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

ITEM
2.8
(ID # 4449)

MEETING DATE:
Tuesday, June 6, 2017

FROM : EXECUTIVE OFFICE:

SUBJECT: EXECUTIVE OFFICE: Legislative Update - June 6, All Districts. [$0]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Receive and File the Legislative Update for June 6, 2017.

ACTION: Consent

Brian Nestande 5/30/2017

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Tavaglione, seconded by Supervisor Washington and duly carried, IT WAS ORDERED that the above matter is received and filed as recommended.

Ayes:	Jeffries, Tavaglione, Washington and Perez
Nays:	None
Absent:	Ashley
Date:	June 6, 2017
xc:	EO

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

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

C.E.O. RECOMMENDATION: APPROVE

BACKGROUND:

Summary

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

Letters of Support/Opposition

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

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

Legislation/Policy: SB 171 (Hernandez) – Medi-Cal: Medi-Cal Managed Care Plans

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

Legislation/Policy: SB 362 (Galgiani): Department of Motor Vehicles: Records: Confidentiality
Position: SUPPORT – Per Previous Legislative Support
Recipient: Senator Cathleen Galgiani
Summary: Current law prohibits the disclosure of the home addresses of certain public employees and officials that appear in records of the Department of Motor Vehicles, except to a court, a law enforcement agency, an attorney in a civil or criminal action under certain circumstances, and certain other official entities. This bill would extend that prohibition, subject to those same exceptions, to the disclosure of the home addresses of investigators employed by the Department of Insurance, code enforcement officers, as defined, and parking control officers, as specified.

Legislation/Policy: In-Home Supportive Services Maintenance of Effort Unwind
Position: Support May Revision – Per Legislative Platform
Recipient: Assembly Member Joaquin Arambula, MD
Summary: Language contained within the Governors Proposed Budget called for the conclusion of the Coordinated Care Initiative and therefore a $623 million estimated total cost to the 7 participating CCI counties. With the release of the Governors Revised Budget, counties found relief in adjusted cuts to the CCI program presented in the form of General Fund Assistance—$400 million in 2017/18; $330 million in 2018/19; $200 million in 2019/20 and $150 million in 2020/21 and ongoing, to mitigate transition costs. The anticipated first year impact from the proposed budgets actions to Riverside County was an estimated $43 million; under the May Revision proposal, local impact is reduced to an estimated $10 million in the first year with costs set to increase as assistance is reduced.

Legislation/Policy: In-Home Supportive Services Maintenance of Effort Unwind
Position: Support May Revision – Per Legislative Platform

Recipient: Senator Richard Pan
Summary: Language contained within the Governors Proposed Budget called for the conclusion of the Coordinated Care Initiative and therefore a $623 million estimated total cost to the 7 participating CCI counties. With the release of the Governors Revised Budget, counties found relief in adjusted cuts to the CCI program presented in the form of General Fund Assistance—$400 million in 2017/18; $330 million in 2018/19; $200 million in 2019/20 and $150 million in 2020/21 and ongoing, to mitigate transition costs. The anticipated first year impact from the proposed budgets actions to Riverside County was an estimated $43 million; under the May Revision proposal, local impact is reduced to an estimated $10 million in the first year with costs set to increase as assistance is reduced.

Legislation/Policy: Budget Item 5227 – Board of State and Community Corrections (BSCC) Proposed In-Person Jail Visitation Requirements
Position: OPPOSE – Per Legislative Platform
Recipient: Senator Holly Mitchell and Assembly Member Philip Y. Ting
Summary: Proposed trailer bill language concerning jail visitation and the requirement that a county providing video visitation, also provide in-person visitation would be detrimental to Riverside County. The County currently operates the Larry Smith Correctional facility, which houses a 582-bed all video visitation section. In addition, the new John J. Benoit Detention Center, which will open during the summer of 2018, is an all-video visitation 1600 bed facility. The retrofitting of both facilities at this current time would cost millions of dollars as well as on going labor costs that would have a substantial impact on an already strained county budget.

Legislation/Policy: Budget Item 2660 – California Department of Transportation SB 1 Implementation: Proposed Trailer Bill Language to Expedite SB 132 Projects
Position: SUPPORT – Per Legislative Platform
Recipient: Senator Holly Mitchell and Assembly Member Philip Y. Ting
Summary: The proposed trailer bill language would help expedite project delivery for the five projects in the Riverside County Transportation Efficiency Corridor (RCTEC) as outlined in SB 132, as well as other projects in the region. Specifically the proposed trailer bill language:

- Expands the pilot program for Construction Manager/General Contractor (CM/GC) on the state highway system and provides similar authority for the Riverside County Transportation Commission (RCTC).
- Expands the pilot program for design-build on local streets and roads.
- Provides new statutory authority for the RCTC to use innovative procurement and project delivery methods on the SR-91 Toll Connector to I-15 North.
- Authorizes the use of CM/GC procurement and project delivery method on off-system projects in Riverside County, including bridge rehabilitation and replacement and railroad grade separations.
- Allows the use of cost-plus-time (A+B) contracting authority to encourage early completion of projects.

Impact on Residents and Businesses

The action presented should not affect residents or businesses within Riverside County.

ATTACHMENT A. Legislative Update – June 6

COUNTY OF RIVERSIDE

Board of Supervisors

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

May 18, 2017

The Honorable Lorena Gonzalez Fletcher
Chair, Assembly Appropriations Committee
State Capitol, Room 2114
Sacramento, CA 95814

Re: AB 205 (Wood) – Medi-Cal: Medi-Cal Managed Care Plans
As Amended May 2, 2017
Assembly Appropriations Suspense File
County of Riverside: SUPPORT – Per Legislative Platform

Dear Assembly Member Gonzalez Fletcher:

On behalf of the Riverside County Board of Supervisors, I write in support of AB 205, Assembly Member Wood's measure which addresses the Medicaid supplemental payments changes required by the federal Medicaid Managed Care Rule.

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

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

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

COUNTY OF RIVERSIDE

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

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

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

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

Sincerely,

John Tavaglione
Chairman, Riverside County Board of Supervisors

cc: County of Riverside Delegation
Members, Assembly Appropriations Committee
Lisa Murawski, Consultant, Assembly Appropriations Committee
Peter Anderson, Consultant, Assembly Republican Caucus

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:

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

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

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

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

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

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

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

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

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

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

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

Article 6.3. Medi-Cal Managed Care Plans

14197. (a) It is the intent of the Legislature that the department implement the time and distance requirements set forth in ~~Section~~ *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.

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

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

(A) Primary care, adult and pediatric.

(B) Obstetrics and gynecology.

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

(D) Specialist, adult and pediatric.

(E) Hospital.

(F) Pharmacy.

(G) Pediatric dental.

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

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

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

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

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

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

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

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

(d) In developing the time and distance standards, if the department elects a county standard for time and distance, the department shall categorize counties ~~in to~~ *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).

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

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

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

(G) Chapter 8.9 (commencing with Section 14700).

(H) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services and described in the Special Terms and Conditions. For purposes of this subdivision, "Special Terms and Conditions" shall have the same meaning as set forth in subdivision (o) of Section 14184.10.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. The department shall adopt regulations by July 1, 2019, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing July 1, 2018, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations are adopted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any regulations are adopted. The department shall adopt regulations by July 1, 2019, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing July 1, 2018, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations are adopted.

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

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

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

(3) The Legislature intends to continue to provide levels of support for designated public hospital systems in light of their reliance on Medi-Cal funding to provide quality care to everyone, regardless of insurance status, ability to pay, or other circumstance, the significant proportion of Medi-Cal services provided under managed care by these public hospital systems, and new federal requirements related to Medicaid managed care.

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

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

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

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

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

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

(2) The department, in consultation with the designated public hospital systems, shall annually determine the applicable uniform percentages for each class identified in paragraph (1) and the

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

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

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

(A) A Medi-Cal managed care plan and the designated public hospital systems shall determine the manner, timing, and amount of payment for ~~contracted~~ *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

managed care plan is not in compliance with the requirements of this subdivision, or is otherwise circumventing the purposes thereof, to the material detriment of an applicable designated public hospital system, and, independent of any remedy available to the designated public hospital system, the department may reduce the default assignment into the Medi-Cal managed care plan with respect to all Medi-Cal managed care beneficiaries by up to 25 percent, so long as the other Medi-Cal managed care plan or Medi-Cal managed care plans in the applicable county have the capacity to receive the additional default membership. The department's determination, whether to exercise discretion under this paragraph, shall not be subject to judicial review. Nothing in this paragraph shall be construed to preclude or otherwise limit the right of any designated public hospital system to pursue a breach of contract action in connection with the requirements of this subdivision.

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

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

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

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

(B) Each designated public hospital system shall submit reports to the department containing information required to evaluate its performance on all applicable performance measures, at the times and in the form and manner specified by the department. A Medi-Cal managed care plan shall assist a designated public hospital system in collecting information necessary for these reports.

(2) The department, in consultation with each designated public hospital system, shall determine a maximum amount that each class *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.

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

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

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

(f) (1) The nonfederal share of the portion of the capitation rates specifically associated with directed payments to designated public hospital systems required under subdivision (b) and for the quality incentive payments established pursuant to subdivision (c)

may consist of voluntary intergovernmental transfers of funds provided by designated public hospitals and their affiliated governmental entities, or other public entities, pursuant to Section 14164. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to applicable federal Medicaid laws, and in the form and manner specified by the department. Any intergovernmental transfer of funds made pursuant to this section shall be considered voluntary for purposes of all federal laws. Notwithstanding any other law, the department shall not assess the fee described in subdivision (d) of Section 14301.4 or any other similar fee.

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

(g) (1) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

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

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

(2) The department shall consult with the designated public hospital systems with regard to the development and

implementation of the directed payment levels and the quality incentive payments established pursuant to this section.

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

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, provider bulletins, or other similar instructions, without taking regulatory action. The department shall make use of appropriate processes to ensure that affected designated public hospital systems and Medi-Cal managed care plans are timely informed of, and have access to, applicable guidance issued pursuant to this authority, and that this guidance remains publicly available until all payments made pursuant to this section are finalized.

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

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

system that are within the scope of services of the subcontracted or delegated arrangement so long as the designated public hospital system holds a contract with the primary Medi-Cal managed care plan.

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

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

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

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

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

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

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

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

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

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

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

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

O

COUNTY OF RIVERSIDE

May 18, 2017

The Honorable Ricardo Lara
Chair, Senate Appropriations Committee
State Capitol, Room 5050
Sacramento, CA 95814

Re: SB 171 (Hernandez) – Medi-Cal: Medi-Cal Managed Care Plans
As Amended May 2, 2017
Senate Appropriations Suspense File
County of Riverside: SUPPORT – Per Legislative Platform

Dear Senator Lara:

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

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

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

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

COUNTY OF RIVERSIDE

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

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

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

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

Sincerely,

John Tavaglione
Chairman, Riverside County Board of Supervisors

cc: County of Riverside Delegation
Members, Senate Appropriations Committee
Brendan McCarthy, Consultant, Senate Appropriations Committee
Kirk Feely, Consultant, Senate Republican Caucus

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:

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

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

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

(2) Notwithstanding paragraph (1), a person shall be entitled to a hearing pursuant to this chapter if he or she files the request more than 90 days after the order or action complained of and there is good cause for filing the request beyond the 90-day period. The director may determine whether good cause exists.

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

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

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

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

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

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

Article 6.3. Medi-Cal Managed Care Plans

14197. (a) It is the intent of the Legislature that the department implement the time and distance requirements set forth in ~~Section~~ *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.

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

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

(A) Primary care, adult and pediatric.

(B) Obstetrics and gynecology.

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

(D) Specialist, adult and pediatric.

(E) Hospital.

(F) Pharmacy.

(G) Pediatric dental.

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

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

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

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

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

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

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

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

(d) In developing the time and distance standards, if the department elects a county standard for time and distance, the department shall categorize counties ~~in to~~ *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).

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

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

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

(G) Chapter 8.9 (commencing with Section 14700).

(H) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services and described in the Special Terms and Conditions. For purposes of this subdivision, "Special Terms and Conditions" shall have the same meaning as set forth in subdivision (o) of Section 14184.10.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. The department shall adopt regulations by July 1, 2019, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing July 1, 2018, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations are adopted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any regulations are adopted. The department shall adopt regulations by July 1, 2019, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing July 1, 2018, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations are adopted.

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

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

(2) Designated public hospital systems provide comprehensive health care services to low-income patients and life-saving trauma, burn, and disaster-response services for entire communities, and train the next generation of doctors and other health care

professionals, such as nurses and paramedical professionals, who are critical to new team-based care models that achieve more efficient and patient-centered care.

(3) The Legislature intends to continue to provide levels of support for designated public hospital systems in light of their reliance on Medi-Cal funding to provide quality care to everyone, regardless of insurance status, ability to pay, or other circumstance, the significant proportion of Medi-Cal services provided under managed care by these public hospital systems, and new federal requirements related to Medicaid managed care.

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

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

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

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

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

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

(2) The department, in consultation with the designated public hospital systems, shall annually determine the applicable uniform percentages for each class identified in paragraph (1) and the classification of each designated public hospital system. Once the department determines the classification for each designated public hospital system for a particular state fiscal year, that classification shall not be eligible to change until no sooner than the subsequent

state fiscal year. To the extent necessary to meet the objectives identified in subdivisions (a) and (d) or to comply with federal requirements, the department may, in consultation with the designated public hospital systems, adjust or modify the applicable percentages or the classifications. The department shall consult with the designated public hospital systems and each affected Medi-Cal managed care plan with regard to the implementation of the directed payment requirements once these payment levels have been established.

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

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

(A) A Medi-Cal managed care plan and the designated public hospital systems shall determine the manner, timing, and amount of payment for ~~contracted~~ *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 managed care plan is not in compliance with the requirements of this subdivision, or is otherwise circumventing the purposes thereof, to the material detriment of an applicable designated public hospital system , and, independent of any remedy available to the designated public hospital system, the department may reduce the

default assignment into the Medi-Cal managed care plan with respect to all Medi-Cal managed care beneficiaries by up to 25 percent, so long as the other Medi-Cal managed care plan or Medi-Cal managed care plans in the applicable county have the capacity to receive the additional default membership. The department's determination, whether to exercise discretion under this paragraph, shall not be subject to judicial review. Nothing in this paragraph shall be construed to preclude or otherwise limit the right of any designated public hospital system to pursue a breach of contract action in connection with the requirements of this subdivision.

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

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

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

(A) The department, in consultation with the designated public hospital systems and each Medi-Cal managed care plan, shall establish and provide a method for updating uniform performance measures for the performance-based quality incentive payment

program and parameters for the designated public hospital systems to select the applicable measures. The performance measures shall advance at least one goal identified in the state's Medicaid quality strategy. Measures shall not duplicate measures utilized in the PRIME program established pursuant to Section 14184.50.

(B) Each designated public hospital system shall submit reports to the department containing information required to evaluate its performance on all applicable performance measures, at the times and in the form and manner specified by the department. A Medi-Cal managed care plan shall assist a designated public hospital system in collecting information necessary for these reports.

(2) The department, in consultation with each designated public hospital system, shall determine a maximum amount that each class *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.

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

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

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

(f) (1) The nonfederal share of the portion of the capitation rates specifically associated with directed payments to designated public hospital systems required under subdivision (b) and for the quality incentive payments established pursuant to subdivision (c) may consist of voluntary intergovernmental transfers of funds provided by designated public hospitals and their affiliated governmental entities, or other public entities, pursuant to Section 14164. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to applicable federal Medicaid laws, and in the form and manner specified by the department. Any intergovernmental transfer of funds made

pursuant to this section shall be considered voluntary for purposes of all federal laws. Notwithstanding any other law, the department shall not assess the fee described in subdivision (d) of Section 14301.4 or any other similar fee.

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

(g) (1) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

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

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

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

(3) The director, after consultation with the designated public hospital systems, may modify the requirements set forth in this section to the extent necessary to meet federal requirements or to maximize available federal financial participation. In the event federal approval is only available with significant limitations or modifications, or in the event of changes to the federal Medicaid

program that result in a loss of funding currently available to the designated public hospital systems, the department shall consult with the designated public hospitals to consider alternative methodologies.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, provider bulletins, or other similar instructions, without taking regulatory action. The department shall make use of appropriate processes to ensure that affected designated public hospital systems and Medi-Cal managed care plans are timely informed of, and have access to, applicable guidance issued pursuant to this authority, and that this guidance remains publicly available until all payments made pursuant to this section are finalized.

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

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

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

(3) "Designated public hospital system" means a designated public hospital and its affiliated government entity clinics,

practices, and other health care providers, including the respective affiliated hospital authority and county government entities described in Chapter 5 (commencing with Section 101850) and Chapter 5.5 (commencing with Section 101852), of Part 4 of Division 101 of the Health and Safety Code.

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

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

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

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

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

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

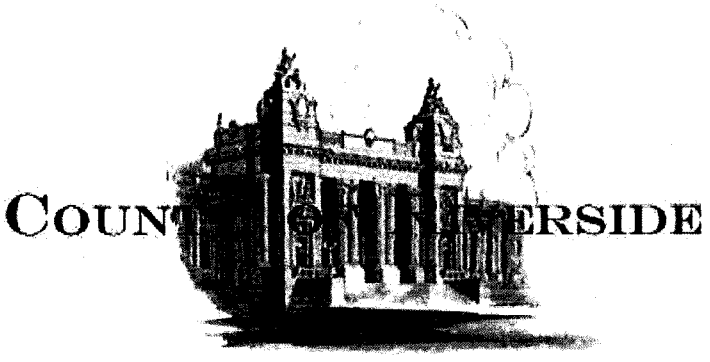
(B) "Medi-cal managed care plan" does not include any of the following:

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

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

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

O



May 19, 2017

The Honorable Cathleen Galgiani
California State Senate
State Capitol, Room 5097
Sacramento, CA 95814

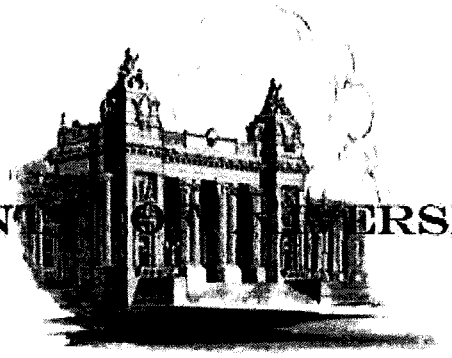
Re: SB 362 (Galgiani): Department of Motor Vehicles: records: confidentiality
As introduced February 14, 2017
Senate Appropriations Committee Suspense File
County of Riverside: SUPPORT – Per Previous Legislative Support

Dear Senator Galgiani:

On behalf of the Riverside County Board of Supervisors, I write to express our support for your SB 362, a measure that seeks to protect code enforcement officers and others by prohibiting the Department of Motor Vehicles (DMV) from disclosing their home addresses. The County of Riverside strongly supports additional protections for our code enforcement personnel and believes they should be afforded a certain level of protection from harm following them home.

The profession of code enforcement is inherently dangerous. Code enforcement personnel enforce state and local laws that potentially impact the businesses and individuals involved. These laws involve health and safety, building violations, business regulations, property nuisances, and poor housing conditions. Additionally, code enforcement personnel may enforce various codes that are typically not handled by law enforcement professionals as they involve land use, housing related violations, or specific local ordinances. Examples of those codes include but are not limited to; enforcement of marijuana grows linked to cartels, abatement of honey oil labs or meth labs, human trafficking as it relates to prostitution in the cover of massage establishments, rental inspection, multi-family housing in gang-ridden or drug-ridden areas, etc. Enforcing such regulations may expose officers to disgruntled property owners, mentally unstable people, or criminal organizations, which hinder an officer's ability to perform their duties without the fear of retaliation and can expose an officer to unsafe conditions in and out of the workplace.

COUNTY OF RIVERSIDE



The Code Enforcement profession parallels the majority of professions already authorized for DMV confidentiality. For these reasons, we strongly support SB 362. Should you have any questions about our position, please do not hesitate to contact Deputy County Executive Officer Brian Nestande at (951) 955-1110 or bnestande@rceo.org.

Sincerely,

John F. Tavaglione
Chairman, Riverside County Board of Supervisors

Cc: The Honorable Ricardo Lara, Chair, Senate Appropriations Committee
Members and Consultants, Senate Appropriations Committee

SENATE BILL No. 362

Introduced by Senator Galgiani

February 14, 2017

An act to amend Section 1808.4 of the Vehicle Code, relating to the Department of Motor Vehicles.

LEGISLATIVE COUNSEL'S DIGEST

SB 362, as introduced, Galgiani. Department of Motor Vehicles: records: confidentiality.

(1) Existing law prohibits the disclosure of the home addresses of certain public employees and officials that appear in records of the Department of Motor Vehicles, except to a court, a law enforcement agency, an attorney in a civil or criminal action under certain circumstances, and certain other official entities.

This bill would extend that prohibition, subject to those same exceptions, to the disclosure of the home addresses of investigators employed by the Department of Insurance, code enforcement officers, as defined, and parking control officers, as specified.

(2) Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

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

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

SECTION 1. Section 1808.4 of the Vehicle Code is amended to read:

1808.4. (a) For all of the following persons, his or her home address that appears in a record of the department is confidential if the person requests the confidentiality of that information:

(1) Attorney General.

(2) State Public Defender.

(3) A Member of the Legislature.

(4) A judge or court commissioner.

(5) A district attorney.

(6) A public defender.

(7) An attorney employed by the Department of Justice, the office of the State Public Defender, or a county office of the district attorney or public defender.

(8) A city attorney and an attorney who submits verification from his or her public employer that the attorney represents the city in matters that routinely place the attorney in personal contact with persons under investigation for, charged with, or convicted of, committing criminal acts, if that attorney is employed by a city attorney.

(9) A nonsworn police dispatcher.

(10) A child abuse investigator or social worker, working in child protective services within a social services department.

(11) An active or retired peace officer, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code.

(12) An employee of the Department of Corrections and Rehabilitation, Division of Juvenile Facilities, or the Prison Industry Authority specified in Sections 20403 and 20405 of the Government Code.

(13) A nonsworn employee of a city police department, a county sheriff's office, the Department of the California Highway Patrol, a federal, state, or local detention facility, or a local juvenile hall, camp, ranch, or home, who submits agency verification that, in the normal course of his or her employment, he or she controls or supervises inmates or is required to have a prisoner in his or her care or custody.

(14) A county counsel assigned to child abuse cases.

(15) An investigator employed by the Department of Justice, *the Department of Insurance,* a county district attorney, or a county public defender.

(16) A member of a city council.

(17) A member of a board of supervisors.

(18) A federal prosecutor, criminal investigator, or National Park Service Ranger working in this state.

(19) An active or retired city enforcement officer engaged in the enforcement of the Vehicle Code or municipal parking ordinances.

(20) An employee of a trial court.

(21) A psychiatric social worker employed by a county.

(22) A police or sheriff department employee designated by the chief of police of the department or the sheriff of the county as being in a sensitive position. A designation pursuant to this paragraph shall, for purposes of this section, remain in effect for three years subject to additional designations that, for purposes of this section, shall remain in effect for additional three-year periods.

(23) A state employee in one of the following classifications:

(A) Licensing-Registration Examiner, Department of Motor Vehicles.

(B) Motor Carrier Specialist I, Department of the California Highway Patrol.

(C) Museum Security Officer and Supervising Museum Security Officer.

(D) Licensing Program Analyst, State Department of Social Services.

(24) A code enforcement officer, as defined in Section 829.5 of the Penal Code.

(25) A parking control officer employed by a city, county, or city and county, university, college, public hospital, public airport, special district, or other public agency to monitor and enforce state laws and ordinances relating to parking.

~~(24)~~

(26) (A) The spouse or child of a person listed in paragraphs (1) to ~~(23),~~ *(25),* inclusive, regardless of the spouse's or child's place of residence.

(B) The surviving spouse or child of a peace officer, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code, if the peace officer died in the line of duty.

(C) (i) Subparagraphs (A) and (B) shall not apply if the person listed in those subparagraphs was convicted of a crime and is on active parole or probation.

(ii) For requests made on or after January 1, 2011, the person requesting confidentiality for their spouse or child listed in subparagraph (A) or (B) shall declare, at the time of the request for confidentiality, whether the spouse or child has been convicted of a crime and is on active parole or probation.

(iii) Neither the listed person's employer nor the department shall be required to verify, or be responsible for verifying, that a person listed in subparagraph (A) or (B) was convicted of a crime and is on active parole or probation.

(D) (i) The department shall discontinue holding a home address confidential pursuant to this subdivision for a person specified in subparagraph (A) or (B) who is the child or spouse of a person described in paragraph (9), (11), (13), or (22) if the child or spouse is convicted of a felony in this state or is convicted of an offense in another jurisdiction that, if committed in California, would be a felony.

(ii) The department shall comply with this subparagraph upon receiving notice of a disqualifying conviction from the agency that employs or formerly employed the parent or spouse of the convicted person, or as soon as the department otherwise becomes aware of the disqualifying conviction.

(b) The confidential home address of a person listed in subdivision (a) shall not be disclosed, except to any of the following:

(1) A court.

(2) A law enforcement agency.

(3) The State Board of Equalization.

(4) An attorney in a civil or criminal action that demonstrates to a court the need for the home address, if the disclosure is made pursuant to a subpoena.

(5) A governmental agency to which, under any provision of law, information is required to be furnished from records maintained by the department.

(c) (1) A record of the department containing a confidential home address shall be open to public inspection, as provided in Section 1808, if the address is completely obliterated or otherwise removed from the record.

(2) Following termination of office or employment, a confidential home address shall be withheld from public inspection for three years, unless the termination is the result of conviction of a criminal offense. If the termination or separation is the result of the filing of a criminal complaint, a confidential home address shall be withheld from public inspection during the time in which the terminated individual may file an appeal from termination, while an appeal from termination is ongoing, and until the appeal process is exhausted, after which confidentiality shall be at the discretion of the employing agency if the termination or separation is upheld. Upon reinstatement to an office or employment, the protections of this section are available.

(3) With respect to a retired peace officer, his or her home address shall be withheld from public inspection permanently upon request of confidentiality at the time the information would otherwise be opened. The home address of the surviving spouse or child listed in subparagraph (B) of paragraph ~~(24)~~ *(26)* of subdivision (a) shall be withheld from public inspection for three years following the death of the peace officer.

(4) The department shall inform a person who requests a confidential home address what agency the individual whose address was requested is employed by or the court at which the judge or court commissioner presides.

(d) A violation of subdivision (a) by the disclosure of the confidential home address of a peace officer, as specified in paragraph (11) of subdivision (a), a nonsworn employee of the city police department or county sheriff's office, or the spouses or children of these persons, including, but not limited to, the surviving spouse or child listed in subparagraph (B) of paragraph ~~(24)~~ *(26)* of subdivision (a), that results in bodily injury to the peace officer, employee of the city police department or county sheriff's office, or the spouses or children of these persons is a felony.

SEC. 2. The Legislature finds and declares that Section 1 of this act, which amends Section 1808.4 of the Vehicle Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the

Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

The need to protect the privacy of specified officers from the public disclosure of their home addresses outweighs the interest in public disclosure of that information.

O

COUNTY OF RIVERSIDE

Board of Supervisors

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

May 18, 2017

The Honorable Richard Pan
Chair, Senate Budget & Fiscal Review Subcommittee No. 3
State Capitol, Room 5114
Sacramento, CA 95814

Re: In-Home Supportive Services Maintenance of Effort Unwind
County of Riverside: Support May Revision – Per Legislative Platform

Dear Senator Pan:

On behalf of the Riverside County Board of Supervisors, I write to support the Governor's May proposal to mitigate the impact of ceasing the Coordinated Care Initiative (CCI) and the In-Home Supportive Services (IHSS) Maintenance of Effort (MOE) on California counties.

Riverside County appreciates the Administration's recognition that their January actions would have a devastating effect on services across counties – including health, mental health, social services and public safety. The anticipated first year impact from the January action in Riverside County was $43 million; under the May Revision proposal, our local impact is reduced to an estimated $10 million in the first year. Although the County will still experience challenges in managing this new cost, we recognize the good faith with which the Administration worked with counties to achieve a compromise.

The County is gratified that the Administration acknowledges the growing out year costs associated with the May proposal and that they have committed to ongoing dialogue related to IHSS costs and 1991 Realignment revenues.

Riverside County respectfully requests your Subcommittee to approve the May Revision proposal for IHSS costs. If you have any questions about the County's position, please do not hesitate to contact Deputy County Executive Officer, Brian Nestande at (951) 955-1110 or bnestande@rceo.org.

Sincerely,

John Tavaglione
Chairman, Riverside County Board of Supervisors

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

COUNTY OF RIVERSIDE

May 18, 2017

The Honorable Joaquin Arambula, MD
Chair, Assembly Budget Subcommittee No. 1
State Capitol, Room 5155
Sacramento, CA 95814

Re: In-Home Supportive Services Maintenance of Effort Unwind
County of Riverside: Support May Revision – Per Legislative Platform

Dear Assembly Member Arambula:

On behalf of the Riverside County Board of Supervisors, I write in support of the Governor's May proposal to mitigate the impact of ceasing the Coordinated Care Initiative (CCI) and the In-Home Supportive Services (IHSS) Maintenance of Effort (MOE) on California counties.

Riverside County appreciates the Administration's recognition that their January actions would have a devastating effect on services across counties – including health, mental health, social services and public safety. The anticipated first year impact from the January action in Riverside County was $43 million; under the May Revision proposal, our local impact is reduced to an estimated $10 million in the first year. Although the County will still experience challenges in managing this new cost, we recognize the good faith with which the Administration worked with counties to achieve a compromise.

The County is gratified that the Administration acknowledges the growing out year costs associated with the May proposal and that they have committed to ongoing dialogue related to IHSS costs and 1991 Realignment revenues.

Riverside County respectfully requests your Subcommittee to approve the May Revision proposal for IHSS costs. If you have any questions about the County's position, please do not hesitate to contact Deputy County Executive Officer, Brian Nestande at (951) 955-1110 or bnestande@rceo.org.

Sincerely,

John Tavaglione
Chairman, Riverside County Board of Supervisors

cc: Members, Assembly Budget Subcommittee No. 1
Nicole Vazquez, Consultant, Assembly Budget Committee
Cyndi Hillery, Consultant, Assembly Republican Caucus
County of Riverside Legislative Delegation
Michael Cohen, Director, Department of Finance
Will Lightbourne, Director, Department of Social Services
Jennifer Kent, Director, Department of Health Care Services

HEALTH AND HUMAN SERVICES

The Health and Human Services Agency oversees departments and other state entities that provide health and social services to California's vulnerable and at-risk residents.

The May Revision includes $158.7 billion ($33.7 billion General Fund and $125.1 billion other funds) for all health and human services programs, a decrease of $324.8 million General Fund compared to the Governor's Budget.

END OF COORDINATED CARE INITIATIVE

The Coordinated Care Initiative (CCI) was created in 2012 in an effort to reduce state costs and improve health care delivery by coordinating services through a single health plan. The Governor's Budget reflected the finding that the CCI was no longer cost-effective and that under current law, the program would end in 2017-18. This resulted in removing In-Home Supportive Services (IHSS) benefits from Medi-Cal managed care capitation rates, returning bargaining for IHSS workers' wages and benefits to the seven CCI counties, and re-establishing the county share-of cost in IHSS at 35 percent of non-federal costs rather than a maintenance-of-effort structure. The state pays 65 percent of the non-federal costs. The net fiscal result to counties was an estimated cost of $623 million. In recognition that 1991 Realignment funds, which fund counties' share of IHSS, were insufficient to cover this magnitude of increase, the Administration indicated its desire to mitigate, to the extent possible, the impact on counties.

The May Revision reflects an updated estimate of $592.2 million to return to the share-of-cost structure for counties. In discussions this spring, counties emphasized the need for financial assistance, more predictability of costs, and time to adjust to any changes. The May Revision provides significant help in each of these areas. The May Revision includes an infusion of General Fund and other state resources to help offset these costs as well as additional mitigations to assist the counties during this transition. The proposal assumes all other programs supported by the 1991 Realignment Social Services Subaccount continue to be funded as they have been.

The proposal includes the following fiscal provisions:

- General Fund Assistance—$400 million General Fund in 2017-18; $330 million in 2018-19; $200 million in 2019-20 and $150 million in 2020-21 and ongoing.
- Use of Growth Funds—Redirection of all Vehicle License Fee growth for three years from the Health, County Medical Services Program (CMSP), and Mental Health Subaccounts to provide additional resources for IHSS. In years four and five, 50 percent of this Vehicle License Fee growth will be redirected. The portion of the growth funds redirected from the Health Services Subaccount, which would have offset General Fund costs in CalWORKs, are reflected in the General Fund assistance totals above.
- Maintenance-of-Effort Structure—Institute a maintenance-of-effort (MOE) structure rather than a 65-percent state/35-percent county share-of-cost structure. The General Fund will pay the difference between the MOE and the non-federal share of IHSS costs.
- More Current Cost Data—Change the methodology for calculation of IHSS caseload in the Social Services Subaccount to use the current estimate of caseload and cost information.
- Inflation Factor—Create a new base for county costs of IHSS in 2017-18 that includes services and administrative costs. An annual inflation factor will be phased in and applied to the base. In year one (2017-18), the inflation factor will be zero; in the second year, the inflation factor will be 5 percent. In future years, the inflation factor would be on a sliding scale based on 1991 Realignment revenue performance. If revenue growth is negative, then there would be no inflation factor applied. If revenue growth is less than 2 percent, then the inflation factor would be 3.5 percent. If revenue growth is above 2 percent, the inflation factor would be 7 percent (the expected IHSS annual cost growth).

The estimated net amounts of county costs not covered are:

- 2017-18: $141 million
- 2018-19: $129 million
- 2019-20: $230 million
- 2020-21: $251 million

Based on revenue growth allocations under the CCI pilot, the Health, CMSP, and Mental Health Subaccounts received funding that allowed their base amounts to grow beyond normal expectations. While not receiving growth for a limited-time period—as proposed in the May Revision—requires an adjustment, redirecting the growth to IHSS reflects the highest funding priority. Under current law, counties are obligated to provide a 3.5-percent annual rate increase to Institutions for Mental Disease. In recognition of the reduced amount of growth funding going to the Mental Health Subaccount, the May Revision proposes that in any year the Mental Health Subaccount does not receive its full growth allocation, this rate increase requirement will be suspended.

The May Revision also proposes that counties experiencing financial hardship due to the increased costs of IHSS may apply to the Department of Finance for a low-interest loan to help cover those costs. The Department of Finance will work with counties to determine how such a loan would be structured and what documentation would be needed for application.

Because IHSS costs and 1991 Realignment revenues can be volatile, the Administration has agreed to on-going discussions with the counties about the costs of the program within the structure of 1991 Realignment and the impact of the inflation factor as it relates to overall 1991 Realignment revenues.

The May Revision also proposes that any amounts counties may owe the state through 2015-16 because of the Board of Equalization's miscalculations of sales tax revenue allocations will not have to be repaid.

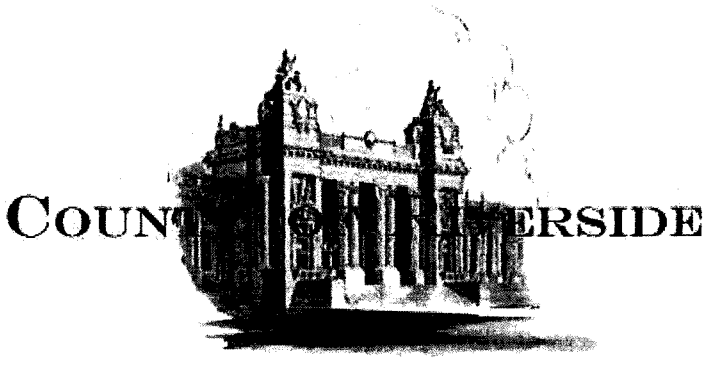
IHSS COLLECTIVE BARGAINING

With the return of collective bargaining to all counties, the Administration reviewed the current structure of local bargaining and is proposing several adjustments.

Under CCI, if a county negotiated a wage and benefit increase, its MOE increased by its 35 percent share. State participation has been capped at $12.10 per hour for wages and benefits since 2007-08. The May Revision maintains the 35-percent county share of negotiated increases and proposes that the state participation cap should float to always be $1.10 above the hourly minimum wage set in Chapter 4, Statutes 2016 (SB 3), for large employers. Like SB 3, the cap would rise with inflation once the minimum wage reaches $15 per hour.

Many counties are at or exceed the current state cap of $12.10. For those counties, the state would agree to participate at its 65-percent share of costs up to a 10-percent increase in wages and benefits over three years.

Beginning July 1, 2017, the May Revision proposes that if a county does not conclude bargaining with its IHSS workers within nine months, the union may appeal to the Public Employment Relations Board.



May 18, 2017

The Honorable Holly Mitchell
Chair, Senate Budget and Fiscal Review Committee
State Capitol, Room 5019
Sacramento CA 95814

The Honorable Philip Y. Ting
Chair, Assembly Budget Committee
State Capitol, Room 6026
Sacramento CA 95814

RE: Budget Item 5227 – Board of State and Community Corrections (BSCC)
Proposed In-Person Jail Visitation Requirements
County of Riverside: OPPOSE – Per Legislative Platform

Dear Senator Mitchell and Assembly Member Ting:

The Riverside County Board of Supervisors writes to oppose the legislative budget proposal that would change jail visitation requirements. Placeholder trailer bill language to impose an in-person visitation standard on completed as well as under-construction facilities was approved in the Senate Budget and Fiscal Review Subcommittee No. 5; this same item was scheduled for hearing in the Assembly Budget Subcommittee No. 5 on May 17.

In Riverside County, this proposal would require a one-time investment of tens of millions to construct adjacent facilities for visitation and dedication of ongoing resources for facility staffing. Those latter costs would be in the low millions of dollars per year initially, but would be subject to steady growth given that employee costs tend to rise over time.

The County is simply not in a position to absorb these unanticipated costs. Regrettably, the County of Riverside is already facing significant fiscal constraints. Like many other counties in our state, our County has not fully recovered from the Great Recession; our short- and long-term economic outlook is very challenging and somewhat unknown given other state budget proposals under consideration.

The County offers in-person visitation in several of our existing jail facilities and does not dispute the benefits of a face-to-face visitation option. However, like similarly situated counties, the County of Riverside fully complied with the law and regulations in effect at the time that our most recent construction projects were undertaken. Requiring the County to revisit its design and construction choices after the fact at a cost that will likely exceed tens of millions of dollars would come at the expense of other important programming and service investments within and outside of the sheriff's department.

COUNTY OF RIVERSIDE

Given the Board of State and Community Corrections regulation revision approved by the Board in February which requires prospective application of an in-person visitation standard coupled with the significant, unanticipated costs imposed upon counties were this standard to be applied immediately, the County of Riverside urges your rejection of the trailer bill language.

Should you have any questions regarding our position on the proposed trailer bill language, please do not hesitate to contact Deputy County Executive Officer, Brian Nestande at (951) 955-1110 or bnestande@rceo.org. Thank you for considering our perspective.

Sincerely,

John Tavaglione
Chairman, Riverside County Board of Supervisors

Cc: Members and Consultants, Senate Budget and Fiscal Review Committee
Members and Consultants, Assembly Budget Committee
Riverside County Delegation
Chris Ryan, Department of Finance

ISSUE 25: JAIL VISITATION REQUIREMENTS

BACKGROUND

As discussed during the February 21st joint hearing, in recent years it has come to the State's attention that some county jails are no longer providing in-person visitation. Instead they are allowing only visitation via video. In addition, despite significant concern from the Legislature, BSCC has recently developed regulations that grandfather in a large number of counties who have expressed an interest in only providing video visitation. According to the last information from the BSCC, over 20 counties have either already stopped providing in-person visitation or plan on stopping in-person visitation. Of those jails, eight do not appear to have the physical space to accommodate in-person visits.

Previous Subcommittee Hearing. This item was discussed during a joint hearing between the Senate Public Safety Committee, and both the Senate and Assembly public safety budget subcommittees on February 21, 2017. The agenda and video recordings from that hearing are available on the State Senate website.

STAFF COMMENTS

Staff recommends that the Subcommittee do the following:

Adopt placeholder trailer bill language that does the following:

- Requires that a county providing video visitation, also provide in-person visitation.
- Temporarily exempts the following eight county jails from providing in-person visitation once BSCC has inspected the jail and certified that it does not have space for in-person visitation:
  - Kings County Jail Facility
  - Kings County Branch Jail
  - Madera County Adult Correctional Facility
  - San Bernardino High Desert Detention Center
  - San Mateo Maple Street Correctional Facility
  - Solano County -- Stanton Correctional Facility
  - Tulare South County Detention Facility
  - Imperial Oren R. Foy Medical Security Facility
- Requires all other county jail facilities to provide in-person visitation, if they are providing video visitation.
- Requires the eight exempt county facilities to provide for in-person visitation within five years of passage of the 2017 budget. In addition, those counties will receive priority for any jail construction funding that is relinquished to the

BSCC in order to retrofit the existing jails to provide for in-person visitation. Any additional construction funding provided by the state can only be used for in-person visitation space.

- Temporarily suspends all construction (with the exception of counties that have broken ground on new facilities) pending certification from the BSCC that the new facilities, funded with the assistance of the state, will have appropriate space for in-person visitation.

- Prohibits counties from charging for video visitation, whether the visitor is in the facility or conducting visitation from a remote location.

Staff Recommendation: Approve Staff Recommendation.

COUNTY OF RIVERSIDE

May 18, 2017

The Honorable Holly Mitchell
Chair, Senate Budget and Fiscal Review Committee
State Capitol, Room 5019
Sacramento CA 95814

The Honorable Philip Y. Ting
Chair, Assembly Budget Committee
State Capitol, Room 6026
Sacramento CA 95814

Re: Budget Item 2660 – California Department of Transportation
SB 1 Implementation: Proposed Trailer Bill Language to Expedite SB 132 Projects
County of Riverside: SUPPORT – Per Legislative Platform

Dear Senator Mitchell and Assembly Member Ting:

On behalf of the Riverside County Board of Supervisors, I write in support of the Administration's proposed trailer bill language to expedite project delivery for the fives projects in the Riverside County Transportation Efficiency Corridor (RCTEC) as outlined in SB 132, as well as other projects in the region. The County of Riverside is a participant in the task force to develop the recommendations contained in the trailer bill language and appreciates the Administration's collaborative approach to ensure that these important regional projects are delivered efficiently and effectively.

Specifically, the Administration's proposed trailer bill language:

- Expands the pilot program for Construction Manager/General Contractor (CM/GC) on the state highway system and provides similar authority for the Riverside County Transportation Commission (RCTC).
- Expands the pilot program for design-build on local streets and roads.
- Provides new statutory authority for the RCTC to use innovative procurement and project delivery methods on the SR-91 Toll Connector to I-15 North.
- Authorizes the use of CM/GC procurement and project delivery method on off-system projects in Riverside County, including bridge rehabilitation and replacement and railroad grade separations.
- Allows the use of cost-plus-time (A+B) contracting authority to encourage early completion of projects.

COUNTY OF RIVERSIDE

These statutory changes will allow the County of Riverside, RCTC, and the State to work in partnership to deliver the five projects identified in SB 132, as well as other projects in the region, in a timely, cost-effective manner. If you have any questions about the County's position, please do not hesitate to contact Deputy County Executive Officer, Brian Nestande at (951) 955-1110 or bnestande@rceo.org.

Sincerely,

John Tavaglione
Chairman, Riverside County Board of Supervisors

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

Issue 5 – Project Acceleration Trailer Bill Language

Governor's Proposal. The Governor's May Revision includes trailer bill language related to the implementation of SB 132 (Committee on Budget and Fiscal Review), Chapter 7, Statutes of 2017, which, among other requirements, required the Secretary of Transportation to convene a task force of state, local, and private sector experts to accelerate the schedule of delivery for these and other projects in the region, and requires that any recommendations from this task force requiring statutory changes be included in the May Revision to the 2017-18 Governor's Budget.

Background. Senate Bill 132 created the Riverside County Transportation Efficiency Corridor (RCTEC) and appropriated $427 million of current budget year resources to five projects. SB 132 assigned the CalSTA Secretary to convene a task force of state, local, and private sector stakeholders to make recommendations to expedite delivery of the five RCTEC projects and other projects in the region. SB 132 directs statutory changes recommended by the task force to expedite RCTEC and other projects to be included in the Governor's May Revision. The items below represent the statutory changes recommended by the task force that primarily benefit the RCTEC, but some authority also provides statewide benefit to expedite other SB 1 projects.

- **Section 1 - Expands pilot program for Construction Manager/General Contractor (CM/GC) on state highway system.** *(PCC 6701).* Allows Caltrans to use CM/GC on twelve (12) projects in addition to the twelve (12) projects already authorized by law. Authorizes the Riverside County Transportation Commission (RCTC) to use CM/GC for two projects on the state highway system, with priority on SB 132 projects. Increases the number of Caltrans-delivered CM/GC projects that must use Caltrans employees or consultants for engineering and design services from eight to sixteen projects. Specifies that all twenty-four CM/GC projects delivered by Caltrans must use Caltrans employees or consultants for construction inspection.
- **Section 2 - Expands pilot program for Design-Build on local streets and roads.** *(PCC 22161).* Authorizes Caltrans to select six local street and road projects to use design-build, which may include bridge replacements and rehabilitations, and railroad grade separations. Three of these projects are reserved for RCTC, with priority on SB 132 projects.
- **Section 3 - Contracting flexibility to expedite delivery of SR-91 Toll Connector to I-15 North** (*New Code).* Authorizes RCTC to determine the best project delivery method to accelerate the SR-91 Toll Connector to I-15 North and minimize disruption to the traveling public. Such methods may include design-build, CM/GC, or amendment or change to existing contracts RCTC holds. Explicitly authorizes RCTC to use low-bid *and* acceleration of delivery as the basis for contract awards for this project.
- **Section 4 - Expands authority for use of Construction Manager/General Contractor (CM/GC) off of the state highway system** *(PCC 6971).* Adds railroad grade separations and bridge replacements and rehabs in Riverside County to projects for which regional transportation agencies may use CM/GC; otherwise regional agencies may only use CM/GC on off-system expressways. Adds the County of Riverside to the definition of "regional agency."
- **Section 5 - A+B contracting authority for SB 132 lead agencies** *(new PCC 20155.10).* Authorizes agencies delivering SB 132 projects to use "cost-plus-time" bidding (also known as "A+B") whereby cost and time parameters are evaluated in public works contracts to determine best value.

- **Other – via a budget bill amendment, provides a direct appropriation of SB 132 to Riverside County Transportation Commission (RCTC)** *(new Provision 3 of FY 2016-17 Budget Item 2660-110-0042).* Clarifies that RCTC may be the recipient of appropriations for SB 132 projects.

Staff Comments. The proposed language is the result of the work of the task force called for in SB 132. The Subcommittee may want to consider the extent to which the proposed language would meet the goal of expediting projects in the Riverside County Transportation Efficiency Corridor, and the extent to which the proposed language is consistent with statewide transportation project planning and delivery mechanisms.

Staff Recommendation: Hold Open.