Health and Human Services Policy Committee

Wednesday, August 5 ▪ 3:00 – 4:00 p.m.
Via Conference Call
Dial In: (800) 867-2581 ▪ Passcode: 7500559#

Supervisor Ken Yeager, Santa Clara County, Chair
Supervisor Hub Walsh, Merced County, Vice Chair

3:00 p.m.	**I.**	**Welcome and Introductions** *Supervisor Ken Yeager, Santa Clara County* *Supervisor Hub Walsh, Merced County*
3:05 – 3:25	**II.**	**Special Session Update** *Farrah McDaid Ting, Legislative Representative* *Michelle Gibbons, Legislative Analyst*
3:25 – 3:30	**III.**	**Budget and Legislative Update** *Farrah McDaid Ting, Legislative Representative* *Michelle Gibbons, Legislative Analyst*
3:30 –3:45	**IV.**	**California Children's Program Redesign Update** *Michelle Gibbons, Legislative Analyst*
3:45 – 4:00	**V.**	**Medi-Cal Inmate Claiming Program Update** *Farrah McDaid Ting, Legislative Representative* *Michelle Gibbons, Legislative Analyst*
INFORMATION ONLY ITEM	**VI.**	**Waiver Update**
4:00 p.m.	**VII.**	**Adjournment**

NOTES:
Please note new passcode digits: 7500559#
For those who wish to attend the meeting, it will be held in CSAC's Peterson Conference Room (1st floor, 1100 K Street, Sacramento).
The conference call number is noted above for those who wish to call in.

Conference Call Etiquette

1. Place your line on **mute** at all times until you wish to participate in the conversation.
2. **DO NOT PLACE THE LINE ON HOLD.**
3. Please identify yourself when speaking.

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July 28, 2015

To: CSAC Health and Human Services Policy Commtitee

From: Farrah McDaid Ting, Legislative Representative
Michelle Gibbons, Legislative Analyst

Re: Second Extraordinary Session on Health Care

Background. Governor Brown opened a second extraordinary special session on health care financing issues on June 16 as part of the 2015-16 budget agreement with Legislative Leaders. The Governor also declared a first extraordinary special session on Transportation issues. Hence, the Health Care Special Session is known as the second extraordinary session. For the purposes of this memo, CSAC will refer to the second extraordinary session as the "health special session."

The Governor's declaration (attached) lays out the goals for the special session: "to consider and act upon legislation necessary to enact permanent and sustainable funding from a new managed care organization tax and/or alternative fund sources…"

The Governor is seeking at least $1.1 billion in funding to stabilize the state's General Fund costs for Medi-Cal, but, in conjunction with Legislative Leaders, has also signaled the need for funding for additional priorities, including:

- Funding the 7 percent restoration of In-Home Supportive Services hours beyond the 2015-16 fiscal year ($266 million)
- Providing funding for Medi-Cal Fee-For-Service provider rate increases (estimated to cost $250 million annually)
- Providing funding for developmental disability community provider rate increases and services ($100 million to provide a 10 percent rate increase)

The top priority for the Governor and the Legislature is to authorize a new Managed Care Organization (MCO) tax to provide at least the first $1.1 billion in funding to the state for Medi-Cal costs. The current MCO tax expires June 30, 2016 and the Brown Administration has proposed a new, flat MCO tax on all health plans providing Medi-Cal services (link attached).

Any funds raised by a new MCO tax above the $1.1 billion could be used for the additional priorities, which total roughly $616 million.

Special Session Process and Legislation. Both houses of the Legislature organized new committees for the health special session:

Senate
Appropriations, chaired by Senator Ricardo Lara
Public Health and Developmental Services, chaired by Senator Ed Hernandez
Rules, chaired by Senate President pro Tempore Kevin de León

Assembly
Finance, chaired by Assembly Member Shirley Weber
Public Health and Developmental Services, chaired by Assembly Member Rob Bonta
Rules, chaired by Assembly Member Rich Gordon

Both the Senate and Assembly's Public Health and Developmental Services Committees met for overview hearings prior to the recess. They are expected to reconvene when the Legislature returns to Sacramento on August 17.

At the time of this writing, six identical bills on tobacco issues have been introduced in each house, along with an Assembly alternative proposal for a new MCO tax.

MCO Tax
ABX2 4 (Levine) would institute a $7.88 monthly flat tax for each plan enrollee for 45 managed care organizations which cover 21 million Californians, of which 9 million are Medi-Cal patients. The Author has stated that it will raise at least the $1.1 billion needed to fund existing obligations as well as up to $1.9 billion to provide funding for the additional stated priorities above (the IHSS 7 percent restorations, Medi-Cal provider rate increases, and disability services rate increases).

As of this writing, the Administration has not yet formally introduced their MCO tax proposal in the extraordinary session. However, the measure that has been in print since March would impose the new tax on most MCOs, not just those licensed for Medi-Cal Managed Care. It proposes a tiered tax structure based on enrollment size: For example, according to the Legislative Analyst's Office, a MCO with 1 million taxable member months would pay $3.50 per unit for the first 125,000 member months, $25.25 per unit for the next 150,000 member months, and $13.75 per unit for the remaining 725,000 member months, resulting in a total payment of $14.2 million. A link to the text of the Administration's MCO proposal is included at the end of this document.

Tobacco Legislation
The six-bill package of tobacco legislation is sponsored by Save Lives California, a coalition comprised of SEIU, CMA, CHA, American Cancer Society, American Lung Association, some health plans and the Dentists (CDA). The coalition's goal is to raise the tax on tobacco by $2 by 2016 to raise $1.5 billion annually for unspecified health spending.

SBX2 9 (McGuire)/ ABX2 10 (Bloom) would allow counties to levy taxes on tobacco distributers. Implementation at the county level would be subject to the usual rules for the adoption of local taxes (two-thirds local vote).

SBX2 7 (Hernandez)/ ABX2 8 (Wood) increase the age of sale for tobacco products to 21. The CSAC HHS Policy Committee adopted a support position on Hernandez's SB 151, which was identical to these special session bills. SB 151 died in the Assembly Governmental Organizations Committee last month due to strong opposition from the tobacco industry.

SBX2 5 (Leno)/ ABX2 6 (Cooper) would add e-cigarettes to existing tobacco products definitions. The CSAC HHS Policy Committee also adopted a support position on Leno's SB 140, which was identical to these specials session bills. SB 140 also died in the Assembly Governmental Organizations Committee after committee members added hostile amendments to the bill, forcing author Senator Leno to abandon the bill.

SBX2 10 (Beall) / ABX2 11(Nazarian) would establish an annual Board of Equalization (BOE) tobacco licensing fee program. Funds would be used for existing tobacco control programs.

SBX2 8 (Liu)/ ABX2 9 (Thurmond and Nazarian) would require all schools to be tobacco free.

SBX2 6 (Monning)/ ABX2 7 (Stone) would close loopholes in smoke-free workplace laws, including hotel lobbies, small businesses, break rooms, and tobacco retailers.

County Impacts of Special Session. The MCO tax issue is of importance to counties because the current MCO tax provides critical implementation funding for the Coordinated Care Initiative (CCI). The continuation of the CCI is tied to the county In-Home Supportive Services (IHSS) Maintenance of Effort (MOE) and the eventual plan to transition collective bargaining for IHSS workers from each county to the state, which was negotiated between the Administration and CSAC in 2012. If the CCI is unsuccessful, or MCO funding for the CCI is not continued, the county IHSS MOE could possibly cease as well.

It is worth noting that the Governor's proclamation calling for the special session does not mention continued funding for the CCI.

CSAC may weigh in on the tobacco legislation, especially SBX2 5 (Leno)/ ABX2 6 (Cooper) and SBX2 7 (Hernandez)/ ABX2 8 (Wood), both of which the CSAC Health and Human Services Policy Committee voted to support during the regular session. CSAC is working with counties to determine the impacts of SBX2 9 (McGuire)/ ABX2 10 (Bloom), including attempting to understand whether a county-imposed tax on tobacco distributers is viable and how counties could potentially use the funding.

Staff Contacts

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Resources

CSAC has created as Special Session page to gather all materials and resources related to the 2015 special sessions on transportation and health: http://www.counties.org/special-sessions

CSAC Explanation of MCO Tax and CCI Issues (January 2015): http://www.counties.org/sites/main/files/file-attachments/mco_and_cci_and_the_ihss_moe_june_2015.pdf

The IHSS MOE: Frequently Asked Questions

http://www.counties.org/sites/main/files/file-attachments/ihss_labor_faq_oct_15_final.pdf

Governor's Proclamation for Extraordinary Session

http://gov.ca.gov/docs/6.16.15_Health_Care_Special_Session.pdf

Draft Administration Language on MCO Tax (March 2015)

http://www.dof.ca.gov/budgeting/trailer_bill_language/health_and_human_services/documents/647DHCSManagedCareOrganizationTaxTBL_000.pdf

Assembly MCO Tax Proposal (ABX2 4):

http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0001-0050/abx2_4_bill_20150716_introduced.pdf

Executive Department
State of California

A PROCLAMATION
BY THE GOVERNOR OF THE STATE OF CALIFORNIA

WHEREAS the state's recent expansion of health care coverage has resulted in more than four million additional Californians receiving coverage through Medi-Cal; and

WHEREAS to date, the managed care organization tax has provided a stable source of funding to help pay for the costs of the health care expansion; and

WHEREAS the federal government has issued guidance to the state that it cannot extend the managed care organization tax in its current format; and

WHEREAS the state will be forced to make more than $1 billion in program cuts beginning next year if the managed care organization tax is not extended; and

WHEREAS the state's General Fund cannot afford to provide additional rate increases for providers of services for Medi-Cal recipients and consumers with developmental disabilities; and

WHEREAS the state's General Fund cannot afford to permanently maintain a restoration of 7 percent of hours in the In-Home Supportive Services program; and

WHEREAS these extraordinary circumstances require the Legislature of the State of California to be convened in a special session.

NOW, THEREFORE, I, EDMUND G. BROWN JR., Governor of the State of California, in accordance with Section 3(b) of Article IV of the Constitution of the State of California, hereby convene the Legislature of the State of California to assemble in extraordinary session in Sacramento, California, on the 19th day of June, 2015, at a time to be determined, for the following purposes:

To consider and act upon legislation necessary to enact permanent and sustainable funding from a new managed care organization tax and/or alternative fund sources to provide:

a. At least $1.1 billion annually to stabilize the General Fund's costs for Medi-Cal; and

b. Sufficient funding to continue the 7 percent restoration of In-Home Supportive Services hours beyond 2015-16; and

c. Sufficient funding to provide additional rate increases for providers of Medi-Cal and developmental disability services.

To consider and act upon legislation necessary to:

a. Establish mechanisms so that that any additional rate increases expand access to services; and

b. Increase oversight and the effective management of services provided to consumers with developmental disabilities through the regional center system; and

c. Improve the efficiency and efficacy of the health care system, reduce the cost of providing health care services, and improve the health of Californians.

I FURTHER DIRECT that as soon as hereafter possible, this Proclamation be filed in the Office of the Secretary of State and that widespread publicity and notice be given of this Proclamation.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of California to be affixed this 16th day of June 2015.

EDMUND G. BROWN JR.
Governor of California

ATTEST:

ALEX PADILLA
Secretary of State

MCO and CCI and the IHSS MOE: It's All Connected
From CSAC Budget Action Bulletin, January 2015

Coordinated Care Initiative (CCI)

The Governor spends a significant amount of space in the January 2015-16 budget proposal to warn that the state's federal demonstration project known as either the Coordinated Care Initiative (CCI) or Cal Medi-Connect is in danger of failing.

This is significant to counties for several reasons, as the success of the CCI is directly tied to the continuation of the In Home Supportive Services (IHSS) Maintenance of Effort (MOE) negotiated between the Administration and counties in 2012.

First, the Governor outlines a number of troubling statistics and events related to CCI:

- When the CCI was approved by the Legislature, the state expected to share savings 50-50 with the federal government. However, the federal government notified the state that it would only be allowed to retain 25 percent of any savings.

- Much lower participation is being realized, including the exemption of more than 100,000 potential participants and an extremely high opt-out rate (initial projections estimated a 33 percent opt-out rate, but data as of November 1, 2014 shows a 69 percent opt-out rate, including a whopping 80 percent opt-out rate for IHSS participants). Further, enrollment delays have occurred in each of the 7 remaining participating counties.

- The state's Managed Care Organization tax (MCO tax) helps fund the CCI and allows for a 4-percent tax on managed care organizations through June 30, 2016. However, the federal government recently informed the state that the tax was inconsistent with Medicaid regulations and would not be allowed to continue past the 2016 date. This blows a significant hole in funding for the CCI project and could be the death knell for the project if the MCO tax is not continued.

Which brings us to the IHSS MOE.

In Home Supportive Services Maintenance of Effort (IHSS MOE)

Counties negotiated the IHSS MOE with the state in 2012. In 2013-14, the county share of the MOE is nearly $1 billion. The implementation of the IHSS MOE was directly tied to the success of the CCI project, i.e. the state required savings through the CCI to guarantee the continuation of the county MOE. The California Department of Finance (DoF) is required to report each January on whether the CCI is cost effective. If the DoF determines that it is not, the CCI automatically ceases operation.

Further, the loss of the MCO tax as outlined in the previous section is not the only fiscal emergency threatening the operation of the CCI and the continuation of the IHSS MOE. According to the Governor, the current federal interpretation of Federal Labor

Standards Act overtime regulations for IHSS workers also increases the state's exposure to costs for the IHSS program.

While the IHSS overtime costs are currently stayed under a federal court order, the state continues to be cautious and budget for increased costs in IHSS overtime in 2015-16 .

From the state's perspective, the potential loss of the MCO tax, coupled with increased costs for IHSS overtime, increase the state's costs and make the continuation of the CCI less tenable. If the CCI ceases operation, the move of IHSS collective bargaining to the State, and the County IHSS MOE, would end. The Administration proposes that unless factors are improved, the CCI trigger could be pulled in January 2016, which would trigger off the County IHSS MOE the following fiscal year, July 2017.

CSAC is concerned about any changes to IHSS MOE as negotiated and outlined in current statute. We note that it would be a complex fiscal nightmare to "unwind" the MOE and a negotiated deal. Counties also vow to continue efforts with the state, federal government, and health plans to implement the CCI and support the continuation of the MCO tax or a modified version that provides the necessary revenue to balance CCI implementation and preserve the IHSS MOE.

ASSEMBLY BILL No. 4

Introduced by Assembly Member Levine
(Coauthors: Assembly Members Bloom, Brown, Chau, Chu, Cristina Garcia, Roger Hernández, Jones-Sawyer, McCarty, Nazarian, Quirk, Rendon, Mark Stone, and Williams)

July 16, 2015

An act to amend Section 6172 of, and to amend and repeal Section 17131.9 of, the Revenue and Taxation Code, and to amend Section 12302.2 of, to amend and repeal Section 12306.6 of, and to add Article 6.3 (commencing with Section 14197.50) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to public social services.

LEGISLATIVE COUNSEL'S DIGEST

AB 4, as introduced, Levine. Managed care organization provider tax.

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 law provides for the county-administered In-Home Supportive Services (IHSS) program, under which qualified aged, blind, and disabled persons are provided with services to permit them to remain in their own homes and avoid institutionalization. Existing law provides, as part of the Coordinated Care Initiative, that IHSS is a Medi-Cal

benefit available through managed care health plans in specified counties. Existing law provides for a 7% reduction in hours of service to each IHSS recipient of services.

Existing law imposes a sales tax on providers of support services for the privilege of selling support services at retail, measured by the gross receipts from the sale of those services in this state at a specified rate of those gross receipts. Existing law specifies that a seller is the State Department of Social Services, a county, or other person or entity, as provided. Existing law also imposes a sales tax on sellers of Medi-Cal managed care plans.

This bill would repeal the support services sales tax and would establish a new managed care organization provider tax, to be administered by the department in consultation with the Department of Managed Health Care. The tax would be assessed by the department on licensed health care service plans and managed care plans contracted with the department to provide Medi-Cal services, except as excluded by the bill. The bill would require the health plans to report to the department specified enrollment information, on a quarterly basis, beginning with the 2016–17 state fiscal year. On December 1, 2016, or the date upon which the department receives approval for federal financial participation, whichever is later, the department would commence notification to the health plans of the assessed tax amount and due date for the first taxable quarter. The amount of the tax would be $7.88 per plan enrollee, as defined.

The bill would require the department to request approval from the federal Centers for Medicare and Medicaid Services as necessary to implement the bill. The bill would authorize the department to implement its provisions by means of provider bulletins, all-plan letters, or similar instructions, and to notify the Legislature of this action.

This bill would establish the Health and Human Services Special Fund in the State Treasury, into which all revenues, less refunds, derived from taxes imposed by the bill would be deposited. Moneys in the fund would be used for designated health care purposes, subject to appropriation in the annual Budget Act. The remaining moneys in the fund would be available to the department for the purpose of funding the nonfederal share of Medi-Cal managed care rates, as prescribed, upon appropriation in the annual Budget Act.

This bill would also make conforming and technical changes.

This bill would include a change in state statute that would result in a taxpayer paying a higher tax within the meaning of Section 3 of Article

XIII A of the California Constitution, and thus would require for passage the approval of ⅔ of the membership of each house of the Legislature.

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

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

SECTION 1. Section 6172 of the Revenue and Taxation Code is amended to read:

6172. This article shall remain in effect only until ~~the January 1 following the date the tax extended by this article becomes inoperative pursuant to subdivision (b) of Section 6170,~~ *July 1, 2016,* and as of ~~that date~~ *January 1, 2017,* is repealed.

SEC. 2. Section 17131.9 of the Revenue and Taxation Code is amended to read:

17131.9. *(a)* Gross income does not include any supplementary payment received by an individual pursuant to Section 12306.6 of the Welfare and Institutions Code.

(b) This section shall remain in effect only until July 1, 2016, and as of January 1, 2017, is repealed.

SEC. 3. Section 12302.2 of the Welfare and Institutions Code is amended to read:

12302.2. (a) (1) If the state or a county makes or provides for direct payment to a provider chosen by a recipient or to the recipient for the purchase of in-home supportive services, the department shall perform or assure the performance of all rights, duties and obligations of the recipient relating to those services as required for purposes of unemployment compensation, unemployment compensation disability benefits, workers' compensation, federal and state income tax, and federal old-age survivors and disability insurance benefits. Those rights, duties, and obligations include, but are not limited to, registration and obtaining employer account numbers, providing information, notices, and reports, making applications and returns, and withholding in trust from the payments made to or on behalf of a recipient amounts to be withheld from the wages of the provider by the recipient as an employer, ~~including the sales tax extended to support services by Article 4 (commencing with Section 6150) of Chapter 2 of Part 1 of Division 2 of the Revenue and Taxation Code,~~ and transmitting those amounts along with amounts required

for all contributions, premiums, and taxes payable by the recipient as the employer to the appropriate person or state or federal agency. The department may assure the performance of any or all of these rights, duties, and obligations by contract with any person, or any public or private agency.

(2) Contributions, premiums, and taxes shall be paid or transmitted on the recipient's behalf as the employer for any period commencing on or after January 1, 1978, except that contributions, premiums, and taxes for federal and state income taxes and federal old-age, survivors and disability insurance contributions shall be paid or transmitted pursuant to this section commencing with the first full month that begins 90 days after the effective date of this section.

(3) Contributions, premiums, and taxes paid or transmitted on the recipient's behalf for unemployment compensation, workers' compensation, and the employer's share of federal old-age survivors and disability insurance benefits shall be payable in addition to the maximum monthly amount established pursuant to Section 12303.5 or subdivision (a) of Section 12304 or other amount payable to or on behalf of a recipient. Contributions, premiums, or taxes resulting from liability incurred by the recipient as employer for unemployment compensation, workers' compensation, and federal old-age, survivors and disability insurance benefits with respect to any period commencing on or after January 1, 1978, and ending on or before the effective date of this section shall also be payable in addition to the maximum monthly amount established pursuant to Section 12303.5 or subdivision (a) of Section 12304 or other amount payable to or on behalf of the recipient. Nothing in this section shall be construed to permit any interference with the recipient's right to select the provider of services or to authorize a charge for administrative costs against any amount payable to or on behalf of a recipient.

(b) If the state makes or provides for direct payment to a provider chosen by a recipient, the Controller shall make any deductions from the wages of in-home supportive services personnel that are authorized by Sections 1152 and 1153 of the Government Code, as limited by Section 3515.6 of the Government ~~Code, and for the sales tax extended to support services by Article 4 (commencing with Section 6150) of Chapter 2 of Part 1 of Division 2 of the Revenue and Taxation Code.~~ *Code.*

(c) Funding for the costs of administering this section and for contributions, premiums, and taxes paid or transmitted on the recipient's behalf as an employer pursuant to this section shall qualify, where possible, for the maximum federal reimbursement. To the extent that federal funds are inadequate, notwithstanding Section 12306, the state shall provide funding for the purposes of this section.

SEC. 4. Section 12306.6 of the Welfare and Institutions Code is amended to read:

12306.6. (a) (1) Notwithstanding any other provision of law, beginning on the date for which the federal Centers for Medicare and Medicaid Services authorizes commencement of the implementation of this section, but no earlier than January 1, 2012, and concurrent with the collection of the sales tax extended to support services pursuant to Article 4 (commencing with Section 6150) of Chapter 2 of Part 1 of Division 2 of the Revenue and Taxation Code, a provider of in-home supportive services shall receive a supplementary payment under this article equal to a percentage, as set forth in paragraph (2), of the gross receipts, as defined in subdivision (b) of Section 6150 of the Revenue and Taxation Code, of the provider for the sale of in-home supportive services, plus an amount described in paragraph (3) if applicable. If the underlying payment for in-home supportive services that is being supplemented is a Medi-Cal payment, then the supplementary payment shall also be a Medi-Cal payment. Supplementary payments shall be made only to those providers from whom the tax imposed pursuant to Section 6151 of the Revenue and Taxation Code has been collected.

(2) The percentage applicable to the supplementary payment required by paragraph (1) shall equal the rate described in subdivision (b) of Section 6151 of the Revenue and Taxation Code and shall only be applied to services provided under this article, including personal care option services reimbursable under the Medi-Cal program.

(3) The supplementary payment of an individual provider whose payroll withholding required for federal income tax purposes and for purposes of taxation for the Social Security and Medicare programs is increased due to the supplementary payment, in comparison to the amounts for those purposes that would be withheld without the supplementary payment, shall be increased

by an additional amount that is equal to the amount of this additional federal withholding.

(b) (1) All revenues deposited in the Personal Care IHSS Quality Assurance Revenue Fund established pursuant to Section 6168 of the Revenue and Taxation Code shall be used solely for purposes of the In-Home Supportive Services program, including, but not limited to, those services provided under the Medi-Cal program. All supplementary payments required by this section shall be paid from the Personal Care IHSS Quality Assurance Revenue Fund.

(2) The Director of Finance shall determine the sum required to be deposited in the Personal Care IHSS Quality Assurance Revenue Fund to fund the initial supplementary payments from the fund. As soon thereafter as reasonably possible, this sum shall be transferred, in the form of a loan, from the General Fund to the Personal Care IHSS Quality Assurance Revenue Fund. At the time sufficient revenues have been deposited in the Personal Care IHSS Quality Assurance Revenue Fund pursuant to Section 6168 of the Revenue and Taxation Code to sustain the continued operation of the fund for that portion of the supplementary payment described in paragraph (2) of subdivision (a) plus an additional amount equal to the General Fund loan made pursuant to this paragraph, plus interest, the sum transferred from the General Fund, including interest, shall be repaid to the General Fund. Subsequent supplementary payments pursuant to this section shall be made from revenue deposited in the Personal Care IHSS Quality Assurance Revenue Fund pursuant to Section 6168 of the Revenue and Taxation Code.

(3) The Department of Finance, on an ongoing basis, shall determine the amount necessary to implement paragraph (3) of subdivision (a), and subdivision (c) of Section 12302.2, and immediately transfer this amount from the General Fund to the Personal Care IHSS Quality Assurance Revenue Fund.

(c) (1) The Director of Health Care Services shall seek all federal Medicaid approvals necessary to implement this section, including using the revenues obtained pursuant to Article 4 (commencing with Section 6150) of Chapter 2 of Part 1 of Division 2 of the Revenue and Taxation Code as the nonfederal share for supplementary payments. As part of that request for approval, the

director shall seek to make the supplementary payments effective as of January 1, 2012.

(2) This section shall become operative only if the federal Centers for Medicare and Medicaid Services grants Medicaid approvals sought pursuant to paragraph (1).

(3) If Medicaid approval is granted pursuant to paragraph (2), within 10 days of that approval the Director of Health Care Services shall notify the State Board of Equalization and the appropriate fiscal and policy committees of the Legislature of the approval.

(d) If Article 4 (commencing with Section 6150) of Chapter 2 of Part 1 of Division 2 of the Revenue and Taxation Code becomes inoperative pursuant to subdivision (b) of Section 6170 of the Revenue and Taxation Code, supplementary payments shall cease to be made pursuant to subdivision (a) when all moneys in the fund have been expended.

(e) (1) Notwithstanding 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, the department and the State Department of Health Care Services may implement and administer this section through all-county letters or similar instruction from the department and the State Department of Health Care Services until regulations are adopted. The department and the State Department of Health Care Services shall adopt emergency regulations implementing this section no later than 12 months following the initial effective date of the supplementary payments. The department and the State Department of Health Care Services may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the one readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review and approval by the Office of Administrative Law. The initial emergency regulations and the one readoption of emergency regulations authorized by this section

shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

~~(f) This section shall remain in effect only until the January 1 following the date supplementary payments cease to be made pursuant to subdivision (d), and as of that date is repealed.~~

(f) This section shall remain in effect only until July 1, 2016, and as of January 1, 2017, is repealed.

SEC. 5. Article 6.3 (commencing with Section 14197.50) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 6.3. Managed Care Organization Provider Tax

14197.50. (a) The Legislature finds and declares the following:

(1) California's expansion of health care coverage has resulted in more than four million additional Californians receiving coverage through Medi–Cal.

(2) California is in need of at least one billion one hundred million dollars ($1,100,000,000) annually to stabilize the cost of Medi-Cal.

(3) The In-Home Supportive Services Program provides vital services to elderly and disabled populations across our state to ensure that they are able to remain in their homes and continue to receive the care and attention they need.

(4) Thousands of dedicated care providers have suffered years of rate cuts to In-Home Supportive Services and are in desperate need of stable funding source.

(5) The State Department of Developmental Services oversees the care of our state's most vulnerable population, and these services have continuously been underfunded.

(6) As the state transitions away from the use of developmental centers, a population of medically fragile and behaviorally challenged individuals will need to identify adequate care in the community.

(7) It is essential that these programs be funded through a reliable funding mechanism that allows services to be provided on an ongoing basis.

(b) Accordingly, it is the intent of the Legislature that the State Department of Health Care Services implement a managed care organization provider tax, effective July 1, 2016, to provide reliable ongoing funding for the Medi-Cal program, minimize to the extent possible any need for new reductions to the program, and meet all of the following goals:

(1) Generate an amount of nonfederal funds for the Medi-Cal program equivalent to the funds generated by the tax imposed pursuant to Article 5 (commencing with Section 6174) of Chapter 2 of Part 1 of Division 2 of the Revenue and Taxation Code.

(2) In addition to the amount in paragraph (1), and in a manner consistent with Section 12301.03, generate an amount of nonfederal funds sufficient to offset the 7 percent reduction to the In-Home Supportive Services Program imposed pursuant to Section 12301.02.

(3) Comply with federal Medicaid requirements applicable to permissible health care-related taxes.

(4) Provide funding for developmental services at rates that allow for appropriate levels of service.

14197.51. The following definitions shall apply for purposes of this article:

(a) "Countable enrollee" means an individual enrolled in a health plan, as defined in subdivision (e), each month of a taxable quarter. "Countable enrollee" does not include an individual enrolled in a Medicare plan, or a plan-to-plan enrollee, as defined in subdivision (g).

(b) "Department" means the State Department of Health Care Services.

(c) "Director" means the Director of Health Care Services.

(d) "Excluded plan" means a health plan licensed pursuant to Section 1351.2 of the Health and Safety Code.

(e) "Health care service plan" or "health plan" means a full service health care service plan licensed by the Department of Managed Health Care 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) or a managed care plan contracted with the State Department of Health Care Services to provide Medi-Cal services.

(f) "Per enrollee tax amount" means the amount of tax assessed per countable enrollee within a taxing tier.

(g) "Plan-to-plan enrollee" means an individual who receives his or her health care services through a full service health plan pursuant to a subcontract from another full service health plan.

(h) "Taxable quarter" means a calendar quarter of the state fiscal year.

14197.52. (a) The Health and Human Services Special Fund is hereby created in the State Treasury.

(b) All revenues, less refunds, derived from the taxes provided for in this article shall be deposited in the State Treasury to the credit of the fund.

(c) Notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on moneys in the fund shall be retained in the fund for the purposes specified in subdivisions (d) and (e).

(d) Subject to an appropriation in the annual Budget Act, moneys in the fund shall be available for health services including, but not limited to, all of the following:

(1) To the State Department of Social Services, to offset the reductions to the In-Home Supportive Services Program imposed pursuant to Section 12301.02, not to exceed an amount beyond a 7 percent reduction in hours of service, in a manner consistent with Section 12301.03.

(2) To the State Department of Health Care Services, for purposes of reinstating previous reductions to Medi-Cal reimbursement rates pursuant to Sections 14105.192 and 14105.194.

(3) To the State Department of Developmental Services, for purposes of increasing provider rates for vendor services, establishing adequate care for those individuals transitioning out of the developmental centers, and providing funds to community-based resources.

(e) Subject to an appropriation in the annual Budget Act, after meeting the funding obligations pursuant to subdivision (d), the remaining funds deposited in the Health and Human Services Special Fund pursuant to this article shall be available to the State Department of Health Care Services for purposes of funding the nonfederal share of Medi-Cal managed care rates for children, adults, seniors and persons with disabilities, and persons dually eligible for Medi-Cal and Medicare.

14197.53. (a) Beginning with the 2016–17 state fiscal year, each health plan, within 45 days after the end of each state fiscal quarter, shall submit a report to the department for the state fiscal quarter that includes all of the following information:

(1) Total cumulative enrollment for the quarter.

(2) Total Medicare cumulative enrollment for the quarter.

(3) Total Medi-Cal cumulative enrollment for the quarter.

(4) Total plan-to-plan cumulative enrollment for the quarter.

(5) Total other cumulative enrollment for the quarter that is not otherwise counted in paragraphs (2) through (4), inclusive.

(b) The department, in consultation with the Department of Managed Health Care, shall develop the methodologies used to determine the enrollments required to be reported by health plans and the format of those submissions.

(c) A report submitted under this section shall be accompanied by a certification by the health plan attesting to the accuracy of the reports.

(d) For the efficient operation of this section, the director, in consultation with the Director of the Department of Managed Health Care, may delegate the development of the format of the reports or the collection of the reports, or both, to the Department of Managed Health Care.

14197.54. (a) A managed care organization provider tax shall be imposed on every health plan that is not an excluded plan.

(b) The department shall compute the quarterly tax for each health plan subject to the tax during the fiscal year, pursuant to Section 14197.55.

(c) On December 1, 2016, or the date the department receives federal approval necessary for receipt of federal financial participation in conjunction with the tax created by this article, whichever is later, the following activities shall commence:

(1) The director shall certify in writing that federal approval has been received, and within 5 business days shall post the certification on its Internet Web site and send a copy of the certification to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(2) Within 10 business days following the receipt of the notice of federal approval, the department shall send a notice to each health plan subject to the tax, which shall contain the following information:

(A) The quarterly tax due for the first taxable quarter, and any subsequent taxable quarters for which data has been submitted and a tax has been calculated.

(B) The date on which the tax payments are due.

(3) A health plan shall pay the quarterly tax, based on a schedule developed by the department. The department shall establish the date that each payment is due, provided that the first payment shall be due no earlier than 20 days following the date the department sends the notice pursuant to paragraph (2), and the payments shall be paid at least one month apart, but no more than one quarter apart.

(4) A health plan shall pay the quarterly taxes that are due, if any, in the amounts and at the times set forth in the notice, unless superseded by a subsequent notice issued by the department.

(d) The managed care organization provider tax, as assessed pursuant to this article, shall be paid to the department by each health plan subject to the tax, and deposited by the department into the Health and Human Services Special Fund created pursuant to Section 14197.52.

(e) (1) Interest shall be assessed on managed care organization provider taxes that are not paid on the date due at a rate of 10 percent per annum. Interest shall begin to accrue the day after the date the payment was due, and shall be deposited in the Health and Human Services Special Fund created pursuant to Section 14197.52.

(2) If a tax payment is more than 60 days overdue, a penalty equal to the interest charge described in paragraph (1) shall be assessed and due for each month for which the payment is not received after 60 days.

(f) (1) Subject to paragraph (2), the director may waive any or all interest and penalties assessed under this article in the event that the director determines, in his or her sole discretion, that the health plan has demonstrated that imposition of the full amount of the managed care organization provider tax pursuant to the timelines applicable under this article has a high likelihood of creating an undue financial hardship for the health plan, or creates a significant financial difficulty in providing needed services to Medi-Cal beneficiaries.

(2) Waiver of some or all of the interest or penalties imposed pursuant to this subdivision shall be conditioned on the health

plan's agreement to make tax payments on an alternative schedule developed by the department that takes into account the financial situation of the health plan and the potential impact on services.

(g) For the efficient operation of this section, the director, in consultation with the Director of the Department of Managed Health Care, may delegate the collection of the taxes under this article to the Department of Managed Health Care.

14197.55. (a) Effective July 1, 2016, in order to achieve the goals specified in Section 14197.50, the per enrollee tax amount shall be seven dollars and eighty-eight cents ($7.88).

(b) The department shall request approval from the federal Centers for Medicare and Medicaid Services as is necessary to implement this article. In making the request, the department may seek, as it deems necessary, a request for waiver of the broad based requirement, waiver of the uniformity requirement, or both, pursuant to paragraphs (1) and (2) of subsection (e) of Section 433.68 of Title 42 of the Code of Federal Regulations, or a request for waiver of any other provision of federal law or regulation necessary to implement this article.

(c) 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 this article by means of provider bulletins, all plan letters, or other similar instruction, without taking legal regulatory action. The department shall provide notification to the Joint Legislative Budget Committee and to the Senate Committees on Appropriations, Budget and Fiscal Review, and Health and the Assembly Committees on Appropriations, Budget, and Health within 10 business days after the above-described action is taken to inform the Legislature that the action is being implemented.

O

An act to amend Sections 6172 and 6189 of, and to amend and repeal Section 17131.9 of, the Revenue and Taxation Code, and to amend Section 12302.2 of, to amend and repeal Section 12306.6 of, and to add Article 6.3 (commencing with Section 14197.50) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to public social services, and making an appropriation therefor, to take effect immediately, bill related to the budget.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 6172 of the Revenue and Taxation Code is amended to read:

6172. This article shall remain in effect only until ~~the January 1 following the date the tax extended by this article becomes inoperative pursuant to subdivision (b) of Section 6170~~, July 1, 2015, and as of ~~that date~~ January 1, 2016, is repealed.

SEC. 2. Section 6189 of the Revenue and Taxation Code is amended to read:

6189. This article shall be operative on July 1, 2013, and shall become inoperative ~~on July 1, 2016. As of January 1, 2017, this article is repealed.~~ on the effective date of any necessary federal approvals required to implement the tax imposed pursuant to Article 6.3 (commencing with Section 14197.50) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code. This article shall be repealed on January 1 of the year following the date upon which it becomes inoperative. A tax imposed by this article shall continue to be due and payable until the tax is paid.

SEC. 3. Section 17131.9 of the Revenue and Taxation Code is amended to read:

17131.9. (a) Gross income does not include any supplementary payment received by an individual pursuant to Section 12306.6 of the Welfare and Institutions Code.

(b) This section shall remain in effect only until July 1, 2015, and as of January 1, 2016, is repealed.

SEC. 4. Section 12302.2 of the Welfare and Institutions Code is amended to read:

12302.2. (a) (1) If the state or a county makes or provides for direct payment to a provider chosen by a recipient or to the recipient for the purchase of in-home

supportive services, the department shall perform or assure the performance of all rights, duties and obligations of the recipient relating to those services as required for purposes of unemployment compensation, unemployment compensation disability benefits, workers' compensation, federal and state income tax, and federal old-age survivors and disability insurance benefits. Those rights, duties, and obligations include, but are not limited to, registration and obtaining employer account numbers, providing information, notices, and reports, making applications and returns, and withholding in trust from the payments made to or on behalf of a recipient amounts to be withheld from the wages of the provider by the recipient as an employer, ~~including the sales tax extended to support services by Article 4 (commencing with Section 6150) of Chapter 2 of Part 1 of Division 2 of the Revenue and Taxation Code,~~ and transmitting those amounts along with amounts required for all contributions, premiums, and taxes payable by the recipient as the employer to the appropriate person or state or federal agency. The department may assure the performance of any or all of these rights, duties, and obligations by contract with any person, or any public or private agency.

(2) Contributions, premiums, and taxes shall be paid or transmitted on the recipient's behalf as the employer for any period commencing on or after January 1, 1978, except that contributions, premiums, and taxes for federal and state income taxes and federal old-age, survivors and disability insurance contributions shall be paid or transmitted pursuant to this section commencing with the first full month that begins 90 days after the effective date of this section.

(3) Contributions, premiums, and taxes paid or transmitted on the recipient's behalf for unemployment compensation, workers' compensation, and the employer's

share of federal old-age survivors and disability insurance benefits shall be payable in addition to the maximum monthly amount established pursuant to Section 12303.5 or subdivision (a) of Section 12304 or other amount payable to or on behalf of a recipient. Contributions, premiums, or taxes resulting from liability incurred by the recipient as employer for unemployment compensation, workers' compensation, and federal old-age, survivors and disability insurance benefits with respect to any period commencing on or after January 1, 1978, and ending on or before the effective date of this section shall also be payable in addition to the maximum monthly amount established pursuant to Section 12303.5 or subdivision (a) of Section 12304 or other amount payable to or on behalf of the recipient. Nothing in this section shall be construed to permit any interference with the recipient's right to select the provider of services or to authorize a charge for administrative costs against any amount payable to or on behalf of a recipient.

(b) If the state makes or provides for direct payment to a provider chosen by a recipient, the Controller shall make any deductions from the wages of in-home supportive services personnel that are authorized by Sections 1152 and 1153 of the Government Code, as limited by Section 3515.6 of the Government ~~Code, and for the sales tax extended to support services by Article 4 (commencing with Section 6150) of Chapter 2 of Part 1 of Division 2 of the Revenue and Taxation Code.~~ Code.

(c) Funding for the costs of administering this section and for contributions, premiums, and taxes paid or transmitted on the recipient's behalf as an employer pursuant to this section shall qualify, where possible, for the maximum federal

reimbursement. To the extent that federal funds are inadequate, notwithstanding Section 12306, the state shall provide funding for the purposes of this section.

SEC. 5. Section 12306.6 of the Welfare and Institutions Code is amended to read:

12306.6. (a) (1) Notwithstanding any other provision of law, beginning on the date for which the federal Centers for Medicare and Medicaid Services authorizes commencement of the implementation of this section, but no earlier than January 1, 2012, and concurrent with the collection of the sales tax extended to support services pursuant to Article 4 (commencing with Section 6150) of Chapter 2 of Part 1 of Division 2 of the Revenue and Taxation Code, a provider of in-home supportive services shall receive a supplementary payment under this article equal to a percentage, as set forth in paragraph (2), of the gross receipts, as defined in subdivision (b) of Section 6150 of the Revenue and Taxation Code, of the provider for the sale of in-home supportive services, plus an amount described in paragraph (3) if applicable. If the underlying payment for in-home supportive services that is being supplemented is a Medi-Cal payment, then the supplementary payment shall also be a Medi-Cal payment. Supplementary payments shall be made only to those providers from whom the tax imposed pursuant to Section 6151 of the Revenue and Taxation Code has been collected.

(2) The percentage applicable to the supplementary payment required by paragraph (1) shall equal the rate described in subdivision (b) of Section 6151 of the Revenue and Taxation Code and shall only be applied to services provided under this article, including personal care option services reimbursable under the Medi-Cal program.

(3) The supplementary payment of an individual provider whose payroll withholding required for federal income tax purposes and for purposes of taxation for the Social Security and Medicare programs is increased due to the supplementary payment, in comparison to the amounts for those purposes that would be withheld without the supplementary payment, shall be increased by an additional amount that is equal to the amount of this additional federal withholding.

(b) (1) All revenues deposited in the Personal Care IHSS Quality Assurance Revenue Fund established pursuant to Section 6168 of the Revenue and Taxation Code shall be used solely for purposes of the In-Home Supportive Services program, including, but not limited to, those services provided under the Medi-Cal program. All supplementary payments required by this section shall be paid from the Personal Care IHSS Quality Assurance Revenue Fund.

(2) The Director of Finance shall determine the sum required to be deposited in the Personal Care IHSS Quality Assurance Revenue Fund to fund the initial supplementary payments from the fund. As soon thereafter as reasonably possible, this sum shall be transferred, in the form of a loan, from the General Fund to the Personal Care IHSS Quality Assurance Revenue Fund. At the time sufficient revenues have been deposited in the Personal Care IHSS Quality Assurance Revenue Fund pursuant to Section 6168 of the Revenue and Taxation Code to sustain the continued operation of the fund for that portion of the supplementary payment described in paragraph (2) of subdivision (a) plus an additional amount equal to the General Fund loan made pursuant to this paragraph, plus interest, the sum transferred from the General Fund, including interest, shall be repaid to the General Fund. Subsequent supplementary

payments pursuant to this section shall be made from revenue deposited in the Personal Care IHSS Quality Assurance Revenue Fund pursuant to Section 6168 of the Revenue and Taxation Code.

(3) The Department of Finance, on an ongoing basis, shall determine the amount necessary to implement paragraph (3) of subdivision (a), and subdivision (c) of Section 12302.2, and immediately transfer this amount from the General Fund to the Personal Care IHSS Quality Assurance Revenue Fund.

(c) (1) The Director of Health Care Services shall seek all federal Medicaid approvals necessary to implement this section, including using the revenues obtained pursuant to Article 4 (commencing with Section 6150) of Chapter 2 of Part 1 of Division 2 of the Revenue and Taxation Code as the nonfederal share for supplementary payments. As part of that request for approval, the director shall seek to make the supplementary payments effective as of January 1, 2012.

(2) This section shall become operative only if the federal Centers for Medicare and Medicaid Services grants Medicaid approvals sought pursuant to paragraph (1).

(3) If Medicaid approval is granted pursuant to paragraph (2), within 10 days of that approval the Director of Health Care Services shall notify the State Board of Equalization and the appropriate fiscal and policy committees of the Legislature of the approval.

(d) If Article 4 (commencing with Section 6150) of Chapter 2 of Part 1 of Division 2 of the Revenue and Taxation Code becomes inoperative pursuant to subdivision (b) of Section 6170 of the Revenue and Taxation Code, supplementary

payments shall cease to be made pursuant to subdivision (a) when all moneys in the fund have been expended.

(e) (1) Notwithstanding 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, the department and the State Department of Health Care Services may implement and administer this section through all-county letters or similar instruction from the department and the State Department of Health Care Services until regulations are adopted. The department and the State Department of Health Care Services shall adopt emergency regulations implementing this section no later than 12 months following the initial effective date of the supplementary payments. The department and the State Department of Health Care Services may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the one readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review and approval by the Office of Administrative Law. The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(f) This section shall remain in effect only until the January 1 following the date supplementary payments cease to be made pursuant to subdivision (d), and as of that date is repealed.

(g) This section shall remain in effect only until July 1, 2015, and as of January 1, 2016, is repealed.

SEC. 6. Article 6.3 (commencing with Section 14197.50) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 6.3. Managed Care Organization Provider Tax

14197.50. It is the intent of the Legislature that the department implement a managed care organization provider tax, effective July 1, 2015, to provide ongoing funding for the Medi-Cal program, minimize to the extent possible any need for new reductions to the program, and meet all of the following goals:

(a) Generate an amount of nonfederal funds for the Medi-Cal program equivalent to the funds generated by the tax imposed pursuant to Article 5 (commencing with Section 6174) of Chapter 2 of Part 1 of Division 2 of the Revenue and Taxation Code.

(b) In addition to the amount in subdivision (a), and in a manner consistent with Section 12301.03, generate an amount of nonfederal funds sufficient to offset the 7 percent reduction to the In-Home Supportive Services Program imposed pursuant to Section 12301.02.

(c) Comply with federal Medicaid requirements applicable to permissible health care-related taxes.

(d) Structure the tax, to the extent possible, to have the lowest aggregate net financial impact on the health plans subject to the tax imposed pursuant to this article.

14197.51. The following definitions shall apply for purposes of this article:

(a) "Countable enrollee" means an individual enrolled in a health plan, as defined in subdivision (e), each month of a taxable quarter. "Countable enrollee" does not include an individual enrolled in a Medicare plan, or a plan-to-plan enrollee, as defined in subdivision (g).

(b) "Department" means the State Department of Health Care Services.

(c) "Director" means the Director of Health Care Services.

(d) "Excluded plan" means a health plan licensed pursuant to Section 1351.2 of the Health and Safety Code.

(e) "Health care service plan" or "health plan" means a full service health care service plan licensed by the Department of Managed Health Care 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) or a managed care plan contracted with the State Department of Health Care Services to provide Medi-Cal services.

(f) "Per enrollee tax amount" means the amount of tax assessed per countable enrollee within a taxing tier.

(g) "Plan-to-plan enrollee" means an individual who receives his or her health care services through a full service health plan pursuant to a subcontract from another full service health plan.

(h) "Taxable quarter" means a calendar quarter of the state fiscal year.

(i) "Taxing tier" means a range of cumulative enrollment of countable enrollees for a taxable quarter.

14197.52. (a) The Health and Human Services Special Fund is hereby created in the State Treasury.

(b) All revenues, less refunds, derived from the taxes provided for in this article shall be deposited in the State Treasury to the credit of the fund.

(c) Notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on moneys in the fund shall be retained in the fund for the purposes specified in subdivisions (d) and (e).

(d) Subject to an appropriation in the annual Budget Act to the State Department of Social Services, moneys in the fund shall be used to offset the reductions to the In-Home Supportive Services Program imposed pursuant to Section 12301.02, in a manner consistent with Section 12301.03.

(e) After meeting the funding obligations pursuant to subdivision (d), and notwithstanding Section 13340 of the Government Code, the remaining funds deposited in the Health and Human Services Special Fund pursuant to this article shall be continuously appropriated, without regard to fiscal years, to the State Department of Health Care Services for purposes of funding the nonfederal share of Medi-Cal managed care rates for health care services furnished to children, adults, seniors and persons with disabilities, and persons dually eligible for Medi-Cal and Medicare.

14197.53. (a) Beginning with the 2015–16 state fiscal year, each health plan shall, within 45 days after the end of each state fiscal quarter, submit a report to the department for the state fiscal quarter that includes all of the following information:

(1) Total cumulative enrollment for the quarter.

(2) Total Medicare cumulative enrollment for the quarter.

(3) Total Medi-Cal cumulative enrollment for the quarter.

(4) Total plan-to-plan cumulative enrollment for the quarter.

(5) Total other cumulative enrollment for the quarter that is not otherwise counted in paragraphs (2) through (4), inclusive.

(b) The department, in consultation with the Department of Managed Health Care, shall develop the methodologies used to determine the enrollments required to be reported by health plans and the format of those submissions.

(c) A report submitted under this section shall be accompanied by a certification by the health plan attesting to the accuracy of the reports.

(d) For the efficient operation of this section, the director, in consultation with the Director of the Department of Managed Health Care, may delegate the development of the format of the reports or the collection of the reports, or both, to the Department of Managed Health Care.

14197.54. (a) A managed care organization provider tax shall be imposed on every health plan that is not an excluded plan.

(b) The department shall compute the quarterly tax for each health plan subject to the tax during the fiscal year pursuant to Section 14197.55.

(c) On December 1, 2015, or the date the department receives federal approval necessary for receipt of federal financial participation in conjunction with the tax created by this article, whichever is later, the following activities shall commence:

(1) The director shall certify in writing that federal approval has been received, and within 5 business days shall post the certification on its Internet Web site and send a copy of the certification to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(2) Within 10 business days following the receipt of the notice of federal approval, the department shall send a notice to each health plan subject to the tax, which shall contain the following information:

(A) The quarterly tax due for the first taxable quarter, and any subsequent taxable quarters for which data has been submitted and a tax has been calculated.

(B) The date on which the tax payments are due.

(3) A health plan shall pay the quarterly tax, based on a schedule developed by the department. The department shall establish the date that each payment is due, provided that the first payment shall be due no earlier than 20 days following the date the department sends the notice pursuant to paragraph (2), and the payments shall be paid at least one month apart, but no more than one quarter apart.

(4) A health plan shall pay the quarterly taxes that are due, if any, in the amounts and at the times set forth in the notice unless superseded by a subsequent notice issued by the department.

(d) The managed care organization provider tax as assessed pursuant to this article shall be paid by each health plan subject to the tax to the department for deposit in the Health and Human Services Special Fund created pursuant to Section 14197.52.

(e) (1) Interest shall be assessed on managed care organization provider taxes that are not paid on the date due at a rate of 10 percent per annum. Interest shall begin

to accrue the day after the date the payment was due, and shall be deposited in the Health and Human Services Special Fund created pursuant to Section 14197.52.

(2) If a tax payment is more than 60 days overdue, a penalty equal to the interest charge described in paragraph (1) shall be assessed and due for each month for which the payment is not received after 60 days.

(f) (1) Subject to paragraph (2), the director may waive any or all interest and penalties assessed under this article in the event that the director determines, in his or her sole discretion, that the health plan has demonstrated that imposition of the full amount of the managed care organization provider tax pursuant to the timelines applicable under this article has a high likelihood of creating an undue financial hardship for the health plan, or creates a significant financial difficulty in providing needed services to Medi-Cal beneficiaries.

(2) Waiver of some or all of the interest or penalties imposed pursuant to this subdivision shall be conditioned on the health plan's agreement to make tax payments on an alternative schedule developed by the department that takes into account the financial situation of the health plan and the potential impact on services.

(g) For the efficient operation of this section, the director, in consultation with the Director of the Department of Managed Health Care, may delegate the collection of the taxes under this article to the Department of Managed Health Care.

14197.55. (a) Prior to each fiscal year, beginning with the 2016–17 fiscal year and each fiscal year thereafter, the department, in consultation with the Department of Managed Health Care, shall determine the taxing tiers and per enrollee tax amounts

for each tier, for the fiscal year, in order to achieve the goals specified in Section 14197.50.

(b) For each fiscal year, beginning with the 2016–17 fiscal year, the department shall include in the Medi-Cal Local Assistance Estimate, released each January and May of the preceding fiscal year, the taxing tiers and per enrollee tax amounts determined pursuant to subdivision (a) and attributable to the applicable fiscal year.

(c) For the 2015–16 fiscal year, the taxing tiers for each fiscal quarter shall be as follows:

(1) Taxing tier I shall consist of all countable enrollees in a health plan for the fiscal quarter from 0 through 125,000, inclusive.

(2) Taxing tier II shall consist of all countable enrollees in a health plan for the fiscal quarter from 125,001 through 275,000, inclusive.

(3) Taxing tier III shall consist of all countable enrollees in a health plan for the fiscal quarter from 275,001 through 1,250,000, inclusive.

(4) Taxing tier IV shall consist of all countable enrollees in a health plan for the fiscal quarter from 1,250,001 through 2,500,000, inclusive.

(5) Taxing tier V shall consist of all countable enrollees in a health plan for the fiscal quarter greater than 2,500,000.

(d) For the 2015–16 fiscal year, the per enrollee tax amount for each taxing tier for each fiscal quarter shall be as follows:

(1) The per enrollee tax for taxing tier I shall be three dollars and fifty cents ($3.50).

(2) The per enrollee tax for taxing tier II shall be twenty-five dollars and twenty-five cents ($25.25).

(3) The per enrollee tax for taxing tier III shall be thirteen dollars and seventy-five cents ($13.75).

(4) The per enrollee tax for taxing tier IV shall be five dollars and fifty cents ($5.50).

(5) The per enrollee tax for taxing tier V shall be seventy-five cents ($0.75).

(e) The department may modify any methodology or other provision specified in this article to the extent necessary to meet the requirements of federal law or regulations, obtain federal approval, or ensure federal financial participation is available, provided the modifications do not otherwise conflict with the purposes of this article.

(f) The department shall make adjustments, as necessary, to the tax amounts determined in this section in order to ensure compliance with the federal requirements set forth in Section 433.68 of Title 42 of the Code of Federal Regulations, or elsewhere in federal law or regulation.

(g) The department shall request approval from the federal Centers for Medicare and Medicaid Services as is necessary to implement this article. In making the request, the department may seek, as it deems necessary, a request for waiver of the broad based requirement, waiver of the uniformity requirement, or both, pursuant to paragraphs (1) and (2) of subsection (e) of Section 433.68 of Title 42 of the Code of Federal Regulations, or a request for waiver of any other provision of federal law or regulation necessary to implement this article.

(h) 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 this article by means of provider bulletins, all plan letters, or other similar instruction, without taking regulatory action. The department shall provide notification to the Joint Legislative Budget Committee and to the Senate Committees on Appropriations, Budget and Fiscal Review, and Health, and the Assembly Committees on Appropriations, Budget, and Health within 10 business days after the above-described action is taken to inform the Legislature that the action is being implemented.

SEC. 7. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

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LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Managed care organization provider tax.

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 law provides for the county-administered In-Home Supportive Services (IHSS) program, under which qualified aged, blind, and disabled persons are provided with services to permit them to remain in their own homes and avoid institutionalization. Existing law provides, as part of the Coordinated Care Initiative, that IHSS is a Medi-Cal benefit available through managed care health plans in specified counties. Existing law provides for a 7% reduction in hours of service to each IHSS recipient of services.

Existing law imposes a sales tax on providers of support services for the privilege of selling support services at retail, measured by the gross receipts from the sale of those services in this state at a specified rate of those gross receipts. Existing law specifies that a seller is the State Department of Social Services, a county, or other person or entity, as provided. Existing law also imposes a sales tax on sellers of Medi-Cal managed care plans.

This bill would repeal these sales taxes and would establish a new managed care organization provider tax, to be administered by the department in consultation with the Department of Managed Health Care. The tax would be assessed by the department on licensed health care service plans and managed care plans contracted with the department to provide Medi-Cal services, except as excluded by the bill. The bill would require the health plans to report to the department specified enrollment information, on a quarterly basis, beginning with the 2015–16 state fiscal year. On December 1, 2015, or the date upon which the department receives approval for federal financial participation, whichever is later, the department would commence notification to the health plans of the assessed tax amount and due date for the first taxable quarter.

This bill would establish applicable taxing tiers and per enrollee amounts for the 2015–16 fiscal year. Commencing with the 2016–17 fiscal year, the bill would require the department and the Department of Managed Health Care to determine tax tiers and per enrollee tax amounts. The bill would require the department to request approval from the federal Centers for Medicare and Medicaid Services as necessary to implement the bill. The bill would authorize the department to implement its provisions by means

of provider bulletins, all-plan letters, or similar instructions, and to notify the Legislature of this action.

This bill would establish the Health and Human Services Special Fund in the State Treasury, into which all revenues, less refunds, derived from taxes imposed by the bill would be deposited. Moneys in the fund would first be used to offset specified reductions to the IHSS program, subject to appropriation in the annual Budget Act. The remaining moneys in the fund would be continuously appropriated to the department for the purpose of funding the nonfederal share of Medi-Cal managed care rates, as prescribed, thereby making an appropriation.

This bill would also make conforming and technical changes.

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

This bill would include a change in state statute that would result in a taxpayer paying a higher tax within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of $^{2}/_{3}$ of the membership of each house of the Legislature.

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

IHSS Coordinated Care Initiative: Transition to Statewide Bargaining and County MOE Frequently Asked Questions

As part of the 2012-13 state budget, the Legislature and Governor approved major policy changes within the Medi-Cal program aimed at improving care coordination, particularly for people on both Medi-Cal and Medicare. Also approved as part of this Coordinated Care Initiative (CCI) are a number of changes to the In-Home Supportive Services (IHSS) program, including state collective bargaining for IHSS, creation of a county IHSS Maintenance of Effort (MOE), and creation of a Statewide Authority. The following are Frequently Asked Questions (FAQs) about the IHSS changes contained in SB 1036 (Senate Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012) and AB 1471 (Assembly Budget Committee, Chapter Number 439, Statutes of 2012), the follow-up clean-up measure.[1]

When will IHSS collective bargaining transfer to the state? SB 1036 and AB 1471 specify that collective bargaining will transfer to the state once the director of the Department of Health Care Services certifies that enrollment into CCI has finished, but no sooner than March 1, 2013. The transfer date is referred to as the "county implementation date". *[Welfare & Institutions Code §12300.7 (a)]* CCI enrollment in the initial counties is expected to conclude no sooner than March 1, 2014.

Which of the 58 counties are affected by the transfer? Eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara are part of the initial transfer, and while the Legislature has stated its intent to expand the CCI to 58 counties, further legislation is necessary to complete the transfer.[2]

Who will be the IHSS employer of record? The state will form a joint powers authority (JPA), the California In-Home Supportive Services Authority, to be the employer of record. The JPA will be comprised of two county officials appointed by the Governor, the Director of the Department of

[1] SB 1008 (Chapter 33, Statutes of 2012) is the companion bill that contains non-IHSS elements of the Coordinated Care Initiative.

[2] Welfare & Institutions Code 14132.275 (g) establishes the limit of 8 CCI pilot counties, however the specific counties are not designated in the statute. The 8 counties are specified in the state's Transition Plan and CMS/MOU.

Social Services, the Director of the Department of Health Care Services, and the Director of the Department of Finance. *[Government Code §6531.5]*

What happens to existing Memoranda of Understanding (MOU) in the 8 counties? A locally bargained MOU or contract that is in place on the county implementation date remains in effect until it would otherwise expire – unless the union and the Statewide Authority mutually agree to reopen the contract. The state inherits the responsibility to maintain the existing contract until a new contract is in place. After the county implementation date, once a locally bargained MOU or contract expires, the Statewide Authority and the union begin negotiations on a new agreement. *[Government Code §11011 (b)]*

Can the state make changes in IHSS provider wages or benefits? The state cannot reduce wages or benefits for IHSS workers in counties where the state inherits an MOU that is not expired. In counties where the local collective bargaining contract has expired, the state is required to meet and confer with the union but is not precluded from unilaterally imposing new terms and conditions (including lower wages or benefits) after completing impasse procedures. *[Government Code §11011 (c)]*

Will the collective bargaining process change in counties that are not part of the CCI pilot? The requirement for counties to act as or establish an employer of record for IHSS providers has not changed, except in the CCI pilot counties. *[Welfare & Institutions Code §12302.25 (a)]*

Will IHSS wages and benefits be the same in the 8 counties? That will depend on the outcome of collective bargaining between the state and the unions. The law permits the state to have different collective bargaining agreements in each county. *[Government Code §110010 (d)]*

Will counties continue to negotiate new MOUs until the transfer? All counties are required to meet and confer pursuant to the Meyers Milias Brown Act and are bound by the terms of their existing contracts until the responsibility to bargain transfers to the state. In addition to the current authority to review the economic terms of a local agreement, once a county begins the transition to state bargaining, AB 1471 gives the state authority to review the non-economic terms of labor contracts negotiated between the eight counties and representatives of IHSS recipients. If the state is concerned with a contract provision approved prior to the transfer of bargaining responsibility to the state, the state is authorized to contact the labor representative, no more than 180 days after the review, to directly to discuss the concerns. The state and the labor representative may negotiate a separate agreement regarding the non-economic term and that agreement would take effect after the county implementation date. If no agreement is reached, the non-economic term becomes inoperable after the county implementation date. All terms to which no objection is made are deemed accepted by the state. *[Government Code §11011]*

Does the state have authority to approve or deny local collective bargaining agreements? No; there can only be one employer for purposes of collective bargaining. When the local agency is responsible for collective bargaining, the state has no authority or role in the ratification of the collective bargaining agreement. However, the state can reject the Public Authority rate package.

What happens if the state does not approve the rates or other economic terms of a local agreement? The state continues to have the authority to review and approve the rates for wages, health benefits, and other economic terms of a local agreement. If the economic terms of the contract are not approved by the state, the county is required to pay the entire non-federal share of the cost increase. Some counties have included language in their labor contracts to ensure that if the state does not approve the rates or other economic terms, then the contract does not take effect and the county is not required to implement the related rate increases. Counties may wish to consider this issue when negotiating contracts prior to the transfer to the state.

What happens to the local public authorities? With the exception of collective bargaining, the eight counties will continue to administer the other functions of the IHSS program locally, including maintenance of the registry, background checks, and provider training. The eight counties may continue these functions through a public authority, bring the services into a county agency, or contract with another entity. Non-demonstration counties must continue to meet the requirements of Welfare and Institutions Code §12302.25 to act as or establish an employer of record for IHSS. The non-demonstration counties also continue to have immunity under the Welfare and Institutions Code from liability related to implementing the employer of record mandate if the county has a public authority or a nonprofit consortium. The eight counties are provided with immunity from liability for negligence or intentional torts of the individual provider once the counties transition the collective bargaining responsibilities to the State Authority. *[Welfare & Institutions Code §12300.5]*

How does the County IHSS MOE interact with the collective bargaining transfer? All 58 counties begin paying the MOE on July 1, 2012, regardless of the date of transfer of collective bargaining. The MOE replaces the county share of cost for IHSS, as long as the Coordinated Care Initiative (CCI) and state collective bargaining are in place. The MOE is based on each county's IHSS expenditures in 2011-12. Any negotiated wage and benefit increases for IHSS providers approved after July 1, 2012 and before the transfer of collective bargaining will increase the county MOE. However, once the transfer of collective bargaining occurs, the county MOE cannot be increased due to state negotiated wage and benefit increases. *[Welfare & Institutions Code 12306.15]*

How is the MOE calculated? The MOE base expenditures are based on each county's IHSS expenditures in 2011-12. The IHSS expenditures include IHSS county administration and public authority administration, defined as the amount actually expended by each county in fiscal year 2011-12, except that for administration the MOE base shall include no more or no less than the full match for the county's allocation from the state.

The MOE would only be adjusted for the following reasons:

- A county negotiates an increase in IHSS provider wages and/or benefits after July 1, 2012 and before the state takes over bargaining.
- An inflation factor of 3.5%. The inflation factor is applied annually beginning July 1, 2014.

In years when 1991 Realignment revenues decline (year-over-year negative growth), the inflation factor is zero. The Department of Finance shall provide notification to the appropriate legislative fiscal committees and the California State Association of Counties by May 14 of each year whether the inflation factor will apply for the following fiscal year. *[Welfare & Institutions Code 12306.15]*

How do the CFCO savings interact with the MOE and possible wages and benefits increases under the MOE? California's Community First Choice Option (CFCO) state plan amendment was approved by the federal government on September 4, 2012 and will result in enhanced federal financial participation of six percentage points for IHSS services (but not towards IHSS Administration nor PA Administration). This will result in a lower share of cost that will be applied to both State and county IHSS expenditures from December 1, 2011 through June 30, 2012. The savings will reduce the counties' expenditures for the 2011-12 fiscal year for those seven months, and thus will reduce the county's MOE base. Although CFCO was approved, the State continues to negotiate with the federal government to determine the total number of IHSS clients who will be in CFCO, and the commensurate savings that will result to counties. It is not known how long this process will take, nor when counties will know their exact level of savings resulting from CFCO.

What will happen with health benefits for IHSS providers? As stated above, the Statewide Authority will inherit the existing contracts for wages and benefits in the eight counties. State officials and labor representatives agree that issues around health benefits will be difficult to resolve. Public Authorities have arrangements for health benefits that vary widely. Additionally, the state will have to determine how federal health reform interacts with the providers (will they be eligible for the Exchange or Medicaid?). Once a locally bargained MOU or contract expires, the Statewide Authority and the union begin negotiations on a new agreement – which could include changes to health benefits.

What are the "poison pills"? There are two poison pills related to the CCI legislation.
SB 1036 contains a poison pill that would allow the state to end the CCI. If the CCI is halted, state collective bargaining would return to counties and the MOE would revert to the pre-existing 35% nonfederal county share of cost. The MOE would end at the end of a fiscal year.

Under this poison pill, if the federal government does not provide by February 1, 2013 federal approval – or notification indicating pending approval – of a mutual rate setting process, shared federal savings and a six-month enrollment period in the CCI, the act becomes inoperative on March 1, 2013. However, the demonstration could continue if these provisions are not met but the Department of Finance determines, in consultation with the Director of Health Care Services and the Joint Legislative Budget Committee, that an alternate methodology would result in the same level of ongoing savings. SB 1036 includes a methodology for determining shared federal savings.

SB 1008 contains a second relevant poison pill; this measure contains much of the detail on the CCI. SB 1008 allows the director of the Department of Health Care Services – after consulting with the Director of Finance, stakeholders and the Legislature – to halt all or part of the CCI at any time. This

determination can be made if the director determines the quality of care for managed care beneficiaries, efficiency or cost-effectiveness of the program would be jeopardized. If the CCI is halted, state collective bargaining would return to counties and the MOE would revert to the pre-existing share of cost. The MOE would end at the end of a fiscal year.

There is no specificity in the trailer bills about how the MOE would revert back to a share of cost. Likewise, there is no specificity about how the CCI would end. Outstanding questions include:

- Would counties have to pay for state-negotiated changes in wages and benefits under a reversion to a share of cost?
- How does Proposition 1A interact with a change from a MOE to a share of cost?
- Once the director of DHCS triggers the poison pill, can it be executed without additional legislation?

For questions about this document please contact Kelly Brooks-Lindsey at (916) 327-7500 ext. 531 or kbrooks@counties.org or Eraina Ortega at ext. 521 or eortega@counties.org.

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July 28, 2015

To: Health and Human Services Policy Committee Members

From: Farrah McDaid Ting, Legislative Representative
Michelle Gibbons, Legislative Analyst

Re: Budget and Legislative Update

Budget. Since the Health and Human Services Policy Committee last met in May, the Legislature passed and the Governor signed the 2015-16 Budget Act and related trailer bills.

Attached is the health and human services portion of the CSAC Budget Action Bulletin.

Legislation. The Legislature is on Summer Recess and will reconvene on August 17. There remain several problematic bills to resolve before the end of the session on September 11, including:

AB 193 (Maienschein) – OPPOSE
As Amended on May 28, 2015

AB 193, by Assembly Member Brian Maienschein, would authorize a Probate Court judge to recommend a Lanterman-Petris-Short Act (LPS) conservatorship to the county officer providing conservatorship investigations if the court determines, based on evidence and the opinion of a medical professional, that a person for whom a probate conservatorship has been established may be gravely disabled and is unwilling to accept, or is incapable of accepting, treatment voluntarily and is thus eligible for a LPS conservatorship.

Essentially, AB 193 assumes that because a Probate conservatorship has been established a person should qualify for involuntary mental health treatment or a conservatorship. The LPS Act was created so that individuals could not be indiscriminately placed in involuntary settings without due process, which includes the involuntary hold process and LPS conservatorship. Throughout this process there must be sufficient evidence to hold the person involuntary and the ability for the person to fight these holds and the administration of psychiatric medication against their will.

Despite the continued opposition of CSAC and CSAC affiliates – the Urban Counties Caucus and the County Behavioral Health Directors Association - the measure was passed unanimously by the Assembly Judiciary Committee and is awaiting a hearing in the Assembly Appropriations Committee once the Legislature reconvenes. CSAC urges individual counties to send letters of opposition to AB 193, which infringes upon the due process afforded by the LPS Act.

AB 1299 (Ridley-Thomas) – SUPPORT IF AMENDED
As Amended July 16, 2015

AB 1299, by Assembly Member Sebastian Ridley -Thomas, would make changes to how foster children placed outside of their county of original jurisdiction are able to access mental health services. It would require the Department of Health Care Services to issue policy guidance that

establishes the presumptive transfer of responsibility from the county of original jurisdiction to the foster child's county of residence.

CSAC has taken a SUPPORT IN CONCEPT on AB 1299, as it seeks to ensure foster children receive services mental health services in a timely manner. However, CSAC continues to work with the author's office and the sponsors – the California Alliance of Child and Family Services – to address county concerns regarding the bill language.

AB 1299 was passed unanimously by the Senate Health Committee and will be heard next in the Senate Appropriations Committee.

While we have worked hard to provide technical assistance and solutions for this bill, the language as amended still raises concerns for counties. We will continue to work with the author and sponsor to resolve these issues for the Appropriations hearing; however, if we cannot achieve this goal, CSAC will oppose AB 1299 on the Senate Floor.

SB 476 (Tony Mendoza) –OPPOSE UNLESS AMENDED
As Amended July 16, 2015

SB 476, by Senator Tony Mendoza, would expand the definition of organized camps and create a new mandate on local health departments.

After working with the Assembly Health Committee, the committee accepted amendments to clarify that the role of local health departments is limited to the health and sanitation of day camps. As a result, CSAC and the County Health Executives Association of California removed our opposition. CSAC and CHEAC will work on our remaining concerns related to the definition and scope of day camps included in the bill.

The measure was passed by the Assembly Human Services Committee and will proceed next to the Assembly Appropriations Committee.

On a more positive note, CSAC is continuing to work with the Department of Social Services and CSAC Affiliates on the Continuum of Care Reform, which DSS Director Will Lightbourne spoke about during the May policy committee meeting:

AB 403 (Stone) – SUPPORT IN CONCEPT
As Amended on July 7, 2015

Sponsored by the Department of Social Services (DSS), AB 403 reflects DSS' attempt to reform the continuum of care for foster youth. In January, DSS released their Continuum of Care Report, which outlined a comprehensive approach to improving the experience and outcomes of children and youth in foster care.

AB 403 would provide for the reclassification of treatment facilities and the transition from the use of group homes for children in foster care to the use of short-term residential treatment centers – defined in the amendments. AB 403 revises foster parent training requirements and provides for the development of Child-Family Teams to inform the process of placement and services to children.

Additionally, the bill seeks to develop a new payment structure to fund placement options for children in foster care.

CSAC, along with our county affiliates – CWDA, CBHDA and CPOC – continue to work closely with the Department of Social Services. Over the next month discussions related to the financing are anticipated to begin.

CSAC asks each county to review these bills and submit letters no later than August 11.

Attachments:
CSAC Budget Action Bulletin: Health and Human Services, June 19, 2015
CSAC Joint Letter: AB 193 Oppose, June 24, 2015
CSAC Joint Letter: AB 1299 Support if Amended, July 9, 2015
CSAC Joint Letter: SB 476 Oppose Unless Amended, July 7, 2015
CSAC Joint Letter: SB 403 Support in Concept, July 13, 2015

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While the Legislature passed most of the budget trailer bills today, several items remain outstanding for 2015-16, including the implementation of a Managed Care Organization (MCO) tax and increases to fee-for-service Medi-Cal providers. The Governor has agreed to call a special session on the MCO and provider rates issue. CSAC will watch the special session closely as the fate of the MCO is also tied to ongoing funding for the Coordinated Care Initiative (CCI) and other critical health care programs.

HEALTH

Medi-Cal for Undocumented Children

SB 75 allows undocumented children under age 19 to be eligible for full-scope Medi-Cal, effective May 1, 2016. Estimates for 2015-16 costs range from $40 to $65 million, and up to $130 million in 2016-17 and beyond. This proposal effectively funds Senator Ricardo Lara's SB 4, which would extend full scope Medi-Cal to undocumented children. Additional provisions of SB 4 that would have allowed undocumented adults to access Covered California were not included in the budget.

Mental Health Peer Respite Funds

SB 75 provides $3 million to the California Health Facilities Financing Authority (CHFFA) for Mental Health Wellness Grants to develop peer respite sites. The funding will be used to expand local resources for development, capital, equipment acquisition and applicable startup or expansion costs to increase bed capacity for peer respite support services. This budget item was supported by the County Behavioral Health Directors Association.

Dental Rate Restorations

The budget restores a 10 percent cut to Denti-Cal dental provider reimbursement rates that were enacted in 2013. The rate restoration is effective July 1, 2015. The budget also reduces the age from three years to one year for county child health and disability prevention programs to refer Medi-Cal eligible children to a participating Denti-Cal provider.

Medi-Cal Copayments

The 2015-16 budget repeals Medi-Cal copayments ($5 for provider visits, $3 for prescriptions, and $100 for each inpatient hospital day) that were enacted by the state at the height of the Great Recession.

Health Homes

The budget creates a Health Home Program Account within the State Treasury to collect and allocate non-General Fund public or private grant funds for the Health Home Program. Additionally, the Legislature appropriated $50 million to the Health Home Program Account for implementation of the program.

Coordinated Care Initiative

While the budget is silent on any additional changes to the Coordinated Care Initiative (CCI) beyond the January Budget Proposal's warning that CCI enrollment must increase or the CCI project will be discontinued, the budget passed by the Legislature today extends the date for transitioning the Multipurpose Senior Services Program (MSSP) to managed care plans from 2015 to December 31, 2017. Both the managed care plans and MSSP must meet readiness criteria before the transfer may occur. Should the CCI project become inoperative, then the MSSP transfer to plans would also be reversed.

Needle Exchange Programs

SB 75 authorizes the Department of Public Health to purchase hypodermic needles, syringes, and other supplies for distribution to authorized local needle exchange programs.

AIDS Drug Assistance Program

Further, SB 75 expands the income eligibility for the AIDS Drug Assistance Program (ADAP) from $50,000 a year to a modified adjusted gross income based on family size and household income of less than 500 percent of the Federal Poverty Level (FPL). No payments would be required for a person whose modified adjusted gross income is less than four times the FPL. The 2015 FPL is for a single person is $11,770.

AIDS Prevention

The budget requires the state Department of Public Health to establish a Pre-Exposure Prophylaxis (PrEP) Navigator Services Program, which would provide grant funding to local health departments and community-based organizations for outreach and prevention services for those at high risk for contracting HIV.

Hepatitis C Prevention

The budget also establishes a 3-year Hepatitis C Linkage to Care demonstration project to provide outreach, screening, and linkage to services for those vulnerable to Hepatitis

C infection and underserved areas at risk for the disease. Local health departments and community-based organizations would be eligible for the funds.

HUMAN SERVICES

County Medi-Cal Eligibility

The 2015-16 budget includes $150 million for county Medi-Cal administration duties as well as an additional $31 million General Fund to bring the total proposed Medi-Cal County Administration funding for 2015-16 to about $245 million (all funds). The additional $31 million in funding utilizes unused current-year funding associated with CalFresh Caseload. In addition, the Conference Committee adopted budget bill language allowing the Department of Finance to augment county eligibility funding during the budget year if additional costs are identified.

On a smaller note, the state suspended the annual Medi-Cal eligibility cost of doing business adjustment for the seventh year in a row.

Approved Relative Caregiver Funding Option Program (ARC)

The ARC program was enacted last year, and this year's budget includes a current year augmentation of $15 million and not less than $30 million in 2015-16. The budget also contains critical technical cleanup language to assist counties in implementing the program at the local level. Clean up includes allowing ARC children to also qualify for CalWORKs grant funding, specifying that the county with payment responsibility – or court jurisdiction for the child – is responsible for CalWORKs grant payments (as is the practice in the foster care system), and waiving some CalWORKs eligibility work for foster children. It also includes retroactive eligibility for foster children who are also eligible for CalWORKs grants back to January 1, 2015.

On the funding side, the technical cleanup also makes is clear that each participating county's base caseload of ARC program participants will be fully funded and creates a mechanism by which future annual state funding for the program is determined. Under this mechanism, the annual funding for the program must not be less than $30 million.

Earned Income Tax Credit

The 2015-16 budget included the Governor's proposed Earned Income Tax Credit (EITC), which CSAC supported. The Governor proposed a new $380 million (EITC) to assist working Californians at the lowest rungs of the economic ladder; the final budget bill also included language indicating the Legislature's intent to increase the allocation

amount in the future. The Governor estimates that this new tax credit will assist 2 million residents/825,000 families and slide up or down based on the number of dependents in a household. Those with less than $6,580 in income with no dependents and up to $13,870 with three or more dependents will qualify and may receive $460 to $2,653 annually. The CSAC Women's Leadership Forum, the CSAC Poverty Working Group, and the CSAC Health and Human Services Policy Committee all voted to support the EITC.

2011 Realignment Technical Clean-up

SB 79 includes technical clean-up to eliminate the "swap" of sales tax and vehicle license fee revenues between the Health and Social Services Subaccounts. It also further deletes obsolete language and allows the State Controller to make annual deposits versus monthly deposits as done in current practice. SB 79 also allows counties to submit fund disbursement reports annually rather than quarterly. CSAC and county affiliates worked closely with the Department of Finance and Legislature on this technical language.

A detailed summary of statewide estimates for 2011 Realignment is included in the appendix of this Budget Action Bulletin.

Human Trafficking

The General Government budget bill (SB 84) established a Human Trafficking Victims Assistance Fund within the Office of Emergency Services. Grants from the new fund may go to qualified nonprofit organizations to provide direct services to victims of human trafficking. It is not clear at the time of this writing how much will be appropriated to the Fund initially.

Housing Support Program

SB 79 includes a $35 million appropriation for the CalWORKs housing support program for counties. While the $35 million in 2015-16 is less than CSAC and the County Welfare Directors Association's $30 million augmentation request, counties are pleased with the $15 million augmentation to the Governor's May Revision. The budget also makes changes to the provisions of the housing support program by allowing recipients who would have previously been discontinued because they no longer met the income eligibility requirement to continue to receive housing support services under certain circumstances. The Housing Support Program, even its first year, has been very

successful and CSAC will continue to work with county affiliates and other stakeholders to expand the program's reach and funding.

In-Home Supportive Services

The budget appropriates $226 million from the General Fund to restore the 7 percent reduction of IHSS service hours in 2015-16. Funding for future years will likely be contingent upon the Managed Care Organizations (MCO) tax. The 2015-16 budget does not implement overtime for IHSS workers and likely will not unless the federal courts move on the issue.

Adult Protective Services

The budget provides one full-time position at the Department of Social Services to assist counties in the operation of the Adult Protective Services system.

Community Care Licensing

SB 79 increases frequency in which the Department of Social Services conducts inspections of licensed community care facilities. Current law requires inspections to occur once every five years. This bill would increase frequency based on facility type, but would continue random inspections of at least 30 percent of all facilities annually.

- *Child care facilities* would be inspected once every three years.
- *Children's residential care facilities* would be inspected every three years and should phase in inspections every two years in 2018.
- *Adult and senior care facilities* would be inspected every three years and would phase in two-year inspections in 2018 and annual inspections by 2019.

CalFresh Reporting

The 2015-16 budget updates the change-reporting requirements for CalFresh recipients. Current law requires CalFresh recipients to report changes at the time they occur. This budget will delete those requirements and instead require changes to be reported annually during CalFresh eligibility redeterminations.

Federal Immigration Assistance

SB 79 requires the Department of Social Services to provide grants to non-profit organizations to assist with the application process for those eligible for the Deferred Action for Childhood Arrivals (DACA) and Deferred Action for Parents of Americans (DAPA), starting January 1, 2015.

Child Care

The budget provisions related to child care are included in SB 97 (budget bill) and AB 104 (K-12 Omnibus). While there had been several proposals on child care structure and funding heard in the last few weeks, the final package is largely funded with Proposition 98 dollars and does not include collective bargaining for child care workers.

- *Slots.* SB 97 provides funding for $5,830 full-day slots and 1,200 non-local educational agency full-day slots, starting January 1, 2016. Also, effective July 1, 2015, it provides funding for 6,800 voucher slots.
- *Reimbursement.* AB 104 provides a 5 percent increase to the Standard Reimbursement Rate (SRR) ($61 million funded in AB 123) and establishes a full-day state preschool rate for the SRR effective July 1, 2015. Effective October 1, 2015, the budget increases the family child care home rate from 60 to 65 percent ($18m funded by AB 123), for license-exempt child care providers and increases the regional market rate for all counties by 4.5 percent ($44 million funded in AB 123). It also establishes income eligibility limits for state-subsidized child care at 70 percent of the state median income.
- *San Francisco Pilot Program.* AB 104 removes the sunset date for the San Francisco Individualized child care subsidy pilot program and instead extends the program indefinitely.
- *Stakeholder Group.* AB 104 also requires the Department of Education to convene a stakeholder group to examine CalWORKs Stage 2 and Stage 3 child care programs and the Alternative Payment program.

Medi-Cal Outreach Grants

The budget continues the Medi-Cal and Affordable Care Act enrollment assistance outreach payments to counties to then pass to community based organizations. DHCS is required to make payments for applicants submitted through June 30, 2015 that result in approved applications. The budget also requires that any remaining funds be allocated to county outreach and enrollment grants, which also must be distributed to community-based organizations. The budget grants counties the authority to retain up to 10 percent of the grants for county administrative costs. The initial allocations will be made by January 1, 2016, with the final allocation being no later than June 30, 2016.

Workforce Development

AB 104 includes budget provisions related to workforce development:

- *Adult Education*. The budget establishes the Adult Education Block Grant program to provide education through regional consortia.
- *Career Technical Education*. The budget provides $400 million for the Career Technical Education Incentive Grant Program in FY 2015-16, $300 million in 2016-17 and $200 million in 2017-18.

1991 Realignment Funding

A detailed summary of statewide estimates for 1991 Realignment is included in the appendix of this Budget Action Bulletin.

Housing, Land Use and Transportation

The 2015-16 budget package presented to the Governor was largely silent on local transportation funding needs, with the exception of programs funded through cap and trade auction process (please see Agriculture, Environment and Natural Resources section).

CSAC continues to support legislative efforts to determine comprehensive interim and long-term funding solutions that invest in both the state and local systems, including the solutions offered by Senate Bill 16 (Beall). The substantive transportation funding negotiations will take place during the Transportation Special Session, called into session for the first time earlier today. The Governor's press release included the following language on the special session:

> "Fixing California Roads, Highways and Other Infrastructure: Caltrans, the state's Transportation Department, maintains 50,000 lane-miles of highway and nearly 13,000 state-owned bridges. While the repair, maintenance and efficient operation of the state's highway system are vital to the state's continued economic growth, current funding fails to adequately fund this necessary work. The state's current fuel excise tax is sufficient to fund only $2.3 billion of work—leaving $5.7 billion in unfunded repairs each year.
>
> The Governor proposes that the Legislature enact permanent and sustainable funding to maintain and repair the state's transportation and critical infrastructure, improve the state's key trade corridors and *complement local infrastructure efforts* [emphasis added]."

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June 24, 2015

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

Re: AB 193 (Maienschein) – Mental Health: Conservatorship Hearings
As Amended on June 22, 2015 – OPPOSE
Set for Hearing on June 30, 2015 – Senate Judiciary Committee

Dear Senator Jackson,

The California State Association of Counties (CSAC), the County Behavioral Health Directors Association of California, and the Urban Counties Caucus regretfully must oppose AB 193, by Assembly Member Maienschein, which would authorize the Probate Court – if a conservatorship has already been established under the Probate Code – to recommend a Lanterman-Petris-Short Act (LPS) conservatorship to a county conservatorship officer and compel that officer to submit a report to the Probate Court.

Despite recent amendments, counties remain concerned about the potential costs, workload levels, and overall erosion of county authority in conservatorship investigations should this measure move forward.

Currently, only a county conservatorship officer or such designated official of the county can conduct LPS conservatorship investigations to determine whether a person meets the statutory definition of gravely disabled. The county must receive a recommendation from a medical or psychological professional to initiate an investigation, and the conservatorship officer retains the sole authority to apply statutory standards to determine whether a person is gravely disabled. Should a conservatorship officer conclude that a person meets the statutory definition of gravely disabled, that officer is also responsible for petitioning the court for conservatorship. Once the petition is received, the court must find beyond a reasonable doubt that a person cannot take care of his or her basic needs for food, clothing, and shelter. If a conservatorship is granted, it is only in effect for one year.

While the proposed language in AB 193 does not require the conservatorship officer to recommend conservatorship, it does compel the conservatorship officer to conduct a conservatorship investigation and report back to the Probate Court their findings. This is contrary to current law as outlined above, will increase the number of LPS conservatorship referrals, and will increase county costs. For example, Los Angeles County estimated in 2014 that the average LPS conservatorship investigation is more than $1,600 per case, with ongoing administration costs of more than $3,100 per case.

Should the mandate in AB 193 become law, counties not only anticipate a significant increase in workload and county costs for conservatorship investigations, but will also face increased costs due to the submission of a report to the probate court.

Counties understand that the root issue and reason for this bill is to provide treatment to those who may be unable to comprehend their illnesses or actions. However, we note that a person suffering from a mental illness will likely touch the county mental health system and currently may be referred by that system for a LPS conservatorship. AB 193 would bypass the established mental health system and give probate judges the same authority over mental health evaluations as mental health practitioners. Also, by making it easier to conserve a person under the LPS Act, AB 193 would then potentially open the door to increased involuntary treatment, as the LPS Act allows.

However, in the past two years, the issue of assisted outpatient treatment (AOT), or involuntary treatment, has received a significant amount of media and clinical attention and is rapidly becoming an option in the state's largest counties. Six California counties, including San Diego, Los Angeles, and San Francisco, have implemented or are implementing AOT programs under the existing statute of Laura's Law (AB 1421, Chapter 1017, Statutes of 2002) since 2013.

County supervisors also grapple with AOT issues and, as stewards of specialty behavioral health systems – including mental health and substance use disorder treatment – and the offices of the Public Guardian, pay close attention to serving those who are gravely disabled due to mental illness or substance abuse. This issue touches almost everyone's lives, from close family members and friends, in workplace, school, and community environments, and in the areas of public safety and early intervention and prevention efforts. Counties continue to seek safe programs and treatments that will ensure a good quality of life for all of our residents, and especially for those who struggle with mental illness or substance use disorders.
We regret having to oppose AB 193, and remain open to seeking mutual solutions to further this issue.

We appreciate the opportunity to outline our concerns to your committee and the author's commitment to seeking solutions for some of the state's most gravely ill residents. Should you have any questions about our position, please do not hesitate to contact Farrah McDaid Ting at 650-8110, Patricia Ryan at 556-3477 ext. 1108, or Jolena Voorhis at 327-7531. Thank you.

Sincerely,

Farrah McDaid Ting
CSAC Legislative Representative

Patricia Ryan
CBHDA Interim Executive Director

Jolena Voorhis
UCC Executive Director

cc: Honorable Members, Senate Judiciary Committee
The Honorable Brian Maienschein, Member, California State Assembly
Nichole Rapier, Consultant, Senate Judiciary Committee
Mike Peterson, Consultant, Senate Republican Caucus

July 9, 2015

The Honorable Mike McGuire
Chair, Senate Human Services Committee
State Capitol, Room 5064
Sacramento, CA 95814

Re: AB 1299 (Ridley-Thomas) – Medi-Cal: specialty mental health services: foster children
As Proposed to Be Amended – SUPPORT IF AMENDED
Set for Hearing on July 14, 2015 – Senate Human Services Committee

Dear Senator McGuire:

The California State Association of Counties (CSAC), the County Welfare Directors Association (CWDA), and the County Behavioral Health Directors Association (CBHDA) have a SUPPORT IF AMENDED position on AB 1299 by Assembly Member Sebastian Ridley-Thomas.

AB 1299 attempts to address how mental health services are provided in a timely manner to foster or probation youth who are placed out of the county of original jurisdiction. Counties share the goal of ensuring critical services for foster and probation youth regardless of their county of residence, and we have been working closely with the author, the California Alliance of Child and Family Services, and the Steinberg Institute to amend the bill to meet this goal.

As the providers responsible for the safety and well-being of children – the child welfare social workers, the probation officers, and the behavioral health staff – we are tasked with finding appropriate placements for vulnerable foster youth that are in the best interests of the child.

To that end, we had asked for amendments to the current version (April 21) of the bill, some of which were incorporated into the proposed amendments before this committee. However, we believe the language does not reflect the agreements reached between the county agencies and co-sponsors and that additional work is needed. We remain committed to continue working with the author and sponsors to develop workable language.

Some areas that still need refinement in the mock-up form of the bill includes the role of the child welfare social worker or probation officer to evaluate on a case-by-case basis whether an exception to presumptive transfer applies, with the decision informed by the county behavioral health department, the child's parent or guardian or other medical rights holder, and the child and family team, if one exists.

We are also working toward a solution for the fiscal aspects of the bill, and the most recent amendments provided by the author include a reference to reimbursements made within a "fiscal quarter." This language was not discussed in previous meetings, and we are reviewing to assess whether it is workable or whether alternative language or timelines are necessary to implement the presumptive transfer policy as proposed by this bill. We also need to ensure that the policy is implementable by the Department of Health Care Services.

We have made significant progress in understanding the author and sponsors' aim for AB 1299 and pledge to continue working to ensure a workable policy bill with the potential to improve the provision of services to thousands of our most vulnerable foster and probation youth. It is our hope that the next round of amendments will more fully reflect our input and enable CSAC, CWDA, and CBHDA to support the bill.

Thank you,

Farrah McDaid Ting, Legislative Representative
California State Association of Counties (CSAC)

Cathy Senderling-McDonald, Deputy Executive Director
County Welfare Directors Association of California (CWDA)

Patricia Ryan, Interim Executive Director
County Behavioral Health Directors Association of California (CBHDA)

cc: The Honorable Sebastian Ridley-Thomas, Member, California State Assembly
Honorable Members, Senate Human Services
Jennifer Kent, Director, California Department of Health Care Services
Sara Rogers, Consultant, Senate Human Services Committee
Jennifer Troia, Consultant, Office of pro Tempore de León
Gail Gronert, Consultant, Office of Assembly Speaker Atkins
Joe Parra, Consultant, Senate Republican Caucus
Rosie McCool, Chief Probation Officers of California
Carroll Schroeder, California Alliance of Child and Family Services
Patrick Gardner, Young Minds Advocacy Project
Anna Hasselblad, The Steinberg Institute

California State Association of Counties

County Health Executives Association of California

July 7, 2015

The Honorable Rob Bonta
Chair, Assembly Health Committee
State Capitol, Room 6005
Sacramento, CA 95814

Re: SB 476/Mendoza (as amended 7/1/15) – OPPOSE UNLESS AMENDED

Dear Assemblyman Bonta:

The California State Association of Counties (CSAC) and the County Health Executives Association of California (CHEAC) have taken an Oppose Unless Amended position on SB 476, authored by Senator Tony Mendoza. SB 476 would expand the definition of organized camps to include day camps, creating a new mandate on local health departments.

While CSAC and CHEAC appreciate the intent of the bill to assure that day camps provide a safe environment for children, our concern is that the bill would significantly expand the enforcement role of county health departments. If this expansion is to occur, statute needs to clarify that the role of local health departments will be restricted to overseeing health and sanitation requirements at day camps.

While we have been working with the author's office regarding our concerns, the amendments taken to date do not address are core concern that the role of local health departments be limited to activities within our scope.

For the above reasons, CSAC and CHEAC must oppose SB 476 as it is currently written. Should you require additional information regarding our position on this bill, please do not hesitate to contact Farrah McDaid Ting (CSAC) at 916-650-8117 and Judith Reigel (CHEAC) at 916-327-7540.

Sincerely,

As signed by

Farrah McDaid Ting
Legislative Representative
CSAC

As signed by

Judith Reigel
Executive Director
CHEAC

cc: The Honorable Tony Mendoza
Members, Assembly Health Committee
Paula Villescaz, Consultant, Assembly Health Committee
Peter Anderson, Consultant, Assembly Republican Caucus

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July 13, 2015

The Honorable Mike McGuire
Chair, Senate Human Services Committee
State Capitol, Room 5064
Sacramento, CA 95814

Re: AB 403 (Stone) – Public Social Services: Foster Care Placement Funding
As Amended on July 7, 2015 – SUPPORT IN CONCEPT
Set for hearing on July 14 – Senate Human Services Committee

Dear Senator McGuire:

The California State Association of Counties (CSAC), the County Welfare Directors Association (CWDA), and the County Behavioral Health Directors Association (CBHDA) have collectively adopted a county SUPPORT IN CONCEPT position on AB 403 by Assembly Member Mark Stone.

Assembly Member Stone's AB 403 reflects a much-needed foundational change in how California cares for its most vulnerable children who have been removed from their homes due to abuse and neglect and are served by child welfare and probation agencies. By reforming the group home system from the ground up, AB 403 seeks to provide better, more appropriate care and services for children and youth in home-based settings as well as reduce the time a child might spend in congregate care settings. The counties, which administer foster care services on the state's behalf, support the state's effort to make these important and timely changes to improve the care and outcomes for our foster and probation youth.

Since AB 403 was introduced, Assembly Member Stone and Department of Social Services staff have engaged our organizations and solicited our input, for which we are grateful. The sweeping policy changes in AB 403 are ambitious and can only be achieved through significant interagency and state and county effort, timely identification of child and system needs, and the prudent application of resources to meet those needs.

Our comments below are based on our understanding of the recent amendments which will be heard in your Senate Human Services Committee and are presented here with the understanding that the Author is committed to crafting good policy and open to county input – for which we are also grateful. Our Associations look forward to continuing our participation as this measure evolves.

Temporary Exceptions
Implementing AB 403 will be a significant undertaking for all involved – the state, counties (including county child welfare services, county behavioral health, and county probation), foster caregivers and other service providers. While we support comprehensive reforms to promote family-based care and permanency, certain current practices by counties – such as operating emergency temporary shelters, providing year-round educational environments, or continuing to provide secure placements for probation youth – must not be suddenly and dramatically prohibited. We want to thank the Department of Social Services for their prompt attention to the above issues.

Policy Issues
Large policy issues remain unresolved at this time, such as the role of the Child and Family Teams (CFT) and Interagency Placement Committees (IPC) with respect to assessments of children, youth and families and subsequent identification of services and supports. It is also not clear if the IPC will determine eligibility for treatment in the newly-formed Short-Term Residential Treatment Centers (STRTCs) for all children with a serious emotional disturbance or for a subset of eligible children.

Counties will need clear statute on these issues to ensure a seamless process and the provision of necessary services for foster and probation youth. We appreciate the continued discussion on these issues with the Department and their acknowledgement that additional work is needed to resolve these issues.

Capacity and Fiscal Concerns
Clearly the bill has fiscal implications and requires at a minimum funding for capacity building and for new practice requirements in county welfare, probation, and mental health agencies. We have been in discussions with the Administration to refine those estimates and we appreciate the Governor's provision of initial start-up funds. We continue to discuss the adequacy of those funds and additional fiscal requirements and hope to have those issues better refined by the time the bill is heard in Appropriations.

Certification
AB 403 mentions a certification process for FFAs and the new STRTCs, and implies that certifications will be conducted by county Mental Health Plans (MHPs). Timely certification is part of the capacity issue above, and is also a necessary component for the continuum of care. Counties require clarity on the certification process, the role of the Department of Health Care Services, and a clear delineation of each county's new certification duties and contracting authority.

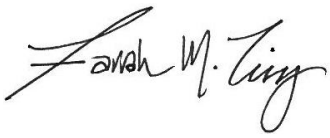
Timeline and Implementation
As recently amended, AB 403 does include intent language requiring periodic progress updates to the Legislature, which is a reasonable goal. From the view of counties as the on-the-ground implementers, we look forward to working with the state to develop an implementation timeline and series of readiness goals to ensure a smooth transition from the congregate care model to the services-follow-the-child model. We also understand that different populations, such as probation youth, will require extra care and that the vision of AB 403 will take time to implement fully.

By working collaboratively and taking the time to ensure all parts of the system are ready and adequately resourced to meet the needs of children, counties believe that the Continuum of Care reform package in AB 403 will become a landmark of system-wide change to better serve vulnerable children now and for generations to come.

We remain committed to the process and support the goal of increasing foster family homes and placements, reducing group home placements and duration of stays, and creating a more robust and responsive continuum of care to best meet the needs of each child.

It is for these reasons that CSAC, CWDA, and CBHDA have taken a SUPPORT IN CONCEPT position on AB 403. Each individual association will also be commenting on AB 403 from their specific policy perspectives. Again, we commend the Author and Director Lightbourne and DSS staff for their inclusiveness and work on the Continuum of Care Reform effort and look forward to continued discussions to further develop the bill. Should you have any questions about our position, please do not hesitate to contact us. Thank you.

Sincerely,



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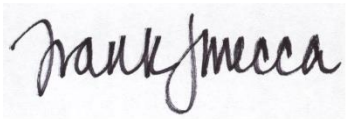

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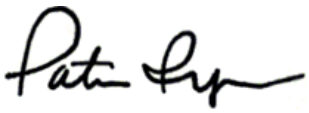

Patricia Ryan, Interim Executive Director
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cc: Honorable Members, Senate Human Services Committee
The Honorable Mark Stone, Member, California State Assembly
The Honorable Kevin de León, Senate President pro Tempore
Will Lightbourne, Director, California Department of Social Services
Jennifer Kent, Director, California Department of Health Care Services
Sara Rogers, Consultant, Senate Human Services Committee
Jennifer Troia, Consultant, Office of pro Tempore de León
Gail Gronert, Consultant, Office of Assembly Speaker Atkins
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July 28, 2015

To: Health and Human Services Policy Committee Members

From: Farrah McDaid Ting, Legislative Representative
Michelle Gibbons, Legislative Analyst

Re: California Children's Services Redesign

In June, the Department of Health Care Services (DHCS) released their redesign proposal – the 'Whole-Child Model' – for the California Children's Services (CCS) program.

This memo will provide: 1) a brief background of the CCS program; 2) an overview of the Whole-Child Model; 3) an indication of the potential impact on counties; and 4) understanding of next steps.

Background. The CCS program provides medical treatment and therapy services to eligible children and young adults under age 21 with debilitating medical conditions or major traumatic injuries.

Throughout the years, there has been much debate about redesigning the CCS program to best meet the needs of these children and youth. Additionally, CCS has historically operated on a fee-for-services (FFS) basis, however with the shift in California from FFS to Medi-Cal managed care, there has been discussion regarding whether the CCS program should remain a FFS program. In 1994, the Legislature enacted a CCS "carve out", which allowed the CCS program to remain on a FFS basis. The carve-out expires in January 2016.

Advocates have expressed concern surrounding a potential shift from FFS to managed care. Concerns include ensuring the managed care plans have adequate networks to serve this high-need population; that there is no disruption to specialty care and that beneficiaries do not receive a fragmentation of primary care versus CCS care.

In 2010, the Section 1115 "Bridge to Reform" Waiver included CCS demonstration pilots to test new models for delivering health care for children in the CCS program. There were four models set to be piloted – 1) Managed Care Organization – Health Plan of San Mateo; 2) Enhanced primary care case management – Alameda County Health Care Services Agency; Specialty Health Care Plan – Los Angeles Care Health Plan ; and 4) Provider based Accountable Care Organization – Children's Hospital or Orange County and Rady's Children's Hospital San Diego. Of the four pilot models, only the Health Plan of San Mateo's managed care organization model has been implemented.

In late 2014, DHCS initiated a stakeholder process in an effort to redesign the current CCS system and created the CCS Redesign Stakeholder Advisory Board (RSAB). The RSAB had six goals for the redesign process:

- Implement a patient and family centered approach;
- Improve care coordination through an Organized Delivery System;
- Maintain Quality;
- Streamline Care Delivery;
- Build on Lessons Learned; and
- Ensure the redesigned program is cost-effective.

The RSAB convened meetings throughout the year and discussed an array of potential models. DHCS' proposal is modeled after the pilot with the Health Plan of San Mateo.

Current County Roles. Under the CCS program, the county CCS program and/or the State (depending on whether a county is a dependent or independent county) has the following responsibilities:

- Eligibility – Assess whether the person meets the age criteria, has an eligible medical condition, resides within the county and meets the income requirements.
- Service Authorizations – Determine and authorize the level of service needed for the CCS patient
- Case Management – Provide medical case management for the patients and outreach to potential CCS eligible families.
- Medical Therapy Program – provides physical therapy services to eligible patients.

Currently, under the Health Plan of San Mateo pilot, the plan assumed the responsibility of the service authorizations and case management services. The Plan contracts with the county for CCS program staff to continue to provide those services; however, the plan now has ultimate decision making authority.

For the other five of the CCS "carved-in" counties – Marin, Napa, Solano, Santa Barbara and Yolo – CCS services are paid for by the plan, however the county CCS program still retains the responsibility and authority for the service authorization and case management.

Whole-Child Model. DHCS' proposal would allow the existing fully integrated model under the Health Plan of San Mateo to continue. Additionally, the Whole-Child Model would shift CCS from FFS to managed care beginning with most of the County Organized Health Systems (COHS):

- CenCal Health (Santa Barbara and San Luis Obispo Counties);

- Central California Alliance for Health (Santa Cruz, Monterey, and Merced Counties);
- Partnership Health Plan of California (Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo Counties)
- CalOptima (Orange)

The model also allows for up to four Two-Plan model counties (Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus and Tulare). DHCS may allow only one plan in two-plan model counties to carve-in CCS. Implementation will be subject to a readiness review and will be implemented no sooner than July 1, 2017.

Under the Whole-Child Model, health plans would assume full financial risk for the CCS program and would be required to coordinate all primary care and specialty care for CCS patients. Further, health plans would be required to demonstrate they have sufficient network adequacy to meet the needs of this high-need population through contracts with children's hospitals, specialty providers and with the county as appropriate. Health plans would be required to demonstrate support from various stakeholders, including the county CCS program, local hospitals and providers, and local families.

The role of case management and ability to select which services to authorize for CCS patients would be transferred from the county CCS program to the health plan. County CCS programs would retain the medical, financial and residential eligibility determination roles.

The Department has suggested a phased-in approach to carving CCS into managed care under this model. COHS counties would begin implementation no earlier than January 2017, the Two-Plan counties would be implemented no earlier than July 2017. The carve-out for the remaining counties would expire in January 2019, at which time the carve-out could potentially be implemented in the remaining counties.

Administration Next Steps. DHCS has proposed statutory changes and are soliciting stakeholder feedback. They have also begun meeting with Assembly Member Rob Bonta, author of AB 187, a measure that would extend the carve-out until January 2017. It is unknown at this time whether Assembly Member Bonta will amend his bill to reflect the department's proposal. The last day to pass legislation is September 11, 2015.

DHCS has also released an initial draft timeline for discussion and development which can be found at the following link:
http://www.dhcs.ca.gov/services/ccs/Documents/TimelineCCSImp.pdf

Attachments:
DHCS Whole-Child Care Model – June 11, 2015
DHCS Proposed Statutory Changes

Resources:
CCS Redesign Webpage:
http://www.dhcs.ca.gov/services/ccs/Pages/CCSStakeholderProcess.aspx

Staff Contacts:
Farrah McDaid Ting can be reached at (916) 327-7500 Ext. 559 or fmcdaid@counties.org.
Michelle Gibbons can be reached at (916) 327-7500 Ext. 524 or mgibbons@counties.org.

Department of Health Care Services
California Children's Services (CCS) Redesign
Whole-Child Model
June 11, 2015

Based on an extensive six-month stakeholder process to identify strategies to improve and integrate care for children who qualify for the California Children's Services (CCS) program, the Department of Health Care Services (DHCS) has developed a proposed "Whole-Child Model" to be implemented in *specified* counties only, no sooner than January 2017. This approach meets the six goals for CCS Redesign (listed below); including the primary goal to provide comprehensive treatment, and focus on the whole-child and their full range of needs rather than only their CCS eligible conditions. In the counties that have not been chosen for this Whole-Child approach, DHCS and stakeholders will continue to work on alternative concepts and proposals to improve the care for CCS recipients.

CCS Redesign Goals:

- **Implement Patient and Family-Centered Approach:** Provide comprehensive treatment and focus on the whole-child rather than only their CCS-eligible condition(s).
- **Improve Care Coordination through an Organized Delivery System:** Provide enhanced care coordination among primary, specialty, inpatient, outpatient, mental health, and behavioral health services through an organized delivery system that improves the care experience of the patient and family.
- **Maintain Quality:** Ensure providers and organized delivery systems meet quality standards and outcome measures specific to the CCS population.
- **Streamline Care Delivery:** Improve the efficiency and effectiveness of the CCS health care delivery system.
- **Build on Lessons Learned:** Consider lessons learned from current pilots and prior reform efforts, as well as delivery system changes for other Medi-Cal populations.
- **Cost Effective:** Ensure costs are no more than the projected cost that would otherwise occur for CCS children, including all state-funded delivery systems. Consider simplification of the funding structure and value-based payments to support a coordinated service delivery approach.

Based on stakeholder feedback to seek a better integrated and coordinated system but proceed carefully with changes to the program, the department's proposal provides a balanced, measured approach, maintaining the core CCS provider standards and network of specialty care, and implementing a gradual change in a modest portion of the state (less than one-third), with an extended phase-in and stringent readiness and monitoring requirements to ensure continuity of care and continued access to high-quality specialty care.

Current CCS System and Need to Improve Integration and Reduce Fragmentation

Under the current system, most children with CCS-eligible conditions are enrolled in both the CCS fee-for-service system and Med-Cal managed care, and receive services in two or more separate systems of care that do not always coordinate effectively. In addition, as the health care delivery system has evolved, multiple care coordination and authorization roles have emerged across counties, providers, and health plans, at times resulting in confusion for parents and payment delays for providers.

These silos of care are preventive services for non-CCS conditions provided by Primary Care Providers, who may be pediatricians, family practitioners, or general practitioners contracted through Medi-Cal managed care health plans, and CCS-condition specific care provided by CCS-paneled pediatric subspecialists, as well as CCS-paneled acute inpatient hospital services. Behavioral health services may also be provided through a health plan or county mental health plan. Further, Regional Center services or In-Home Supportive Services may be provided through other state or county agencies. Most, but not all, county CCS programs are responsible for medical eligibility determination, care coordination, and service authorization for CCS-eligible services.

While having children in a single integrated system of care would be ideal, the fragile nature of the CCS population requires any change to be carefully vetted and staged to prevent unnecessary disruption or erosion in care. After significant discussion and review of models discussed at the Redesign Stakeholder Advisory Board (RSAB) DHCS has developed a multi-year framework for a "whole child" approach that relies on existing successful models and delivery systems.

Section 1. Whole Child Delivery Model

The department proposes a Whole-Child Model which means an organized delivery system that will assure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals, specialty care providers, and counties. The first phase will incorporate CCS services into the integrated care systems of most County-Organized Health Systems (COHS). COHS are county developed and operated delivery systems with strong community ties. CCS services are already integrated into three COHS in six counties, through the CCS "carve-in," so three of these plans already have experience with key elements of this model. In addition to Health Plan of San Mateo, which has already implemented most elements of this model, the COHS will include Partnership Health Plan (four counties already carved-in), CalOptima, Central California Alliance for Health, and CenCal Health (one county already carved-in). Health plans would be at full financial risk, with a whole-child approach to provide and coordinate all primary and specialty care, similar to the Health Plan of San Mateo model. These plans will be required to demonstrate support from various stakeholders that may include the respective county CCS program, local providers and hospitals, and local families of children with CCS eligible conditions or local advocacy groups representing those families. Implementation in COHS counties without CCS already "carved-in" will start no earlier than January 2017, and is subject to a successful readiness review by DHCS.

The Whole-Child approach may also be implemented in up to four counties in the Two-Plan Medi-Cal managed care model. The Medi-Cal Two-Plan model delivery system provides consumers a choice between a commercial health plan and a county developed health plan. The determination of these counties will be based on an application of interest to DHCS from at least one managed care plan in a Two-Plan model county, with demonstrations of support from various stakeholders that may include the respective county CCS program, local providers and hospitals, and local families of children with CCS eligible conditions or local advocacy groups representing those families. Based on the application, and subject to federal approval, DHCS may propose that CCS covered services be incorporated into only one Medi-Cal managed care health plan in a Two-Plan model county. Implementation will begin no earlier than July 2017, and is subject to a successful readiness review by DHCS.

The table below lists the counties with CCS services currently "carved-in" to Medi-Cal managed care plans, and the additional counties proposed for carve-in as part of the Whole-Child Model.

Counties with current CCS carve-in (6)	Marin, Napa, San Mateo, Solano, Santa Barbara, Yolo
Proposed Additional CCS Whole-Child Counties (19)	Del Norte, Humboldt, Lake, Lassen, Mendocino, Merced, Modoc, Monterey, Orange, Santa Cruz, San Luis Obispo, Shasta, Siskiyou, Sonoma, Trinity, and up to four 2-plan model counties

Overall, DHCS is taking a measured approach that builds on current organized delivery systems, and increases coordination of primary, specialty, and behavioral health services within Medi-Cal managed care plans. Among other benefits, this model proposes to improve care transitions and access to specialty care for youth aging out of CCS, since those youth will most likely be transitioning into Medi-Cal managed care, and the proposed changes will require all Medi-Cal managed care plans to include CCS providers in the health plan's network.

Section 2. Key Features of the Whole-Child Model

- Existing fully integrated models will continue as part of the Whole-Child Model, such as Health Plan of San Mateo and Kaiser Permanente.

- Children included in the Whole-Child Model in each specified county will include CCS Medi-Cal, Optional Targeted Low-Income Children's Program (former Healthy Families), and CCS State-only populations.

- DHCS will require health plans to follow continuity of care requirements to support existing member and provider relationships.

- In the remaining 33 counties where the Whole-Child Model is not offered, DHCS proposes to extend the CCS carve-out for three years, to January 1, 2019, and consider potential implementation of the Whole-Child Model in additional counties. In the meantime, DHCS will promote medical home models and care coordination partnerships between counties, providers, and health plans in these counties, with continued discussion of best practices and future modernization efforts into the remaining counties.

- To improve continuity of care and access to specialty providers for youth aging out of CCS and transitioning to Medi-Cal managed care, the department will require all Medi-Cal managed care health plans, on a phased-in basis, to contract with CCS providers or providers who meet the CCS panel requirements.

- This model will maintain the CCS core program infrastructure including the regional provider network, through the existing DHCS credentialing process, including CCS provider paneling.

- DHCS will work in partnership with recognized experts and stakeholders to develop comprehensive CCS quality measures and ongoing public data reporting.

Section 3. Whole-Child Model Consumer Protections, Plan Readiness, and Access Monitoring

To provide seamless and coordinated access to a full array of primary, specialty, and behavioral health services, detailed readiness requirements will be developed in consultation with stakeholders. Health plans will be required to meet these readiness requirements prior to implementation, and DHCS and the Department of Managed Health Care (DMHC) will conduct program monitoring and oversight for access and quality measures. Key readiness requirements for health plans will include:

- Evidence of adequate network of CCS-paneled providers.
- Specific policies and procedures regarding access to specialty care outside of the designated catchment area consistent with the existing CCS regional provider network.
- Evidence of health plan policies and procedures that include CCS provider standards.
- CCS family advisory committees in each county that meet at least quarterly.
- Detailed protocols for enhanced care coordination among primary, specialty, inpatient, outpatient, mental health, and behavioral health services through an organized delivery system. Specific components will include: Health homes; culturally appropriate care; initial health assessment and annual reassessments; developing a care plan for each child; establishing interdisciplinary care teams; providing health promotion; transitions of care; referrals to social support services; referral to and coordination with behavioral health services; coordination with In-Home Supportive Services and Regional Centers; and links to other community services.
- Evidence of culturally and linguistically appropriate resources and readiness, including physical access.
- Specific policies around transitions, both initial enrollment and aging out of CCS, to ensure continuity of care.
- Integrated electronic health records system.
- Access to a grievance and appeals process for resolution of member issues.

Section 4. CCS Program Improvement and Stakeholder Engagement

DHCS will continue stakeholder engagement through all phases of implementation of the Whole-Child Model, and will also host ongoing discussions of program improvements applicable to all counties and identified in the Title V Needs Assessment, such as improved transitions for youth aging out of CCS, improving access for Durable Medical Equipment, and care coordination protocols. The CCS Advisory Group will replace the Redesign Stakeholder Advisory Board, and ongoing improvement efforts will continue to be guided by the department's six Redesign goals.

Section 5. County Roles, including Medical Therapy Program

Counties have served as a valued partner with providers and the state to provide CCS care coordination and service authorization for children and youth with special health care needs. However, as the health care delivery system has evolved, multiple care coordination and authorization roles have emerged across counties, providers, and health plans, at times resulting in confusion for parents and payment delays for providers.

To establish a single, unified care coordination team that can ensure access across an array of services, responsibility for CCS care coordination and service authorization activities will shift in

phases from counties to the health plans in the Whole-Child model counties. Counties and health plans, with support from DHCS, will jointly develop Memorandums of Understanding (MOUs) to document transition plans for these activities. DHCS will work collaboratively with counties on the accounting process and adjustments to support this structure; no changes to the county realignment structure are expected to be necessary. Counties (or the state, for dependent counties) will continue to perform initial and periodic financial, residential, and medical eligibility determinations.

In addition, the Whole-Child Model seeks to strengthen partnerships among local Medical Therapy Programs, health plans, and providers, to promote improved outcomes and integrated care. Counties will maintain responsibility for Medical Therapy Programs, but enhanced partnerships will be promoted by DHCS and addressed in local MOUs with health plans and counties.

Section 6. Proposed Timeline for CCS Whole-Child Model Implementation

Phase 1: June 2015 – December 2016

- Stakeholder discussions and development of detailed health plan requirements, quality measures, contracts, and readiness criteria.
- County-Health Plan MOUs developed.
- Evaluation of applications of interest in Two-Plan model counties.
- Program Improvement efforts continue.

Phase 2: January – July 2017

- Initial phased-in implementation begins in COHS counties, pending readiness review.
- Ongoing quality monitoring and reporting.
- Assess initial implementation and feedback from families and stakeholders.

Phase 3: July 2017 – December 2018

- Incorporate feedback from assessment of initial implementation.
- Initial phased-in implementation begins in Two-Plan Model counties, pending federal approval and readiness review.
- Ongoing quality monitoring and reporting.
- Stakeholder discussions around Whole-Child Model effectiveness, and potential changes for implementation in additional counties.

Phase 4: January 2019 - Ongoing

- CCS carve-out sunsets in remaining counties.
- Consider potential implementation of the Whole-Child Model in additional counties.

Department of Health Care Services
California Children's Services (CCS) Redesign Proposed Statutory Changes

WELFARE AND INSTITUTIONS CODE

§ 14093.05.

(a) The director shall enter into contracts with managed care plans under this chapter and Chapter 8 (commencing with Section 14200), including, but not limited to, health maintenance organizations, prepaid health plans, and primary care case management plans; counties, primary care providers, independent practice associations, private foundations, children's hospitals, community health centers, rural health centers, community clinics, and university medical center systems, or other entities for the provision of medical benefits to all persons who are eligible to receive medical benefits under publicly supported programs. The director may also amend existing Medi-Cal managed care contracts to include the provision of medical benefits to persons who are eligible to receive medical benefits under publicly supported programs. Contracts may be on an exclusive or nonexclusive basis.

(b) Contractors pursuant to this article and participating providers acting pursuant to subcontracts with those contractors, shall agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the contractor does not ensure sufficient funding to cover program benefits.

(c) Any managed care contractor serving children with conditions eligible under the California Children's Services (CCS) program shall maintain and follow standards of care established by the program, including use of paneled providers and CCS-approved special care centers and shall follow treatment plans approved by the program, including specified services and providers of services. If there are insufficient paneled providers willing to enter into contracts with the managed care contractor, the program shall seek to establish new paneled providers willing to contract. If a paneled provider cannot be found, the managed care contractor shall seek program approval to use a specific non-paneled provider with appropriate qualifications.

(d) (1) Any managed care contractor serving children with conditions eligible under the CCS program shall report expenditures and savings separately for CCS covered services and CCS eligible children.

(2) If the managed care contractor is paid according to a capitated or risk-based payment methodology, there shall be ~~**separate**~~ actuarially sound rates for CCS eligible children.

(3) Notwithstanding paragraph (2), a managed care pilot project may, if approval is obtained from the State CCS program director, utilize an alternative rate structure for CCS eligible children.

(e) This article is not intended to and shall not be interpreted to permit any reduction in benefits or eligibility levels under the CCS program. Any medically necessary service not available under the managed care contracts authorized under this article shall remain the responsibility of the state and county.

(f) To assure CCS benefits are provided to enrollees with a CCS eligible condition according to CCS program standards, there shall be oversight by the state and local CCS program agencies for both services covered and not covered by the managed care contract.

(g) Any managed care contract which will affect the delivery of care to CCS eligible children shall be approved by the state CCS program director prior to execution. The state CCS program

shall continue to be responsible for selection of CCS paneled providers and monitoring of contractors to see that CCS state standards are maintained.

§ 14093.06.
(a) When a managed care contractor authorized to provide California Children's Services (CCS) covered services pursuant to subdivision (a) of Section 14094.3 expands to other counties, the contractor shall comply with CCS program standards including, but not limited to, referral of newborns to the appropriate neonatal intensive care level, referral of children requiring pediatric intensive care to CCS-approved pediatric intensive care units, and referral of children with CCS eligible conditions to CCS-approved inpatient facilities and special care centers in accordance with subdivision (c) of Section 14093.05.
(b) The managed care contractor shall comply with CCS program medical eligibility regulations. Questions regarding interpretation of state CCS medical eligibility regulations, or disagreements between the county CCS program, and the managed care contractor regarding interpretation of those regulations, shall be resolved by the local CCS program, in consultation with the state CCS program. The resolution determined by the CCS program shall be communicated in writing to the managed care contractor.
(c) In following the treatment plan approved by the CCS program, the managed care contractor shall ensure the timely referral of children with special health care needs to CCS-paneled providers who are board-certified in both pediatrics and in the appropriate pediatric subspecialty.
(d) The managed care contractor shall report expenditures and savings separately for CCS covered services and CCS eligible children, in accordance with paragraph (1) of subdivision (d) of Section 14093.05.
(e) All children who are enrolled with a managed care contractor who are seeking CCS program benefits shall retain all rights to CCS program appeals and fair hearings of denials of medical eligibility or **denials, reductions or modifications** of service authorizations. Information regarding the number, nature, and disposition of appeals and fair hearings shall be part of an annual report to the Legislature on managed care contractor compliance with CCS standards, regulations, and procedures. This report shall be made available to the public.
(f) The state, in consultation with stakeholder groups, shall develop unique pediatric plan performance standards and measurements, including, but not limited to, the health outcomes of children with special health care needs.

§ 14094. CCS
For purposes of this article "CCS" means California Children's Services.

§ 14094.1. Managed care contractors; standards of care; use of paneled providers; report of expenditures and savings; payment according to capitated payment methodology
(a) The director shall investigate and to the extent feasible require any managed care contractor serving children with conditions eligible under the CCS program, to maintain and follow standards of care established by the program, including use of paneled providers and CCS approved special care centers and to follow treatment plans approved by the program, including specified services and providers of services. If there are insufficient paneled providers willing to enter into contracts with the managed care contractor, the program shall seek to establish new paneled providers willing to contract. If a paneled provider cannot be found, the managed care

contractor shall seek program approval to use a specific non-paneled provider with appropriate qualifications.

(b) The director shall investigate and to the extent feasible require any managed care contractor serving children with conditions eligible under the CCS program, to report expenditures and savings separately for CCS covered services and CCS eligible children.

(c) (1) **~~If~~ The** managed care contractor is **at full financial risk and** paid according to a capitated or risk-based payment methodology.**~~, there shall be a separate actuarially sound rate for CCS eligible children.~~**

(2) Notwithstanding paragraph (1), a managed care pilot project may, if approval is obtained from the state CCS program director, utilize an alternative rate structure for CCS eligible children.

§ 14094.2. Medically necessary services not available under managed care contracts; state and county responsibility [this section displayed for reference only; no proposed changes]

(a) This article is not intended, and shall not be interpreted, to permit any reduction in benefits or eligibility levels under the CCS program. Any medically necessary service not available under the managed care contracts authorized under this article shall remain the responsibility of the state and county.

(b) In order to ensure that CCS benefits are provided to enrollees with a CCS eligible condition according to CCS program standards, there shall be oversight by the state and local CCS program agencies for both services covered and not covered by the managed care contract.

§ 14094.3. Incorporation of CCS covered services into Medi-Cal managed care contracts; time; fee-for-service billing prior to incorporation; pilot projects

(a)**(1)** Notwithstanding this article or Section 14093.05 or 14094.1, CCS covered services shall not be incorporated into any Medi-Cal managed care contract entered into after August 1, 1994, pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.9 (commencing with Section 14088), Article 2.91 (commencing with Section 14089), Article 2.95 (commencing with Section 14092); or either Article 2 (commencing with Section 14200), or Article 7 (commencing with Section 14490) of Chapter 8, until January 1, **~~2016~~ 2019**, except for contracts entered into for county organized health systems **(COHS)** or Regional Health Authority in the Counties of San Mateo, Santa Barbara, Solano, Yolo, Marin, and Napa**, or as specified in paragraph (2).**

(2)(A) No earlier than January 1, 2017, and upon department review and certification that the COHS meets the readiness criteria specified in paragraph (C), the Department may incorporate CCS covered services into Medi-Cal managed care contracts for a COHS or a Regional Health Authority in the following counties: Del Norte, Humboldt, Lake, Lassen, Mendocino, Merced, Modoc, Monterey, Orange, San Luis Obispo, Santa Cruz, Shasta, Siskiyou, Sonoma, and Trinity.

(B) No earlier than July 1, 2017, and upon department review and certification that the Medi-Cal managed care health plan meets the readiness criteria specified in paragraph (C), the Department may incorporate CCS covered services into Medi-Cal managed care contracts in up to four counties that do not have a COHS or a Regional Health Authority. The director shall determine those counties, based on an application of interest to the department, which may include demonstration of support from local family, county, hospital and provider representatives. Based on the application of interest, the director

may also determine that CCS covered services will be incorporated into only one Medi-Cal managed care health plan in a county even though more than one Medi-Cal managed care contractor operates in the county.

(C) The director shall assess and verify the readiness of the managed care health plans to address the unique needs of CCS eligible beneficiaries including, but not limited to, requirements set forth in paragraphs (1) to (8), inclusive, of subdivision (b) of Section 14087.48 and Section 14094.4.

(D) Paragraph (2) shall be implemented only to the extent that all necessary federal approvals and waivers have been obtained and only if and to the extent that federal financial participation is available for children eligible for Medicaid or S-CHIP.

(b) Notwithstanding any other provision of this chapter, providers serving children under the CCS program who are enrolled with a Medi-Cal managed care contractor but who are not enrolled in a pilot project pursuant to subdivision (c) shall continue to submit billing for CCS covered services on a fee-for-service basis until CCS covered services are incorporated into the Medi-Cal managed care contracts described in subdivision (a).

(c) (1) The department may authorize a pilot project in Solano County in which reimbursement for conditions eligible under the CCS program may be reimbursed on a capitated basis pursuant to Section 14093.05, and provided all CCS program's guidelines, standards, and regulations are adhered to, and CCS program's case management is utilized.

(2) During the time period described in subdivision (a), the department may approve, implement, and evaluate limited pilot projects under the CCS program to test alternative managed care models tailored to the special health care needs of children under the CCS program. The pilot projects may include, but need not be limited to, coverage of different geographic areas, focusing on certain subpopulations, and the employment of different payment and incentive models. Pilot project proposals from CCS program-approved providers shall be given preference. All pilot projects shall utilize CCS program-approved standards and providers pursuant to Section 14094.1.

(d) For purposes of this section, CCS covered services include all program benefits administered by the program specified in Section 123840 of the Health and Safety Code regardless of the funding source.

(e) Nothing in this section shall be construed to exclude or restrict CCS eligible children from enrollment with a managed care contractor, or from receiving from the managed care contractor with which they are enrolled primary and other health care unrelated to the treatment of the CCS eligible condition.

(f) Notwithstanding Section 10231.5 of the Government Code, the department shall conduct a review to assess health plan performance and the outcomes and the experience of CCS eligible children served by managed care contractors in the counties specified in paragraph (a) (2), and shall provide a report to the Legislature after all CCS services have been incorporated into managed care contracts for all CCS eligible children in counties specified in paragraph (a) (2). A report submitted to the Legislature pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code. The department shall consult with stakeholders regarding the scope and structure of the review.

(g) The director shall solicit stakeholder and CCS family participation in advisory groups for the planning and development activities related to incorporating CCS covered services into Medi-Cal managed care contracts.

(h) 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 and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, CCS numbered letters, plan or provider bulletins, or similar instructions, without taking regulatory action. The department shall notify stakeholders and the fiscal and appropriate policy committees of the Legislature of its intent to issue plan letters, numbered letters or other similar instructions prior to issuance.

Proposed New § 14094.4. Consumer protections for CCS covered services in Medi-Cal managed care contracts

(a) To provide the care coordination and integration of health care services for CCS eligible children, the Department shall develop and implement CCS program monitoring and oversight standards for managed care plans, including access monitoring, quality measures, and ongoing public data reporting.

(b) Before the department contracts with managed care contractors to furnish CCS services, pursuant to paragraph (a) (2) of section 14093.2, and on an ongoing basis, the department shall work with stakeholders to develop and implement consumer protection guidelines and standards as determined by the department that address the following:

(1) Timely and appropriate communications with affected CCS eligible children and their parents or guardians.

(2) That managed care contractors demonstrate the availability of an appropriate provider network, including primary care physicians, specialists, professional, allied, and medical supportive personnel, and an adequate number of accessible facilities within each CCS service area. Maintain an updated and accessible listing of providers and make it available to CCS eligible children and their parents or guardians, at a minimum, by phone, written material, and Internet Web site.

(3) That managed care contractors have entered into agreements with county CCS programs or the state as necessary to reflect the role, if any, of counties or the state for the provision of CCS care coordination and service authorization, and any transition plan for that role, in accordance with paragraph (b) of Health and Safety Code section 123850.

(4) That managed care contractors serving children with CCS eligible conditions under the CCS program:

(A) Comply with continuity of care requirements in Section 1373.96 of the Health and Safety Code and Section 14185 of Welfare and Institutions Code.

(B) Maintain a liaison to coordinate with each regional center operating within the plan's service area to assist CCS eligible children with developmental disabilities and their families in understanding and accessing services and act as a central point of contact for questions, access and care concerns, and problem resolution.

(C) Maintain a liaison and provide access to out-of-network CCS providers, for up to 12 months, for CCS eligible children receiving CCS services through managed care contractors under the following conditions:

(i) The CCS eligible child has an ongoing relationship with a provider who is a CCS approved provider;

(ii) The provider will accept the health plan's rate for the service offered or the applicable Medi-Cal CCS fee-for-service rate, whichever is higher;

(iii) The managed care health plan determines that the provider meets applicable CCS standards and has no disqualifying quality of care issues in accordance with guidance from the department, including all-plan letters and CCS numbered letters or other administrative communication.

(iv) The provider must provide treatment information to the health plan, to the extent authorized by state and federal patient privacy provisions.

(v) This subparagraph shall apply to out-of-network primary care and specialist providers.

(D) Facilitate communication among a CCS child's health care and personal care providers, including In-Home Supportive Services and behavioral health providers when appropriate with the CCS eligible child, parent, or guardian.

(E) Facilitate timely access to primary care, specialty care, medications, and other health services needed by the CCS child, including referrals to address any physical or cognitive barriers to access.

(F) Provide a mechanism for CCS eligible children to request a specialist or clinic as a primary care provider. A specialist or clinic may serve as a primary care provider if the specialist or clinic agrees to serve in a primary care provider role and is qualified to treat the required range of CCS eligible conditions of the CCS child.

(G) Provide that communication to and services for CCS eligible children and their families are available in alternative formats that are culturally, linguistically, and physically appropriate through means, including, but not limited to, assistive listening systems, sign language interpreters, captioning, written communication, plain language, and written translations.

(H) Provide that materials are available and provided to inform CCS children and their families of procedures for obtaining CCS specialty services and Medi-Cal primary care and mental health benefits, including grievance and appeals procedures that are offered by the plan or are available through the Medi-Cal program.

(I) Provide timely processes for accepting and acting upon complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits. The grievance process shall comply with Section 14450, and Sections 1368 and 1368.01 of the Health and Safety Code.

(J) Perform an assessment process that, at a minimum, does all of the following:

- **(i) Assesses each CCS eligible child's risk level and needs by performing a risk assessment process using means such as telephonic, or in-person communication, or review of utilization and claims processing data, or by other means as determined by the department. The risk assessment process shall be performed in accordance with all applicable federal and state laws.**
- **(ii) Assesses, in accordance with the agreement with the county CCS program specified in paragraph (b) (3), the care needs of CCS eligible children and coordinates their CCS specialty services, Medi-Cal primary care services, mental health and behavioral health benefits, and regional center services across all settings, including coordination of necessary services within, and, when necessary, outside of the managed care health plan's provider network.**
- **(iii) Reviews historical CCS fee-for-service utilization data for CCS eligible children upon transition of CCS services to managed care contractors so that the**

managed care health plans are better able to assist CCS eligible children and prioritize assessment and care planning.

(iv) Follows timeframes for reassessment and, if necessary, circumstances or conditions that require redetermination of risk level, which shall be set by the department.

(L) Perform, at a minimum, and in addition to, other statutory and contractual requirements, care coordination, and care management activities as follows:

(i) Reflect a CCS child/family-centered, outcome-based approach to care planning.

(ii) Adhere to the CCS child or the CCS child's family's determination about the appropriate involvement of his or her medical providers and caregivers, according to the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(iii) Develop care management and care coordination for the CCS child across CCS specialty services, Medi-Cal primary care services, mental health and behavioral health benefits, regional center services, and In-Home Supportive Services (IHSS) including transitions among levels of care and between service locations.

(iv) Develop individual care plans for CCS eligible children based on the results of the risk assessment process with a particular focus on CCS specialty care.

(v) Consider behavioral health needs of CCS eligible children and coordinate those services with the county mental health department as part of the CCS child's individual care plan when appropriate and facilitate a CCS child's ability to access appropriate community resources and other agencies, including referrals as necessary and appropriate for behavioral services, such as mental health services.

(M) Incorporate into the CCS child's plan of care patterns and processes:

(i) A primary or specialty care physician who is the primary clinician for the CCS eligible child and who provides core clinical management functions.

(ii) Care management and care coordination for the CCS eligible child across the health care system including transitions among levels of care, and interdisciplinary care teams.

(iii) Provision of referrals to qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the managed care health plan.

(iv) Use of clinical data to identify CCS eligible children at the care site with chronic illness or other significant health issues.

(v) Timely preventive, acute, and chronic illness treatment of CCS eligible children in the appropriate setting.

(vi) Use of clinical guidelines or other evidence-based medicine when applicable for treatment of the CCS eligible child's health care issues or timing of clinical preventive services.

(5) In implementing this section, the department may alter the medical home elements described in paragraph (b) (4) (M) as necessary to secure the increased federal financial participation associated with the provision of medical assistance in conjunction with a health home, as made available under the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and codified in Section 1945 of Title XIX of the federal Social Security Act. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to alter medical home elements under this section at least five days in advance of taking this action.

(c) 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 and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, CCS numbered letters, plan or provider bulletins, or similar instructions, without taking regulatory action. The department shall notify stakeholders and the fiscal and appropriate policy committees of the Legislature of its intent to issue plan letters, numbered letters or other similar instructions prior to issuance.

HEALTH AND SAFETY CODE

§ **123850.**
(a) The board of supervisors of each county shall designate the county department of public health or the county department of social welfare as the designated agency to administer the California Children's Services Program. Counties with total population under 200,000 persons may administer the county program independently or jointly with the department. Counties with a total population in excess of 200,000 persons shall administer the county program independently. Except as otherwise provided in this article, the director shall establish standards relating to the local administration and minimum services to be offered by counties in the conduct of the California Children's Services Program.

(b) In counties specified in Welfare and Institutions Code section 14094.3, where the California Children's Services Program covered services specified in section 14103.8 of the Welfare and Institutions Code and this article are incorporated into Medi-Cal managed care contracts, the county shall delegate the case management, care coordination, provider referral, and service authorization functions for the CCS program to the Medi-Cal managed care health plan, in accordance with a transition plan and written agreement approved by the county agency designated in paragraph (a) of this section and the Medi-Cal managed care health plan identified in section 14094.3. The written agreement shall provide that the Medi-Cal managed care health plan is responsible for fulfillment of the requirements of sections 123855, 123925, and 123960.

(c) 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 and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, CCS numbered letters, plan or provider bulletins, or similar instructions, without taking regulatory action. The department shall notify stakeholders and the fiscal and appropriate policy committees of the Legislature of its intent to issue plan letters, numbered letters or other similar instructions prior to issuance.

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Additional Code Sections Displayed Below for Reference Only, No Changes Proposed

Health and Safety Code 123855.
The department or designated county agency shall cooperate with, or arrange through, local public or private agencies and providers of medical care to seek out handicapped children, bringing them expert diagnosis near their homes. Case finding shall include, but not be limited to, children with impaired sense of hearing. This section does not give the department or designated agency power to require medical or other form of physical examination without consent of parent or guardian.

H&S 123905.
A county of under 200,000 population, administering its county program jointly with the department, shall forward to the department a statement certifying the family of the handicapped child as financially eligible for treatment services. The department shall authorize necessary services within the limits of available funds. Payment for services shall be made by the department, with reimbursement from the county for its proportionate share as specified in this article.

H&S 123929.
(a) Except as otherwise provided in this section and Section 14133.05 of the Welfare and Institutions Code, California Children's Services program services provided pursuant to this article require prior authorization by the department or its designee. Prior authorization is contingent on determination by the department or its designee of all of the following:
(1) The child receiving the services is confirmed to be medically eligible for the CCS program.
(2) The provider of the services is approved in accordance with the standards of the CCS program.
(3) The services authorized are medically necessary to treat the child's CCS-eligible medical condition.
(b) The department or its designee may approve a request for a treatment authorization that is otherwise in conformance with subdivision (a) for services for a child participating in the Healthy Families Program or the AIM-Linked Infants Program pursuant to clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 of the Insurance Code or Chapter 2 (commencing with Section 15810) of Part 3.3 of Division 9 of the Welfare and Institutions Code, received by the department or its designee after the requested treatment has been provided to the child.
(c) If a provider of services who meets the requirements of paragraph (2) of subdivision (a) incurs costs for services described in paragraph (3) of subdivision (a) to treat a child described in subdivision (b) who is subsequently determined to be medically eligible for the CCS program as determined by the department or its designee, the department may reimburse the provider for those costs. Reimbursement under this section shall conform to the requirements of Section 14105.18 of the Welfare and Institutions Code.
(d) (1) By July 1, 2016, or a subsequent date determined by the department, requests for authorization of services, excluding requests for authorization of services submitted by dental providers enrolled in the Medi-Cal Dental program, shall be submitted in an electronic format determined by the department and shall be submitted via the department's Internet Web site or other electronic means designated by the department. The department may implement this requirement in phases.

(2) The department shall designate an alternate format for submitting requests for authorization of services when the department's Internet Web site or other electronic means designated in paragraph (1) are unavailable due to a system disruption.
(3) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may, without taking regulatory action, implement, interpret, or make specific this subdivision and any applicable waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions. Thereafter, 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. The department shall consult with interested parties and appropriate stakeholders in implementing this subdivision.

H&S 123985.
(a) A bone marrow transplant for the treatment of cancer shall be reimbursable under this article, when all of the following conditions are met:
(1) The bone marrow transplant is recommended by the recipient's attending physician.
(2) The bone marrow transplant is performed in a hospital that is approved for participation in the California Children's Services program.
(3) The bone marrow transplant is a reasonable course of treatment and is approved by the appropriate hospital medical policy committee.
(4) The bone marrow transplant has been deemed appropriate for the recipient by the program's medical consultant. The medical consultant shall not disapprove the bone marrow transplant solely on the basis that it is classified as experimental or investigational.
(b) The program shall provide reimbursement for both donor and recipient surgery.
(c) Any county that has a population of not more than 600,000, as determined by the most recent decennial census conducted by the United States Bureau of the Census, shall be exempt from complying with the 25-percent matching requirement provided for under this article, for any bone marrow transplant reimbursable under this section.

Insurance Code 12693.62.
Notwithstanding any other provision of law, for a subscriber who is determined by the California Children's Services Program to be eligible for benefits under the program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, a participating plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. Participating plans shall refer a child who they reasonably suspect of having a medical condition that is eligible for services under the California Children's Services Program to the California Children's Services Program. The California Children's Services Program shall provide case management and authorization of services if the child is found to be medically eligible for the California Children's Services Program. Diagnosis and treatment services that are authorized by the California Children's Services Program shall be performed by paneled providers for that program and approved special care centers of that program in accordance with treatment plans approved by the California Children's Services Program. All other services provided under the participating plan shall be available to the subscriber.

WIC 14103.8.
(a) Medi-Cal services for beneficiaries who are eligible for services under the California Children's Services Act (Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code) as well as the Medi-Cal program shall be subject to prior authorization by the director.

(b) Claims for payment of prior authorized services shall be reviewed by postpayment audit conducted by the department, and shall not be subject to prepayment review under the California Children's Services Act prior to submission to the Medi-Cal fiscal intermediary.
(c) The California Children's Services program may require all applicants who are potentially eligible for cash grant public assistance to apply for Medi-Cal eligibility prior to becoming eligible for funded services.

Department of Health Care Services
California Children's Services (CCS) Redesign
Whole-Child Model Implementation Timeline
July 17, 2015

In a continued effort to improve and integrate care for California Children's Services (CCS) program eligible children, the Department of Health Care Services (DHCS) has developed a Whole-Child Model to be implemented no sooner than January 2017 in specified counties. An initial draft timeline for discussion is as follows:

Dates	Action Items
July 2015 **<u>Key date(s):</u>** • July 17, 2015 – RSAB Stakeholder Meeting # 5	Development of the Whole-Child Model: • Document public comments and responses to the Whole-Child Model • Revise the Whole-Child Model incorporating public comments and responses as appropriate • Share potential statutory changes
Fall 2015 **<u>Key date(s):</u>** • September 11, 2015 – Last day to pass any bills • October 7, 2015 – CCS Advisory Group Meeting # 1 • October 11, 2015 – Last day for Governor to sign or veto bills	Readiness Review: • Develop Health Plan Readiness Review criteria • Develop template contracts between DHCS and Health Plans (example of components include care coordination, provider network, quality improvement, performance measurements, grievance & appeal process, etc.) • Draft detailed Consumer Protection processes Stakeholder Engagement: • Begin technical workgroup discussions on care coordination/medical home requirements, and quality/performance measures • Begin discussions with stakeholders around an evaluation plan for the Whole-Child Model • Further development of county roles and MOUs • Potential local town-hall meetings to be scheduled • Develop request for applications of interest for two-plan model counties. • Develop any needed requests for federal authority

Winter/Spring 2016 **<u>Key date(s):</u>** • January 1, 2016 – Statute takes effect • January 6, 2016 – CCS Advisory Group Meeting # 2 • April 6, 2016 – CCS Advisory Group Meeting # 3	Implementation of the Whole-Child Model: • Continue development of technical policy guidance • Develop County–Health Plan MOU/MOA guidance • Continue developing key elements that will go into the contracts between DHCS and Health Plans • Request and review applications of interest for two-plan model counties Readiness Review: • Finalize the Readiness Review criteria Consumer Protection: • Continue development/refinement of public Consumer Protection processes Provider Network Adequacy: • Develop CCS provider specific network adequacy monitoring tools • Discuss provider network adequacy with health plans Stakeholder Engagement: • Hold local discussions on the Whole Child Model • Hold on-going technical workgroup discussions on care coordination/medical home requirements, and quality/performance measures
Summer 2016 **<u>Key date(s):</u>** • July 13, 2016 – CCS Advisory Group # 4	Implementation of the Whole-Child Model: • Continue development of technical policy guidance • Continue developing key elements that will go into managed care contracts. Provider Network Adequacy: • Hold on-going discussions with Health Plans to ensure Provider Network Adequacy Stakeholder Engagement: • Hold on-going technical workgroup discussions on care coordination/medical home requirements, and quality/performance measures

Fall 2016 **<u>Key date(s):</u>** • October 1, 2016 – Consumer notification • October 5, 2016 – CCS Advisory Group Meeting # 5	Implementation of the Whole-Child Model: • Continue development of technical policy guidance • Plan the implementation of the Whole-Child Model with Health Plans, Counties, families, and other stakeholders • Begin a transitional notification process for consumers/families in November 2016 Provider Network Adequacy: • Conduct readiness review for Health Plans regarding Provider Network Adequacy and other readiness criteria Stakeholder Engagement: • Hold on-going technical workgroup discussions on care coordination/medical home requirements, and quality/performance measures
January 1, 2017	**Earliest Possible Date to implement the Whole-Child Model**
Winter/Spring 2017	Implementation of the Whole-Child Model: • Continue to monitor Provider Network Adequacy • Conduct initial review of the implementation of the Whole-Child Model including collecting feedback from families and stakeholders • Conduct on-going quality monitoring and reporting

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July 28, 2015

To: Health and Human Services Policy Committee Members

From: Farrah McDaid Ting, Legislative Representative
Michelle Gibbons, Legislative Analyst

Re: Medi-Cal County Inmate Program

Background. The 2010 budget – AB 1628 (Chapter 729, Statutes of 2010) – and AB 396 (Chapter 394, Statutes of 2011) – by then Assembly Member, now Senator Holly Mitchell – authorizes DHCS to allow counties to receive FFP to the extent available for acute inpatient hospital services provided off the grounds of the jail for stays longer than 24 hours for adults and juveniles, respectively.

DHCS has been working in consultation with CSAC and our county affiliate organizations, since early 2014 on developing a framework and guidance for counties to receive FFP for these services. While the development is still underway, CSAC staff will provide an update on the progress made thus far and expectations moving forward.

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HURST+BROOKS+ESPINOSA

July 23, 2015

TO: Matt Cate, CSAC Executive Director

FROM: Kelly Brooks-Lindsey, Partner

Re: Medicaid Section 1115 Waiver Renewal: Medi-Cal 2020 Update

Since the Department of Health Care Services (DHCS) submitted its Medi-Cal 2020 Medicaid Section 1115 Waiver renewal to the Centers for Medicare and Medicaid Services (CMS) on March 27, 2015, there has been little public information about the status of negotiations. On July 22, the Administration shared new details about the state/federal conversations with Medi-Cal stakeholders.

DHCS and CMS have recently agreed to a process for regular discussions about the waiver and are meeting weekly to discuss pre-determined topics. Upcoming topics of discussion include:

Month	Topics
July	Managed care transformation incentive program Accountability measures, including metrics for measuring achievements during the five-year waiver
August	Financing, including budget neutrality Federal/state shared savings concept Public hospital transformation incentives (aka Delivery System Reform Incentive Payment successor)
September	Fee-for-service proposal (dental and maternity care) Housing Whole Person Care

Public Safety Net Global Payments for the Remaining Uninsured. DHCS and CMS recently discussed the public safety net global payments for the remaining uninsured. Please recall that the Brown Administration is proposing to transform California's public safety net for the remaining uninsured by unifying the Disproportionate Share Hospital (DSH) and Safety Net Care Pool (SNCP) funding streams into a global payment system. DHCS believes they achieved the following outcomes in the global payments conversation: 1) CMS understands and is interested in the proposal and 2) DHCS has satisfactorily addressed CMS's questions. CMS has indicated they are developing a new federal policy on uncompensated care pools based on what was recently agreed to with the state of Florida. The impending federal policy likely impacts the global payments for the uninsured because the state is

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proposing to continue the use of SNCP revenue. It is unclear whether and how California's proposal may align with CMS's new national policy. Details on Florida's recent waiver agreement are currently unavailable as it relates to uncompensated care pools.

Budget Neutrality. CMS also indicated to California that they are developing a national policy on budget neutrality that includes the concept of rebasing away from the use of fee-for-service (FFS) assumptions. Part of the budget neutrality calculation requires states to calculate their costs without the waiver and then to update those costs with the waiver. The difference between the "without" waiver and "with" waiver costs is the basis for budget neutrality. States use the budget neutrality calculation to inform how they approach CMS in asking for additional federal funds. California is proposing to continue to calculate budget neutrality by using a comparison of FFS costs with managed care costs, which is how the state calculates budget neutrality in the existing waiver.

While CMS has indicated that the move away from FFS is their policy goal, it is not clear what that may mean for California's waiver proposal. CMS is still developing policy on budget neutrality and it is unknown whether the policy will be drafted for purposes of the budget neutrality calculation discussion slated to occur with California on August 12. CMS has assured the state that it is not their intention to zero out California's waiver savings. California is not aware of CMS raising the new policy with other states in waiver negotiations.

***Shared Savings*.** California is proposing to test a new investment strategy with the federal government by initiating a federal-state shared savings model. CMS continues to indicate they are not sure whether they currently have the authority to approve the federal-state shared savings proposed by California. DHCS is hoping to learn more in August.

It is unclear how quickly some of the major financing questions will be settled; many of the financing questions will impact the policy portions of the waiver. It's important to keep in mind that California's existing "Bridge to Reform" Medicaid Section 1115 Waiver expires on October 31, 2015.

FEDERAL & STATE NEXT STEPS

The current waiver provides approximately $10 billion to California over its five-year life, with $2 billion directly benefiting the state General Fund. California's waiver renewal, Medi-Cal 2020, seeks $17 billion in federal funds for the next five years.

CMS remains very engaged, and DHCS indicates CMS is committed to completing the waiver by November 1, 2015. After July 25, 2015, fewer than 100 days remain until the existing waiver expires. DHCS is hoping to share more information about the financing and metrics discussions via a briefing webinar for stakeholders in August.

Once more is known about the CMS discussions with California – particularly the outcome of the financing conversations – counties may need to engage on a federal and state communications and outreach strategy. If the national budget neutrality policy results in a complete rebasing of California's budget neutrality, the waiver would be worth significantly less than the $17 billion under discussion – and likely less than the $10 billion in the current waiver. Outreach may include members of the

California's federal delegation and members of the California State Legislature – likely with the goal of influencing key officials in CMS and the White House.

Once negotiations conclude on the financing and major policy proposals, CMS will create the Special Terms and Conditions (STCs), the legal document governing the waiver. State implementation cannot begin until the STCs are complete. The state and federal governments are focused on completing negotiations in order to begin implementation in November 2015.

The Legislature remains interested in working with the Brown Administration to enact statutory changes necessary to implement a new waiver. However, timing remains a challenge. Currently, there is not enough detail from the state/federal negotiations to develop a statutory framework. AB 72 by Assembly Member Rob Bonta and SB 36 by Senator Ed Hernandez continue to work their way through the legislative process as spot bills. However, staff is expecting to make substantive amendments to the bills in late August or early September once more is known about waiver negotiations. If sufficient information is not available prior to the Legislature's departure on September 11, additional legislation could be contemplated in January 2016 when the houses reconvene for the second year of the 2015-16 session.

Hurst Brooks Espinosa will continue to provide regular policy and political updates to counties on Medi-Cal 2020 Waiver renewal details as they become available. For additional questions, please contact Kelly Brooks-Lindsey at kbl@hbeadvocacy.com or 916.272.0011.

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July 28, 2015

To: Health and Human Services Policy Committee Members

From: Farrah McDaid Ting, Legislative Representative
Michelle Gibbons, Legislative Analyst

Re: 'Medi-Cal 2020' Waiver Renewal Update – INFORMATION ONLY

On July 22, the Department of Health Care Services provided stakeholders with updates on the Medi-Cal 2020 Waiver Renewal and negotiations thus far.

CSAC has contracted with Hurst Brooks Espinosa to represent CSAC on the many facets concerning the waiver renewal. In the attached memo, Kelly Brooks-Lindsey shares details regarding the waiver negotiations.

This memo has been provided as an INFORMATION ONLY item. We will continue to provide updates as negotiations progress and new details emerge.

For more information about the state's proposal, please visit the Department of Health Care Service's Section 1115 Waiver Renewal page at:
http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx

Attachments:
Hurst Brooks Espinosa Memo: Medicaid Section 1115 Waiver Renewal: Medi-Cal 2020 Update

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