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

ITEM
2.31
(ID # 4836)

MEETING DATE:
Tuesday, July 25, 2017

FROM : EXECUTIVE OFFICE:

SUBJECT: EXECUTIVE OFFICE: Legislative Update: July 25, All Districts. [$0]

RECOMMENDED MOTION: That the Board of Supervisors:
1. Receive and File the July 25 Legislative Update.

ACTION: Consent

Brian Nestande 7/18/2017 Paul McDonnell, County Finance Director 7/20/2017

MINUTES OF THE BOARD OF SUPERVISORS

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

Ayes:	Jeffries, Tavaglione, Washington, Perez and Ashley
Nays:	None
Absent:	None
Date:	July 25, 2017
xc:	E.O.

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 (Amended: Changes - Non-Substantive)
Position: CONTINUED SUPPORT – Per Legislative Platform
Recipient: Senator Ed Hernandez, O.D.
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.

Legislation/Policy: AB 511 (Arambula) -Tuberculosis risk assessment and examination
Position: SUPPORT – Per Board Action
Recipient: Senator Ed Hernandez, O.D.
Summary: This bill would require the employment agency to verify that the individual/employee has submitted to a tuberculosis risk assessment, developed by the State Department of Public Health and the California Tuberculosis Controllers Association, within 90 days prior to employment and annually thereafter, and, if risk factors are present, an examination to determine that he or she is free of infectious tuberculosis.

Legislation/Policy: AB 668 (Gonzalez Fletcher) - Voting Modernization Bond Act of 2018 (Amended: Changes - Non-Substantive)
Position: CONTINUED SUPPORT – Per Board Action
Recipient: Senator Henry Stern
Summary: The Voting Modernization Bond Act of 2002 authorizes the Voting Modernization Finance Committee to issue and sell bonds in the amount of $200,000,000, as specified. Current law authorizes a county to apply to the Voting Modernization Board for money from the proceeds of the sale of bonds (1) to pay for or purchase new voting systems that are certified or conditionally approved by the Secretary of State, (2) to research and develop new voting systems, or (3) to manufacture the minimum number of voting system units reasonably necessary to test and seek certification or conditional approval of the voting system, or test and demonstrate the capabilities of a voting system in a pilot program.

Legislation/Policy: AB 1401 (Maienschein) - Juveniles: Protective Custody Warrant
Position: SUPPORT – Per Board Action
Recipient: Senator Hannah-Beth Jackson
Summary: Would authorize the court to issue a protective custody warrant, without filing a petition in the juvenile court alleging that the minor comes within the jurisdiction of the juvenile court as a dependent, if there is probable cause to believe the minor comes within the jurisdiction of the juvenile court as a dependent, there is a substantial danger to the safety or physical health of the child, and there are no reasonable means to protect the child's safety or physical health without removal.

Legislation/Policy: SB 171 (Hernandez) - Medi-Cal: Medi-Cal Managed Care Plans (Amended: Changes - Non-Substantive)
Position: CONTINUED SUPPORT – Per Legislative Platform
Recipient: Assembly Member Jim Wood
Summary: This bill ensures the continuation of supplemental funding to public hospitals, which is worth $1-1.5 billion statewide. As Riverside County currently operates a level 2 trauma center, Riverside County would qualify for the highest levels of supplemental payments available under this bill.

Legislation/Policy: SB 649 (Hueso) - Wireless Telecommunications Facilities (Amended: Changes - Non-Substantive)
Position: CONTINUED OPPOSE – Per Legislative Platform
Recipient: Assembly Member Miguel Santiago
Summary: This bill would provide that a small cell is a permitted use, subject only to a specified permitting process adopted by a city or county, if the small cell meets specified requirements.

Legislation/Policy: SR 40 (Morrell) - Relative to First Responder Day
Position: SUPPORT
Recipient: Senator Mike Morrell
Summary: This measure would resolve that the Senate declares September 23, 2017, as First Responder Day, in honor of the contributions and dedication of first responders.

Legislative Status Update

As per Board Policy A-27, amended on March 7, 2017: The Board shall receive a regular written report on the status of legislation that the Board has officially endorsed or opposed, to be included as part of the consent calendar.

State Issues

Since the last update provided to the Board, Governor Brown has signed the last few budget trailer bills thus wrapping up nearly all action on the 2017-18 budget. It is with the end of budget negotiations that the State Legislature and the Administration moved on to the pressing issue of cap-and-trade.

CAP & Trade

New developments on cap-and-trade negotiations have turned into a normal occurrence as the Governor and legislative leaders attempted to work out a deal that would muster a 2/3 vote in the Senate and Assembly.

Efforts to extend the states cap-and-trade program to 2030 have culminated in the form of a two bill package (AB 398 & AB 617).

- AB 398, by Assembly Member Eduardo Garcia, extends the authority for the State Air Resources Board (ARB) to administer the cap-and-trade program. Additionally, AB 398 requires the ARB to develop regulations that include price containment methodologies, requires 50% of all offsets to occur in California, and sets priorities for

allocation of cap-and-trade revenues. The bill also includes a suspension and eventual elimination of the State Responsibility Area (SRA) fees that homeowners in SRAs pay to fund CalFIRE's fire protection activities and extends and expands the existing manufacturer's tax credit to include certain activities associated with generation of electric power. State revenue losses associated with these tax provisions would be backfilled with revenue from the cap-and-trade program.

- AB 617, by Assembly Member Cristina Garcia, the companion measure to AB 398, would:
  - Require the ARB to establish a uniform, statewide system for stationary sources to report emissions data.
  - Authorize local air quality management districts (AQMDs) to implement an expedited schedule for retrofitting of certain facilities to address pollution issues.
  - Increase civil penalties for certain types of emissions.
  - Requires local AQMDs to deploy community air monitoring systems under certain circumstances.

Both measures were heard in committee and appropriations and now move on to the Governor's desk for signature.

Federal Issues

Healthcare

With four Senate Republicans, Susan Collins (ME), Rand Paul (KY), Mike Lee (UT) and Jerry Moran (KS) coming out against the most recent repeal and replace plan of the Affordable Care Act (ACA), the measure was pulled from any consideration. Briefly, Senate Leader Mitch McConnell speculated that the Senate might simply vote on a repeal of the ACA with a two-year delay built in during which time replacement legislation might be considered. Unfortunately, less than 24 hours after McConnell dropped his replacement plan it appears that his latest proposal to simply repeal Obamacare is already dead for lack of support among fellow Republicans.

As an offshoot to the pulling of the repeal and replace legislation, some Senators are moving to develop short-term fixes for the health insurance market while others seek to kick start discussions on the matter. Further details will be provided as these efforts move forward.

Tax Reform

Tax reform continues be the subject of much speculation and discussion, but both the Administration and Congressional leadership have indicated healthcare reform will have to move prior to starting work in earnest on tax reform. The focus now seems to be on whether the effort will truly result in reform (an overhaul of the existing code) or become primarily a tax cut (reducing existing rates). The latter option is thought to be easier to achieve, while the former is still the goal of House Speaker Paul Ryan.

Infrastructure

Annual Transportation Appropriations

The $56.5 billion transportation-housing spending bill approved in the House appropriations subcommittee July 11 strikes a balance between supporting projects with bipartisan popularity and making cuts in the president's proposed budget. The bill would provide $17.8 billion in discretionary spending for transportation programs in fiscal year 2018 and $38.3 billion for housing programs. The bill was approved by a unanimous voice vote and went before the full House committee the week of July 17 for markup.

Water Infrastructure Bill Approved by House Subcommittee

Draft legislation to reauthorize a program that provides low-interest loans for drinking water infrastructure projects gained approval from the House environment subcommittee. It would reauthorize the drinking water state revolving fund, which provides financial support to water systems, and makes some changes to how that program works.

The Drinking Water System Improvement Act would amend the Safe Drinking Water Act to add contractual agreements for enforcement of correcting violations and improving the accuracy and availability of compliance data. The bill would also require the Environmental Protection Agency to update technical information and training materials on asset management every five years. The bill was approved by voice vote and moved to the full Energy and Commerce Committee for consideration.

The subcommittee did adopt an amendment, filed by Rep. John Shimkus (R-Ill.), that would:

- Require states to reserve 6 percent of available funds for capitalization grants to disadvantaged communities,
- Task the EPA administrator to create a grant program to aid local education agencies in replacing older water fountains,
- Require the EPA to consider the cost of replacing lead service lines in its periodic review of drinking water infrastructure needs, and
- Make the comptroller general submit a report to Congress on compliance demonstrations and enforcement of the act.

Budget Reconciliation

So far this year, the Congressional budget reconciliation process has been tied very closely with the health care repeal/replace efforts.

For House Republican leaders their draft fiscal 2018 budget was set for release on Tuesday, July 18 in concurrence with all 12 appropriations bills which are currently on track to be out of committee by the end of the week. The $1.132 trillion top-line spending level Republicans are using puts them on a collision course with the 2011 Budget Control Act, Public Law 112-25. Under the law, discretionary budget authority for fiscal 2018 cannot exceed a $1.065 trillion cap. Appropriations bills will need at least 60 votes in the Senate, requiring support from at least eight Democrats or independents, to be enacted.

Senate Democrats have said any increase in the Budget Control Act's $549 billion cap on defense spending would need to be accompanied by an increase in the $516 billion limit for non-defense programs. They have also said they will not accept using a giant war funding mechanism (Overseas Contingency Operations or "OCO") to funnel money to the Pentagon in order to bypass the cap.

That means one of three outcomes in the coming months will occur, in order of likelihood:

1. A stopgap spending bill (a Continuing Resolution or CR, or a CR + a partial Omnibus, the so-called "CRomnibus");
2. A bipartisan deal raising defense and domestic spending caps; and/or
3. A government shutdown Oct. 1 that either causes Democrats to back down or results in option No. 1 or option No. 2.

Debt Ceiling

Republicans are divided over whether to raise the debt ceiling before the August recess, with senators preferring to act soon and members of the more conservative House reluctant to take the contentious vote before the break.

Congress will need to pass an increase in federal borrowing authority sometime this year. Technically, the federal government has already reached the existing borrowing cap, but incoming tax receipts coupled with "extraordinary measures" being implemented by the Treasury are taking the pressure off of a needed immediate increase.

The Administration is reportedly seeking an increase of $2 trillion and the conservative Freedoms Caucus has signaled support for an increase of $1.5 trillion which would finance government spending until right after the 2018 mid-term

elections. Secretary Mnuchin indicated recently that an increase would be needed in early September and is hopeful Congress can act before leaving for the August recess.

Significantly, Treasury has been taking the lead on the debt ceiling as opposed to OMB which could suggest the Administration's support for a "clean" debt limit increase. A clean increase, though, would be a marked departure from the recent past where debt ceiling negotiations have been used to set discretionary spending levels, to change mandatory programs like Medicaid, and enact mandatory cuts through sequestration.

Appropriations

In July the House began FY18 markups in earnest using the FY17 numbers as a baseline. This is a reflection on the lack of progress on the overall budget talks and the need to get the FY18 process moving. Both the House and Senate have said the MilCon-VA bills will be the first to move in both chambers – it is a relatively non-controversial bill that has been used in the past as the vehicles for continuing resolutions. Agreement must be reached on the budget caps between the House and Senate to avoid $3 billion in cuts to defense and $2 billion in domestic programs resulting from sequestration. Agreement may not be reached until late in FY17 and could result in the House and Senate simply "deeming" the ultimate numbers in the appropriations bills as the caps rather than adopting a budget agreement. This an ongoing process and will be the subject of negotiations and debate throughout the year.

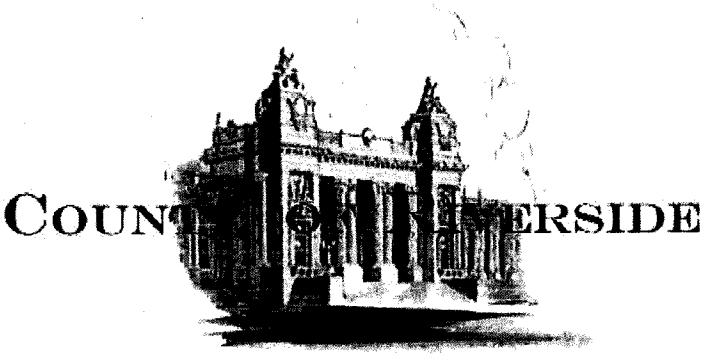
Status of Appropriations bills:

House Subcommittee	**Latest Status**
Ag/FDA	Voice voted out of full committee on 7-12
Commerce/Justice/Science	Voted 31 to 21 out of full committee on 7-13
Defense	Voice voted out of full committee on 6-29
Energy & Water	Voice voted out of full committee on 7-12
Financial Services	Voted 31 to 21 out of full committee on 7-13
Homeland Security	Voice voted out of subcommittee on 7-12
Interior & Environment	Voice voted out of subcommittee on 7-12
Labor/HHA/Education	Voted 9-6 out of subcommittee on 7-13
Legislative Branch	Voice voted out full committee on 6-29
State & Foreign Ops	Voice voted out of subcommittee on 7-13
Transportation/HUD	Voice voted out of subcommittee on 7-11
Military Construction and Veterans Affairs was voice voted out of the House full committee on 6-15 and voted 31-0 out of the Senate full committee on 7-13.	

Impact on Residents and Businesses

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

ATTACHMENT A. Legislative Letters Sent & Legislation
ATTACHMENT B. Legislative Letters Sent Fact Sheet
ATTACHMENT C. County Legislative Positions – Status Update
ATTACHMENT D. County Legislative Positions – Legislation
ATTACHMENT E. Cap-and-Trade Bills



June 30, 2017

The Honorable Ed Hernandez, O.D.
Chair, Senate Health Committee
State Capitol, Room 2080
Sacramento, CA 95814

Re: AB 205 (Wood) – Medi-Cal: Medi-Cal Managed Care Plans
As Amended May 2, 2017
Set for Hearing July 12, 2017 – Senate Health Committee
County of Riverside: SUPPORT – Per Legislative Platform

Dear Senator Hernandez:

On behalf of the Riverside County Board of Supervisors, I write in support of 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 a 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.

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.

COUNTY OF RIVERSIDE

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. Pending amendments will create the first element – a fixed pool of directed payments, for classes of providers including (1) Level I or II trauma centers, (2) University of California Medical Centers, (3) fully capitated health systems, and (4) 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@rivco.org.

Sincerely,

John Tavaglione
Chairman, Riverside County Board of Supervisors

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

AMENDED IN SENATE JULY 5, 2017

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~~ *1367.035 of the Health and Safety Code, and to amend Sections 10950 and 10951* of, *to add Section 10959.5 to,* 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. *These federal regulations require, with regards to a state fair hearing request filed by an enrollee entitled to an expedited resolution of an appeal by a managed care plan, an agency to take final administrative action as expeditiously as the enrollee's health condition requires, but not later than 3 working days after the agency receives, from the managed care plan, the case file and information for any appeal of a denial or a service that, as indicated by the managed care plan meets the criteria for expedited resolution of an appeal, but was not resolved within the timeframe for expedited resolution, or was resolved within the timeframe for expedited resolution of an appeal, but the managed care plan reached a decision wholly or partially adverse to the enrollee.*

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~~ *person, after he or she has exhausted the Medi-Cal managed care plan's appeals process,* to request a hearing involving a Medi-Cal managed care plan within 120 calendar days after ~~the order or action complained of,~~ *he or she has either received verbal or written notice from the Medi-Cal managed care plan that the adverse benefit determination, as defined, is upheld or the appeal or expedited appeal is denied, or the person is deemed to have exhausted the Medi-Cal managed care plans appeals process, as specified,* 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. *The bill would require the State Department of Social Services to adopt any necessary rules and regulations to implement these changes, and, until July 1, 2018, would*

authorize the State Department of Social Services to adopt any necessary rules and regulations as emergency regulations.

The bill would require the State Department of Social Services, for a beneficiary of a Medi-Cal managed care plan who meets the criteria for an expedited resolution of an appeal, to take final administrative action as expeditiously as the individual's health condition requires, but no later than 3 working days after the State Department of Social Services receives certain information from the Medi-Cal managed care plan consistent with the federal regulation described above. The bill would require a Medi-Cal managed care plan, upon notice from the State Department of Social Services that a beneficiary has requested a state fair hearing, to provide to the department a copy of the case file and any information for any appeal of a denial of a service within 3 business days of the Medi-Cal managed care plan's receipt of the department's notice of a request by a beneficiary for a state fair hearing.

(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 *that covered and* 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 *covered and medically necessary* 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.~~ *contracts, and would require the department, in developing these standards, to take into consideration requirements under a specified federal regulation.* 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,~~ *basis and when requested by the State Department of Health Care Services,* a Medi-Cal managed care plan, as defined, to demonstrate to the ~~department~~ *State Department of Health Care Services and, for Medi-Cal managed care plans licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), the Department of Managed Health Care* its compliance with the standards developed under this provision. *The bill would also require a health care service plan licensed under the Knox-Keene Act that provides services to Medi-Cal beneficiaries to provide to the Department of Managed Health Care, in a manner specified by the department, data regarding the standards developed under this provision. Because a willful violation of the Knox-Keene Act by a health care service plan is a crime, this bill would impose a state-mandated local program.*

The bill would require a Medi-Cal managed care plan, as defined, to comply with the MLR *calculation and* 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 generally provide that these MLR requirements do not apply to a health care service plan under a subcontract with a Medi-Cal managed care plan to provide covered health care services to Medi-Cal beneficiaries enrolled in the Medi-Cal managed care plan. The bill would require the department to post specified information on its Internet Web site, including any required remittances owed by a Medi-Cal managed care plan.*

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) These federal regulations require specified managed care plans to have a grievance and appeal system in place for enrollees, and requires managed care plans to resolve each grievance and appeal, and to provide timely and adequate notice, as expeditiously as the enrollee's health condition requires, within certain state-established timeframes that may not exceed specified timeframes.

This bill would require a Medi-Cal managed care plan, as defined, to give a beneficiary timely and adequate notice of an adverse benefit determination, as defined, in writing consistent with those federal regulations. The bill would require a Medi-Cal managed care plan to establish and maintain an expedited review process for a beneficiary or the beneficiary's provider to request an expedited resolution of an appeal based on specified circumstances, including when the beneficiary's condition is such that the beneficiary faces an imminent and serious threat to his or her health, or the standard timeline would be detrimental to the beneficiary's life or health or could jeopardize the beneficiary's ability to regain maximum function. The bill would require a Medi-Cal managed care plan to resolve a standard appeal no more than 30 calendar days from the day the Medi-Cal managed care plan receives the appeal, and would require the Medi-Cal managed care plan to resolve an expedited appeal no longer than 72 hours after the Medi-Cal managed care plan receives the appeal.

(4) Existing federal regulations, published on March 30, 2016, revise regulations governing mental health parity requirements to address the application of certain mental health parity requirements under a specified federal law to certain Medicaid managed care plans, Medicaid benchmark and benchmark-equivalent plans, and the Children's Health Insurance Program (CHIP).

This bill would require the State Department of Health Care Services to ensure that all covered mental health and substance use disorder benefits are provided in compliance with those revised federal regulations. The bill would require the department to implement, interpret, or make specific this provision by means of all-county letters, plan letters, or plan or provider bulletins, or similar instructions until regulations are adopted, and would require the department to adopt regulations by July 1, 2018. The bill would require, on an annual basis and when requested by the department, a Medi-Cal managed care plan, as defined, to demonstrate to the department its compliance with these

mental health parity requirements, and would require the department to make an annual compliance report available on its Internet Web site.

~~(3)~~

(5) 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~~ *payments, as defined,* to designated public hospital systems, as defined, by ~~a uniform percentage applied uniformly across~~ *an amount determined under a prescribed uniform distribution methodology to be developed by the department, and would authorize these directed payments to separately*

account for inpatient and noninpatient hospital services and require these directed payments to be developed and applied separately for and uniformly within specified classes of designated public hospital ~~systems in accordance with a prescribed methodology.~~ *systems.* 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~~ *department, after providing notice of its determination to the affected Medi-Cal managed care plan and allowing a reasonable period to cure the deficiencies,* to reduce the default assignment into a Medi-Cal managed care plan by up to ~~25%,~~ *25% in the applicable county,* 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~~ *applicable Medi-Cal* managed care ~~plan,~~ *plans,* to establish a program under which a designated public hospital system may earn performance-based quality incentive payments from Medi-Cal managed care plans, as specified, and would require payments to be earned by each designated public hospital system based on its performance in achieving identified targets for quality of care. The bill would require the department to establish uniform performance measures and parameters for the designated public hospital systems to select the applicable measures, and would require these performance measures to advance at least one goal identified in the state's Medicaid quality strategy.

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

The bill would prohibit the department *or a Medi-Cal managed care plan* from 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.

The bill would provide that these provisions shall cease to be operative on the first day of the state fiscal year beginning on or after the date the department determines, after consultation with the designated public hospital systems, that implementation of these provisions is no longer financially and programmatically supportive of the Medi-Cal program, as specified. The bill would require the department to post notice of the determination on its Internet Web site, and to provide written notice of the determination to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

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

This bill would provide that no reimbursement is required by this act for a specified reason.

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

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 1367.035 of the Health and Safety Code is amended to read:

1367.035. (a) As part of the reports submitted to the department pursuant to subdivision (f) of Section 1367.03 and regulations adopted pursuant to that section, a health care service plan shall submit to the department, in a manner specified by the

department, data regarding network adequacy, including, but not limited to, the following:

(1) Provider office location.

(2) Area of specialty.

(3) Hospitals where providers have admitting privileges, if any.

(4) Providers with open practices.

(5) The number of patients assigned to a primary care provider or, for providers who do not have assigned enrollees, information that demonstrates the capacity of primary care providers to be accessible and available to enrollees.

(6) Grievances regarding network adequacy and timely access that the health care service plan received during the preceding calendar year.

(b) A health care service plan that uses a network for its Medi-Cal managed care product line that is different from the network used for its other product lines shall submit the data required under subdivision (a) for its Medi-Cal managed care product line separately from the data submitted for its other product lines.

(c) A health care service plan that uses a network for its individual market product line that is different from the network used for its small group market product line shall submit the data required under subdivision (a) for its individual market product line separate from the data submitted for its small group market product line.

(d) The department shall review the data submitted pursuant to this section for compliance with this chapter.

(e) *(1)* In submitting data under this section, a health care service plan that provides services to Medi-Cal beneficiaries pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code shall provide the same data to the State Department of Health Care Services pursuant to Section 14456.3 of the Welfare and Institutions Code.

(2) A health care service plan that provides services to Medi-Cal beneficiaries also shall provide to the department, in a manner specified by the department, data regarding the standards set forth in Section 14197 of the Welfare and Institutions Code.

(f) In developing the format and requirements for reports, data, or other information provided by plans pursuant to subdivision

(a), the department shall not create duplicate reporting requirements, but, instead, shall take into consideration all existing relevant reports, data, or other information provided by plans to the department. This subdivision does not limit the authority of the department to request additional information from the plan as deemed necessary to carry out and complete any enforcement action initiated under this chapter.

(g) If the department requests additional information or data to be reported pursuant to subdivision (a), which is different or in addition to the information required to be reported in paragraphs (1) to (6), inclusive, of subdivision (a), the department shall provide health care service plans notice of that change by November 1 of the year prior to the change.

(h) A health care service plan may include in the provider contract provisions requiring compliance with the reporting requirements of Section 1367.03 and this section.

SEC. 3. Section 10950 of the Welfare and Institutions Code is amended to read:

10950. (a) If any applicant for or recipient of public social services is dissatisfied with any action of the county department relating to his or her application for or receipt of public social services, if his or her application is not acted upon with reasonable promptness, or if any person who desires to apply for public social services is refused the opportunity to submit a signed application therefor, and is dissatisfied with that refusal, he or she shall, in person or through an authorized representative, without the necessity of filing a claim with the board of supervisors, upon filing a request with the State Department of Social Services or the State Department of Health Care Services, whichever department administers the public social service, be accorded an opportunity for a state hearing.

(b) (1) The requirements of Sections 100506.2 and 100506.4 of the Government Code apply to state hearings regarding eligibility for or enrollment in an insurance affordability program administered by the State Department of Health Care Services to the extent that those sections conflict with the state hearing requirements under this chapter.

(2) 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 subdivision 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, 2017, 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. Notwithstanding Section 10231.5 of the Government Code, beginning July 1, 2015, the department shall provide a semiannual status report to the Legislature, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(3) This subdivision shall be implemented only to the extent it does not conflict with federal law.

(c) Priority in setting and deciding cases shall be given in those cases in which aid is not being provided pending the outcome of the hearing. This priority shall not be construed to permit or excuse the failure to render decisions within the time allowed under federal and state law.

(d) Notwithstanding any other provision of this code, there is no right to a state hearing when either (1) state or federal law requires automatic grant adjustments for classes of recipients unless the reason for an individual request is incorrect grant computation, or (2) the sole issue is a federal or state law requiring an automatic change in services or medical assistance which adversely affects some or all recipients.

(e) For the purposes of administering health care services and medical assistance, the Director of Health Care Services shall have those powers and duties conferred on the Director of Social Services by this chapter to conduct state hearings in order to secure approval of a state plan under applicable federal law.

(f) The Director of Health Care Services may contract with the State Department of Social Services for the provisions of state hearings in accordance with this chapter.

(g) As used in this chapter, ~~"recipient"~~ *the following terms have the following meanings:*

(1) "Adverse benefit determination" means, in the case of a Medi-Cal managed care plan, any of the following:

(A) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(B) The reduction, suspension, or termination of a previously authorized service.

(C) The denial, in whole or in part, of payment for a service.

(D) The failure to provide services in a timely manner, as defined by the State Department of Health Care Services.

(E) The failure of a Medi-Cal managed care plan to act within the timeframes provided in Section 438.408(b)(1) of Title 42 of the Code of Federal Regulations regarding the standard resolution of grievances and appeals.

(F) For a resident of a rural area with only one Medi-Cal managed care plan, the denial of an enrollee's request to exercise his or her right under Section 438.52(b)(2)(i) of Title 42 of the Code of Federal Regulations to obtain services outside the network.

(G) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

(2) "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) of Chapter 7 of Part 3, including dental managed care programs developed pursuant to Section 14087.46.

(B) Article 2.8 (commencing with Section 14087.5) of Chapter 7 of Part 3.

(C) Article 2.81 (commencing with Section 14087.96) of Chapter 7 of Part 3.

(D) Article 2.9 (commencing with Section 14088) of Chapter 7 of Part 3.

(E) Article 2.91 (commencing with Section 14089) of Chapter 7 of Part 3.

(F) Chapter 8 (commencing with Section 14200) of Part 3, including dental managed care plans.

(G) Chapter 8.9 (commencing with Section 14700) of Part 3.

(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.

(3) "Recipient" means an applicant for or recipient of public social services except aid exclusively financed by county funds or aid under Article 1 (commencing with Section 12000) to Article 6 (commencing with Section 12250), inclusive, of Chapter 3 of Part 3, and under Article 8 (commencing with Section 12350) of Chapter 3 of Part 3, or those activities conducted under Chapter 6 (commencing with Section 18350) of Part 6, and shall include any individual who is an approved adoptive parent, as described in subdivision (C) of Section 8708 of the Family Code, and who alleges that he or she has been denied or has experienced delay in the placement of a child for adoption solely because he or she lives outside the jurisdiction of the department.

~~SEC. 2.~~

SEC. 4. 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. *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.*

(b) (1) Notwithstanding subdivision (a), a person *who is enrolled in a Medi-Cal managed care plan and who has received an adverse benefit determination from the Medi-Cal managed care plan shall, to the extent required by federal law or regulation, appeal the adverse benefit determination to the Medi-Cal managed care plan before requesting a state fair hearing pursuant to this chapter. After appealing to the Medi-Cal managed care plan, the enrollee* 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.~~ *either of the following:*

(A) Receiving verbal or written notice from the Medi-Cal managed care plan that the adverse benefit determination is upheld or the appeal or expedited appeal is denied.

(B) When the enrollee's appeal is deemed exhausted because the Medi-Cal managed care plan failed to comply with state or federal requirements for notice and timeliness related to the disputed action or the appeal, including when a Medi-Cal managed care plan fails to respond to an appeal within 30 days as required pursuant to subdivision (b) of Section 14197.2 or asks the enrollee or his or her treating provider for more information to resolve the appeal solely for purposes of delaying a decision.

(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~~ *receiving notice from the Medi-Cal managed care plan that the adverse benefit determination is upheld* and there is good cause for filing the request beyond the 120-calendar day period. The director may determine whether good cause exists. *The department shall not grant a request for a hearing for good cause if the request is filed more than 180 days after receipt of the notice from the Medi-Cal managed care plan that the adverse benefit determination is upheld.*

(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.

(f) Notwithstanding subdivision (e), the department shall implement the amendments made to this section by the act that added this subdivision by adopting any necessary rules and regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Until July 1, 2018, any rules and regulations necessary to implement the amendments made to this section by the act that added this subdivision may be adopted as emergency regulations in accordance with the Administrative Procedure Act. The adoption of emergency regulations pursuant to this subdivision shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

SEC. 5. Section 10959.5 is added to the Welfare and Institutions Code, to read:

10959.5. (a) Notwithstanding Sections 10952 and 10959, for a beneficiary of a Medi-Cal managed care plan who meets the criteria for an expedited resolution of an appeal as set forth in subdivision (c) of Section 14197.2, the department shall take final administrative action as expeditiously as the individual's health condition requires, but no later than three working days after the department receives, from the Medi-Cal managed care plan, the case file and information for any appeal of a denial of a service that, as indicated by the Medi-Cal managed care plan, meets either of the following criteria:

(1) Meets the criteria for expedited resolution as set forth in Section 438.410 (a) of Title 42 of the Code of Federal Regulations, but was not resolved within the timeframe for expedited resolution.

(2) Was resolved within the timeframe for expedited resolution, but reached a decision wholly or partially adverse to the beneficiary.

(b) Upon notice from the department that a Medi-Cal managed care plan's beneficiary has requested a state fair hearing, the Medi-Cal managed care plan shall provide to the department a copy of the following information within three business days of the Medi-Cal managed care plan's receipt of the department's notice of a request by a beneficiary for a state fair hearing:

(1) The case file.

(2) Any information for any appeal of a denial of a service that, as indicated by the Medi-Cal managed care plan, meets either of the criteria described in paragraph (1) or (2) of subdivision (a).

~~SEC. 3.~~

SEC. 6. 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 Sections 438.68, 438.206, and 438.207 of Title 42 of the Code of Federal Regulations, to ensure that all *Medi-Cal covered* 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 *covered and* 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 *covered and medically necessary* 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~~ *all* of the following:

(1) Meet ~~or exceed~~ existing time and distance standards ~~developed pursuant to Section 1367.03 of the Health and Safety Code~~ *set forth in Section 1300.51 of Title 28 of the California Code of Regulations* and the standards set forth in Medi-Cal managed care contracts entered into with the department as of January 1, 2016. *In the event of a conflict between the time and distance standards set forth in Section 1300.51 of Title 28 of the California Code of Regulations and the Medi-Cal managed care contracts entered into within the department as of January 1, 2016, the standard that requires a shorter travel time or less distance shall prevail.*

(2) Meet ~~or exceed~~ the appointment time standards developed pursuant to Section 1367.03 of the Health and Safety ~~Code~~ *Code, Section 1300.67.2.2 of Title 28 of the California Code of Regulations,* and the standards set forth in contracts entered into between the department and Medi-Cal managed care plans.

(3) Take into consideration the requirements of subdivision (c) of Section 438.68 of Title 42 of the Code of Federal Regulations.

(d) In developing the time and distance standards, if the department elects a county standard for time and distance, the department shall categorize counties into at least five or more county 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,~~ *telehealth consistent with the requirements of Section 2290.5 of the Business and Professions Code,* 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) *(1)* A Medi-Cal managed care plan shall, on ~~at least~~ an annual ~~basis,~~ *basis and when requested by the department,* demonstrate to the department its compliance with the time and distance and ~~timeliness~~ *appointment wait time* standards developed pursuant to this section. *The report shall measure compliance separately for adult and pediatric services for primary care, behavioral health, and core specialist services. A Medi-Cal managed care plan licensed 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) shall also, on an annual basis, demonstrate to the Department of Managed Health Care its compliance with the time and distance and appointment wait time standards developed pursuant to this section.*

(2) The department shall annually publish on its Internet Web site a report for each Medi-Cal managed care plan that specifies any areas where the Medi-Cal managed care plan was found to be out of compliance and the Medi-Cal managed care plan's corrective action plan.

(i) The department shall consult with Medi-Cal managed care plans, including mental health plans, health care providers, consumers, providers and consumers of LTSS, and organizations representing Medi-Cal beneficiaries in the implementation of the requirements of this section.

~~(i)~~ ~~(1)~~

(j) 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)~~

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

~~(B)~~

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

~~(C)~~

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

~~(D)~~

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

~~(E)~~

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

~~(F)~~

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

~~(G)~~

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

~~(H)~~

(8) 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.

~~(I)~~

(k) 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) The department shall ensure that all covered mental health and substance use disorder benefits are provided in compliance with Parts 438, 440, 456, and 457 of Title 42 of the Code of Federal Regulations, as amended March 30, 2016, as published in the Federal Register (81 Fed. Reg. 18390), and any subsequent amendment to those regulations, and any associated federal policy guidance issued by the federal Centers for Medicare and Medicaid Services.

(b) 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 subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. In doing so, the director shall consult with managed care plans and consumer advocates. By July 1, 2018, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) A Medi-Cal managed care plan, on an annual basis and when requested by the department, shall demonstrate compliance with this section. The department shall make an annual compliance report available on its Internet Web site.

(d) 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:

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

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

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

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

(5) Chapter 8 (commencing with Section 14200), excluding dental managed care plans.

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

(7) 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.

~~14197.1.~~

14197.2. (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) Except as otherwise required under this section, the requirements under this section do not apply to a health care service plan under a subcontract with a Medi-Cal managed care plan to provide covered health care services to Medi-Cal beneficiaries enrolled in the Medi-Cal managed care plan.

(e) The department shall post on its Internet Web site all of the following information:

(1) The aggregate MLR of all Medi-Cal managed care plans.

(2) The MLR of each Medi-Cal managed care plan.

(3) Any required remittances owed by each Medi-Cal managed care plan.

~~(d)~~

(f) 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)~~
(iv) Article 2.91 (commencing with Section 14089).
~~(vi)~~
(v) Article 1 (commencing with Section 14200) of Chapter 8.
~~(vii)~~
(vi) Article 7 (commencing with Section 14490) of Chapter 8.
(B) ~~"Medi-Cal~~ *For purposes of the remittance requirement described in subdivision (c), "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).
~~(c)~~
(g) 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.

14197.3. (a) A Medi-Cal managed care plan shall give a beneficiary timely and adequate notice of an adverse benefit determination in writing consistent with the requirements in Sections 438.404, 438.408, and 438.10 of Title 42 of the Code of Federal Regulations. For purposes of this subdivision, "adverse benefit determination" means either of the following:
(1) Any action described in Section 10950.
(2) Any health care service eligible for coverage and payment under a Medi-Cal managed care plan contract that has been denied, modified, or delayed by a decision of the Medi-Cal managed care plan, or by one of its contracting providers.

(b) Except as provided in subdivision (c), a Medi-Cal managed care plan shall resolve an appeal no more than 30 calendar days from the day the Medi-Cal managed care plan receives the appeal.

(c) A Medi-Cal managed care plan shall resolve an expedited appeal no longer than 72 hours after the Medi-Cal managed care plan receives the appeal. A Medi-Cal managed care plan shall establish and maintain an expedited review process for a beneficiary or the beneficiary's provider to request an expedited resolution of an appeal based on either of the following circumstances:

(1) If the Medi-Cal managed care plan determines, for a request from the beneficiary, or the provider indicates, in making the request on the beneficiary's behalf or supporting the beneficiary's request, that taking the time for a standard resolution under the timeframe described in subdivision (b) could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, or regain, maximum function.

(2) When the beneficiary's condition is such that the beneficiary faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the timeframe described in subdivision (b) would be detrimental to the beneficiary's life or health or could jeopardize the beneficiary's ability to regain maximum function.

(d) 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:

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

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

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

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

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

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

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

(8) 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.

~~14197.2.~~

14197.4. (a) The Legislature finds and declares all of the following:

(1) Designated public ~~hospitals~~ *hospital* 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~~ *lifesaving* 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 *that may enter into contracts to provide services for Medi-Cal beneficiaries* 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 *Medi-Cal managed care plans and* designated public hospital systems and to maintain access to services for Medi-Cal managed care beneficiaries and other low-income patients.

(5) It is the intent of the Legislature that, in order to ensure both the financial viability of Medi-Cal managed care plans and support the participation of designated public hospital systems in Medi-Cal

managed care, the department shall provide Medi-Cal managed care plans timely notice of and actuarially sound rates reflecting the enhanced contract services payments implemented to comply with the new federal requirements relating to Medicaid managed care.

(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~~ *by amounts determined under a uniform methodology that meets federal requirements and* as described in this subdivision. *The enhancements may be determined and applied as distributions from directed enhanced payment pools, as a uniform percentage increase, or other basis, and may incorporate acuity adjustments or other factors.*

(1) ~~The applicable percentage for purposes of the directed payments shall be uniformly applied across all~~ *The directed payments may separately account for inpatient hospital services and noninpatient hospital services and shall be developed and applied separately for and uniformly within each* 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 that hold a risk-based per member per month capitated contract with one or more Medi-Cal managed care plans that includes capitation for the provision of inpatient hospital services.

~~(B)~~

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

~~(C)~~

(D) Designated public hospital systems not identified in subparagraph ~~(A) or (B).~~ *(A), (B), or (C).*

(2) To the extent permitted by federal law and to meet the objectives identified in subdivisions (a) and (d), the department shall develop and implement the directed payment program in consultation with designated public hospital systems or Medi-Cal managed care plans, or both, as follows:

~~(2)~~

(A) The department, in consultation with the designated public hospital systems, shall annually determine ~~the applicable uniform percentages for each class identified in paragraph (1)~~ *on a prospective basis the aggregate amount of payments that will be directed to each class of designated public hospitals systems pursuant to this subdivision* 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~~ *For state fiscal years following the 2017–18 state fiscal year, the aggregate amounts of payments to a class of designated public hospital systems shall include an increase for the rate of inflation to the aggregate amounts available during the prior state fiscal year, subject to any modifications to account for changes in the classification of designated public hospital systems, changes required by federal law, changes to account for the size of the payments made pursuant to subdivision (c), or other material changes.*

(B) The department, in consultation with the designated public hospital systems, shall develop the methodologies for determining the required directed payments for each designated public hospital system.

(C) 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~~ *the amounts of the aggregate directed payments for any class of designated public hospital systems, the method for determining the distribution of the directed payment amounts within any class of designated public hospital systems, and may modify, consolidate, or subdivide the classes of designated public hospital systems described in paragraph (1).*

(D) After the aggregate amounts and the distribution methodology of directed payments for each designated public hospital system class have been established, the department shall consult with the designated public hospital systems and each affected Medi-Cal managed care plan with regard to the *impact on the Medi-Cal managed care plan capitation ratesetting process and* implementation of the directed payment ~~requirements once~~

~~these payment levels have been established.~~ *requirements, including applicable interim and final payment processes, to ensure that 100 percent of the aggregate amounts are paid to the applicable designated public hospital system.*

(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.~~ *paid by the Medi-Cal managed care plans as adjustments to the total amounts of contract services payments otherwise paid to the designated public hospital systems in accordance with the department's directions and methodologies established pursuant to 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 contract services, including through fee-for-service, capitation, or other permissible manner. The rates of payment for 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)~~

(B) 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.~~ *year, and the Medi-Cal managed care plan shall not impose a fee or retention amount that would result in a direct or indirect reduction to the amounts required under this subdivision.*

~~(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.~~

(C) A contract between a Medi-Cal managed care plan and a designated public hospital system shall not be terminated by either party for the specific purpose of circumventing or otherwise impacting the payment obligations implemented pursuant to this subdivision.

~~(E)~~

(D) 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~~ *be responsible for paying* 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.~~ *arrangement. The designated public hospital system and the applicable subcontractor or delegated entity shall together work with the Medi-Cal managed care plan to provide the information necessary*

to facilitate the Medi-Cal managed care plan's compliance with the payments requirements under this subdivision.

(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 contract rates and the directed payments, to demonstrate compliance with this subdivision. To the extent the department ~~determines, in its sole discretion,~~ *determines* 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~~ *the department may, after providing notice of its determination to the affected Medi-Cal managed care plan and allowing a reasonable period for the Medi-Cal managed care plan to cure the specified deficiencies,* 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,~~ *percent in the applicable county,* 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 *Medi-Cal managed care plan or* designated public hospital system to pursue a breach of contract ~~action~~ *action, or any other available remedy as appropriate,* in connection with the requirements of this subdivision.

(6) Capitation rates paid by the department to a Medi-Cal managed care plan shall *be actuarially sound and* 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 *or actual* 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,~~ *data and reasonable projections,* as determined by the department, when accounting for the directed payments required under this subdivision, and *shall account for additional clinics, practices, or other health care providers added to a designated public hospital system. In implementing the requirements of this section, including the Medi-Cal managed care plan ratesetting process, the department* may *additionally* account for material adjustments, as appropriate *under federal law and actuarial standards, as described above,* and as determined by the department, to contracts entered into between a Medi-Cal managed care plan *or applicable subcontracted or delegated entity* 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~~ *applicable* Medi-Cal managed care ~~plan,~~ *plans,* 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~~ *applicable* Medi-Cal managed care ~~plan,~~ *plans,* 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 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.~~

(B) A contract between a Medi-Cal managed care plan and designated public hospital system shall not be terminated by either party for the specific purpose of circumventing or otherwise impacting the payment obligations implemented pursuant to this subdivision.

(C) Each Medi-Cal managed care plan shall be responsible for payment of the quality incentive payments described in this ~~subdivision.~~ *subdivision, subject to funding by the department pursuant to paragraph (4).*

~~(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)~~

(4) 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) *(1)* In determining the ~~uniform percentages~~ *amount of the required directed payments* 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~~ *directed payments* or quality incentive payment program. *Once these payment levels are established, the department shall consult with the designated public hospital systems and the Medi-Cal managed care plans in the development of the Medi-Cal managed care rates needed for the directed payments and the structure of the quality incentive payment program.*

(2) For the state fiscal year 2017–18, the department shall provide written notice of the directed payment and quality incentive payment amounts established pursuant to this section. For each annual determination thereafter, the department shall provide written notice at least 90 days in advance to each affected Medi-Cal managed care plan and designated public hospital system of the applicable Medi-Cal managed care plan's directed payment amounts, the classification of designated public hospital systems, quality incentive payment amounts, and any other information deemed necessary for the Medi-Cal managed care plan to fulfill its payment obligations under subdivisions (b) and (c). If the modification of either or both directed payment amounts or quality incentive payment amounts is necessary after receipt of the written notification, the department shall notify the Medi-Cal managed care plan and designated public hospital system in writing of the revised amounts prior to implementation of the revised amounts.

(3) A Medi-Cal managed care plan's obligation to pay the directed payments and quality incentive payments required under subdivisions (b) and (c) to a designated public hospital shall be contingent upon receipt of notice from the department that the department is in receipt of the necessary federal approvals pursuant to paragraph (1) of subdivision (g).

(e) The provisions of paragraphs ~~(3) and (4)~~ *(3), (4), and (5)* of subdivision (a), ~~and~~ *paragraphs (3) and (4)* of subdivisions (b) and ~~(c)~~ *(c), and paragraph (3) of subdivision (d)* 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 *by the designated public hospital system or the Medi-Cal managed care plan* 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,~~ *transfers described in paragraph (1),* the department, in consultation with the designated public hospital systems, shall develop and maintain a protocol to determine *the available funding for the nonfederal share associated with payments for* 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 *by those specific public entities for the 2015–16 state fiscal year* pursuant to Section 14182.15 or ~~14199.2.~~ *14199.2, but excluding any contributions made pursuant to Sections 14301.4 and 14301.5.* 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 *or a Medi-Cal managed care plan* 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. *Nothing in this section shall be construed to preclude or otherwise impose limitations on payment amounts or arrangements that may be negotiated and agreed to between the relevant parties, including, but not limited to, the continuation of existing or the creation of new quality incentive or pay-for-performance programs in addition to the quality incentive payment program described in subdivision (c) and contract services payments that may be in excess of the directed payment amounts required under subdivision (b).*

(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 *size of the* quality incentive payments established pursuant to this ~~section.~~ *section, and shall consult with both the designated public hospital systems and Medi-Cal managed care plans with regards to the implementation of payments under this section.*

(3) The director, after consultation with the designated public hospital ~~systems,~~ *systems and Medi-Cal managed care plans,* 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 *and Medi-Cal managed care plans* 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) (1) This section shall cease to be operative on the first day of the state fiscal year beginning on or after the date the department determines, after consultation with the designated public hospital systems, that implementation of this section is no longer financially and programmatically supportive of the Medi-Cal program. This determination shall be based solely on both of the following factors:

(A) The projected amount of nonfederal share funds available is insufficient to support implementation of this section in the subject state fiscal year.

(B) The degree to which the payment arrangements will no longer materially advance the goals and objectives reflected in this section and in the department's managed care quality strategy drafted and implemented pursuant to Section 438.340 of Title 42 of the Code of Federal Regulations in the subject state fiscal year.

(2) In making its determination, the department shall consider all reasonable options for mitigating the circumstances set forth in paragraph (1), including, but not limited to, options for curing projected funding shortfalls and options for program revisions and strategy updates to better coordinate payment requirements with the goals and objectives of this section and the managed care quality strategy.

(3) The department shall post notice of the determination on its Internet Web site, and shall provide written notice of the determination to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(k) The department, in consultation with the designated public hospital systems and the Medi-Cal managed care plans, shall provide the Legislature with the evaluation plan required in Section 438.6(c)(2)(I)(D) of Title 42 of the Code of Federal Regulations to measure the degree to which the payments authorized under this section advance at least one of the goals and objectives of the department's managed care quality strategy. The department, in consultation with the designated public hospital systems and the Medi-Cal managed care plans, shall report to the Legislature the results of this evaluation no earlier than January 1, 2021.

~~(j)~~

(l) 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,~~ *capitation amounts* prior to any adjustments for service payment withholds or deductions, or *payments made on any* other basis, under a *network provider* contract with a Medi-Cal managed care plan for *medically necessary and covered* services, drugs, supplies or other items provided to ~~a~~ *an eligible* Medi-Cal beneficiary enrolled in the Medi-Cal managed care ~~plan.~~ *plan, excluding services provided to individuals who are dually eligible for both the Medicare and Medi-Cal programs.* Contract services includes all *covered* 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 *network provider* 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, "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 *network provider* 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~~ *"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).

(5) "Network provider" shall have the same meaning as that term is defined in Section 438.2 of Title 42 of the Code of Federal Regulations, and does not include arrangements where a designated public hospital system provides or arranges for services under an agreement intended to cover a specific range of services for a single identified patient for a single inpatient admission, including any directly related followup care, outpatient visit or service, or other similar patient specific nonnetwork contractual arrangement, such as a letter of agreement or single case agreement, with a Medi-Cal managed care plan or subcontractor of a Medi-Cal managed care plan.

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because

the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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COUNTY OF RIVERSIDE

July 5, 2017

The Honorable Ed Hernandez, OD
Chair, Senate Health Committee
State Capitol, Room 2080
Sacramento, CA 95814

Re: AB 511 (Arambula) – Tuberculosis Risk Assessment and Examination.
As Amended March 27, 2017
County of Riverside: SUPPORT – Per Board Action

Dear Senator Hernandez:

On behalf of the Riverside County Board of Supervisors, I write to express our support for AB 511 by Assemblymember Juan Arambula. This measure would make a number of changes to California's tuberculosis (TB) testing laws.

Specifically AB 511 requires, instead of a TB test, that a TB risk assessment developed by the Department of Public Health (DPH) and the California Tuberculosis Controllers Association (CTCA) be completed for a number of individuals, including employees and volunteers of heritage schools; applicants to be a relative foster parent; home care aides; and a person employed in connection with a park, playground, recreational center, or beach used for recreational purposes by a city or county in a position requiring contact with children, or as a food concessionaire or other licensed concessionaire in that area.

AB 511 implements the recommendations of the federal Centers for Disease Control (CDC) and numerous expert bodies by replacing mandated universal TB testing with risk assessment screening and testing only of high-risk individuals. The best scientific guidance suggests we should not test low-risk populations, but only high-risk individuals. To implement this guidance, AB 511 eliminates widespread TB testing requirements, and instead requires assessment of TB risk. Doing so will protect employees and others from unnecessary treatment. This bill will help avoid periodic shortages of TB testing antigens, will save medical resources for those who need them most, and will protect workers and volunteers from unnecessary testing and treatment

COUNTY OF RIVERSIDE

For this reason, the County of Riverside supports AB 511. 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@rivco.org.

Sincerely,

John Tavaglione
Chairman, Riverside County Board of Supervisors

cc: The Honorable Juan Arambula, Member, California State Assembly
County of Riverside Delegation
Members, Senate Health Committee
Melanie Moreno, Consultant, Senate Health Committee
Joe Parra, Consultant, Senate Republican Caucus

AMENDED IN ASSEMBLY MARCH 27, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 511

Introduced by Assembly Member Arambula

February 13, 2017

An act ~~to amend Sections 1812.541 and 1812.542 of the Civil Code,~~ to amend Section 33195.6 of, and to repeal Section 59150 of, the Education Code, to amend Section 8732 of the Family Code, to amend Sections ~~1226.1,~~ 1526.8, 1796.43, 1796.45, and 121525 of the Health and Safety Code, and to amend Sections 5163 and 5163.1 of the Public Resources Code, relating to tuberculosis.

LEGISLATIVE COUNSEL'S DIGEST

AB 511, as amended, Arambula. Tuberculosis risk assessment and examination.

~~Existing law requires an employment agency that refers temporary certified nurse assistants or temporary licensed nursing staff to an employer who is a licensed long-term health care facility to provide the employer with verification that the individual has had tuberculosis screening within 90 days prior to employment and annually thereafter.~~

~~This bill would instead require the employment agency to verify that the individual has submitted to a tuberculosis risk assessment, developed by the State Department of Public Health and the California Tuberculosis Controllers Association, within 90 days prior to employment and annually thereafter, and, if risk factors are present, an examination to determine that he or she is free of infectious tuberculosis.~~

Existing law requires employees and volunteers of a heritage school to be in good health, as verified by a health screening, including a test for tuberculosis, as ~~specified~~ *specified.*

This bill would instead require the health screening to include a tuberculosis risk assessment within the prior 60 days of initial employment or volunteer assignment, and every 4 years thereafter, and, if risk factors are present, an examination to determine that he or she is free of infectious tuberculosis.

Existing law requires students attending specified schools for blind and deaf persons to be tested for exposure to tuberculosis at least every 2 years.

This bill would repeal those provisions.

Existing law requires a foster parent applicant and each adult residing in the applicant's home to receive a test for communicable tuberculosis.

This bill would instead require those individuals to receive a tuberculosis risk assessment, and, if risk factors are present, an examination to determine that he or she is free of infectious tuberculosis.

~~Existing law requires an individual working in a primary care clinic to comply with specified requirements regarding health examinations and public health protections, including testing for tuberculosis.~~

~~This bill would instead require those individuals to receive a tuberculosis risk assessment, and, if risk factors are present, an examination consisting of a test for tuberculosis infection. The bill would require a positive tuberculosis test to be followed by a chest X-ray to determine if the employee is free of infectious tuberculosis.~~

Existing law requires a volunteer caregiver in a crisis nursery to be in good physical health and be tested for tuberculosis, not more than one year prior to, or 7 days after, initial presence in the facility.

This bill would instead require those individuals to submit to a tuberculosis risk assessment, and, if risk factors are present, an examination to determine that he or she is free of infectious tuberculosis.

Existing law requires an affiliated home care aide employed by a home care organization to demonstrate that he or she is free from tuberculosis, by submitting to an examination 90 days prior to, or 7 days after, employment, to determine that he or she is free of active tuberculosis. Under existing law, an affiliated home care aide whose test for tuberculosis infection is negative is required to undergo an examination at least once every 2 years.

This bill would instead prohibit an affiliated home care aide from being initially employed by a home care organization unless he or she has submitted to a tuberculosis risk assessment within the prior 90 days, or within 7 days after employment, and, if risk factors are present, an examination, as specified. The bill would extend the required period

for subsequent examinations to once every 4 years for affiliated home care aides with no identified tuberculosis risk, or a negative tuberculosis test.

Existing law prohibits a person from being initially employed by a private or parochial elementary or secondary school, or a nursery school, unless that person produces or has on file with the school a certificate showing that he or she has submitted to a tuberculosis risk assessment, and, if risk factors are present, an examination to determine that he or she is free of infectious tuberculosis.

This bill would replace obsolete references to "nursery school" in these provisions to refer instead to "preschool" for purposes of tuberculosis risk assessment.

Existing law prohibits a person from being initially employed in connection with specified city or county public recreation areas and facilities unless that person produces or has on file with the city or county a certificate showing that within the prior 2 years he or she has been examined and found to be free of communicable tuberculosis. Existing law requires an employee with a negative skin test to repeat the test once every 4 years and, if a subsequent skin test is positive, to have an X-ray and a referral to the local health officer for followup care.

This bill would instead require the employees to submit to a tuberculosis risk assessment, and, if risk factors are present, an examination to determine that he or she is free of infectious tuberculosis. Employees with a negative test or no identified risk factors would be required to repeat the test every 4 years and receive an examination and followup care if a subsequent test is positive, as specified. This bill would require the examination to consist of any test for tuberculosis infection recommended by the federal Centers for Disease Control and Prevention and licensed by the federal Food and Drug Administration.

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 1812.541 of the Civil Code is amended to read:~~

~~1812.541. Every employment agency that refers temporary certified nurse assistants to an employer that is a long-term health care facility shall provide the employer with all of the following:~~

~~(a) Written verification that the employment agency has verified that any certified nurse assistant referred by the agency is registered on the state registry of certified nurse assistants and is in good standing. The employment agency shall provide to the employer the certified nurse assistant's professional certification number and date of expiration.~~

~~(b) A statement that the certified nurse assistant has at least six months of experience working in a long-term health care facility.~~

~~(c) A statement that the certified nurse assistant has had a health examination within 90 days prior to employment with the employment agency or seven days after employment with the employment agency and at least annually thereafter by a person lawfully authorized to perform that procedure. Each examination shall include a medical history and physical evaluation. The employment agency shall also provide verification that the individual has submitted to a tuberculosis risk assessment developed by the State Department of Public Health and the California Tuberculosis Controllers Association within 90 days prior to employment and annually thereafter, and, if risk factors are present, an examination to determine that he or she is free of infectious tuberculosis.~~

~~(d) A statement that the certified nurse assistant will participate in the facility's orientation program and any in-service training programs at the request of the long-term health care employer.~~

~~(e) A statement that a certified nurse assistant is in compliance with the in-service training requirements of paragraph (1) of subdivision (a) of Section 1337.6 of the Health and Safety Code.~~

~~SEC. 2. Section 1812.542 of the Civil Code is amended to read:~~

~~1812.542. Every employment agency that refers temporary licensed nursing staff to an employer who is a licensed long-term health care facility shall provide the employer with all of the following:~~

~~(a) Written verification that the individual is in good standing with the Board of Registered Nursing or the Board of Vocational Nursing and Psychiatric Technicians, as applicable, and has successfully secured a criminal record clearance. The employment agency shall provide to the employer the individual's professional license and registration number and date of expiration.~~

~~(b) A statement that the licensed nursing staff person has had a health examination within 90 days prior to employment with the employment agency or seven days after employment with the employment agency and at least annually thereafter by a person lawfully authorized to perform that procedure. Each examination shall include a medical history and physical evaluation. The employment agency shall also provide verification that the individual has submitted to a tuberculosis risk assessment developed by the State Department of Public Health and the California Tuberculosis Controllers Association within 90 days prior to employment and annually thereafter, and, if risk factors are present, an examination to determine that he or she is free of infectious tuberculosis.~~

~~SEC. 3.~~

SECTION 1. Section 33195.6 of the Education Code is amended to read:

33195.6. (a) A director of a heritage school shall undergo at least 15 hours of health and safety training. The training shall include all of the following components:

(1) Pediatric first aid.

(2) Pediatric cardiopulmonary resuscitation (CPR).

(3) A preventive health practices course or courses that include instruction in the recognition, management, and prevention of infectious diseases, including immunizations, and prevention of childhood injuries.

(4) Training in pediatric first aid and CPR pursuant to paragraphs (1) and (2) shall be provided by a program approved by the American Red Cross, the American Heart Association, or the Emergency Medical Services Authority pursuant to Section 1797.191 of the Health and Safety Code.

(5) Training in preventive health practices pursuant to paragraph (3) shall be provided by a training program approved by the Emergency Medical Services Authority.

(6) In addition to the training programs specified in paragraphs (4) and (5), training programs or courses in pediatric first aid, pediatric CPR, and preventive health practices offered or approved by an accredited postsecondary educational institution are considered to be approved sources of training that may be used to satisfy the training requirements of paragraphs (1) to (3), inclusive.

(7) Persons who, prior to the effective date of this section, have completed a course or courses in preventive health practices as described in paragraph (3), and have a certificate of completion of a course or courses in preventive health practices, or certified copies of transcripts that identify the number of hours and the specific course or courses taken for training in preventive health practices, shall be deemed to have met the training requirement for preventive health practices pursuant to paragraph (3).

(b) All employees and volunteers of a heritage school shall be in good health, as verified by a health screening performed by, or under the supervision of, a licensed physician and surgeon. The screening shall include a tuberculosis risk assessment developed by the State Department of Public Health and the California Tuberculosis Controllers Association within the prior 60 days of initial employment or volunteer assignment and every four years thereafter, and, if risk factors are present, an examination to determine that he or she is free of infectious tuberculosis.

(c) Pupils attending heritage schools shall have access to working sinks, toilets, and drinking water.

(d) No pupil attending a heritage school shall have access to medication or cleaning supplies, except as otherwise provided by law.

(e) A heritage school, as defined in Section 33195.4, shall not be subject to licensure by the State Department of Social Services as a child day care center pursuant to Chapter 3.4 (commencing with Section 1596.70) or Chapter 3.5 (commencing with Section 1596.90) of Division 2 of the Health and Safety Code.

(f) Upon a pupil's enrollment in a heritage school, the heritage school shall provide a notice to the pupil's parent or guardian stating that the heritage school is exempt from child care licensure, and that attendance at a heritage school does not satisfy California's compulsory education requirements pursuant to Section 48200.

~~SEC. 4.~~

SEC. 2. Section 59150 of the Education Code is repealed.

~~SEC. 5.~~

SEC. 3. Section 8732 of the Family Code is amended to read:

8732. A report of a medical examination of the foster parent with whom the child has lived for a minimum of six months or the relative caregiver who has had an ongoing and significant relationship with the child shall be included in the assessment of

each applicant unless the department, county adoption agency, or licensed adoption agency determines that, based on other available information, this report is unnecessary. The assessment shall require certification that the applicant and each adult residing in the applicant's home has received a tuberculosis risk assessment developed by the State Department of Public Health and the California Tuberculosis Controllers Association, and, if risk factors are present, an examination to determine that he or she is free of infectious tuberculosis.

~~SEC. 6. Section 1226.1 of the Health and Safety Code is amended to read:~~

~~1226.1. (a) A primary care clinic shall comply with the following requirements regarding health examinations and other public health protections for individuals working in a primary care clinic:~~

~~(1) An employee working in a primary care clinic who has direct contact with patients shall have a health examination within six months prior to employment or within 15 days after employment. Each examination shall include a medical history and physical evaluation. A written examination report, signed by the person performing the examination, shall verify that the employee is able to perform his or her assigned duties.~~

~~(2) At the time of employment, an employee shall receive a tuberculosis risk assessment developed by the State Department of Public Health and the California Tuberculosis Controllers Association, and, if risk factors are present, an examination. The examination for tuberculosis shall consist of a test for tuberculosis infection recommended by the federal Centers for Disease Control and Prevention (CDC) and licensed by the federal Food and Drug Administration (FDA). If a test for tuberculosis is positive, the test shall be followed by an X-ray of the lungs and subsequently interpreted by a physician to determine if the employee is free of infectious tuberculosis. Annual examinations shall be performed only when medically indicated.~~

~~(3) The clinic shall maintain a health record for each employee that includes reports of all employment-related health examinations. These records shall be kept for a minimum of three years following termination of employment.~~

~~(4) An employee known to have or exhibiting signs or symptoms of a communicable disease shall not be permitted to work until he~~

~~or she submits a physician's certification that the employee is sufficiently free of the communicable disease to return to his or her assigned duties.~~

~~(b) Any regulation adopted before January 1, 2004, that imposes a standard on a primary care clinic that is more stringent than described in this section is void.~~

~~SEC. 7.~~

SEC. 4. Section 1526.8 of the Health and Safety Code is amended to read:

1526.8. (a) It is the intent of the Legislature that the department develop modified staffing levels and requirements for crisis nurseries, provided that the health, safety, and well-being of the children in care are protected and maintained.

(1) All caregivers shall be certified in pediatric cardiopulmonary resuscitation (CPR) and pediatric first aid. Certification shall be demonstrated by current and valid pediatric CPR and pediatric first aid cards issued by the American Red Cross, the American Heart Association, by a training program that has been approved by the Emergency Medical Services Authority pursuant to Section 1797.191, or from an accredited college or university.

(2) The licensee shall develop, maintain, and implement a written staff training plan for the orientation, continuing education, on-the-job training and development, supervision, and evaluation of all lead caregivers, caregivers, and volunteers. The licensee shall incorporate the training plan in the crisis nursery plan of operation.

(3) The licensee shall designate at least one lead caregiver to be present at the crisis nursery at all times when children are present. The lead caregiver shall have one of the following education and experience qualifications:

(A) Completion of 12 postsecondary semester units or equivalent quarter units, with a passing grade, as determined by the institution, in classes with a focus on early childhood education, child development, or child health at an accredited college or university, as determined by the department, and six months of work experience in a licensed group home, licensed infant care center, or comparable group child care program or family day care. At least three semester units, or equivalent quarter units, or equivalent experience shall include coursework or experience in the care of infants.

(B) A current and valid Child Development Associate (CDA) credential, with the appropriate age level endorsement issued by the CDA National Credentialing Program, and at least six months of on-the-job training or work experience in a licensed child care center or comparable group child care program.

(C) A current and valid Child Development Associate Teacher Permit issued by the California Commission on Teacher Credentialing pursuant to Sections 80105 to 80116, inclusive, of Title 5 of the California Code of Regulations.

(4) Lead caregivers shall have a minimum of 24 hours of training and orientation before working with children. One year experience in a supervisory position in a child care or group care facility may substitute for 16 hours of training and orientation. The written staff training plan shall require the lead caregiver to receive and document a minimum of 20 hours of annual training directly related to the functions of his or her position.

(5) Caregiver staff shall complete a minimum of 24 hours of initial training within the first 90 days of employment. Eight hours of training shall be completed before the caregiver staff are responsible for children, left alone with children, and counted in the staff-to-child ratios described in subdivision (c). A maximum of four hours of training may be satisfied by job shadowing.

(b) The department shall allow the use of fully trained and qualified volunteers as caregivers in a crisis nursery, subject to the following conditions:

(1) Volunteers shall be fingerprinted for the purpose of conducting a criminal record review as specified in subdivision (b) of Section 1522.

(2) Volunteers shall complete a child abuse central index check as specified in Section 1522.1.

(3) Volunteers shall be in good physical health and shall submit to a tuberculosis risk assessment developed by the State Department of Public Health and the California Tuberculosis Controllers Association, and, if risk factors are present, an examination to determine that he or she is free of infectious tuberculosis, not more than one year prior to, or seven days after, initial presence in the facility.

(4) Volunteers shall complete a minimum of 16 hours of training as specified in paragraphs (5) and (6).

(5) Prior to assuming the duties and responsibilities of a crisis caregiver or being counted in the staff-to-child ratio, volunteers shall complete at least five hours of initial training divided as follows:

(A) Two hours of crisis nursery job shadowing.

(B) One hour of review of community care licensing regulations.

(C) Two hours of review of the crisis nursery program, including the facility mission statement, goals and objectives, child guidance techniques, and special needs of the client population they serve.

(6) Within 90 days, volunteers who are included in the staff-to-child ratios shall do both of the following:

(A) Acquire a certification in pediatric first aid and pediatric cardiopulmonary resuscitation.

(B) Complete at least 11 hours of training covering child care health and safety issues, trauma informed care, the importance of family and sibling relationships, temperaments of children, self-regulation skills and techniques, and program child guidance techniques.

(7) Volunteers who meet the requirements of paragraphs (1), (2), and (3), but who have not completed the training specified in paragraph (4), (5), or (6) may assist a fully trained and qualified staff person in performing child care duties. However, these volunteers shall not be left alone with children, shall always be under the direct supervision and observation of a fully trained and qualified staff person, and shall not be counted in meeting the minimum staff-to-child ratio requirements.

(c) The department shall allow the use of fully trained and qualified volunteers to be counted in the staff-to-child ratio in a crisis nursery subject to the following conditions:

(1) The volunteers have fulfilled the requirements in paragraphs (1) to (6), inclusive, of subdivision (b).

(2) There shall be at least one fully qualified and employed staff person on site at all times.

(3) (A) There shall be at least one employed staff person or volunteer caregiver for each group of six children, or fraction thereof, who are 18 months of age or older, and one employed staff person or volunteer caregiver for each group of three children, or fraction thereof, who are under 18 months of age from 7 a.m. to 7 p.m.

(B) There shall be at least one employed staff person or volunteer caregiver for each group of six children, or fraction thereof, who are 18 months of age or older, and one employed staff person or volunteer caregiver for each group of four children, or fraction thereof, who are under 18 months of age from 7 p.m. to 7 a.m.

(C) There shall be at least one employed staff person present for every volunteer caregiver used by the crisis nursery for the purpose of meeting the minimum caregiver staffing requirements.

(D) The crisis nursery's plan of operation shall address how it will deal with unexpected circumstances related to staffing and ensure that additional caregivers are available when needed.

(d) There shall be at least one staff person or volunteer caregiver awake at all times from 7 p.m. to 7 a.m.

(e) (1) When a child has a health condition that requires prescription medication, the licensee shall ensure that the caregiver does all of the following:

(A) Assists children with the taking of the medication as needed.

(B) Ensures that instructions are followed as outlined by the appropriate medical professional.

(C) Stores the medication in accordance with the label instructions in the original container with the original unaltered label in a locked and safe area that is not accessible to children.

(D) Administers the medication as directed on the label and prescribed by the physician in writing.

(i) The licensee shall obtain, in writing, approval and instructions from the child's authorized representative for administration of the prescription medication for the child. This documentation shall be kept in the child's record.

(ii) The licensee shall not administer prescription medication to a child in accordance with instructions from the child's authorized representative if the authorized representative's instructions conflict with the physician's written instructions or the label directions as prescribed by the child's physician.

(2) Nonprescription medications may be administered without approval or instructions from the child's physician if all of the following conditions are met:

(A) Nonprescription medications shall be administered in accordance with the product label directions on the nonprescription medication container or containers.

(B) (i) For each nonprescription medication, the licensee shall obtain, in writing, approval and instructions from the child's authorized representative for administration of the nonprescription medication to the child. This documentation shall be kept in the child's record.

(ii) The licensee shall not administer nonprescription medication to a child in accordance with instructions from the child's authorized representative if the authorized representative's instructions conflict with the product label directions on the nonprescription medication container or containers.

(3) The licensee shall develop and implement a written plan to record the administration of the prescription and nonprescription medications and to inform the child's authorized representative daily, for crisis day services, and upon discharge for overnight care, when the medications have been given.

(4) When no longer needed by the child, or when the child is removed or discharged from the crisis nursery, all medications shall be returned to the child's authorized representative or disposed of after an attempt to reach the authorized representative.

~~SEC. 8.~~

SEC. 5. Section 1796.43 of the Health and Safety Code is amended to read:

1796.43. (a) Home care organizations that employ affiliated home care aides shall ensure the affiliated home care aides are cleared on the home care aide registry before placing the individual in direct contact with clients. In addition, the home care organization shall do all of the following:

(1) Ensure any staff person, volunteer, or employee of a home care organization who has contact with clients, prospective clients, or confidential client information that may pose a risk to the clients' health and safety has met the requirements of Sections 1796.23, 1796.24, 1796.25, 1796.26, and 1796.28 before there is contact with clients or prospective clients or access to confidential client information.

(2) Require home care aides to submit to a screening or examination for tuberculosis to determine that he or she is free of infectious tuberculosis, pursuant to Section 1796.45.

(3) Immediately notify the department when the home care organization no longer employs an individual as an affiliated home care aide.

(b) This section shall not prevent a licensee from requiring a criminal record clearance of any individual exempt from the requirements of this section, provided that the individual has client contact.

~~SEC. 9.~~

SEC. 6. Section 1796.45 of the Health and Safety Code is amended to read:

1796.45. (a) Affiliated home care aides shall not be initially employed by a home care organization unless the person has submitted to a tuberculosis risk assessment developed by the State Department of Public Health and the California Tuberculosis Controllers Association within the prior 90 days or within seven days after employment, and, if risk factors are present, an examination.

(b) For purposes of this section, "examination" means a test for tuberculosis infection that is recommended by the federal Centers for Disease Control and Prevention (CDC) and licensed by the federal Food and Drug Administration (FDA) and, if that test is positive, an X-ray of the lungs. The aide shall not work as an affiliated home care aide unless the licensee obtains documentation from a licensed medical professional that he or she is free of infectious tuberculosis.

(c) After submitting to an examination, an affiliated home care aide who has no identified tuberculosis risk factors or whose test for tuberculosis infection is negative shall be required to undergo an examination at least once every four years. Once an affiliated home care aide has a documented positive test for tuberculosis infection that has been followed by an X-ray, the examination is no longer required.

(d) After each examination, an affiliated home care aide shall submit, and the home care organization shall keep on file, a certificate from the examining practitioner showing that the affiliated home care aide was examined and found free from infectious tuberculosis disease.

(e) The examination is a condition of initial and continuing employment with the home care organization.

(f) An affiliated home care aide ~~who transfers employment from one home care organization to another~~ shall be deemed to meet the requirements of subdivision (a) or (c) if the affiliated home care aide can produce a certificate showing that he or she submitted

to the examination within the past two years and was found to be free of active tuberculosis disease, or if it is verified by the home care organization previously employing him or her that it has a certificate on file that contains that showing and a copy of the certificate is provided to the new home care organization prior to the affiliated home care aide beginning employment.

~~SEC. 10.~~

SEC. 7. Section 121525 of the Health and Safety Code is amended to read:

121525. (a) Except as provided in Section 121555, a person shall not be initially employed, or employed under contract, by a private or parochial elementary or secondary school, or any preschool, unless that person produces or has on file with the school a certificate showing that within the last 60 days the person has submitted to a tuberculosis risk assessment and, if tuberculosis risk factors are identified, has been examined and has been found to be free of infectious tuberculosis. If no risk factors are identified, an examination is not required. A person who is subject to the requirements of this subdivision may submit to an examination that complies with the requirements of Section 121530 instead of submitting to a tuberculosis risk assessment.

(b) Thereafter, an employee who has no identified risk factors or who tests negative for the tuberculosis infection by either the tuberculin skin test or any other test for tuberculosis recommended by the federal Centers for Disease Control and Prevention (CDC) and licensed by the federal Food and Drug Administration (FDA), shall be required to undergo the foregoing tuberculosis risk assessment and, if risk factors are identified, the examination, at least once each four years, or more often if directed by the governing authority of the school upon recommendation of the local health officer. Once an employee has a documented positive test for the tuberculosis infection conducted pursuant to this subdivision, the tuberculosis risk assessment is no longer required. A referral shall be made within 30 days of completion of the examination to the local health officer to determine the need for followup care.

(c) At the discretion of the governing authority of a private school, this section shall not apply to employees who are employed for any period of time less than a school year whose functions do not require frequent or prolonged contact with pupils.

(d) The governing authority of a private school providing for the transportation of pupils under authorized contract shall require as a condition of the contract that every person transporting pupils produce a certificate showing that within the last 60 days the person has submitted to a tuberculosis risk assessment, and, if tuberculosis risk factors are identified, has been examined and has been found to be free of infectious tuberculosis. At the discretion of the governing authority of the school, this section shall not apply to a private contracted driver who transports pupils infrequently and without prolonged contact with the pupils.

(e) The examination attested to in the certificate required pursuant to subdivision (d) shall be made available without charge by the local health officer.

(f) "Certificate," as used in this chapter, means a document signed by the examining physician and surgeon who is licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, or a notice from a public health agency that indicates freedom from infectious tuberculosis.

(g) Nothing in this section shall prevent the governing authority of a private, parochial, or preschool, upon recommendation of the local health officer, from establishing a rule requiring a more extensive or more frequent examination than required by this section.

(h) The State Department of Public Health, in consultation with the California Tuberculosis Controllers Association, shall develop a risk assessment questionnaire, to be used to conduct tuberculosis risk assessments pursuant to this section. The risk assessment questionnaire shall be administered by a health care provider, which shall be specified on the questionnaire. This risk assessment questionnaire shall be exempt from the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

~~SEC. 11.~~

SEC. 8. Section 5163 of the Public Resources Code is amended to read:

5163. (a) No person shall initially be employed in connection with a park, playground, recreational center, or beach used for recreational purposes by a city or county in a position requiring contact with children, or as a food concessionaire or other licensed

concessionaire in that area, unless the person submits to a tuberculosis risk assessment developed by the State Department of Public Health and the California Tuberculosis Controllers Association, and, if risk factors are present, an examination as described in Section 5163.1.

(b) Thereafter, those employees who do not have identified tuberculosis risk factors, or whose test for tuberculosis infection is negative shall be required to undergo the foregoing examination at least once each four years. Once an employee has a documented positive skin test which has been followed by an X-ray, and subsequently determined by a physician to be free of infectious tuberculosis, the foregoing examination is no longer required and a referral shall be made within 30 days of the examination to the local health officer to determine the need for followup care.

"Certificate" means a document signed by the examining physician and surgeon who is licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, or a notice from a public health agency or unit of the tuberculosis association which indicates freedom from infectious tuberculosis.

~~SEC. 12.~~

SEC. 9. Section 5163.1 of the Public Resources Code is amended to read:

5163.1. If tuberculosis risk factors are present, the employee shall be examined to determine that he or she is free of infectious tuberculosis. The examination shall consist of any test for tuberculosis infection that is recommended by the federal Centers for Disease Control and Prevention and licensed by the federal Food and Drug Administration, which, if positive, shall be followed by an X-ray of the lungs.

Sections 5163 to 5163.2, inclusive, do not prevent the governing body of any city or county, upon recommendation of the local health officer, from establishing a rule requiring a more extensive or more frequent examination than required by Section 5163 and this section.

O

HURST+BROOKS+ESPINOSA

July 5, 2017

The Honorable Henry Stern, Chair
Senate Elections and Constitutional Amendments Committee
State Capitol
Sacramento, CA 95814

Re: **AB 668 (Gonzalez-Fletcher) – Voting Modernization Bond Act of 2018**
As amended 7/3/2017
Set for hearing 7/12/2017 – Senate Elections and Constitutional Amendments Committee
County of Riverside: SUPPORT – Per Board Action

Dear Senator Stern:

On behalf of the Riverside County Board of Supervisors, I write in support of Assembly Bill 668 by Assembly Member Lorena Gonzalez-Fletcher, which would, if approved by voters, authorize the issuance and sale of $450 million in general obligation bond funds for the purchase of specified voting equipment and related technology in California counties. The County of Riverside recognizes the significant need for investment in upgraded technology to conduct fair, accessible, and secure elections that meet the expectations and needs of California's voters.

California counties are responsible for administering federal, state, and local elections. While counties can bill other local governments for their proportional share of administering elections, the state and federal government typically do not pay for their proportional share of elections. The state has provided one-time funding in certain circumstances for elections costs; however, the state does not provide regular funding to counties for elections purposes. In fact, the Legislative Analyst's Office (LAO), in a recent report discussing the roles and responsibilities of the state and counties in the administration of the elections system, suggested that the Legislature consider one-time support to help replace voting systems.

Additionally, the California Voters Choice Act (CVCA) – enacted in SB 450 (Ch. 832, Statues 2016) – challenges counties to improve voter participation and outreach by (1) authorizing counties to conduct elections in which all voters are mailed ballots and (2) providing voters with the opportunity to vote on those ballots or to vote in person at a vote center for a period of 10 days leading up to election day. Fourteen specified counties are permitted to conduct elections under this system in 2018, while the remaining counties (including Riverside County) may use this system beginning in 2020. Participation in SB 450 will necessitate an upgraded voter system and modern technology to successfully advance the goals of CVCA; AB 668 would offer needed resources to achieve CVCA objectives.

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For these reasons, we support AB 668. 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,

Jean Kinney Hurst

cc: The Honorable Lorena Gonzalez-Fletcher, California State Assembly
Members and Consultants, Senate Elections and Constitutional Amendments Committee
County of Riverside Delegation

AMENDED IN SENATE JULY 6, 2017

AMENDED IN SENATE JULY 3, 2017

AMENDED IN ASSEMBLY MAY 2, 2017

AMENDED IN ASSEMBLY APRIL 6, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 668

Introduced by Assembly Member Gonzalez Fletcher
(Coauthors: Assembly Members Chiu and Chu)
(Coauthor: Senator Hertzberg)

February 14, 2017

An act to add Chapter 5 (commencing with Section 19400) to Division 19 of the Elections Code, relating to elections, by providing the funds necessary therefor through an election for the issuance and sale of bonds of the State of California and for the handling and disposition of those funds.

LEGISLATIVE COUNSEL'S DIGEST

AB 668, as amended, Gonzalez Fletcher. Voting Modernization Bond Act of 2018.

Existing law, the Voting Modernization Bond Act of 2002, authorizes the Voting Modernization Finance Committee to issue and sell bonds in the amount of $200,000,000, as specified. Existing law authorizes a county to apply to the Voting Modernization Board for money from the proceeds of the sale of bonds (1) to pay for or purchase new voting systems that are certified or conditionally approved by the Secretary of State, (2) to research and develop new voting systems, or (3) to manufacture the minimum number of voting system units reasonably

necessary to test and seek certification or conditional approval of the voting system, or test and demonstrate the capabilities of a voting system in a pilot program.

This bill would enact the Voting Modernization Bond Act of 2018 which, if approved, would authorize the issuance and sale of bonds in the amount of $450,000,000, as specified, for similar purposes. This bill would authorize the Voting Modernization Finance Committee and the Voting Modernization Board to administer the Voting Modernization Bond Act of 2018.

This bill would provide for submission of the act to the voters at the June 5, 2018, statewide direct primary election.

Vote: ⅔. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Chapter 5 (commencing with Section 19400) is added to Division 19 of the Elections Code, to read:

CHAPTER 5. VOTING MODERNIZATION BOND ACT OF 2018

19400. This chapter shall be known and may be cited as the Voting Modernization Bond Act of 2018.

19401. The State General Obligation Bond Law (Chapter 4 (commencing with Section 16720) of Part 3 of Division 4 of Title 2 of the Government Code), except as otherwise provided herein, is adopted for the purpose of the issuance, sale, and repayment of, and otherwise providing with respect to, the bonds authorized to be issued by this chapter, and the provisions of that law, as amended from time to time, apply to the bonds and are incorporated into this chapter as though set out in full in this chapter.

19402. For purposes of this chapter, the following definitions apply:

(a) "Ballot on demand system" means a ballot manufacturing system, as defined in Section 303.4, that is subject to Sections 13004 and 13004.5.

(b) "Board" means the Voting Modernization Board, established pursuant to Section 19256.

(c) "Bond" means a state general obligation bond issued pursuant to this chapter.

(d) "Bond act" means this chapter authorizing the issuance of state general obligation bonds.

(e) "Committee" means the Voting Modernization Finance Committee, established pursuant to Section 19253.

(f) "Electronic poll book" means an electronic list of registered voters that may be transported to the polling location or vote center pursuant to Section 2550.

(g) "Fund" means the Voting Modernization Fund of 2018, established pursuant to Section 19403.

(h) "Remote accessible vote by mail system" means a system, as defined in Section 303.3, that is certified pursuant to Chapter 3.5 (commencing with Section 19280) of Division 19.

(i) "Vote by mail ballot drop box" means a secure receptacle established by a county or city and county elections official whereby a voted vote by mail ballot may be returned to the elections official from whom it was obtained pursuant to Section 3025.

(j) "Voting system" means any voting machine, voting device, or vote tabulating device that does not use prescored punch card ballots.

(k) "Open source software or firmware" means software or firmware licensed using a software license approved by the Open Source Initiative.

19402.5. (a) The Voting Modernization Fund of 2018 is hereby established.

(b) The committee may authorize the issuance and sale, pursuant to the State General Obligation Bond Law, of the bonds authorized by this chapter.

(c) The board may administer the fund and may reject any application for fund money it deems inappropriate, excessive, or that does not comply with the intent of this chapter.

19403. (a) The committee may create a debt or debts, liability or liabilities, of the State of California, in the aggregate amount of not more than four hundred fifty million dollars ($450,000,000), exclusive of refunding bonds, in the manner provided herein for the purpose of creating a fund to assist counties in paying for an expense listed in subdivision (d).

(b) The proceeds of bonds (exclusive of refunding bonds issued pursuant to Section 19410) issued and sold pursuant to this chapter shall be deposited in the fund.

(c) A county is eligible to apply to the board for fund money if it meets both of the following requirements:

(1) After ~~January 1, 2017,~~ *April 29, 2015,* the county has agreed to pay for an expense listed in subdivision (d) for which it continues to make payments on the date that this chapter becomes effective.

(2) The county matches fund moneys at one of the following ratios:

(A) If the county conducts an election pursuant to Section 4005 or 4007, one dollar ($1) of county moneys for every three dollars ($3) of fund moneys.

(B) If the county does not conduct an election pursuant to Section 4005 or 4007, one dollar ($1) of county moneys for every two dollars ($2) of fund moneys.

(d) (1) A county may use fund moneys to purchase or lease the following:

(A) Voting systems certified or conditionally approved by the Secretary of State that do not use prescored punch card ballots.

(B) Electronic poll books certified by the Secretary of State.

(C) Ballot on demand systems certified by the Secretary of State.

(D) Vote by mail ballot drop boxes that comply with any relevant regulations promulgated by the Secretary of State pursuant to subdivision (b) of Section 3025.

(E) Remote accessible vote by mail systems certified or conditionally approved by the Secretary of State.

(F) Technology to facilitate electronic connection between polling places, vote centers, and the office of the county elections official or the Secretary of State's office.

(G) Vote by mail ballot sorting and processing equipment.

(2) A county may use fund moneys to contract and pay for the following:

(A) Research and development of a new voting system that has not been certified or conditionally approved by the Secretary of State. A voting system developed pursuant to this subparagraph shall use only nonproprietary software and firmware with disclosed source code, except that it may use unmodified commercial off-the-shelf software and firmware, as defined in paragraph (1) of subdivision (a) of Section 19209.

(B) Manufacture of the minimum number of voting system units reasonably necessary for either of the following purposes:

(i) Testing and seeking certification or conditional approval for the voting system pursuant to Sections 19210 to 19214, inclusive.

(ii) Testing and demonstrating the capabilities of the voting system in a pilot program pursuant to paragraph (2) of subdivision (b) and subdivision (c) of Section 19209.

(iii) For purposes of this paragraph, "voting system" includes a part of a voting system.

(e) Any voting system purchased or leased using bond funds that does not require a voter to directly mark on the ballot must produce, at the time the voter votes his or her ballot or at the time the polls are closed, a paper version or representation of the voted ballot or of all the ballots cast on a unit of the voting system. The paper version shall not be provided to the voter but shall be retained by elections officials for use during the 1 percent manual tally described in Section 15360, or any recount, audit, or contest.

19404. The Legislature may amend subdivision (c) of Section 19402.5, subdivisions (c) and (d) of Section 19403, and Section 19256 by a statute, passed in each house of the Legislature by rollcall vote entered in the respective journals, by not less than two-thirds of the membership in each house concurring, if the statute is consistent with, and furthers the purposes of, this chapter.

19405. (a) All bonds authorized by this chapter, when duly sold, issued, and delivered as provided herein, constitute valid and legally binding general obligations of the State of California, and the full faith and credit of the state is hereby pledged for the punctual payment of both principal of, and interest on, the bonds as that interest becomes due and payable. The bonds issued pursuant to this chapter shall be repaid within 10 years from the date they are issued.

(b) There shall be collected annually, in the same manner and at the same time as other state revenue is collected, a sum of money, in addition to the ordinary revenues of the state, sufficient to pay the principal of, and interest on, the bonds as provided herein. All officers required by law to perform any duty in regard to the collection of state revenues shall collect this additional sum.

19406. (a) Notwithstanding Section 13340 of the Government Code, there is hereby continuously appropriated from the General Fund, for purposes of this chapter, a sum of money that will equal the sum annually necessary to pay the principal of, and the interest

on, the bonds issued and sold as provided in this chapter, as that principal and interest become due and payable.

(b) The board may request the Pooled Money Investment Board to make a loan from the Pooled Money Investment Account, in accordance with Section 16312 of the Government Code, for purposes of this chapter. The amount of the request shall not exceed the amount of the unsold bonds that the committee has, by resolution, authorized to be sold, excluding any refunding bonds authorized pursuant to Section 19410, for purposes of this chapter, less any amount withdrawn pursuant to subdivision (c). The board shall execute any documents as required by the Pooled Money Investment Board to obtain and repay the loan. Any amount loaned shall be deposited in the fund to be allocated in accordance with this chapter.

(c) For purposes of carrying out this chapter, the Director of Finance may, by executive order, authorize the withdrawal from the General Fund of any amount or amounts not to exceed the amount of the unsold bonds that the committee has, by resolution, authorized to be sold, excluding any refunding bonds authorized pursuant to Section 19410, for purposes of this chapter, less any amount withdrawn pursuant to subdivision (b). Any amounts withdrawn shall be deposited in the fund to be allocated in accordance with this chapter. Any moneys made available under this subdivision shall be returned to the General Fund, plus the interest that the amounts would have earned in the Pooled Money Investment Account, from moneys received from the sale of bonds which would otherwise be deposited in that fund.

19407. Upon request of the board, supported by a statement of its plans and projects approved by the Governor, the committee shall determine whether to issue any bonds authorized under this chapter in order to carry out the board's plans and projects and, if so, the amount of bonds to be issued and sold. Successive issues of bonds may be authorized and sold to carry out these plans and projects progressively, and it is not necessary that all of the bonds be issued or sold at any one time.

19408. (a) The committee may authorize the Treasurer to sell all or any part of the bonds authorized by this chapter at the time or times established by the Treasurer. Bonds shall be sold upon the terms and conditions specified in one or more resolutions

adopted by the committee pursuant to Section 16731 of the Government Code.

(b) Whenever the committee deems it necessary for an effective sale of the bonds, the committee may authorize the Treasurer to sell any issue of bonds at less than their par value, notwithstanding Section 16754 of the Government Code. However, the discount on the bonds shall not exceed 3 percent of the par value thereof.

19409. Out of the first money realized from the sale of bonds as provided by this chapter, there shall be redeposited in the General Obligation Bond Expense Revolving Fund, established by Section 16724.5 of the Government Code, the amount of all expenditures made for purposes specified in that section, and this money may be used for the same purpose and repaid in the same manner whenever additional bond sales are made.

19410. Any bonds issued and sold pursuant to this chapter may be refunded in accordance with Article 6 (commencing with Section 16780) of Chapter 4 of Part 3 of Division 4 of Title 2 of the Government Code. The approval of the voters for the issuance of bonds under this chapter includes approval for the issuance of bonds issued to refund bonds originally issued or any previously issued refunding bonds. Any bond refunded with the proceeds of a refunding bond as authorized by this section may be legally defeased to the extent permitted by law in the manner and to the extent set forth in the resolution, as amended from time to time, authorizing that refunded bond.

19411. Notwithstanding any provision of the bond act, if the Treasurer sells bonds under this chapter for which bond counsel has issued an opinion to the effect that the interest on the bonds is excludable from gross income for purposes of federal income tax, subject to any conditions that may be designated, the Treasurer may establish separate accounts for the investment of bond proceeds and for the earnings on those proceeds, and may use those proceeds or earnings to pay any rebate, penalty, or other payment required by federal law or take any other action with respect to the investment and use of bond proceeds required or permitted under federal law necessary to maintain the tax-exempt status of the bonds or to obtain any other advantage under federal law on behalf of the funds of this state.

19412. All moneys derived from premiums and accrued interest on bonds sold pursuant to this chapter shall be transferred to the

General Fund as a credit to expenditures for bond interest; provided, however, that amounts derived from premiums may be reserved and used to pay the costs of issuance of the related bonds prior to transfer to the General Fund.

19413. The Legislature hereby finds and declares that, inasmuch as the proceeds from the sale of bonds authorized by this chapter are not "proceeds of taxes" as that term is used in Article XIII B of the California Constitution, the disbursement of these proceeds is not subject to the limitations imposed by Article XIII B.

SEC. 2. Section 1 of this act shall take effect upon the approval by the people of the Voting Modernization Bond Act of 2018, submitted to the voters pursuant to Section 3 of this act.

SEC. 3. Notwithstanding Section 9040 of the Elections Code, a ballot measure that sets forth the Voting Modernization Bond Act of 2018, as set forth in Section 1 of this act, shall be submitted to the voters at the June 5, 2018, statewide direct primary election.

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COUNTY OF RIVERSIDE

June 30, 2017

The Honorable Hannah-Beth Jackson
Chair, Senate Judiciary Committee
State Capitol, Room 2032
Sacramento, CA 95814

RE: AB 1401 (Maienschein): Juveniles: Protective Custody Warrant
As Amended April 19, 2017
Set for Hearing: July 11, 2017 – Senate Judiciary Committee
County of Riverside: SUPPORT – Per Board Action

Dear Senator Jackson:

On behalf of the Riverside County Board of Supervisors, I write to express our support for AB 1401 by Assembly Member Maienschein. The measure would clarify that a court may issue a protective custody warrant for the protection of a child under specified circumstances when the child is not already the subject of a dependency petition.

Under existing law, the juvenile court is allowed to order removal of a child from his or her home when a petition is filed simultaneously or if social workers investigating child abuse and neglect find that there is imminent danger or bodily harm. There is some ambiguity in existing law regarding the issue of obtaining warrants without the filing of a petition. Some courts will issue warrants without a petition, because they believe that authority is inherent in their judicial powers to protect the interests of a minor. However, in some counties, judges will not do so without a warrant.

AB 1401 would clarify this ambiguity by allowing social workers, under certain circumstances, to seek a court order to remove a child without filing a petition while still retaining the judge's discretion as to whether a warrant is appropriate or needed as a precondition. This bill would provide an additional tool for social workers and help to protect vulnerable children.

For this reason, the County of Riverside supports AB 1401. 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@rivco.org.

Sincerely,

John Tavaglione
Chairman, Riverside County Board of Supervisors

cc: The Honorable Brian Maienschein, Member, California State Assembly
County of Riverside Delegation
Members, Senate Judiciary Committee
Marisa Shea, Counsel, Senate Judiciary Committee
Mike Petersen, Consultant, Senate Republican Caucus

AMENDED IN ASSEMBLY APRIL 19, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 1401

Introduced by Assembly Member Maienschein

February 17, 2017

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

LEGISLATIVE COUNSEL'S DIGEST

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

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

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

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

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

This bill would provide that no reimbursement is required by this act for a specified reason.

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

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

SECTION 1. Section 340 of the Welfare and Institutions Code is amended to read:

340. (a) Whenever a petition has been filed in the juvenile court alleging that a minor comes within Section 300 and praying for a hearing on that petition, or whenever any subsequent petition has been filed praying for a hearing in the matter of the minor and it appears to the court that the circumstances of his or her home environment may endanger the health, person, or welfare of the minor, or whenever a dependent minor has run away from his or her court-ordered placement, a protective custody warrant may be issued immediately for the minor.

(b) A protective custody warrant may be issued without filing a petition under Section 300 if the court finds probable cause to support all of the following:

(1) The child is a person described in Section 300.

(2) There is a substantial danger to the ~~physical or emotional health, or both,~~ *safety or physical health* of the child.

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

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

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

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

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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

June 30, 2017

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

Re: SB 171 (Hernandez) – Medi-Cal: Medi-Cal Managed Care Plans
As Amended May 2, 2017
Set for Hearing: July 11, 2017 – Assembly Health Committee
County of Riverside: SUPPORT – Per Legislative Platform

Dear Assembly Member Wood:

On behalf of the Riverside County Board of Supervisors, I write in support of SB 171, Senator Hernandez's measure which address 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 a 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.

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 agreement. SB 171 contains important statutory changes to bring California into compliance with the Rule and enables supplemental payments to continue.

COUNTY OF RIVERSIDE

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. Pending amendments will create the first element – a fixed pool of directed payments, for classes of providers including (1) Level I or II trauma centers, (2) University of California Medical Centers, (3) fully capitated health systems, and (4) 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@rivco.org.

Sincerely,

John Tavaglione
Chairman, Riverside County Board of Supervisors

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

AMENDED IN ASSEMBLY JULY 5, 2017

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~~ *1367.035 of the Health and Safety Code, and to amend Sections 10950 and 10951* of, *to add Section 10959.5 to,* 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. *These federal regulations require, with regards to a state fair hearing request filed by an enrollee entitled to an expedited resolution of an appeal by a managed care plan, an agency to take final administrative action as expeditiously as the enrollee's health condition requires, but not later than 3 working days after the agency receives, from the managed care plan, the case file and information for any appeal of a denial or a service that, as indicated by the managed care plan meets the criteria for expedited resolution of an appeal, but was not resolved within the timeframe for expedited resolution, or was resolved within the timeframe for expedited resolution of an appeal, but the managed care plan reached a decision wholly or partially adverse to the enrollee.*

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~~ *person, after he or she has exhausted the Medi-Cal managed care plan's appeals process,* to request a hearing involving a Medi-Cal managed care plan within 120 calendar days after ~~the order or action complained of,~~ *he or she has either received verbal or written notice from the Medi-Cal managed care plan that the adverse benefit determination, as defined, is upheld or the appeal or expedited appeal is denied, or the person is deemed to have exhausted the Medi-Cal managed care plans appeals process, as specified,* 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. *The bill would require the State Department of Social Services to adopt any necessary rules and regulations to implement these changes, and, until July 1, 2018, would*

authorize the State Department of Social Services to adopt any necessary rules and regulations as emergency regulations.

The bill would require the State Department of Social Services, for a beneficiary of a Medi-Cal managed care plan who meets the criteria for an expedited resolution of an appeal, to take final administrative action as expeditiously as the individual's health condition requires, but no later than 3 working days after the State Department of Social Services receives certain information from the Medi-Cal managed care plan consistent with the federal regulation described above. The bill would require a Medi-Cal managed care plan, upon notice from the State Department of Social Services that a beneficiary has requested a state fair hearing, to provide to the department a copy of the case file and any information for any appeal of a denial of a service within 3 business days of the Medi-Cal managed care plan's receipt of the department's notice of a request by a beneficiary for a state fair hearing.

(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 *that covered and* 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 *covered and medically necessary* 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.~~ *contracts, and would require the department, in developing these standards, to take into consideration requirements under a specified federal regulation.* 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,~~ *basis and when requested by the State Department of Health Care Services,* a Medi-Cal managed care plan, as defined, to demonstrate to the ~~department~~ *State Department of Health Care Services and, for Medi-Cal managed care plans licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), the Department of Managed Health Care* its compliance with the standards developed under this provision. *The bill would also require a health care service plan licensed under the Knox-Keene Act that provides services to Medi-Cal beneficiaries to provide to the Department of Managed Health Care, in a manner specified by the department, data regarding the standards developed under this provision. Because a willful violation of the Knox-Keene Act by a health care service plan is a crime, this bill would impose a state-mandated local program.*

The bill would require a Medi-Cal managed care plan, as defined, to comply with the MLR *calculation and* 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 generally provide that these MLR requirements do not apply to a health care service plan under a subcontract with a Medi-Cal managed care plan to provide covered health care services to Medi-Cal beneficiaries enrolled in the Medi-Cal managed care plan. The bill would require the department to post specified information on its Internet Web site, including any required remittances owed by a Medi-Cal managed care plan.*

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) These federal regulations require specified managed care plans to have a grievance and appeal system in place for enrollees, and requires managed care plans to resolve each grievance and appeal, and to provide timely and adequate notice, as expeditiously as the enrollee's health condition requires, within certain state-established timeframes that may not exceed specified timeframes.

This bill would require a Medi-Cal managed care plan, as defined, to give a beneficiary timely and adequate notice of an adverse benefit determination, as defined, in writing consistent with those federal regulations. The bill would require a Medi-Cal managed care plan to establish and maintain an expedited review process for a beneficiary or the beneficiary's provider to request an expedited resolution of an appeal based on specified circumstances, including when the beneficiary's condition is such that the beneficiary faces an imminent and serious threat to his or her health, or the standard timeline would be detrimental to the beneficiary's life or health or could jeopardize the beneficiary's ability to regain maximum function. The bill would require a Medi-Cal managed care plan to resolve a standard appeal no more than 30 calendar days from the day the Medi-Cal managed care plan receives the appeal, and would require the Medi-Cal managed care plan to resolve an expedited appeal no longer than 72 hours after the Medi-Cal managed care plan receives the appeal.

(4) Existing federal regulations, published on March 30, 2016, revise regulations governing mental health parity requirements to address the application of certain mental health parity requirements under a specified federal law to certain Medicaid managed care plans, Medicaid benchmark and benchmark-equivalent plans, and the Children's Health Insurance Program (CHIP).

This bill would require the State Department of Health Care Services to ensure that all covered mental health and substance use disorder benefits are provided in compliance with those revised federal regulations. The bill would require the department to implement, interpret, or make specific this provision by means of all-county letters, plan letters, or plan or provider bulletins, or similar instructions until regulations are adopted, and would require the department to adopt regulations by July 1, 2018. The bill would require, on an annual basis and when requested by the department, a Medi-Cal managed care plan, as defined, to demonstrate to the department its compliance with these

mental health parity requirements, and would require the department to make an annual compliance report available on its Internet Web site.

~~(3)~~

(5) 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~~ *payments, as defined,* to designated public hospital systems, as defined, by ~~a uniform percentage applied uniformly across~~ *an amount determined under a prescribed uniform distribution methodology to be developed by the department, and would authorize these directed payments to separately*

account for inpatient and noninpatient hospital services and require these directed payments to be developed and applied separately for and uniformly within specified classes of designated public hospital ~~systems in accordance with a prescribed methodology.~~ *systems.* 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~~ *department, after providing notice of its determination to the affected Medi-Cal managed care plan and allowing a reasonable period to cure the deficiencies,* to reduce the default assignment into a Medi-Cal managed care plan by up to ~~25%,~~ *25% in the applicable county,* 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~~ *applicable Medi-Cal* managed care ~~plan,~~ *plans,* to establish a program under which a designated public hospital system may earn performance-based quality incentive payments from Medi-Cal managed care plans, as specified, and would require payments to be earned by each designated public hospital system based on its performance in achieving identified targets for quality of care. The bill would require the department to establish uniform performance measures and parameters for the designated public hospital systems to select the applicable measures, and would require these performance measures to advance at least one goal identified in the state's Medicaid quality strategy.

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

The bill would prohibit the department *or a Medi-Cal managed care plan* from 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.

The bill would provide that these provisions shall cease to be operative on the first day of the state fiscal year beginning on or after the date the department determines, after consultation with the designated public hospital systems, that implementation of these provisions is no longer financially and programmatically supportive of the Medi-Cal program, as specified. The bill would require the department to post notice of the determination on its Internet Web site, and to provide written notice of the determination to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

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

This bill would provide that no reimbursement is required by this act for a specified reason.

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

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 1367.035 of the Health and Safety Code is amended to read:

1367.035. (a) As part of the reports submitted to the department pursuant to subdivision (f) of Section 1367.03 and regulations adopted pursuant to that section, a health care service plan shall submit to the department, in a manner specified by the

department, data regarding network adequacy, including, but not limited to, the following:

(1) Provider office location.

(2) Area of specialty.

(3) Hospitals where providers have admitting privileges, if any.

(4) Providers with open practices.

(5) The number of patients assigned to a primary care provider or, for providers who do not have assigned enrollees, information that demonstrates the capacity of primary care providers to be accessible and available to enrollees.

(6) Grievances regarding network adequacy and timely access that the health care service plan received during the preceding calendar year.

(b) A health care service plan that uses a network for its Medi-Cal managed care product line that is different from the network used for its other product lines shall submit the data required under subdivision (a) for its Medi-Cal managed care product line separately from the data submitted for its other product lines.

(c) A health care service plan that uses a network for its individual market product line that is different from the network used for its small group market product line shall submit the data required under subdivision (a) for its individual market product line separate from the data submitted for its small group market product line.

(d) The department shall review the data submitted pursuant to this section for compliance with this chapter.

(e) *(1)* In submitting data under this section, a health care service plan that provides services to Medi-Cal beneficiaries pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code shall provide the same data to the State Department of Health Care Services pursuant to Section 14456.3 of the Welfare and Institutions Code.

(2) A health care service plan that provides services to Medi-Cal beneficiaries also shall provide to the department, in a manner specified by the department, data regarding the standards set forth in Section 14197 of the Welfare and Institutions Code.

(f) In developing the format and requirements for reports, data, or other information provided by plans pursuant to subdivision

(a), the department shall not create duplicate reporting requirements, but, instead, shall take into consideration all existing relevant reports, data, or other information provided by plans to the department. This subdivision does not limit the authority of the department to request additional information from the plan as deemed necessary to carry out and complete any enforcement action initiated under this chapter.

(g) If the department requests additional information or data to be reported pursuant to subdivision (a), which is different or in addition to the information required to be reported in paragraphs (1) to (6), inclusive, of subdivision (a), the department shall provide health care service plans notice of that change by November 1 of the year prior to the change.

(h) A health care service plan may include in the provider contract provisions requiring compliance with the reporting requirements of Section 1367.03 and this section.

SEC. 3. Section 10950 of the Welfare and Institutions Code is amended to read:

10950. (a) If any applicant for or recipient of public social services is dissatisfied with any action of the county department relating to his or her application for or receipt of public social services, if his or her application is not acted upon with reasonable promptness, or if any person who desires to apply for public social services is refused the opportunity to submit a signed application therefor, and is dissatisfied with that refusal, he or she shall, in person or through an authorized representative, without the necessity of filing a claim with the board of supervisors, upon filing a request with the State Department of Social Services or the State Department of Health Care Services, whichever department administers the public social service, be accorded an opportunity for a state hearing.

(b) (1) The requirements of Sections 100506.2 and 100506.4 of the Government Code apply to state hearings regarding eligibility for or enrollment in an insurance affordability program administered by the State Department of Health Care Services to the extent that those sections conflict with the state hearing requirements under this chapter.

(2) 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 subdivision 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, 2017, 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. Notwithstanding Section 10231.5 of the Government Code, beginning July 1, 2015, the department shall provide a semiannual status report to the Legislature, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(3) This subdivision shall be implemented only to the extent it does not conflict with federal law.

(c) Priority in setting and deciding cases shall be given in those cases in which aid is not being provided pending the outcome of the hearing. This priority shall not be construed to permit or excuse the failure to render decisions within the time allowed under federal and state law.

(d) Notwithstanding any other provision of this code, there is no right to a state hearing when either (1) state or federal law requires automatic grant adjustments for classes of recipients unless the reason for an individual request is incorrect grant computation, or (2) the sole issue is a federal or state law requiring an automatic change in services or medical assistance which adversely affects some or all recipients.

(e) For the purposes of administering health care services and medical assistance, the Director of Health Care Services shall have those powers and duties conferred on the Director of Social Services by this chapter to conduct state hearings in order to secure approval of a state plan under applicable federal law.

(f) The Director of Health Care Services may contract with the State Department of Social Services for the provisions of state hearings in accordance with this chapter.

(g) As used in this chapter, ~~"recipient"~~ *the following terms have the following meanings:*

(1) "Adverse benefit determination" means, in the case of a Medi-Cal managed care plan, any of the following:

(A) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(B) The reduction, suspension, or termination of a previously authorized service.

(C) The denial, in whole or in part, of payment for a service.

(D) The failure to provide services in a timely manner, as defined by the State Department of Health Care Services.

(E) The failure of a Medi-Cal managed care plan to act within the timeframes provided in Section 438.408(b)(1) of Title 42 of the Code of Federal Regulations regarding the standard resolution of grievances and appeals.

(F) For a resident of a rural area with only one Medi-Cal managed care plan, the denial of an enrollee's request to exercise his or her right under Section 438.52(b)(2)(i) of Title 42 of the Code of Federal Regulations to obtain services outside the network.

(G) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

(2) "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) of Chapter 7 of Part 3, including dental managed care programs developed pursuant to Section 14087.46.

(B) Article 2.8 (commencing with Section 14087.5) of Chapter 7 of Part 3.

(C) Article 2.81 (commencing with Section 14087.96) of Chapter 7 of Part 3.

(D) Article 2.9 (commencing with Section 14088) of Chapter 7 of Part 3.

(E) Article 2.91 (commencing with Section 14089) of Chapter 7 of Part 3.

(F) Chapter 8 (commencing with Section 14200) of Part 3, including dental managed care plans.

(G) Chapter 8.9 (commencing with Section 14700) of Part 3.

(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.

(3) "Recipient" means an applicant for or recipient of public social services except aid exclusively financed by county funds or aid under Article 1 (commencing with Section 12000) to Article 6 (commencing with Section 12250), inclusive, of Chapter 3 of Part 3, and under Article 8 (commencing with Section 12350) of Chapter 3 of Part 3, or those activities conducted under Chapter 6 (commencing with Section 18350) of Part 6, and shall include any individual who is an approved adoptive parent, as described in subdivision (C) of Section 8708 of the Family Code, and who alleges that he or she has been denied or has experienced delay in the placement of a child for adoption solely because he or she lives outside the jurisdiction of the department.

~~SEC. 2.~~

SEC. 4. 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. *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.*

(b) (1) Notwithstanding subdivision (a), a person *who is enrolled in a Medi-Cal managed care plan and who has received an adverse benefit determination from the Medi-Cal managed care plan shall, to the extent required by federal law or regulation, appeal the adverse benefit determination to the Medi-Cal managed care plan before requesting a state fair hearing pursuant to this chapter. After appealing to the Medi-Cal managed care plan, the enrollee* 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.~~ *either of the following:*

(A) Receiving verbal or written notice from the Medi-Cal managed care plan that the adverse benefit determination is upheld or the appeal or expedited appeal is denied.

(B) When the enrollee's appeal is deemed exhausted because the Medi-Cal managed care plan failed to comply with state or federal requirements for notice and timeliness related to the disputed action or the appeal, including when a Medi-Cal managed care plan fails to respond to an appeal within 30 days as required pursuant to subdivision (b) of Section 14197.2 or asks the enrollee or his or her treating provider for more information to resolve the appeal solely for purposes of delaying a decision.

(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~~ *receiving notice from the Medi-Cal managed care plan that the adverse benefit determination is upheld* and there is good cause for filing the request beyond the 120-calendar day period. The director may determine whether good cause exists. *The department shall not grant a request for a hearing for good cause if the request is filed more than 180 days after receipt of the notice from the Medi-Cal managed care plan that the adverse benefit determination is upheld.*

(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.

(f) Notwithstanding subdivision (e), the department shall implement the amendments made to this section by the act that added this subdivision by adopting any necessary rules and regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Until July 1, 2018, any rules and regulations necessary to implement the amendments made to this section by the act that added this subdivision may be adopted as emergency regulations in accordance with the Administrative Procedure Act. The adoption of emergency regulations pursuant to this subdivision shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

SEC. 5. Section 10959.5 is added to the Welfare and Institutions Code, to read:

10959.5. (a) Notwithstanding Sections 10952 and 10959, for a beneficiary of a Medi-Cal managed care plan who meets the criteria for an expedited resolution of an appeal as set forth in subdivision (c) of Section 14197.2, the department shall take final administrative action as expeditiously as the individual's health condition requires, but no later than three working days after the department receives, from the Medi-Cal managed care plan, the case file and information for any appeal of a denial of a service that, as indicated by the Medi-Cal managed care plan, meets either of the following criteria:

(1) Meets the criteria for expedited resolution as set forth in Section 438.410 (a) of Title 42 of the Code of Federal Regulations, but was not resolved within the timeframe for expedited resolution.

(2) Was resolved within the timeframe for expedited resolution, but reached a decision wholly or partially adverse to the beneficiary.

(b) Upon notice from the department that a Medi-Cal managed care plan's beneficiary has requested a state fair hearing, the Medi-Cal managed care plan shall provide to the department a copy of the following information within three business days of the Medi-Cal managed care plan's receipt of the department's notice of a request by a beneficiary for a state fair hearing:

(1) The case file.

(2) Any information for any appeal of a denial of a service that, as indicated by the Medi-Cal managed care plan, meets either of the criteria described in paragraph (1) or (2) of subdivision (a).

~~SEC. 3.~~

SEC. 6. 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 Sections 438.68, 438.206, and 438.207 of Title 42 of the Code of Federal Regulations, to ensure that all *Medi-Cal covered* 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 *covered and* 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 *covered and medically necessary* 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~~ *all* of the following:

(1) Meet ~~or exceed~~ existing time and distance standards ~~developed pursuant to Section 1367.03 of the Health and Safety Code~~ *set forth in Section 1300.51 of Title 28 of the California Code of Regulations* and the standards set forth in Medi-Cal managed care contracts entered into with the department as of January 1, 2016. *In the event of a conflict between the time and distance standards set forth in Section 1300.51 of Title 28 of the California Code of Regulations and the Medi-Cal managed care contracts entered into within the department as of January 1, 2016, the standard that requires a shorter travel time or less distance shall prevail.*

(2) Meet ~~or exceed~~ the appointment time standards developed pursuant to Section 1367.03 of the Health and Safety ~~Code~~ *Code, Section 1300.67.2.2 of Title 28 of the California Code of Regulations,* and the standards set forth in contracts entered into between the department and Medi-Cal managed care plans.

(3) Take into consideration the requirements of subdivision (c) of Section 438.68 of Title 42 of the Code of Federal Regulations.

(d) In developing the time and distance standards, if the department elects a county standard for time and distance, the department shall categorize counties into at least five or more county 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,~~ *telehealth consistent with the requirements of Section 2290.5 of the Business and Professions Code,* 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) *(1)* A Medi-Cal managed care plan shall, on ~~at least~~ an annual ~~basis,~~ *basis and when requested by the department,* demonstrate to the department its compliance with the time and distance and ~~timeliness~~ *appointment wait time* standards developed pursuant to this section. *The report shall measure compliance separately for adult and pediatric services for primary care, behavioral health, and core specialist services. A Medi-Cal managed care plan licensed 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) shall also, on an annual basis, demonstrate to the Department of Managed Health Care its compliance with the time and distance and appointment wait time standards developed pursuant to this section.*

(2) The department shall annually publish on its Internet Web site a report for each Medi-Cal managed care plan that specifies any areas where the Medi-Cal managed care plan was found to be out of compliance and the Medi-Cal managed care plan's corrective action plan.

(i) The department shall consult with Medi-Cal managed care plans, including mental health plans, health care providers, consumers, providers and consumers of LTSS, and organizations representing Medi-Cal beneficiaries in the implementation of the requirements of this section.

~~(i) (1)~~

(j) 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)~~

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

~~(B)~~

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

~~(C)~~

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

~~(D)~~

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

~~(E)~~

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

~~(F)~~

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

~~(G)~~

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

~~(H)~~

(8) 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.

~~(I)~~

(k) 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) The department shall ensure that all covered mental health and substance use disorder benefits are provided in compliance with Parts 438, 440, 456, and 457 of Title 42 of the Code of Federal Regulations, as amended March 30, 2016, as published in the Federal Register (81 Fed. Reg. 18390), and any subsequent amendment to those regulations, and any associated federal policy guidance issued by the federal Centers for Medicare and Medicaid Services.

(b) 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 subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. In doing so, the director shall consult with managed care plans and consumer advocates. By July 1, 2018, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) A Medi-Cal managed care plan, on an annual basis and when requested by the department, shall demonstrate compliance with this section. The department shall make an annual compliance report available on its Internet Web site.

(d) 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:

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

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

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

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

(5) Chapter 8 (commencing with Section 14200), excluding dental managed care plans.

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

(7) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration,