she is enrolled in as a percentage of full-time enrollment, as defined by the school or program in which he or she is enrolled. The department shall develop regulations establishing a schedule of payments by various term lengths and percentage of full-time enrollment wherein full-time enrollment for the year in any eligible program yields annual stipends totaling two thousand four hundred dollars ($2,400).

11342. (a) ~~When applying~~ *(1) A CalWORKs recipient who applies* for an education incentive ~~grant, a recipient~~ *grant pursuant to subdivision (a) of Section 11341* shall submit evidence of completion of the *high school* educational program to the county. A recipient is not eligible unless all of the following criteria are satisfied:

~~(1)~~

(A) The recipient completed ~~an~~ *a high school* educational program included in the recipient's welfare-to-work plan approved by the county.

~~(2)~~

(B) The recipient completed ~~an~~ *a high school* educational program offered by an accredited educational institution.

~~(3)~~

(C) The recipient completed the *high school* educational program while receiving CalWORKs assistance.

~~(b)~~

(2) Upon verification of completion of the *high school* educational ~~program,~~ *program described in paragraph (1),* 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 *subdivision (a) of* Section 11341.

(b) (1) A CalWORKs recipient who applies for an education stipend described in subdivision (b) of Section 11341 shall submit evidence of enrollment to the county. A recipient is not eligible unless all of the following criteria are satisfied:

(A) The recipient is enrolled in an education or training program that is included in the recipient's welfare-to-work plan approved by the county.

(B) The recipient is enrolled in an education or training program that is offered by an accredited educational institution.

(C) The recipient is enrolled in an education or training program described in subdivision (b) of Section 11341 while receiving CalWORKs assistance.

(2) Within 10 business days of verifying that a recipient is enrolled in an education or training program as described in paragraph (1), the county shall certify that the recipient is eligible for an education stipend and shall ensure that the recipient receives the stipend as prescribed in subdivision (b) of 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) If a CalWORKs recipient who receives an education stipend is unable to satisfactorily complete, as defined by the school or program of enrollment, a portion or all of the coursework for which he or she received a stipend, the subsequent stipend received by the recipient shall be reduced by the prorated amount of the previous stipend attributable to the portion of the coursework that was not satisfactorily completed. This subdivision shall not be construed to reduce a recipient's CalWORKs cash aid.

~~(b)~~

(c) A CalWORKs recipient is permanently ineligible for an education incentive grant *or education stipend* 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).~~ *11476.6).*

~~(c)~~

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

1 *11344. This article shall be operative only upon the*
2 *appropriation in the annual Budget Act of an amount sufficient to*
3 *carry out the purposes of this article, as determined annually by*
4 *the State Department of Social Services.*
5 SEC. 3. ~~The~~ *(a) (1) Contingent upon an appropriation in the*
6 *annual Budget Act for the purposes of this section, as described*
7 *in subdivision (c), the* sum of twenty million dollars ($20,000,000)
8 is hereby ~~appropriated from the General Fund~~ *allocated* to the
9 Board of Governors of the California Community Colleges to fund
10 services provided under the CalWORKs Recipients Education
11 Program (Article 5 (commencing with Section 79200) of Chapter
12 9 of Part 48 of Division 7 of Title 3 of the Education Code),
13 including, but not limited to, education and career counseling
14 services, employment development services, including job
15 development staff positions, and workstudy positions.
16 *(2) Ten million dollars ($10,000,000) of the amount described*
17 *in paragraph (1) shall be used solely to support CalWORKs*
18 *recipients in working toward completion of their high school*
19 *diploma or its equivalent.*
20 *(b) On or before March 31, 2019, the Board of Governors of*
21 *the California Community Colleges shall submit a report, in*
22 *accordance with Section 9795 of the Government Code, to the*
23 *Legislature containing information on the number and description*
24 *of additional services provided and number of CalWORKs*
25 *recipients served as a result of the appropriation described in*
26 *subdivision (a), including data and information regarding the use*
27 *of the sum described in paragraph (2) of subdivision (a), to serve*
28 *CalWORKs recipients pursuing a high school diploma or its*
29 *equivalent, and the number of recipients completing their high*
30 *school diploma or equivalent during the 2018 calendar year.*
31 *(c) This section shall become operative only upon the*
32 *appropriation of $20,000,000 in the annual Budget Act for the*
33 *purposes of this section.*
34 SEC. 4. If the Commission on State Mandates determines that
35 this act contains costs mandated by the state, reimbursement to
36 local agencies and school districts for those costs shall be made
37 pursuant to Part 7 (commencing with Section 17500) of Division
38 4 of Title 2 of the Government Code.

1 *SEC. 5. No appropriation pursuant to Section 15200 of the*
2 *Welfare and Institutions Code shall be made for purposes of*
3 *implementing this act.*

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AMENDED IN ASSEMBLY MARCH 16, 2017

AMENDED IN ASSEMBLY MARCH 6, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 414

Introduced by Assembly Member Medina

February 9, 2017

An act to add Section 69614.6 to the Government Code, relating to judgeships.

LEGISLATIVE COUNSEL'S DIGEST

AB 414, as amended, Medina. Suspension and allocation of vacant judgeships.

Existing law specifies the number of judges for the superior court of each county. Existing law allocates additional judgeships to the various counties in accordance with uniform standards for factually determining additional judicial need in each county, as updated and approved by the Judicial Council, pursuant to the Update of Judicial Needs Study, based on specified criteria, including, among others, workload standards that represent the average amount of time of bench and nonbench work required to resolve each case type.

This bill would require the suspension of ~~5~~ *4* vacant judgeships, as defined, from superior courts with more authorized judgeships than their assessed judicial need and would require the allocation of ~~5~~ *4* judgeships to superior courts with fewer authorized judgeships than their assessed judicial need. The bill would require the suspension ~~to be in accordance with a methodology approved by the Judicial Council, as specified, and would require the determination of a superior court's assessed judicial need to be in accordance with the above uniform~~

~~standards and be based on the criteria described above.~~ *and allocation of judgeships to be based on a superior court's assessed judicial need in accordance with the uniform standards described above.* The bill would require the Judicial Council, if a vacant judgeship is eligible for suspension, to promptly notify the~~ applicable courts,~~ *court with the vacant judgeship,* the Legislature, and the Governor that the judgeship ~~will be suspended.~~ *is subject to suspension, provide an adequate opportunity for public comment, and, after consideration of any comments received, determine if the vacant judgeship should be suspended. The bill would require the Judicial Council to promptly notify the court with the vacant judgeship, the Legislature, and the Governor of its decision regarding suspension of the judgeship.* The bill would provide that a court in which a vacant judgeship is suspended will not have its funding allocation reduced or any of its funding shifted or transferred as a result of, or in connection with, the suspension of a vacant judgeship.

This bill would also make a statement of legislative intent regarding the authority of the Legislature, the Governor, and the Chief Justice of California.

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

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

1 SECTION 1. It is the intent of the Legislature that this act shall
2 not be construed to limit any of the following:
3 (a) The authority of the Legislature to create and fund new
4 judgeships pursuant to Section 4 of Article VI of the California
5 Constitution.
6 (b) The authority of the Governor to appoint a person to fill a
7 vacancy pursuant to subdivision (c) of Section 16 of Article VI of
8 the California Constitution.
9 (c) The authority of the Chief Justice of California to assign
10 judges pursuant to subdivision (e) of Section 6 of Article VI of the
11 California Constitution.
12 SEC. 2. Section 69614.6 is added to the Government Code, to
13 read:
14 69614.6. (a) To provide for a more equitable distribution of
15 judgeships and~~ upon notice to the applicable courts, five~~ *pursuant*
16 *to the process set forth in subdivision (b), four* vacant judgeships

1 shall be suspended in superior courts with more authorized
2 judgeships than their assessed judicial need and ~~five~~ *four*
3 judgeships shall be allocated to superior courts with fewer
4 authorized judgeships than their assessed judicial need.
5 (b) *(1)* The suspension of vacant judgeships *and the allocation*
6 *of judgeships* pursuant to subdivision (a) shall be ~~in accordance~~
7 ~~with a methodology approved by the Judicial Council after~~
8 ~~solicitation of public comments. The determination of~~ *based on* a
9 superior court's assessed judicial need ~~shall be~~ in accordance with
10 the uniform standards for factually determining additional judicial
11 need in each county, as updated and approved by the Judicial
12 Council, pursuant to the Update of Judicial Needs Study, based
13 on the criteria set forth in subdivision (b) of Section 69614.
14 ~~(c)~~
15 *(2)* If a judgeship in a superior court becomes vacant, the Judicial
16 Council shall determine whether the judgeship is eligible for
17 suspension under the ~~methodology, standards, and criteria~~
18 *standards and criteria* described in ~~subdivision (b).~~ *paragraph*
19 *(1).* If the judgeship is eligible for suspension, the Judicial Council
20 shall promptly notify the ~~applicable courts,~~ *court with the vacant*
21 *judgeship,* the Legislature, and the Governor that the vacant
22 judgeship ~~shall be suspended.~~ *is subject to suspension, provide an*
23 *adequate opportunity for public comment, and, after consideration*
24 *of any comments received, determine if the vacant judgeship should*
25 *be suspended. The Judicial Council shall promptly notify the court*
26 *with the vacant judgeship, the Legislature, and the Governor of*
27 *its decision regarding suspension of the judgeship.*
28 ~~(d)~~
29 *(c)* (1) For purposes of this section only, a judgeship shall
30 become "vacant" when an incumbent judge relinquishes the office
31 through resignation, retirement, death, removal, or confirmation
32 to an appellate court judgeship during either of the following:
33 (A) At any time before the deadline to file a declaration of
34 intention to become a candidate for a judicial office pursuant to
35 Section 8023 of the Elections Code.
36 (B) After the deadline to file a declaration of intention to become
37 a candidate for a judicial office pursuant to Section 8023 of the
38 Elections Code if no candidate submits qualifying nomination
39 papers by the deadline pursuant to Section 8020 of the Elections
40 Code.

1 (2) For purposes of this section, a judgeship shall not become
2 "vacant" when an incumbent judge relinquishes the office as a
3 result of being defeated in an election for that office.
4 ~~(c)~~
5 *(d)* For purposes of this section only, the "suspension" of a
6 vacant judgeship means that the vacant judgeship may not be filled
7 by appointment or election, notwithstanding any other law, unless
8 an appropriation by the Legislature is made for the judgeship.
9 ~~(f)~~
10 *(e)* A court in which a vacant judgeship is suspended shall not
11 have its funding allocation reduced or any funding shifted or
12 transferred as a result of, or in connection with, the suspension of
13 a vacant judgeship pursuant to this section.

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AMENDED IN ASSEMBLY APRIL 18, 2017

AMENDED IN ASSEMBLY MARCH 27, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 1164

Introduced by Assembly Member Thurmond

February 17, 2017

An act to amend Section 8212 of the Education Code, and to amend Section 11460 of, and to add Section 11461.6 to, the Welfare and Institutions Code, relating to foster care.

LEGISLATIVE COUNSEL'S DIGEST

AB 1164, as amended, Thurmond. Foster care placement: funding.

Existing law, the Aid to Families with Dependent Children-Foster Care (AFDC-FC) program, requires foster care providers to be paid a per-child per-month rate, established by the State Department of Social Services, for the care and supervision of the child placed with the provider. Existing law defines "care and supervision" to include, among others, food, clothing, shelter, and daily supervision.

This bill would establish the Emergency Child Care Bridge Program for Foster Children (bridge program). The bill would authorize, contingent upon an appropriation of $11,000,000 in the 2017–18 fiscal year and $22,000,000 annually thereafter, county welfare departments to administer the bridge program and distribute ~~vouchers to~~ *vouchers, or payment, for child care and development services for* an eligible child who is placed with an approved resource family, a licensed or certified foster family, or an approved relative or nonrelative extended family member, or who is the child of a young parent involved in the child welfare system. The bill would require, for counties that choose

to participate, that county welfare departments determine eligibility for the bridge program and provide monthly payment either directly to the family or to the child care provider or provide a monthly voucher for child care, in an amount that is commensurate with the regional market rate, for up to 6 months following the child's initial placement, unless the child and ~~resource~~ family are able to access long-term, subsidized child care prior to the end of the 6-month period. The bill would allow eligibility for a child care payment or voucher to be extended for 6 months, at the discretion of the county welfare department, if the child and ~~resource~~ family have been unable to access long-term, subsidized child care during the initial 6-month period. The bill would require that each child receiving a monthly child care payment or voucher be provided with a child care navigator, as specified, and would authorize the county to establish local priorities in the implementation of the bridge program.

Existing law establishes the California Child Care Initiative Project for certain purposes, including increasing the availability of qualified child care programs in the state and establishing child care resource and referral programs to serve a defined geographic area.

This bill would require, contingent upon an appropriation of $2,500,000 in the 2017–18 fiscal year and $5,000,000 annually thereafter, each child care resource and referral program to provide a child care navigator to support children in foster ~~care and~~ *care,* children previously in foster care upon return to their home of ~~origin.~~ *origin, and children of parents involved in the child welfare system.* The bill would also require, contingent upon an appropriation of $2,000,000 in the 2017–18 fiscal year and $4,000,000 annually thereafter, the child care resource and referral program to provide trauma-informed training and coaching to child care providers working with children in the foster care system.

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

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

1 SECTION 1. Section 8212 of the Education Code is amended
2 to read:
3 8212. (a) For purposes of this article, child care resource and
4 referral programs, established to serve a defined geographic area,
5 shall provide the following services:

1 (1) Identification of the full range of existing child care services
2 through information provided by all relevant public and private
3 agencies in the areas of service, and the development of a resource
4 file of those services which shall be maintained and updated at
5 least quarterly. These services shall include, but not be limited to,
6 family day care homes, public and private day care programs,
7 full-time and part-time programs, and infant, preschool, and
8 extended care programs.
9 The resource file shall include, but not be limited to, the
10 following information:
11 (A) Type of program.
12 (B) Hours of service.
13 (C) Ages of children served.
14 (D) Fees and eligibility for services.
15 (E) Significant program information.
16 (2) (A) Establishment of a referral process which responds to
17 parental need for information and which is provided with full
18 recognition of the confidentiality rights of parents. Resource and
19 referral programs shall make referrals to licensed child day care
20 facilities. Referrals shall be made to unlicensed care facilities only
21 if there is no requirement that the facility be licensed. The referral
22 process shall afford parents maximum access to all referral
23 information. This access shall include, but is not limited to,
24 telephone referrals to be made available for at least 30 hours per
25 week as part of a full week of operation. Every effort shall be made
26 to reach all parents within the defined geographic area, including,
27 but not limited to, any of the following:
28 (i) Toll-free telephone lines.
29 (ii) Office space convenient to parents and providers.
30 (iii) Referrals in languages which are spoken in the community.
31 Each child care resource and referral program shall publicize its
32 services through all available media sources, agencies, and other
33 appropriate methods.
34 (B) (i) Provision of information to any person who requests a
35 child care referral of his or her right to view the licensing
36 information of a licensed child day care facility required to be
37 maintained at the facility pursuant to Section 1596.859 of the
38 Health and Safety Code and to access any public files pertaining
39 to the facility that are maintained by the State Department of Social
40 Services Community Care Licensing Division.

(ii) A written or oral advisement in substantially the following form will comply with the requirements of clause (i):

"State law requires licensed child day care facilities to make accessible to the public a copy of any licensing report pertaining to the facility that documents a facility visit or a substantiated complaint investigation. In addition, a more complete file regarding a child care licensee may be available at an office of the State Department of Social Services Community Care Licensing Division. You have the right to access any public information in these files."

(3) Maintenance of ongoing documentation of requests for service tabulated through the internal referral process. The following documentation of requests for service shall be maintained by all child care resource and referral programs:

(A) Number of calls and contacts to the child care information and referral program or component.

(B) Ages of children served.

(C) Time category of child care request for each child.

(D) Special time category, such as nights, weekends, and swing shift.

(E) Reason that the child care is needed.

This information shall be maintained in a manner that is easily accessible for dissemination purposes.

(4) Provision of technical assistance to existing and potential providers of all types of child care services. This assistance shall include, but not be limited to:

(A) Information on all aspects of initiating new child care services including, but not limited to, licensing, zoning, program and budget development, and assistance in finding this information from other sources.

(B) Information and resources that help existing child care services providers to maximize their ability to serve the children and parents of their community.

(C) Dissemination of information on current public issues affecting the local and state delivery of child care services.

(D) Facilitation of communication between existing child care and child-related services providers in the community served.

Services prescribed by this section shall be provided in order to maximize parental choice in the selection of child care to facilitate

the maintenance and development of child care services and resources.

(5) (A) (i) Contingent upon an appropriation of two million five hundred thousand dollars ($2,500,000) in the 2017–18 fiscal year and five million dollars ($5,000,000) annually thereafter for purposes of this subparagraph, provision of a child care navigator to support children in foster care, children previously in foster care upon return to their home of origin, and children of parents involved in the child welfare system, including the children of nonminor dependents. The navigator shall work with the child's resource family~~, social worker,~~ *licensed or certified foster family, or family with whom he or she is placed in an emergency or for a compelling reason, as described in Section 16519.5 of the Welfare and Institutions Code, and the child's social worker* and child and family team to assess child care opportunities appropriate to the child's age and needs, assist th~~e resource~~ family in identifying potential opportunities for an ongoing child care subsidy, assist the caregiver in completing appropriate child care program applications, and develop an overall, long-term child care plan for the child.

(ii) As a condition of receiving funds pursuant to this subparagraph, each resource and referral ~~agency~~ *program* shall develop and enter into a memorandum of understanding, contract, or other formal agreement with the county child welfare agency in order to facilitate interagency communication and, to the maximum extent possible, to leverage federal funding, including administrative funding, available pursuant to Title IV–E of the Social Security Act, to enhance the navigation support authorized under this subparagraph, or the resource and referral ~~agency~~ *program* shall explain, in writing, annually, why entering into a memorandum of understanding, contract, or other formal agreement with the county child welfare agency is not practical or feasible. ~~This section shall not limit the provision of child care navigation support to children who are in the foster care system, including children who are eligible for the Emergency Child Care Bridge Program for Foster Children established pursuant to Section 11461.6 of the Welfare and Institutions Code.~~ *Navigator services provided pursuant to this subparagraph shall be made available to any child in foster care, any child previously in foster care who has returned to his or her home of origin, and any child of parents*

1 *involved in the child welfare system, including any child who meets*
2 *the eligibility criteria for the Emergency Child Care Bridge*
3 *Program for Foster Children established pursuant to Section*
4 *11461.6 of the Welfare and Institutions Code. Eligibility for*
5 *navigator services shall not be contingent on a child's receipt of*
6 *a child care payment or voucher.*
7 (B) (i) Contingent upon an appropriation of two million dollars
8 ($2,000,000) in the 2017–18 fiscal year and four millions dollars
9 ($4,000,000) annually thereafter for purposes of this subparagraph,
10 provision of trauma-informed training and coaching to child care
11 providers working with children in the foster care system. Training
12 shall include, but not be limited to, infant and toddler development
13 and research-based, trauma-informed best care practices. Child
14 care providers shall be provided with coaching to assist them in
15 applying training techniques and strategies for working with
16 children in foster care.
17 (ii) As a condition of receiving funds pursuant to this
18 subparagraph, each resource and referral ~~agency,~~ *program,* in
19 coordination with the California Child Care Resource and Referral
20 Network, shall develop and enter into a memorandum of
21 understanding, contract, or other formal agreement with the county
22 child welfare agency in order to, to the maximum extent possible,
23 leverage federal funding, including training funds, available
24 pursuant to Title IV–E of the Social Security Act, to enhance the
25 training support authorized under this subparagraph, or the resource
26 and referral agency shall explain, in writing, annually, why entering
27 into a memorandum of understanding, contract, or other formal
28 agreement with the county child welfare agency is not practical
29 or feasible.
30 (b) (1) A program operating pursuant to this article shall, within
31 two business days of receiving notice, remove a licensed child day
32 care facility with a revocation or a temporary suspension order, or
33 that is on probation from the program's referral list.
34 (2) A program operating pursuant to this article shall, within
35 two business days of receiving notice, notify all entities, operating
36 a program under Article 3 (commencing with Section 8220) and
37 Article 15.5 (commencing with Section 8350) in the program's
38 jurisdiction, of a licensed child day care facility with a revocation
39 or a temporary suspension order, or that is on probation.

SEC. 2. Section 11460 of the Welfare and Institutions Code is amended to read:

11460. (a) (1) Foster care providers shall be paid a per child per month rate in return for the care and supervision of the AFDC-FC child placed with them. The department is designated the single organizational unit whose duty it shall be to administer a state system for establishing rates in the AFDC-FC program. State functions shall be performed by the department or by delegation of the department to county welfare departments or Indian tribes, consortia of tribes, or tribal organizations that have entered into an agreement pursuant to Section 10553.1.

(2) (A) Foster care providers that care for a child in a home-based setting described in paragraph (1) of subdivision (g) of Section 11461, or in a certified home or an approved resource family of a foster family agency, shall be paid the per child per month rate as set forth in subdivision (g) of Section 11461.

(B) The basic rate paid to either a certified family home or an approved resource family of a foster family agency shall be paid by the agency to the certified family home or approved resource family from the rate that is paid to the agency pursuant to Section 11463.

(b) "Care and supervision" includes food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, reasonable travel to the child's home for visitation, and reasonable travel for the child to remain in the school in which he or she is enrolled at the time of placement. Reimbursement for the costs of educational travel, as provided for in this subdivision, shall be made pursuant to procedures determined by the department, in consultation with representatives of county welfare and probation directors, and additional stakeholders, as appropriate.

(1) A child who meets the eligibility criteria of the Emergency Child Care Bridge Program for Foster Children, as established by Section 11461.6, may be provided with a voucher for child care services for the child for up to six months immediately following the child's placement as well as a child care navigator to assist the child and resource ~~family~~ *family, licensed or certified foster family, or family with whom the child is placed in an emergency or for a compelling reason, as described in Section 16519.5,* in accessing long-term subsidized child care.

(2) For a child or youth placed in a short-term residential therapeutic program or a group home, care and supervision shall also include reasonable administration and operational activities necessary to provide the items listed in this subdivision.

(3) For a child or youth placed in a short-term residential therapeutic program or a group home, care and supervision may also include reasonable activities performed by social workers employed by the program provider that are not otherwise considered daily supervision or administration activities.

(4) The department, in consultation with the California State Foster Parent Association, and other interested stakeholders, shall provide information to the Legislature, no later than January 1, 2017, regarding the availability and cost for liability and property insurance covering acts committed by children in care, and shall make recommendations for any needed program development in this area.

(c) It is the intent of the Legislature to establish the maximum level of financial participation in out-of-state foster care group home program rates for placements in facilities described in subdivision (h) of Section 11402.

(1) The department shall develop regulations that establish the method for determining the level of financial participation in the rate paid for out-of-state placements in facilities described in subdivision (h) of Section 11402. The department shall consider all of the following methods:

(A) Until December 31, 2016, a standardized system based on the rate classification level of care and services per child per month.

(B) The rate developed for a short-term residential therapeutic program pursuant to Section 11462.

(C) A system that considers the actual allowable and reasonable costs of care and supervision incurred by the out-of-state program.

(D) A system that considers the rate established by the host state.

(E) Any other appropriate methods as determined by the department.

(2) Reimbursement for the Aid to Families with Dependent Children-Foster Care rate to be paid to an out-of-state program described in subdivision (h) of Section 11402 shall only be paid to programs that have done all of the following:

1 (A) Submitted a rate application to the department, which shall
2 include, but not be limited to, both of the following:
3 (i) Commencing January 1, 2017, unless granted an extension
4 from the department pursuant to subdivision (d) of Section
5 11462.04, the equivalent of the mental health program approval
6 required in Section 4096.5.
7 (ii) Commencing January 1, 2017, unless granted an extension
8 from the department pursuant to subdivision (d) of Section
9 11462.04, the national accreditation required in paragraph (6) of
10 subdivision (b) of Section 11462.
11 (B) Maintained a level of financial participation that shall not
12 exceed any of the following:
13 (i) The current fiscal year's standard rate for rate classification
14 level 14 for a group home.
15 (ii) Commencing January 1, 2017, the current fiscal year's rate
16 for a short-term residential therapeutic program.
17 (iii) The rate determined by the ratesetting authority of the state
18 in which the facility is located.
19 (C) Agreed to comply with information requests, and program
20 and fiscal audits as determined necessary by the department.
21 (3) Except as specifically provided for in statute, reimbursement
22 for an AFDC-FC rate shall only be paid to a group home or
23 short-term residential therapeutic program organized and operated
24 on a nonprofit basis.
25 (d) A foster care provider that accepts payments, following the
26 effective date of this section, based on a rate established under this
27 section, shall not receive rate increases or retroactive payments as
28 the result of litigation challenging rates established prior to the
29 effective date of this section. This shall apply regardless of whether
30 a provider is a party to the litigation or a member of a class covered
31 by the litigation.
32 (e) Nothing shall preclude a county from using a portion of its
33 county funds to increase rates paid to family homes, foster family
34 agencies, group homes, and short-term residential therapeutic
35 programs within that county, and to make payments for specialized
36 care increments, clothing allowances, or infant supplements to
37 homes within that county, solely at that county's expense.
38 (f) Nothing shall preclude a county from providing a
39 supplemental rate to serve commercially sexually exploited foster
40 children to provide for the additional care and supervision needs

1 of these children. To the extent that federal financial participation
2 is available, it is the intent of the Legislature that the federal
3 funding shall be utilized.
4 SEC. 3. Section 11461.6 is added to the Welfare and
5 Institutions Code, to read:
6 11461.6. (a) The Legislature finds and declares the following:
7 (1) When a child is first placed in foster care he or she is in
8 crisis and in immediate need of a stable placement with a loving
9 resource family.
10 (2) Chapter 773 of the Statutes of 2015 and Chapter 612 of the
11 Statutes of 2016, commonly known as Continuum of Care Reform,
12 ~~aggravates California's shortage of~~ *reinforces California's need*
13 *for* foster care placements and demands that we address the major
14 barriers to parent recruitment.
15 (3) A major barrier to finding resource families for children,
16 especially young children, is the difficulty they experience in
17 accessing subsidized child care for the foster child.
18 (4) The difficulty accessing subsidized child care at the time of
19 placement, in addition to being a barrier to stability, can also lead
20 to delayed placement, subsequent placement changes, or sibling
21 separation, all of which retraumatize foster children.
22 (b) The Emergency Child Care Bridge Program for Foster
23 Children is hereby established, to be implemented at the discretion
24 of each county, for the purpose of stabilizing foster children with
25 families at the time of initial placement by providing a payment
26 or voucher for child care and development services for up to six
27 months immediately following the child's placement and by
28 providing the ~~resource~~ family with a child care navigator to assist
29 the family in accessing long-term subsidized child care.
30 (c) Contingent upon appropriation of eleven million dollars
31 ($11,000,000) in the 2017–18 fiscal year and twenty-two million
32 dollars ($22,000,000) annually thereafter for the purposes of this
33 section, the Emergency Child Care Bridge Program for Foster
34 Children shall be administered by county welfare departments that
35 choose to participate in the program.
36 (d) (1) As determined by the county welfare department, and
37 consistent with guidance issued jointly by the State Department
38 of Social Services and the State Department of Education, counties
39 may establish local priorities and may either provide payment
40 directly to the ~~resource~~ family or child care provider, or contract

with a local alternative payment ~~agency~~ *program* to distribute vouchers for child care.

(2) Counties that elect to provide payment directly to a *family or* child care provider ~~or to distribute vouchers~~ shall pay commensurate with the regional market rates, as described in Section 8357 of the Education Code.

(3) For counties that elect to contract with a local alternative payment agency, as described in Section 8220 of the Education Code, to distribute child care vouchers, the vouchers shall be in an amount commensurate with the regional market rates, as described in Section 8357 of the Education Code and the contract shall not displace, or result in the reduction of, an existing contract with a current local alternative payment program.

(e) (1) Participating county welfare departments shall determine eligibility of a child for the Emergency Child Care Bridge Program for Foster ~~Children.~~ *Children using the criteria outlined in paragraphs (2) and (3).*

(2) Family placements eligible to receive payment or a voucher for child care and developmental services include all of the following:

(A) Approved resource families and families that have a child placed with them ~~based on~~ *in* an emergency or for a compelling reason, as described in Section 16519.5.

(B) Currently licensed or certified foster care providers, as defined in Sections 1502 and 1506.5 of the Health and Safety Code.

(C) Currently approved relatives or nonrelative extended family members as described in Sections 309, 361.4, and 362.7.

(D) Parents under the jurisdiction of the juvenile court, including, but not limited to, nonminor dependent parents.

(3) A participating county welfare department may provide a payment or voucher if work responsibilities preclude resource families from being at home when the child for whom they have care and responsibility is not in school or for periods when the resource ~~family~~ *family, licensed or certified foster family, or family with whom the child is placed in an emergency or for a compelling reason, as described in Section 16519.5* is required to participate, without the child, in activities associated with parenting a child in foster care that are beyond the scope of ordinary parental duties,

including, but not limited to, attendance at administrative or judicial reviews, case conferences, and ~~resource~~ family training.

(f) Each child receiving a monthly child care payment or voucher shall be provided with a child care navigator, pursuant to paragraph (5) of subdivision (a) of Section 8212 of the Education Code, who shall work directly with the child's family, social worker, and the child and family team to assist in accessing child care at the time of placement as well as long-term, subsidized child care for the child, as necessary.

(g) Each child receiving a monthly child care payment or voucher shall be eligible to receive the payment or voucher for up to six months. If the child and family access long-term, subsidized child care prior to the end of the six-month period covered by the payment or voucher, eligibility for the monthly payment or voucher shall terminate upon enrollment in long-term, subsidized child care.

(h) Eligibility for the monthly payment or voucher may be extended beyond the initial six-month period for an additional six-month period, not to exceed 12 months in total, at the discretion of the county welfare department, if the child and family have been unable to access long-term, subsidized child care during the initial six-month period.

(i) The department shall seek all federal approvals necessary to claim federal reimbursement under Title IV–E of the Social Security Act in order to maximize state and local funding for child care.

(j) This section shall not be interpreted to create an entitlement to child care payment or voucher.

(k) The program established pursuant to this section is intended to complement county child welfare agency efforts to recruit, retain, and support resource families as described in Section 16003.5, and any funding provided to counties pursuant to this section shall supplement those county activities to support the goals of Chapter 773 of the Statutes of 2015 and Chapter 612 of the Statutes of 2016.

O

AMENDED IN ASSEMBLY MAY 8, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 1200

Introduced by Assembly Member Cervantes

February 17, 2017

An act to add Article 4 (commencing with Section 9120) to Chapter 2 of Division 8.5 of the Welfare and Institutions Code, relating to aging.

LEGISLATIVE COUNSEL'S DIGEST

AB 1200, as amended, Cervantes. Aging and Disabilities Resource Connection program.

Existing law, the Mello-Granlund Older Californians Act, establishes the California Department of Aging, and states that the mission of the department is to provide leadership to the area agencies on aging in developing systems of home- and community-based services that maintain individuals in their own homes or least restrictive homelike environments.

Existing law vests in the Department of Rehabilitation the responsibility and authority for the encouragement of the planning, development, and funding of independent living centers, which are private, nonprofit organizations that provide specified services to individuals with disabilities, in order to assist those individuals in their attempts to live fuller and freer lives outside institutions.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides that Medi-Cal long-term services and supports, including In-Home Supportive Services (IHSS),

Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP) services, and certain skilled nursing facility and subacute care services, shall be covered services by a specified date under managed care health plan contracts for beneficiaries residing in counties participating in the Coordinated Care Initiative.

This bill would establish the Aging and Disability Resource Connection (ADRC) program, to be administered by the California Department of Aging, to provide information to consumers and their families on available long-term services and supports (LTSS) programs and to assist older adults, caregivers, and persons with disabilities in accessing LTSS programs at the local level. The bill would require the department to establish the Aging and Disability Resource Connection Advisory Committee as the primary ~~advise r~~ *adviser* in the ongoing development and implementation of the ADRC program. The bill would require the department, in consultation with the advisory committee, to formulate criteria for designation and approval of local ADRC program sites, and would specify the services offered by, and responsibilities of, a program site. The bill would require the department and the State Department of Health Care Services to enter into a memorandum of understanding ~~with the federal Centers for Medicare and Medicaid Services to authorize local government agencies to claim federal Medicaid~~ *to explore* reimbursement for qualified administrative activities performed pursuant to these provisions.

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

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) California's long-term services and supports (LTSS) system
4 is plagued by fragmentation of programs at the state, regional, and
5 local levels. In many communities, multiple agencies administer
6 LTSS and have complex, fragmented, and often duplicative intake,
7 assessment, and eligibility functions. This fragmentation results
8 in a lack of access to coordinated services. As a result, consumers
9 and their families struggle to identify and access necessary home-
10 and community-based services, resulting in increased likelihood
11 of hospitalization and institutional placements.

1 (b) In 2003, the federal Administration for Community Living
2 and the federal Centers for Medicare and Medicaid Services
3 established a joint funding opportunity through the Aging and
4 Disability Resource Center (ADRC) initiative, which was designed
5 to provide visible and trusted sources of information, one-on-one
6 counseling, and streamlined access to LTSS.
7 (c) ADRCs build on the strength of existing community
8 agencies, including area agencies on aging and independent living
9 centers, to provide a more coordinated system of information and
10 access for all persons seeking LTSS to minimize confusion,
11 enhance individual choice, and support informed decisionmaking.
12 (d) In California, ADRC partnerships exist in eight areas of the
13 state that facilitate access to LTSS based on individuals' needs,
14 preferences, and goals.
15 (e) California's ADRC Advisory Committee engages
16 stakeholders in identifying and implementing strategies to
17 strengthen, sustain, and expand ADRC services throughout the
18 state.
19 SEC. 2. Article 4 (commencing with Section 9120) is added
20 to Chapter 2 of Division 8.5 of the Welfare and Institutions Code,
21 to read:
22
23 Article 4. Aging and Disability Resource Connection Program
24
25 9120. (a) There is hereby established an Aging and Disability
26 Resource Connection (ADRC) program to provide information to
27 consumers and their families on available long-term services and
28 supports (LTSS) programs and to assist older adults, caregivers,
29 and persons with disabilities in accessing LTSS programs at the
30 local level.
31 (b) This article shall be administered by the California
32 Department of Aging. The department shall enter into interagency
33 agreements with the Department of Rehabilitation and the State
34 Department of Health Care Services for purposes of implementing
35 this article.
36 9121. (a) The department shall establish the Aging and
37 Disability Resource Connection Advisory Committee as the
38 primary adviser to the department, the Department of
39 Rehabilitation, and the State Department of Health Care Services

in the ongoing development and implementation of the ADRC program.

(b) The advisory committee shall do all of the following:

(1) Consider high-level aspects of the ADRC program operations and related systemwide issues.

(2) Provide input and recommendations to the departments in developing ADRC program policies and procedures.

(3) Serve as the forum for ADRC stakeholders to discuss evolving federal guidance, funding opportunities, and best practices.

9122. (a) The department, in consultation with the advisory committee, shall formulate criteria for designation and approval of local ADRC program sites.

(b) Area agencies on aging and independent living centers shall be the core local partners in developing ADRC program sites, but the department may work with other local partners in developing ADRC program sites.

(c) An ADRC program site shall provide all of the following:

(1) Enhanced information and referral services and other assistance at hours that are convenient for the public.

(2) Options counseling concerning available LTSS programs and public and private benefits programs.

(3) Short-term service coordination.

(4) Transition services from hospitals to home and from skilled nursing facilities to the community.

(d) An ADRC program site shall do all of the following:

(1) Provide services within the geographic area served.

(2) Provide information to the public about the services provided by the site.

(3) Submit to the department all reports and data required or requested by the department.

~~(e) The department, in consultation with the advisory committee, shall consider establishing ADRC program sites to cover all geographic regions of the state in order to provide services to the maximum number of consumers and families in the state.~~

(e) The department shall consult with the advisory committee when exploring steps to establish ADRC program sites statewide.

9123. The department and the State Department of Health Care Services shall enter into a memorandum of understanding ~~with the federal Centers for Medicare and Medicaid Services to authorize~~

1 ~~local government agencies to claim federal Medicaid~~
2 ~~reimbursement~~ *to explore reimbursement* for qualified
3 administrative activities performed pursuant to this article,
4 consistent with Section 14132.47.

O

AMENDED IN ASSEMBLY APRIL 19, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 1401

Introduced by Assembly Member Maienschein

February 17, 2017

An act to amend Section 340 of the Welfare and Institutions Code, relating to juveniles.

LEGISLATIVE COUNSEL'S DIGEST

AB 1401, as amended, Maienschein. Juveniles: protective custody warrant.

Existing law establishes the jurisdiction of the juvenile court, which is permitted to adjudge certain children to be dependents of the court under certain circumstances, including when the child is abused, a parent or guardian fails to adequately supervise or protect the child, as specified, or a parent or guardian fails to provide the child with adequate food, clothing, shelter, or medical treatment. Existing law requires a proceeding in the juvenile court to declare a child to be a dependent child of the court to be commenced by the filing with the court, by the social worker, of a petition in conformity with specified requirements. Existing law authorizes the court to issue a protective custody warrant for a minor under certain circumstances, including when a petition has been filed in the juvenile court alleging that the minor comes within the jurisdiction of the juvenile court as a dependent or when a dependent minor has run away from his or her court-ordered placement.

This bill would authorize the court to issue a protective custody warrant, without filing a petition in the juvenile court alleging that the minor comes within the jurisdiction of the juvenile court as a dependent, if there is probable cause to believe the minor comes within the

jurisdiction of the juvenile court as a dependent, there is a substantial danger to the ~~physical or emotional health, or both,~~ *safety or physical health* of the child, and there are no reasonable means to protect the ~~child~~ *child's safety or physical health* without removal. *The bill would require any child taken into protective custody under these provisions to immediately be delivered to the social worker who shall investigate the facts and circumstances of the child and the facts surrounding the child being taken into custody and attempt to maintain the child with the child's family through the provision of services. By imposing additional duties on county social workers, this bill would impose a state-mandated local program.*

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

This bill would provide that 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:

1 SECTION 1. Section 340 of the Welfare and Institutions Code
2 is amended to read:
3 340. (a) Whenever a petition has been filed in the juvenile
4 court alleging that a minor comes within Section 300 and praying
5 for a hearing on that petition, or whenever any subsequent petition
6 has been filed praying for a hearing in the matter of the minor and
7 it appears to the court that the circumstances of his or her home
8 environment may endanger the health, person, or welfare of the
9 minor, or whenever a dependent minor has run away from his or
10 her court-ordered placement, a protective custody warrant may be
11 issued immediately for the minor.
12 (b) A protective custody warrant may be issued without filing
13 a petition under Section 300 if the court finds probable cause to
14 support all of the following:
15 (1) The child is a person described in Section 300.
16 (2) There is a substantial danger to the ~~physical or emotional~~
17 ~~health, or both,~~ *safety or physical health* of the child.

(3) There are no reasonable means to protect the ~~child~~ *child's safety or physical health* without removal.

(c) Any child taken into protective custody pursuant to this section shall immediately be delivered to the social worker who shall investigate, pursuant to Section 309, the facts and circumstances of the child and the facts surrounding the child being taken into custody and attempt to maintain the child with the child's family through the provision of services.

(d) Nothing in this section is intended to limit any other circumstance permitting a magistrate to issue a warrant for a person.

SEC. 2. To the extent that this act has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by the 2011 Realignment Legislation within the meaning of Section 36 of Article XIII of the California Constitution, it shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. Any new program or higher level of service provided by a local agency pursuant to this act above the level for which funding has been provided shall not require a subvention of funds by the state or otherwise be subject to Section 6 of Article XIIIB of the California Constitution.

O

SENATE BILL No. 37

Introduced by Senator Roth
(Principal coauthor: Assembly Member Cervantes)

December 5, 2016

An act to amend Section 97.70 of the Revenue and Taxation Code, relating to local government finance.

LEGISLATIVE COUNSEL'S DIGEST

SB 37, as introduced, Roth. 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.

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

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

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

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

1 SECTION 1. Section 97.70 of the Revenue and Taxation Code
2 is amended to read:
3 97.70. Notwithstanding any other law, for the 2004–05 fiscal
4 year and for each fiscal year thereafter, all of the following apply:
5 (a) (1) (A) The auditor shall reduce the total amount of ad
6 valorem property tax revenue that is otherwise required to be
7 allocated to a county's Educational Revenue Augmentation Fund
8 by the countywide vehicle license fee adjustment amount.
9 (B) If, for the fiscal year, after complying with Section 97.68
10 there is not enough ad valorem property tax revenue that is
11 otherwise required to be allocated to a county Educational Revenue
12 Augmentation Fund for the auditor to complete the allocation
13 reduction required by subparagraph (A), the auditor shall
14 additionally reduce the total amount of ad valorem property tax
15 revenue that is otherwise required to be allocated to all school
16 districts and community college districts in the county for that

1 fiscal year by an amount equal to the difference between the
2 countywide vehicle license fee adjustment amount and the amount
3 of ad valorem property tax revenue that is otherwise required to
4 be allocated to the county Educational Revenue Augmentation
5 Fund for that fiscal year. This reduction for each school district
6 and community college district in the county shall be the percentage
7 share of the total reduction that is equal to the proportion that the
8 total amount of ad valorem property tax revenue that is otherwise
9 required to be allocated to the school district or community college
10 district bears to the total amount of ad valorem property tax revenue
11 that is otherwise required to be allocated to all school districts and
12 community college districts in a county. For purposes of this
13 subparagraph, "school districts" and "community college districts"
14 do not include any districts that are excess tax school entities, as
15 defined in Section 95.
16 (2) The countywide vehicle license fee adjustment amount shall
17 be allocated to the Vehicle License Fee Property Tax Compensation
18 Fund that shall be established in the treasury of each county.
19 (b) (1) The auditor shall allocate moneys in the Vehicle License
20 Fee Property Tax Compensation Fund according to the following:
21 (A) Each city in the county shall receive its vehicle license fee
22 adjustment amount.
23 (B) Each county and city and county shall receive its vehicle
24 license fee adjustment amount.
25 (2) The auditor shall allocate one-half of the amount specified
26 in paragraph (1) on or before January 31 of each fiscal year, and
27 the other one-half on or before May 31 of each fiscal year.
28 (c) For purposes of this section, all of the following apply:
29 (1) "Vehicle license fee adjustment amount" for a particular
30 city, county, or a city and county means, subject to an adjustment
31 under paragraph (2) and Section 97.71, all of the following:
32 (A) For the 2004–05 fiscal year, an amount equal to the
33 difference between the following two amounts:
34 (i) The estimated total amount of revenue that would have been
35 deposited to the credit of the Motor Vehicle License Fee Account
36 in the Transportation Tax Fund, including any amounts that would
37 have been certified to the Controller by the auditor of the County
38 of Ventura under subdivision (j) of Section 98.02, as that section
39 read on January 1, 2004, for distribution under the law as it read
40 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

1 jurisdiction of the entity, as reflected in the equalized assessment
2 roll for those fiscal years. For the first fiscal year for which a
3 change in a city's jurisdictional boundaries first applies, the
4 percentage change in gross taxable assessed valuation from the
5 prior fiscal year to the current fiscal year shall be calculated solely
6 on the basis of the city's previous jurisdictional boundaries, without
7 regard to the change in that city's jurisdictional boundaries. For
8 each following fiscal year, the percentage change in gross taxable
9 assessed valuation from the prior fiscal year to the current fiscal
10 year shall be calculated on the basis of the city's current
11 jurisdictional boundaries.
12 (ii) The amount described in clause (i) shall be adjusted as
13 follows:
14 (I) If the amount described in subclause (I) of clause (i) for a
15 particular city, county, or city and county is greater than the amount
16 described in subparagraph (A) for that city, county, or city and
17 county, the amount described in clause (i) shall be increased by
18 an amount equal to this difference.
19 (II) If the amount described in subclause (I) of clause (i) for a
20 particular city, county, or city and county is less than the amount
21 described in subparagraph (A) for that city, county, or city and
22 county, the amount described in clause (i) shall be decreased by
23 an amount equal to this difference.
24 (C) For the 2006–07 fiscal year and for each fiscal year
25 thereafter, the sum of the following two amounts:
26 (i) The vehicle license fee adjustment amount for the prior fiscal
27 year, if Section 97.71 and clause (ii) of subparagraph (B) did not
28 apply for that fiscal year, for that city, county, and city and county.
29 (ii) The product of the following two amounts:
30 (I) The amount described in clause (i).
31 (II) The percentage change from the prior fiscal year to the
32 current fiscal year in gross taxable assessed valuation within the
33 jurisdiction of the entity, as reflected in the equalized assessment
34 roll for those fiscal years. For the first fiscal year for which a
35 change in a city's jurisdictional boundaries first applies, the
36 percentage change in gross taxable assessed valuation from the
37 prior fiscal year to the current fiscal year shall be calculated solely
38 on the basis of the city's previous jurisdictional boundaries, without
39 regard to the change in that city's jurisdictional boundaries. For
40 each following fiscal year, the percentage change in gross taxable

1 assessed valuation from the prior fiscal year to the current fiscal
2 year shall be calculated on the basis of the city's current
3 jurisdictional boundaries.
4 *(2) Notwithstanding paragraph (1), "vehicle license fee*
5 *adjustment amount," for a city incorporating after January 1,*
6 *2004, and on or before January 1, 2012, means the following:*
7 *(A) For the 2017–18 fiscal year, the quotient derived from the*
8 *following fraction:*
9 *(i) The numerator is the product of the following two amounts:*
10 *(I) The sum of the most recent vehicle license fee adjustment*
11 *amounts determined for all cities in the county.*
12 *(II) The population of the incorporating city.*
13 *(ii) The denominator is the sum of the populations of all cities*
14 *in the county.*
15 *(B) For the 2018–19 fiscal year, and for each fiscal year*
16 *thereafter, the sum of the following two amounts:*
17 *(i) The vehicle license fee adjustment amount for the prior fiscal*
18 *year.*
19 *(ii) The product of the following two amounts:*
20 *(I) The amount described in clause (i).*
21 *(II) The percentage change from the prior fiscal year to the*
22 *current fiscal year in gross taxable assessed valuation within the*
23 *jurisdiction of the entity, as reflected in the equalized assessment*
24 *roll for those fiscal years.*
25 ~~(2)~~
26 *(3)* For the 2013–14 fiscal year, the vehicle license fee
27 adjustment amount that is determined under subparagraph (C) of
28 paragraph (1) for the County of Orange shall be increased by
29 fifty-three million dollars ($53,000,000). For the 2014–15 fiscal
30 year and each fiscal year thereafter, the calculation of the vehicle
31 license fee adjustment amount for the County of Orange under
32 subparagraph (C) of paragraph (1) shall be based on a prior fiscal
33 year amount that reflects the full amount of this one-time increase
34 of fifty-three million dollars ($53,000,000).
35 ~~(3)~~
36 *(4)* "Countywide vehicle license fee adjustment amount" means,
37 for any fiscal year, the total sum of the amounts described in
38 paragraphs ~~(1)~~ *(1), (2),* and ~~(2)~~ *(3)* for a county or city and county,
39 and each city in the county.
40 ~~(4)~~

1 *(5)* On or before June 30 of each fiscal year, the auditor shall
2 report to the Controller the vehicle license fee adjustment amount
3 for the county and each city in the county for that fiscal year.
4 (d) For the 2005–06 fiscal year and each fiscal year thereafter,
5 the amounts determined under subdivision (a) of Section 96.1, or
6 any successor to that provision, shall not reflect, for a preceding
7 fiscal year, any portion of any allocation required by this section.
8 (e) For purposes of Section 15 of Article XI of the California
9 Constitution, the allocations from a Vehicle License Fee Property
10 Tax Compensation Fund constitute successor taxes that are
11 otherwise required to be allocated to counties and cities, and as
12 successor taxes, the obligation to make those transfers as required
13 by this section shall not be extinguished nor disregarded in any
14 manner that adversely affects the security of, or the ability of, a
15 county or city to pay the principal and interest on any debts or
16 obligations that were funded or secured by that city's or county's
17 allocated share of motor vehicle license fee revenues.
18 (f) This section shall not be construed to do any of the following:
19 (1) Reduce any allocations of excess, additional, or remaining
20 funds that would otherwise have been allocated to county
21 superintendents of schools, cities, counties, and cities and counties
22 pursuant to clause (i) of subparagraph (B) of paragraph (4) of
23 subdivision (d) of Sections 97.2 and 97.3 or Article 4 (commencing
24 with Section 98) had this section not been enacted. The allocations
25 required by this section shall be adjusted to comply with this
26 paragraph.
27 (2) Require an increased ad valorem property tax revenue
28 allocation or increased tax increment allocation to a community
29 redevelopment agency.
30 (3) Alter the manner in which ad valorem property tax revenue
31 growth from fiscal year to fiscal year is otherwise determined or
32 allocated in a county.
33 (4) Reduce ad valorem property tax revenue allocations required
34 under Article 4 (commencing with Section 98).
35 (g) Tax exchange or revenue sharing agreements, entered into
36 prior to the operative date of this section, between local agencies
37 or between local agencies and nonlocal agencies are deemed to be
38 modified to account for the reduced vehicle license fee revenues
39 resulting from the act that added this section. These agreements
40 are modified in that these reduced revenues are, in kind and in lieu

1 thereof, replaced with ad valorem property tax revenue from a
2 Vehicle License Fee Property Tax Compensation Fund or an
3 Educational Revenue Augmentation Fund.
4 SEC. 2. If the Commission on State Mandates determines that
5 this act contains costs mandated by the state, reimbursement to
6 local agencies and school districts for those costs shall be made
7 pursuant to Part 7 (commencing with Section 17500) of Division
8 4 of Title 2 of the Government Code.

O

AMENDED IN SENATE MARCH 20, 2017

SENATE BILL No. 39

Introduced by Senator Roth
(Principal coauthors: Assembly Members Cervantes and Obernolte)
(Coauthor: Assembly Member Rodriguez)

December 5, 2016

An act to add Section 69614.5 to the Government Code, relating to judgeships.

LEGISLATIVE COUNSEL'S DIGEST

SB 39, as amended, Roth. Suspension and allocation of judgeships.

Existing law specifies the number of judges for the superior court of each county. Existing law allocates additional judgeships to the various counties in accordance with uniform standards for factually determining additional judicial need in each county, as updated and approved by the Judicial Council, pursuant to the Update of Judicial Needs Study, based on specified criteria, including, among others, workload standards that represent the average amount of time of bench and nonbench work required to resolve each case type.

This bill would require the suspension of 4 vacant judgeships, as defined, in superior courts with more authorized judgeships than their assessed judicial need. The bill would require the allocation of 4 judgeships to superior courts with fewer authorized judgeships than their assessed judicial need and would require the judgeships to be funded using existing appropriations for the compensation of superior court judges. The bill would require the suspension to be in accordance with a methodology approved by the Judicial Council, as specified, and would require the determination of a superior court's assessed judicial need to be in accordance with the above uniform standards and be based

on the criteria described above. The bill would require the Judicial Council, if a vacant judgeship is eligible for suspension, to promptly notify the applicable courts, the Legislature, and the Governor that the judgeship will be suspended, subject to approval by the Governor.

This bill would also make a statement of legislative intent regarding the authority of the Legislature, the Governor, and the Chief Justice of California.

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

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

1 SECTION 1. It is the intent of the Legislature that this act shall
2 not be construed to limit any of the following:
3 (a) The authority of the Legislature to create and fund new
4 judgeships pursuant to Section 4 of Article VI of the California
5 Constitution.
6 (b) The authority of the Governor to appoint a person to fill a
7 vacancy pursuant to subdivision (c) of Section 16 of Article VI of
8 the California Constitution.
9 (c) The authority of the Chief Justice of California to assign
10 judges pursuant to subdivision (e) of Section 6 of Article VI of the
11 California Constitution.
12 SEC. 2. Section 69614.5 is added to the Government Code, to
13 read:
14 69614.5. (a) To provide for a more equitable distribution of
15 judgeships, and pursuant to the requirements described in
16 subdivision (d), both of the following actions shall occur:
17 (1) Four vacant judgeships shall be suspended in superior courts
18 with more authorized judgeships than their assessed judicial need
19 pursuant to subdivision (c).
20 (2) Four judgeships shall be allocated to superior courts with
21 fewer authorized judgeships than their assessed judicial need
22 pursuant to subdivision (c). The four judgeships shall be funded
23 using existing appropriations for the compensation of superior
24 court judges.
25 (b) The suspension of vacant judgeships pursuant to subdivision
26 (a) shall be in accordance with a methodology approved by the
27 Judicial Council after solicitation of public comments.

1 (c) The determination of a superior court's assessed judicial
2 need shall be in accordance with the uniform standards for factually
3 determining additional judicial need in each county, as updated
4 and approved by the Judicial Council, pursuant to the Update of
5 Judicial Needs Study, based on the criteria set forth in subdivision
6 (b) of Section 69614.
7 (d) If a judgeship in a superior court becomes vacant, the Judicial
8 Council shall determine whether the judgeship is eligible for
9 suspension under the methodology, standards, and criteria
10 described in subdivisions (b) and (c). If the judgeship is eligible
11 for suspension, the Judicial Council shall promptly notify the
12 applicable courts, the Legislature, and the Governor that the vacant
13 judgeship shall be suspended, subject to approval by the Governor
14 in compliance with subdivision (c) of Section 16 of Article VI of
15 the California Constitution.
16 (e) (1) For purposes of this section only, a judgeship ~~shall~~
17 ~~become~~ *is* "vacant" when an incumbent judge relinquishes the
18 office through resignation, retirement, death, removal, or
19 confirmation to an appellate court judgeship during either of the
20 following:
21 (A) At any time before the deadline to file a declaration of
22 intention to become a candidate for a judicial office pursuant to
23 Section 8023 of the Elections Code.
24 (B) After the deadline to file a declaration of intention to become
25 a candidate for a judicial office pursuant to Section 8023 of the
26 Elections Code if no candidate submits qualifying nomination
27 papers by the deadline pursuant to Section 8020 of the Elections
28 Code.
29 (2) For purposes of this section, a judgeship ~~shall not become~~
30 *is not* "vacant" when an incumbent judge relinquishes the office
31 as a result of being defeated in an election for that office.
32 (f) For purposes of this section only, the "suspension" of a
33 vacant judgeship means that the vacant judgeship may not be filled
34 by appointment or election, notwithstanding any other law, unless
35 an appropriation by the Legislature is made for the judgeship.
36 (g) A court in which a vacant judgeship is suspended shall not
37 have the court's funding allocation reduced or any of its funding

1 shifted or transferred as a result of, or in connection with, the
2 suspension of a vacant judgeship pursuant to this section.

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AMENDED IN SENATE MAY 2, 2017

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, 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, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 171, as amended, Hernandez. Medi-Cal: Medi-Cal managed care plans.

(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, 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 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,~~ *plan,* 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~~ *being required to make* 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: yes. Fiscal committee: yes. State-mandated local program: no.

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

1 SECTION 1. It is the intent of the Legislature to implement
2 the revisions to federal regulations governing Medicaid managed
3 care plans at Parts 431, 433, 438, 440, 457, and 495 of Title 42 of
4 the Code of Federal Regulations, as amended May 6, 2016, as
5 published in the Federal Register (81 Fed. Reg. 27498).
6 SEC. 2. Section 10951 of the Welfare and Institutions Code is
7 amended to read:
8 10951. (a) (1) A person is not entitled to a hearing pursuant
9 to this chapter unless he or she files his or her request for the same
10 within 90 days after the order or action complained of.
11 (2) Notwithstanding paragraph (1), a person shall be entitled to
12 a hearing pursuant to this chapter if he or she files the request more
13 than 90 days after the order or action complained of and there is
14 good cause for filing the request beyond the 90-day period. The
15 director may determine whether good cause exists.

1 (b) (1) Notwithstanding subdivision (a), a person may request
2 a hearing pursuant to this chapter involving a Medi-Cal managed
3 care plan within 120 calendar days after the order or action
4 complained of.
5 (2) Notwithstanding paragraph (1), a person shall be entitled to
6 a hearing pursuant to this chapter if he or she files the request more
7 than 120 calendar days after the order or action complained of and
8 there is good cause for filing the request beyond the 120-calendar
9 day period. The director may determine whether good cause exists.
10 (c) For purposes of this section, "good cause" means a
11 substantial and compelling reason beyond the party's control,
12 considering the length of the delay, the diligence of the party
13 making the request, and the potential prejudice to the other party.
14 The inability of a person to understand an adequate and
15 language-compliant notice, in and of itself, shall not constitute
16 good cause. The department shall not grant a request for a hearing
17 for good cause if the request is filed more than 180 days after the
18 order or action complained of.
19 (d) This section shall not preclude the application of the
20 principles of equity jurisdiction as otherwise provided by law.
21 (e) Notwithstanding the Administrative Procedure Act (Chapter
22 3.5 (commencing with Section 11340) of Part 1 of Division 3 of
23 Title 2 of the Government Code), the department shall implement
24 this section through an all-county information notice. The
25 department may also provide further instructions through training
26 notes.
27 SEC. 3. Article 6.3 (commencing with Section 14197) is added
28 to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions
29 Code, to read:
30
31 Article 6.3. Medi-Cal Managed Care Plans
32
33 14197. (a) It is the intent of the Legislature that the department
34 implement the time and distance requirements set forth in ~~Section~~
35 *Sections* 438.68, 438.206, and 438.207 of Title 42 of the Code of
36 Federal Regulations, to ensure that all services are available and
37 accessible to enrollees of Medi-Cal managed care plans in a timely
38 manner, as those standards were enacted in May 2016.
39 (b) The department, in consultation with the Department of
40 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~~ *into* at least five or more

1 county ~~categories.~~ *categories, one of which is a rural county*
2 *category.*
3 (e) The department may have varying standards for the same
4 provider type based on geographic areas, subject to the
5 requirements of this section.
6 (f) (1) The department, upon request of a Medi-Cal managed
7 care plan, may allow alternative access standards if the requesting
8 Medi-Cal managed care plan has exhausted all other reasonable
9 options to obtain providers to meet either time and distance or
10 timely access standards, and, if the Medi-Cal managed care plan
11 is licensed as a health care service plan under the Knox-Keene
12 Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing
13 with Section 1340) of Division 2 of the Health and Safety Code),
14 has obtained approval from the Department of Managed Health
15 Care. The department shall post any approved alternative access
16 standards on its Internet Web site.
17 (2) The department may allow for the use of telecommunications
18 technology as a means of alternative access to care, including
19 telemedicine, e-visits, or other evolving and innovative
20 technological solutions that are used to provide care from a
21 distance.
22 (g) The department may permit standards other than time and
23 distance if the health care provider travels to the beneficiary or to
24 a community-based setting to deliver services.
25 (h) A Medi-Cal managed care plan shall, on at least an annual
26 basis, demonstrate to the department its compliance with the time
27 and distance and timeliness standards developed pursuant to this
28 section.
29 (i) (1) For purposes of this section, "Medi-Cal managed care
30 plan" means any individual, organization, or entity that enters into
31 a contract with the department to provide services to enrolled
32 Medi-Cal beneficiaries pursuant to any of the following:
33 (A) Article 2.7 (commencing with Section 14087.3), including
34 dental managed care programs developed pursuant to Section
35 14087.46 .
36 (B) Article 2.8 (commencing with Section 14087.5).
37 (C) Article 2.81 (commencing with Section 14087.96).
38 (D) Article 2.9 (commencing with Section 14088).
39 (E) Article 2.91 (commencing with Section 14089).

1 (F) Chapter 8 (commencing with Section 14200), including
2 dental managed care plans.
3 *(G) Chapter 8.9 (commencing with Section 14700).*
4 *(H) A county Drug Medi-Cal organized delivery system*
5 *authorized under the California Medi-Cal 2020 Demonstration,*
6 *Number 11-W-00193/9, as approved by the federal Centers for*
7 *Medicare and Medicaid Services and described in the Special*
8 *Terms and Conditions. For purposes of this subdivision, "Special*
9 *Terms and Conditions" shall have the same meaning as set forth*
10 *in subdivision (o) of Section 14184.10.*
11 (j) Notwithstanding Chapter 3.5 (commencing with Section
12 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
13 the department, without taking any further regulatory action, shall
14 implement, interpret, or make specific this section by means of
15 all-county letters, plan letters, plan or provider bulletins, or similar
16 instructions until the time regulations are adopted. The department
17 shall adopt regulations by July 1, 2019, in accordance with the
18 requirements of Chapter 3.5 (commencing with Section 11340) of
19 Part 1 of Division 3 of Title 2 of the Government Code.
20 Commencing July 1, 2018, the department shall provide a status
21 report to the Legislature on a semiannual basis, in compliance with
22 Section 9795 of the Government Code, until regulations are
23 adopted.
24 14197.1. (a) This section implements the state option in
25 subdivision (j) of Section 438.8 of Title 42 of the Code of Federal
26 Regulations.
27 (b) A Medi-Cal managed care plan shall comply with a
28 minimum 85 percent medical loss ratio (MLR) consistent with
29 Section 438.8 of Title 42 of the Code of Federal Regulations. The
30 ratio shall be calculated and reported for each MLR reporting year
31 by the Medi-Cal managed care plan consistent with Section 438.8
32 of Title 42 of the Code of Federal Regulations.
33 (c) A Medi-Cal managed care plan shall provide a remittance
34 for an MLR reporting year if the ratio for that MLR reporting year
35 does not meet the minimum MLR standard of 85 percent.
36 (d) For purposes of this section, the following definitions apply:
37 (1) "Medical loss ratio (MLR) reporting year" shall have the
38 same meaning as that term is defined in Section 438.8 of Title 42
39 of the Code of Federal Regulations.

1 (2) (A) "Medi-Cal managed care plan" means any individual,
2 organization, or entity that enters into a contract with the
3 department to provide services to enrolled Medi-Cal beneficiaries
4 pursuant to any of the following:
5 (i) Article 2.7 (commencing with Section 14087.3).
6 (ii) Article 2.8 (commencing with Section 14087.5).
7 (iii) Article 2.81 (commencing with Section 14087.96).
8 (iv) Article 2.9 (commencing with Section 14088).
9 (v) Article 2.91 (commencing with Section 14089).
10 (vi) Article 1 (commencing with Section 14200) of Chapter 8.
11 (vii) Article 7 (commencing with Section 14490) of Chapter 8.
12 (B) "Medi-Cal managed care plan" does not include dental
13 managed care plans that contract with the department pursuant to
14 this chapter or Chapter 8 (commencing with Section 14200).
15 (e) Notwithstanding Chapter 3.5 (commencing with Section
16 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
17 the department, without taking any further regulatory action, shall
18 implement, interpret, or make specific this section by means of
19 all-county letters, plan letters, plan or provider bulletins, or similar
20 instructions until the time any regulations are adopted. The
21 department shall adopt regulations by July 1, 2019, in accordance
22 with the requirements of Chapter 3.5 (commencing with Section
23 11340) of Part 1 of Division 3 of Title 2 of the Government Code.
24 Commencing July 1, 2018, the department shall provide a status
25 report to the Legislature on a semiannual basis, in compliance with
26 Section 9795 of the Government Code, until regulations are
27 adopted.
28 14197.2. (a) The Legislature finds and declares all of the
29 following:
30 (1) Designated public hospitals systems play an essential role
31 in the Medi-Cal program, providing high-quality care to a
32 disproportionate number of low-income Medi-Cal and uninsured
33 populations in the state. Because Medi-Cal covers approximately
34 one-third of the state's population, the strength of these essential
35 public health care systems is of critical importance to the health
36 and welfare of the people of California.
37 (2) Designated public hospital systems provide comprehensive
38 health care services to low-income patients and life-saving trauma,
39 burn, and disaster-response services for entire communities, and
40 train the next generation of doctors and other health care

1 professionals, such as nurses and paramedical professionals, who
2 are critical to new team-based care models that achieve more
3 efficient and patient-centered care.
4 (3) The Legislature intends to continue to provide levels of
5 support for designated public hospital systems in light of their
6 reliance on Medi-Cal funding to provide quality care to everyone,
7 regardless of insurance status, ability to pay, or other circumstance,
8 the significant proportion of Medi-Cal services provided under
9 managed care by these public hospital systems, and new federal
10 requirements related to Medicaid managed care.
11 (4) It is the intent of the Legislature that Medi-Cal managed
12 care plans and designated public hospital systems shall in good
13 faith negotiate for, and implement, contract rates, the provision
14 and arrangement of services and member assignment that are
15 sufficient to ensure continued participation by designated public
16 hospital systems and to maintain access to services for Medi-Cal
17 managed care beneficiaries and other low-income patients.
18 (b) Commencing with the 2017–18 state fiscal year, and for
19 each state fiscal year thereafter, and notwithstanding any other
20 law, the department shall require each Medi-Cal managed care
21 plan to enhance contract services payments to the designated public
22 hospital systems by a uniform percentage as described in this
23 subdivision.
24 (1) The applicable percentage for purposes of the directed
25 payments shall be uniformly applied across all of the following
26 classes of designated public hospital systems:
27 (A) Designated public hospital systems owned and operated by
28 the University of California.
29 (B) Designated public hospital systems not identified in
30 subparagraph (A) that include a designated public hospital with a
31 level 1 or level 2 trauma designation.
32 (C) Designated public hospital systems not identified in
33 subparagraph (A) or (B).
34 (2) The department, in consultation with the designated public
35 hospital systems, shall annually determine the applicable uniform
36 percentages for each class identified in paragraph (1) and the
37 classification of each designated public hospital system. Once the
38 department determines the classification for each designated public
39 hospital system for a particular state fiscal year, that classification
40 shall not be eligible to change until no sooner than the subsequent

1 state fiscal year. To the extent necessary to meet the objectives
2 identified in subdivisions (a) and (d) or to comply with federal
3 requirements, the department may, in consultation with the
4 designated public hospital systems, adjust or modify the applicable
5 percentages or the classifications. The department shall consult
6 with the designated public hospital systems and each affected
7 Medi-Cal managed care plan with regard to the implementation
8 of the directed payment requirements once these payment levels
9 have been established.
10 (3) The required directed payment amounts shall be determined
11 by multiplying the applicable percentage developed pursuant to
12 paragraph (2) by the total amount of contract services payments.
13 Performance-based incentive payments, amounts earned pursuant
14 to the quality incentive program described in subdivision (c), and
15 amounts paid pursuant to Sections 14301.4 and 14301.5 shall not
16 be subject to the required directed payments. Nothing in this
17 subdivision shall prevent a Medi-Cal managed care plan from
18 making additional payments to a designated public hospital system
19 in amounts exceeding the directed payment amounts required under
20 this subdivision, or, at the sole option and request of a designated
21 public hospital system, from working with the designated public
22 hospital system to develop risk-sharing arrangements consistent
23 with the intent and purposes of this subdivision.
24 (4) The directed payments required under this subdivision shall
25 be implemented and documented by each Medi-Cal managed care
26 plan and designated public hospital system in accordance with all
27 of the following parameters and any guidance issued by the
28 department:
29 (A) A Medi-Cal managed care plan and the designated public
30 hospital systems shall determine the manner, timing, and amount
31 of payment for ~~contracted~~ *contract* services, including through
32 fee-for-service, capitation, or other permissible manner. The rates
33 of payment for ~~contracted~~ *contract* services agreed upon by the
34 Medi-Cal managed care plan and the designated public hospital
35 system shall be established and documented without regard to the
36 directed payments and quality incentive payments required by this
37 section.
38 (B) A Medi-Cal managed care plan and a designated public
39 hospital system shall, for the directed payment amounts determined
40 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~~ *contract* 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

1 default assignment into the Medi-Cal managed care plan with
2 respect to all Medi-Cal managed care beneficiaries by up to 25
3 percent, so long as the other Medi-Cal managed care plan or
4 Medi-Cal managed care plans in the applicable county have the
5 capacity to receive the additional default membership. The
6 department's determination, whether to exercise discretion under
7 this paragraph, shall not be subject to judicial review. Nothing in
8 this paragraph shall be construed to preclude or otherwise limit
9 the right of any designated public hospital system to pursue a
10 breach of contract action in connection with the requirements of
11 this subdivision.
12 (6) Capitation rates paid by the department to a Medi-Cal
13 managed care plan shall account for the Medi-Cal managed care
14 plan's obligation to pay the directed payments to designated public
15 hospital systems in accordance with this subdivision. The
16 department may require Medi-Cal managed care plans and the
17 designated public hospital systems to submit information regarding
18 contract rates and expected utilization of services, at the times and
19 in the form and manner specified by the department. To the extent
20 consistent with federal law and actuarial standards of practice, the
21 department shall utilize the most recently available data, as
22 determined by the department, when accounting for the directed
23 payments required under this subdivision, and may account for
24 material adjustments, as appropriate and as determined by the
25 department, to contracts entered into between a Medi-Cal managed
26 care plan and a designated public hospital system.
27 (c) Commencing with the 2017–18 state fiscal year, and for
28 each state fiscal year thereafter, the department, in consultation
29 with the designated public hospital systems and each Medi-Cal
30 managed care plan, shall establish a program under which a
31 designated public hospital system may earn performance-based
32 quality incentive payments from the Medi-Cal managed care plan
33 they contract with in accordance with this subdivision.
34 (1) Payments shall be earned by each designated public hospital
35 system based on its performance in achieving identified targets
36 for quality of care.
37 (A) The department, in consultation with the designated public
38 hospital systems and each Medi-Cal managed care plan, shall
39 establish and provide a method for updating uniform performance
40 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 *identified in paragraph (1) of subdivision (b)* 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.~~ *plans.* 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.

1 (5) The department shall provide appropriate funding to each
2 Medi-Cal managed care plan, to account for and to enable them
3 to make the quality incentive payments described in this
4 subdivision, through the incorporation into actuarially sound
5 capitation rates or any other federally permissible method. The
6 amounts designated by the department for the quality incentive
7 payments made pursuant to this subdivision shall be reserved for
8 the purposes of the performance-based quality incentive payment
9 program.
10 (d) In determining the uniform percentages described in
11 paragraph (2) of subdivision (b), and the aggregate size of the
12 quality incentive payment program described in paragraph (2) of
13 subdivision (c), the department shall consult with designated public
14 hospital systems to establish levels for these payments that, in
15 combination with one another, are projected to result in aggregate
16 payments that will advance the quality and access objectives
17 reflected in prior payment enhancement mechanisms for designated
18 public hospital systems. To the extent necessary to meet these
19 objectives or to comply with any federal requirements, the
20 department may, in consultation with the designated public hospital
21 systems, adjust or modify either or both the applicable percentages
22 or quality incentive payment program.
23 (e) The provisions of paragraphs (3) and (4) of subdivision (a),
24 and of subdivisions (b) and (c) shall be deemed incorporated into
25 each contract between a designated public hospital system and a
26 Medi-Cal managed care plan, and its subcontractor or designee,
27 as applicable, and any claim for breach of those provisions may
28 be brought directly in a court of competent jurisdiction.
29 (f) (1) The nonfederal share of the portion of the capitation
30 rates specifically associated with directed payments to designated
31 public hospital systems required under subdivision (b) and for the
32 quality incentive payments established pursuant to subdivision (c)
33 may consist of voluntary intergovernmental transfers of funds
34 provided by designated public hospitals and their affiliated
35 governmental entities, or other public entities, pursuant to Section
36 14164. Upon providing any intergovernmental transfer of funds,
37 each transferring entity shall certify that the transferred funds
38 qualify for federal financial participation pursuant to applicable
39 federal Medicaid laws, and in the form and manner specified by
40 the department. Any intergovernmental transfer of funds made

1 pursuant to this section shall be considered voluntary for purposes
2 of all federal laws. Notwithstanding any other law, the department
3 shall not assess the fee described in subdivision (d) of Section
4 14301.4 or any other similar fee.
5 (2) When applicable for voluntary intergovernmental transfers,
6 the department, in consultation with the designated public hospital
7 systems, shall develop and maintain a protocol to determine each
8 public entity's intergovernmental transfer amount in an applicable
9 state fiscal year for purposes of funding the nonfederal share
10 associated with payments pursuant to this section. The protocol
11 developed and maintained pursuant to this paragraph shall account
12 for any applicable contributions made by public entities to the
13 nonfederal share of Medi-Cal managed care expenditures,
14 including, but not limited to, contributions previously made
15 pursuant to Section 14182.15 or 14199.2. Nothing in this section
16 shall be construed to limit or otherwise alter any existing authority
17 of the department to accept intergovernmental transfers for
18 purposes of funding the nonfederal share of Medi-Cal managed
19 care expenditures.
20 (g) (1) This section shall be implemented only to the extent
21 that any necessary federal approvals are obtained and federal
22 financial participation is available and is not otherwise jeopardized.
23 (2) For any state fiscal year in which this section is implemented,
24 in whole or in part, and notwithstanding any other law, the
25 department shall not be required to make any payment to a
26 Medi-Cal managed care plan pursuant to Section 14182.15,
27 14199.2, or 14301.5.
28 (h) (1) The department shall seek any necessary federal
29 approvals for the directed payments and the quality incentive
30 payments set forth in this section.
31 (2) The department shall consult with the designated public
32 hospital systems with regard to the development and
33 implementation of the directed payment levels and the quality
34 incentive payments established pursuant to this section.
35 (3) The director, after consultation with the designated public
36 hospital systems, may modify the requirements set forth in this
37 section to the extent necessary to meet federal requirements or to
38 maximize available federal financial participation. In the event
39 federal approval is only available with significant limitations or
40 modifications, or in the event of changes to the federal Medicaid

1 program that result in a loss of funding currently available to the
2 designated public hospital systems, the department shall consult
3 with the designated public hospitals to consider alternative
4 methodologies.
5 (i) Notwithstanding Chapter 3.5 (commencing with Section
6 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
7 the department may implement, interpret, or make specific this
8 section by means of all-county letters, plan letters, provider
9 bulletins, or other similar instructions, without taking regulatory
10 action. The department shall make use of appropriate processes to
11 ensure that affected designated public hospital systems and
12 Medi-Cal managed care plans are timely informed of, and have
13 access to, applicable guidance issued pursuant to this authority,
14 and that this guidance remains publicly available until all payments
15 made pursuant to this section are finalized.
16 (j) For purposes of this section, the following definitions apply:
17 (1) “Contract services payments” means the amount paid or
18 payable to a designated public hospital system, including amounts
19 paid or payable under fee-for-service, capitation, prior to any
20 adjustments for service payment withholds or deductions, or other
21 basis, under a contract with a Medi-Cal managed care plan for
22 services, drugs, supplies or other items provided to a Medi-Cal
23 beneficiary enrolled in the Medi-Cal managed care plan. Contract
24 services includes all services, drugs, supplies, or other items the
25 designated public hospital system provides, or is responsible for
26 providing, or arranging or paying for, pursuant to a contract entered
27 into with a Medi-Cal managed care plan. In the event a Medi-Cal
28 managed care plan subcontracts or otherwise delegates
29 responsibility to a separate entity for either or both the arrangement
30 or payment of services, ~~“contracted~~ *“contract* services payments”
31 also include amounts paid or payable for the services provided by,
32 or otherwise the responsibility of, the designated public hospital
33 system that are within the scope of services of the subcontracted
34 or delegated arrangement so long as the designated public hospital
35 system holds a contract with the primary Medi-Cal managed care
36 plan.
37 (2) “Designated public hospital” shall have the ~~meaning~~ *same*
38 *meaning as* set forth in subdivision (f) of Section 14184.10.
39 (3) “Designated public hospital system” means a designated
40 public hospital and its affiliated government entity clinics,

1 practices, and other health care providers, including the respective
2 affiliated hospital authority and county government entities
3 described in Chapter 5 (commencing with Section 101850) and
4 Chapter 5.5 (commencing with Section 101852), of Part 4 of
5 Division 101 of the Health and Safety Code.
6 (4) (A) "Medi-Cal managed care plan" means an applicable
7 organization or entity that enters into a contract with the department
8 pursuant to any of the following:
9 (i) Article 2.7 (commencing with Section 14087.3).
10 (ii) Article 2.8 (commencing with Section 14087.5).
11 (iii) Article 2.81 (commencing with Section 14087.96).
12 (iv) Article 2.91 (commencing with Section 14089).
13 (v) Chapter 8 (commencing with Section 14200).
14 (B) "Medi-cal managed care plan" does not include any of the
15 following:
16 (i) A mental health plan contracting to provide mental health
17 care for Medi-Cal beneficiaries pursuant to Chapter 8.9
18 (commencing with Section 14700).
19 (ii) A plan not covering inpatient services, such as primary care
20 case management plans, operating pursuant to Section 14088.85.
21 (iii) A Program of All-Inclusive Care for the Elderly
22 organization operating pursuant to Chapter 8.75 (commencing
23 with Section 14591).

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AMENDED IN SENATE APRIL 6, 2017

AMENDED IN SENATE MARCH 20, 2017

SENATE BILL **No. 508**

Introduced by Senator Roth

February 16, 2017

An act to *amend Section 14149.8 of, and to* add Article 2.93 (commencing with Section 14091.40) to Chapter 7 of Part 3 of Division 9 ~~of~~ *of,* the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 508, as amended, Roth. Medi-Cal: dental health.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Existing law provides for a schedule of benefits provided under the Medi-Cal program, which includes certain dental services that are referred to as the Medi-Cal dental program, or Denti-Cal. Existing law requires the department to work with dental managed care plans that contract with the department for the purposes of implementing Denti-Cal, as specified.

This bill would authorize the department, no sooner than July 1, 2019, and to the extent that federal financial participation is available and any necessary federal approvals have been obtained, to authorize a Dental Health Collaboration Pilot Program for Medi-Cal beneficiaries enrolled in Medi-Cal managed care health plans that serve the County of Riverside, the County of San Bernardino, or both of those counties, using a hybrid collaboration model that coordinates the efforts of participating health plans, dental managed care plans, and the

department. The bill would authorize the department to undertake specified activities in support of the pilot program, such as providing technical assistance to participating health plans and dental managed care plans and providing an innovative payment structure, including payment incentives, that facilitates the pilot program's health and dental objectives. The bill would require participating health plans and dental managed care plans to collaborate with each other and *would require a dental managed care plan to collaborate* with the department on the design and implementation of the pilot program for an operating period of up to 5 years. The bill would require participating health plans and dental managed care plans to, among other things, deliver Denti-Cal services to participating beneficiaries, engage in specified beneficiary outreach activities, and coordinate patient care. The bill would authorize a participating dental managed care plan to implement and demonstrate innovative payment methods, including incentive payments. The bill would authorize a participating health plan or dental managed care plan to terminate its participation in the program by giving specific notice to the department, beneficiaries, and participating health plans or dental managed care plans, as applicable.

This bill would require a Medi-Cal dental managed care plan to work with the department to ensure access to, and the provision of, quality dental services to Medi-Cal beneficiaries, and would also require a managed care plan in connection therewith to undertake specified activities, such as ensuring enrolled beneficiaries have access to primary and specialist dental care, maintaining a utilization management program, and conducting or participating in quality improvement projects.

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

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

1 SECTION 1. Article 2.93 (commencing with Section 14091.40)
2 is added to Chapter 7 of Part 3 of Division 9 of the Welfare and
3 Institutions Code, to read:
4
5 Article 2.93. Dental Health Collaboration Pilot Program
6
7 14091.40. The following definitions shall apply for the purposes
8 of this article:

1 (a) "Dental managed care plan" means a plan that contracts with
2 the department for the purpose of implementing the Medi-Cal
3 dental program, which includes, but is not limited to, contracts
4 authorized pursuant to Sections 14087.46, 14089, and 14104.3
5 that provide beneficiaries with access to dental plan liaisons to
6 assist in the coordination of care for enrolled members.
7 (b) "Oral health care" means health care that works toward a
8 state of being free from chronic mouth and facial pain, oral and
9 throat cancer, oral sores, birth defects such as cleft lip and palate,
10 periodontal (gum) disease, tooth decay and tooth loss, and other
11 diseases and disorders that affect the oral cavity.
12 (c) "Oral hygiene education" means education on the practice
13 brushing and flossing to keep the mouth clean and to prevent tooth
14 decay and gum disease.
15 14091.41. The Legislature finds and declares all of the
16 following:
17 (a) Untreated tooth decay affects more children than any other
18 chronic infectious disease in the United States, leading to pain and
19 suffering, loss of school days, and even death, despite being a
20 largely preventable disease, as noted by the Pediatric Oral Health
21 Research and Policy Center.
22 (b) Children at increased risk of developing caries often lack
23 access to dental care and many do not have good home care
24 prevention practices.
25 (c) According to the California State Auditor's report of
26 December 2014, in 2013 less than one-half of the children enrolled
27 in California's Medi-Cal dental program, also known as Denti-Cal,
28 were able to access basic dental care.
29 (d) Recent estimates by the State Department of Health Care
30 Services indicate that only 25 percent of adults enrolled in
31 Denti-Cal accessed any dental treatment benefits during 2014,
32 even though adult benefits were partially restored.
33 (e) The Medi-Cal Dental Services Rate Review, dated July 1,
34 2015, reflects that California's reimbursement rates for Denti-Cal
35 were considerably lower than the comparable states of Florida,
36 New York, and Texas, and only 31 percent of the national average
37 for commercial dental insurance.
38 (f) Research has identified associations between chronic oral
39 infections and diabetes, heart and lung disease, stroke, and poor
40 birth outcomes.

1 (g) The federal Centers for Medicare and Medicaid Services
2 (CMS) is encouraging states to emphasize new approaches to
3 integrated whole-person care, including dental care, as well as
4 developing innovative payment methods for state Medicaid
5 programs.
6 (h) Several states have demonstrated successful outcomes with
7 redesigning their dental programs under Medicaid.
8 (i) Innovative models of health and dental collaboration and
9 innovative payment methods need to be tested in California to
10 improve the overall health of Medi-Cal beneficiaries and to ensure
11 an efficient and effective Denti-Cal program.
12 (j) Documented experience in the Counties of San Bernardino
13 and Riverside has identified a lack of dentists accepting new
14 Medi-Cal beneficiaries and difficulty for Medi-Cal beneficiaries
15 in navigating dental providers.
16 (k) Strategic payment incentive approaches to attract and retain
17 dentists and effectively drive the timely and appropriate use of
18 dental services have been effective in several state Medicaid
19 programs.
20 14091.42. (a) It is the intent of the Legislature to establish the
21 Dental Health Collaboration Pilot Program to test and examine
22 the efficacy of using a hybrid collaboration model to provide
23 comprehensive oral health care, including oral hygiene education,
24 prevention services, and dental treatment, under the auspices of a
25 dental managed care plan and in collaboration with a health plan
26 that is a Medi-Cal managed care health plan that serves the County
27 of San Bernardino or the County of Riverside, or both of those
28 counties.
29 (b) It is the intent of the Legislature for the Dental Health
30 Collaboration Pilot Program to do all of the following, as permitted
31 by federal law:
32 (1) Design and implement an oral hygiene education
33 collaborative to provide parents, caregivers, children, and adults
34 with applicable information and motivation to adopt positive oral
35 health behaviors.
36 (2) Provide direct linkage between health care and dental care
37 for Medi-Cal beneficiaries, including an ongoing relationship with
38 the beneficiary and dental provider.

1 (3) Establish objectives for improving access to comprehensive
2 oral health care, including access to dental prevention services and
3 pediatric dentistry.
4 (4) Establish objectives for improving dental utilization, as
5 medically indicated, for Medi-Cal beneficiaries.
6 (5) Test innovative payment models.
7 (6) Enroll eligible Medi-Cal beneficiaries into the pilot program
8 on a voluntary basis.
9 (7) Achieve improved health and dental outcomes for enrolled
10 Medi-Cal beneficiaries.
11 (8) Collect, measure, and analyze data in collaboration with the
12 department.
13 (9) Conduct ongoing quality improvement to facilitate
14 attainment of pilot program objectives.
15 14091.43. (a) No sooner than July 1, 2019, and subject to any
16 necessary federal approvals and in accordance with this article,
17 the department may authorize a Dental Health Collaboration Pilot
18 Program for Medi-Cal beneficiaries.
19 (b) The department may authorize implementation of the pilot
20 program for a period of up to five years.
21 (c) The department may seek any federal approvals as necessary,
22 including state plan amendments or waivers.
23 (d) The department may provide an innovative payment structure
24 through the pilot program to specifically facilitate ~~health and~~ dental
25 objectives as identified in the pilot program, including ~~health care~~
26 savings attributable to improved dental access and the use of
27 payment incentives to facilitate dental provider participation and
28 the cost-effective utilization of oral health care services.
29 (e) The department may facilitate and assist in any necessary
30 exchange of data ~~between the participating health plan and the~~
31 ~~participating dental managed care plan~~ as needed to implement
32 the pilot program.
33 (f) The department may provide technical assistance as necessary
34 to participating health plans and participating dental managed care
35 plans.
36 ~~(g) The department may develop specific contract language~~
37 ~~with a participating health plan for the purposes of implementing~~
38 ~~the Dental Health Collaboration Pilot Program that shall be~~
39 ~~incorporated into the contracts of each affected health plan.~~
40 ~~(h)~~

(g) The department may develop specific contract language with a participating dental managed care plan for the purposes of implementing the Dental Health Collaboration Pilot Program that shall be incorporated into the contracts of each affected dental managed care plan.

14091.44. (a) A health plan that is a Medi-Cal managed care plan and that serves the County of San Bernardino or the County of Riverside, or both of those counties, may choose to participate in the Dental Health Collaboration Pilot Program in accordance with this section.

(b) A health plan that chooses to participate in the pilot program ~~shall do all of the following:~~ *may participate as follows:*

(1) Engage with the ~~department and the~~ participating dental managed care plan as deemed appropriate to design and implement the pilot program for an operating period of up to five years.

(2) In collaboration with the department and the participating dental managed care plan, as deemed appropriate, ~~identify and~~ establish core objectives for improving dental utilization ~~and overall health care~~ for Medi-Cal beneficiaries who opt to participate in the pilot program.

(3) Collaborate with the participating dental managed care plan to engage in ~~consistent and ongoing~~ outreach to Medi-Cal beneficiaries for the purpose of ~~obtaining their participation in medically appropriate usage of Denti-Cal and enrollment into~~ *participation in* the pilot program. Outreach activities may include, but are not limited to, the following:

(A) ~~Identifying~~ *At the initial dental screening, as described in paragraph (1) of subdivision (g) of Section 14149.8, identifying* Medi-Cal beneficiaries who are not utilizing or underutilizing Denti-Cal program services, as appropriate.

(B) Providing notification *to beneficiaries* regarding the pilot program, as appropriate.

(C) Participating in health and dental community-based events.

(4) Provide ~~linkage with~~ *linkage, as applicable, between* the participating dental managed care plan ~~to ensure a warm handoff of identified~~ *and* Medi-Cal beneficiaries who have opted into the pilot program.

(5) ~~Actively engage~~ *Engage* in patient care coordination functions with the participating dental managed care plans, including, but not limited to, ~~the following:~~ *advising patients of*

the availability of the Dental Health Collaboration Pilot Program, as applicable.

~~(A) Identifying, as applicable, patients with special health care and dental care needs.~~

~~(B) Developing an overall health and dental care strategy that meets the patient's medical needs.~~

~~(C) Coordinating and monitoring patient care with the goal of achieving optimum health care and dental care outcomes in an efficient and cost-effective manner.~~

~~(D) Arranging for patient consultations and postreview activities for continued quality improvement and improved patient compliance with the patient's health and dental plan.~~

(6) ~~Collect, measure, and analyze data in collaboration~~ *Collaborate* with the department and participating dental managed care plans to identify lessons learned and pilot program achievements. *The participating dental managed care plan shall be the lead entity in this collaboration with the department.*

14091.45. (a) A dental managed care plan that chooses to participate in the Dental Health Collaboration Pilot Program in accordance with this section, and that is under contract with the department to serve Medi-Cal beneficiaries in the County of San Bernardino, the County of Riverside, or both of those counties, shall do all of the following:

(1) Engage with the department and the participating health plan as deemed appropriate to design and implement the pilot program for an operating period of up to five years.

(2) In collaboration with the department and participating health plans, as deemed appropriate, identify and establish core objectives for improving dental utilization ~~and overall health care~~ for Medi-Cal beneficiaries who opt to participate in the pilot program.

(3) Collaborate with the participating health ~~plans~~ *plans, as deemed appropriate,* to engage in consistent and ongoing outreach to Medi-Cal beneficiaries for the purpose of obtaining their participation in medically appropriate usage of Denti-Cal and enrollment into the pilot program. Outreach activities may include, but are not limited to, the following:

(A) Identifying Medi-Cal beneficiaries who are not utilizing or underutilizing Denti-Cal program services.

(B) Providing notification regarding the pilot program, as appropriate.

(C) Scheduling appointments and providing regular appointment reminders.

(D) Providing interpreters.

(E) Providing transportation.

(F) Facilitating communication between the Medi-Cal beneficiary and his or her dental provider.

(G) Participating in health and dental community-based events.

(4) Provide culturally appropriate oral hygiene education programs with special emphasis on underserved children.

(5) Provide linkage with the participating health ~~plan~~ *plan, as applicable,* to ensure a warm handoff of identified Medi-Cal beneficiaries who have opted into the pilot program.

(6) Actively engage in patient care coordination functions with the participating health plan, *as applicable,* including, but not limited to, the following:

(A) Identifying, as applicable, patients with special health care and dental care needs.

(B) Engaging with referred patients to ensure that a high level, integrated, and personalized dental care plan is implemented.

(C) Developing an overall ~~health and~~ dental care strategy that meets the patient's medical needs.

(D) Coordinating and monitoring patient care with the goal of achieving ~~optimum~~ health care and dental care outcomes in an efficient and cost-effective manner.

(E) Arranging for patient consultations and post-review activities for continued quality improvement and improved patient compliance with the patient's ~~health and~~ dental plan.

(7) Monitor dental providers for performance and outcomes, including ongoing quality improvement as necessary.

(8) Collect, measure, and analyze data in collaboration with the department, the participating health ~~plan~~ *plan, as necessary,* and dental providers to identify lessons learned and pilot program achievements. *The participating dental managed care plan shall be the lead entity in this collaboration with the department and dental providers.*

(b) Upon the approval of the department, a participating dental managed care plan may implement and demonstrate innovative payment methods designed to provide actuarially sound reimbursement to dental providers, along with incentive payments ~~the~~ *that* recognize established outcome measures and objectives.

14091.46. A health plan may terminate its participation in the pilot program by notifying the department at least 120 days before the termination. The health plan shall give participating Medi-Cal beneficiaries and dental managed care plans at least 90 days' notice of termination.

14091.47. A dental managed care plan may terminate its participation in the pilot program by notifying the department at least 120 days before the termination. The dental managed care plan shall give participating Medi-Cal beneficiaries and health plans at least 90 ~~days~~ *days'* notice of termination.

14091.48. Contracts entered into pursuant to this article may be on a bid or nonbid basis, and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

14091.49. This article shall not be construed to limit or eliminate services provided by the Medi-Cal program or Denti-Cal.

14091.50. This article shall be implemented only to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

14091.51. 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 article by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

SEC. 2. Section 14149.8 of the Welfare and Institutions Code is amended to read:

14149.8. (a) The department shall expedite the enrollment of Medi-Cal dental providers by streamlining the Medi-Cal provider enrollment process. The department shall pursue and implement all of the following activities, to the extent permitted by federal law:

(1) Create a dental-specific enrollment form.

(2) Pursue an alternative automatic enrollment process for a provider already commercially credentialed by either a dental fee-for-service contractor or an administrative services contractor for the purpose of providing services as a commercial provider.

(3) Discontinue requiring providers to resubmit an enrollment application that has been deemed incomplete if the missing information is available elsewhere within the application packet.