AMENDED IN ASSEMBLY APRIL 4, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1066

Introduced by Assembly Member John A. Pérez (Coauthor: Assembly Member Monning)

February 18, 2011

An act to amend Sections 14166.1, 14166.2, 14166.3, 14166.35, 14166.4, 14166.5, 14166.6, 14166.7, 14166.75, 14166.8, 14166.9, 14166.20, 14166.21, 14166.24, 14166.26, 14182, 14182.3, 14182.4, 15908, 15909.1, 15910, 15910.1, 15910.2, 15910.3, 15911, 15912, and 15914 of, to amend the heading of Part 3.6 (commencing with Section 15909) of Division 9 of, and to add Sections 14166.61, 14166.71, 14166.77, and 14182.45 to, the Welfare and Institutions Code, relating to public health care, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 1066, as amended, John A. Pérez. Public health care: Medi-Cal: demonstration project waivers.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law establishes the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, which revises hospital supplemental payment methodologies under the Medi-Cal program in order to maximize the use of federal funds consistent with federal Medicaid law and to stabilize the distribution of funding for hospitals that provide care to Medi-Cal beneficiaries and uninsured

patients. This demonstration project provides for funding, in supplementation of Medi-Cal reimbursement, to various hospitals, including designated public hospitals, nondesignated public hospitals, and private hospitals, as defined, in accordance with certain provisions relating to disproportionate share hospitals.

Existing law requires the department to seek another demonstration project or federal waiver of Medicaid law to implement specified objectives, which may include better care coordination for seniors, persons with disabilities, and children with special health care needs. Existing law provides that to the extent the provisions under the Medi-Cal Hospital/Uninsured Care Demonstration Project Act do not conflict with the provisions of, or the Special Terms and Conditions of, this demonstration project, the provisions of the Medi-Cal Hospital/Uninsured Care Demonstration Project Act shall apply.

Existing law establishes the following continuously appropriated funds to be expended by the department:

(1) The Demonstration Disproportionate Share Hospital Fund, which consists of federal funds claimed and received by the department as federal financial participation with respect to certified public expenditures.

(2) The Health Care Support Fund, which consists of safety net care pool funds claimed and received by the department under the demonstration projects.

(3) The Private Hospital Supplemental Fund, the Nondesignated Public Hospital Supplemental Fund, and the Distressed Hospital Fund, which consist of moneys from various sources, and are used as the source of the nonfederal share of payments to private hospitals, nondesignated hospitals, and distressed hospitals, respectively.

(4) The Public Hospital Investment, Improvement, and Incentive Fund, which consists of moneys that a county, other political subdivision of the state, or other governmental entity in the state elects to transfer to the department for use as the nonfederal share of investment, improvement, and incentive payments to participating designated hospitals and the governmental entities with which they are affiliated.

(5) The Medi-Cal Inpatient Payment Adjustment Fund, which consists of moneys transferred to the fund and used as the nonfederal share of payment adjustments made to hospitals under the Medi-Cal program.

This bill would further distinguish which provisions of the Medi-Cal Hospital/Uninsured Care Demonstration Project Act apply to the successor demonstration project, as defined, and would make other

conforming changes. By extending the term of some of the continuously appropriated funds, this bill would make an appropriation. By revising the purposes for which moneys in the Health Care Support Fund and moneys in the Public Hospital Investment, Improvement, and Incentive Fund shall be used, this bill would make an appropriation. By extending the period of time during which transfers are made to the continuously appropriated Medi-Cal Inpatient Payment Adjustment Fund, this bill would make an appropriation.

Existing law provides for the Health Care Coverage Initiative, which is a federal waiver demonstration project established to expand health care coverage to low-income uninsured individuals who are not currently eligible for the Medi-Cal program, the Healthy Families Program, or the Access for Infants and Mothers program. Existing law also, to the extent that federal financial participation is available and federal financial participation is not jeopardized, requires the department, on or after November 1, 2010, but no later than March 1, 2011, or 180 days after federal approval of a successor demonstration project, as defined, to authorize local Coverage Expansion and Enrollment Demonstration (CEED) projects, as specified, to provide scheduled health care benefits for uninsured adults 19 to 64~~, inclusive, years of age~~ *years of age, inclusive,* with incomes up to 133% of the federal poverty level who are not otherwise eligible for Medi-Cal or Medicare. Existing law also provides that, to the extent federal financial participation is made available under the Special Terms and Conditions of the demonstration project, CEED project services may be made available to individuals with incomes between 134% to 200%, inclusive, of the federal poverty level.

This bill would rename a CEED project a Low Income Health Program (LIHP) and would instead provide that the department shall authorize local LIHPs no later than July 1, 2011. This bill would also provide that LIHP health care services may be provided to eligible individuals, as described, including those with incomes above 133% through 200% of the federal poverty level. This bill also would make technical, nonsubstantive changes to these provisions.

This bill would declare that it is to take effect immediately as an urgency statute.

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 14166.1 of the Welfare and Institutions Code is amended to read:

14166.1. For purposes of this article, the following definitions shall apply:

(a) "Allowable costs" means those costs recognized as allowable under Medicare reasonable cost principles and additional costs recognized under the demonstration project and successor demonstration project, including those expenditures identified in Appendix D to the Special Terms and Conditions for the demonstration project and successor demonstration project. Allowable costs under this subdivision shall be determined in accordance with the Special Terms and Conditions and implementation documents for the demonstration project and successor demonstration project approved by the federal Centers for Medicare and Medicaid Services.

(b) "Base year private DSH hospital" means a nonpublic hospital, nonpublic-converted hospital, or converted hospital, as those terms are defined in paragraphs (26), (27), and (28), respectively, of subdivision (a) of Section 14105.98, that was an eligible hospital under paragraph (3) of subdivision (a) of Section 14105.98 for the 2004–05 state fiscal year.

(c) "Demonstration project" means the Medi-Cal Hospital/Uninsured Care Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services, effective for the period of September 1, 2005, through October 31, 2010.

(d) "Designated public hospital" means any one of the following hospitals to the extent identified in Attachment C, "Government-operated Hospitals to be Reimbursed on a Certified Public Expenditure Basis," to the Special Terms and Conditions for the demonstration project and successor demonstration project, as applicable, issued by the federal Centers for Medicare and Medicaid Services:

(1) UC Davis Medical Center.

(2) UC Irvine Medical Center.

(3) UC San Diego Medical Center.

(4) UC San Francisco Medical Center.

(5) UC Los Angeles Medical Center, including Santa Monica/UCLA Medical Center.
(6) LA County Harbor/UCLA Medical Center.
(7) LA County Martin Luther King Jr.-Harbor Hospital.
(8) LA County Olive View UCLA Medical Center.
(9) LA County Rancho Los Amigos National Rehabilitation Center.
(10) LA County University of Southern California Medical Center.
(11) Alameda County Medical Center.
(12) Arrowhead Regional Medical Center.
(13) Contra Costa Regional Medical Center.
(14) Kern Medical Center.
(15) Natividad Medical Center.
(16) Riverside County Regional Medical Center.
(17) San Francisco General Hospital.
(18) San Joaquin General Hospital.
(19) San Mateo Medical Center.
(20) Santa Clara Valley Medical Center.
(21) Tuolumne General Hospital.
(22) Ventura County Medical Center.

(e) "Federal medical assistance percentage" means the federal medical assistance percentage applicable for federal financial participation purposes for medical services under the Medi-Cal state plan pursuant to Section 1396b(a) of Title 42 of the United States Code.

(f) "Nondesignated public hospital" means a public hospital defined in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(g) "Project year" means the applicable state fiscal year of the Medi-Cal Hospital/Uninsured Care Demonstration Project through October 31, 2010.

(h) "Project year private DSH hospital" means a nonpublic hospital, nonpublic-converted hospital, or converted hospital, as those terms are defined in paragraphs (26), (27), and (28), respectively, of subdivision (a) of Section 14105.98, that was an eligible hospital under paragraph (3) of subdivision (a) of Section 14105.98, for the particular project year.

(i) "Prior supplemental funds" means the Emergency Services and Supplemental Payments Fund, the Medi-Cal Medical Education

Supplemental Payment Fund, the Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund, and the Small and Rural Hospital Supplemental Payments Fund, established under Sections 14085.6, 14085.7, 14085.8, and 14085.9, respectively.

(j) "Private hospital" means a nonpublic hospital, nonpublic converted hospital, or converted hospital, as those terms are defined in paragraphs (26) to (28), inclusive, respectively, of subdivision (a) of Section 14105.98.

(k) "Safety net care pool" means the federal funds available under the Medi-Cal Hospital/Uninsured Care Demonstration Project and the successor demonstration project to ensure continued government support for the provision of health care services to uninsured populations.

(*l*) "Uninsured" shall have the same meaning as that term has in the Special Terms and Conditions issued by the federal Centers for Medicare and Medicaid Services for the demonstration project and the successor demonstration project.

(m) "Successor demonstration project" means the Medicaid demonstration project entitled "California's Bridge to Reform," No. 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services, effective for the period of November 1, 2010, through October 31, 2015.

(n) "Successor demonstration year" means the demonstration year as identified in the Special Terms and Conditions for the successor demonstration project that corresponds to a specific period of time as follows:

(1) Successor demonstration year 6 corresponds to the period of November 1, 2010, through June 30, 2011.

(2) Successor demonstration year 7 corresponds to the period of July 1, 2011, through June 30, 2012.

(3) Successor demonstration year 8 corresponds to the period of July 1, 2012, through June 30, 2013.

(4) Successor demonstration year 9 corresponds to the period of July 1, 2013, through June 30, 2014.

(5) Successor demonstration year 10 corresponds to July 1, 2014, through October 31, 2015.

(o) "Low Income Health Program" means the county-based elective program to provide benefits for low-income individuals

that is authorized by the successor demonstration project and implemented by Part 3.6 (commencing with Section 15909).

(p) "Delivery system reform incentive pool" means the separate federal funding pool created within the safety net care pool under the successor demonstration project that is available to support programs of activity to enhance the quality of care and health of patients served by designated public hospitals and nonhospital clinics and other provider types with which they are affiliated, and, under specified conditions and approval of the federal Centers for Medicare and Medicaid Services, to private disproportionate share hospitals and nondesignated public hospitals.

SEC. 2. Section 14166.2 of the Welfare and Institutions Code is amended to read:

14166.2. (a) The demonstration project, and the successor demonstration project, as applicable, shall be implemented and administered pursuant to this article.

(b) (1) The director may modify any process or methodology specified in this article to the extent necessary to comply with federal law or the terms of the demonstration project or the successor demonstration project, as applicable, but only if the modification results in the equitable distribution of funding, consistent with this article, among the hospitals affected by the modification. If the director, after consulting with affected hospitals, determines that an equitable distribution cannot be achieved, the director shall execute a declaration stating that this determination has been made. The director shall retain the declaration and provide a copy, within five working days of the execution of the declaration, to the fiscal and appropriate policy committees of the Legislature. This article shall become inoperative on the date that the director executes a declaration pursuant to this subdivision, and as of January 1 of the following year shall be repealed.

(2) In addition to the requirements specified in paragraph (1), the director shall post the declaration on the department's Internet Web site and the director shall send the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(c) The director shall administer the demonstration project, the successor demonstration project, and related Medi-Cal payment programs in a manner that attempts to maximize available payment

of federal financial participation, consistent with federal law, the applicable Special Terms and Conditions for the demonstration project and successor demonstration project issued by the federal Centers for Medicare and Medicaid Services, and this article.

(d) As permitted by the federal Centers for Medicare and Medicaid Services, this article shall be effective with regard to services rendered throughout the term of the demonstration project, and retroactively, with regard to services rendered on or after July 1, 2005, but prior to the implementation of the demonstration project, and with regard to services rendered throughout the term of the successor demonstration project.

(e) In the administration of this article, the state shall continue to make payments to hospitals that meet the eligibility requirements for participation in the supplemental reimbursement program for hospital facility construction, renovation, or replacement pursuant to Section 14085.5 and shall continue to make inpatient hospital payments not covered by the contract. These payments shall not duplicate any other payments made under this article.

(f) The department shall continue to operate the selective provider contracting program in accordance with Article 2.6 (commencing with Section 14081) in a manner consistent with this article. A designated public hospital participating in the certified public expenditure process shall maintain a selective provider contracting program contract. These contracts shall continue to be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(g) (1) In the event of a final judicial determination made by any state or federal court that is not appealed in any action by any party or a final determination by the administrator of the federal Centers for Medicare and Medicaid Services that federal financial participation is not available with respect to any payment made under any of the methodologies implemented pursuant to this article because the methodology is invalid, unlawful, or is contrary to any provision of federal law or regulation, the director may modify the process or methodology to comply with law, but only if the modification results in the equitable distribution of demonstration project funding, consistent with this article, among the hospitals affected by the modification. If the director, after consulting with affected hospitals, determines that an equitable distribution cannot be achieved, the director shall execute a

declaration stating that this determination has been made. The director shall retain the declaration and provide a copy, within five working days of the execution of the declaration, to the fiscal and appropriate policy committees of the Legislature. This article shall become inoperative on the date that the director executes a declaration pursuant to this subdivision, and as of January 1 of the following year shall be repealed.

(2) In addition to the requirements specified in paragraph (1), the director shall post the declaration on the department's Internet Web site and the director shall send the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(h) (1) The department may adopt regulations to implement this article. These regulations may initially be adopted as emergency regulations in accordance with 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). For purposes of this article, the adoption of regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare. Any emergency regulations adopted pursuant to this section shall not remain in effect subsequent to 24 months after the effective date of this article.

(2) As an alternative, and notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, or any other provision of law, the department may implement and administer this article by means of provider bulletins, manuals, or other similar instructions, without taking regulatory action. The department shall notify the fiscal and appropriate policy committees of the Legislature of its intent to issue a provider bulletin, manual, or other similar instruction, at least five days prior to issuance. In addition, the department shall provide a copy of any provider bulletin, manual, or other similar instruction issued under this paragraph to the fiscal and appropriate policy committees of the Legislature. The department shall consult with interested parties and appropriate stakeholders, regarding the implementation and ongoing administration of this article.

(i) To the extent necessary to implement this article, the department shall submit, by September 30, 2005, to the federal

Centers for Medicare and Medicaid Services proposed amendments to the Medi-Cal state plan, including, but not limited to, proposals to modify inpatient hospital payments to designated public hospitals, modify the disproportionate share hospital payment program, and provide for supplemental Medi-Cal reimbursement for certain physician and nonphysician professional services. The department shall, subsequent to September 30, 2005, submit any additional proposed amendments to the Medi-Cal state plan that may be required by the federal Centers for Medicare and Medicaid Services, to the extent necessary to implement this article.

(j) Each designated public hospital shall implement a comprehensive process to offer individuals who receive services at the hospital the opportunity to apply for the Medi-Cal program, the Healthy Families Program, or any other public health coverage program for which the individual may be eligible, and shall refer the individual to those programs, as appropriate.

(k) In any judicial challenge of the provisions of this article, nothing shall create an obligation on the part of the state to fund any payment from state funds due to the absence or shortfall of federal funding.

(*l*) Any reference in this article to the "Medicare cost report" shall be deemed a reference to the Medi-Cal cost report to the extent that report is approved by the federal Centers for Medicare and Medicaid Services for any of the uses described in this article.

~~SEC. 3. Section 14166.3 of the Welfare and Institutions Code is amended to read:~~

~~14166.3. (a) During the demonstration project and successor demonstration project terms, payment adjustments to disproportionate share hospitals shall not be made pursuant to Section 14105.98. Payment adjustments to disproportionate share hospitals shall be made solely in accordance with this article.~~

~~(b) Except as otherwise provided in this article, the department shall continue to make all eligibility determinations and perform all payment adjustment amount computations under the disproportionate share hospital payment adjustment program pursuant to Section 14105.98 and pursuant to the disproportionate share hospital provisions of the Medicaid state plan in effect as of the 2004-05 state fiscal year. For purposes of these determinations and computations, services that are rendered under the Health Care Coverage Initiative authorized pursuant to Part 3.5 (commencing~~

~~with Section 15900) or the Low Income Health Program authorized pursuant to Part 3.6 (commencing with Section 15909) shall be included.~~

~~(c) (1) Notwithstanding Section 14105.98, the federal disproportionate share hospital allotment specified for California under Section 1396r-4(f) of Title 42 of the United States Code for each of federal fiscal years 2006 to 2015, inclusive, and federal fiscal year 2016 with respect to the pro rata portion of the allotment that will apply during successor demonstration year 10 pursuant to paragraph (2), shall be distributed solely among the following hospitals:~~

~~(A) Eligible hospitals, as determined pursuant to Section 14105.98 for each project year and successor demonstration year in which the particular federal fiscal year commences, which meet the definition of a public hospital as specified in paragraph (25) of subdivision (a) of Section 14105.98.~~

~~(B) Hospitals that are licensed to the University of California, which meet the requirements set forth in Section 1396r-4(d) of Title 42 of the United States Code.~~

~~(2) The federal disproportionate share hospital allotment for each of the federal fiscal years 2006 to 2015, inclusive, shall be aligned with the project year in which the applicable federal fiscal year commences. The payment adjustment year, as used within the meaning of paragraph (6) of subdivision (a) of Section 14105.98, shall be the corresponding project year or successor demonstration year. With respect to successor demonstration year 10, the period of July 1, 2015, through October 31, 2015, shall be aligned with a pro rata portion of the federal disproportionate share hospital allotment for federal fiscal year 2016.~~

~~(3) Uncompensated Medi-Cal and uninsured costs as reported pursuant to Section 14166.8, shall be used by the department as the basis for determining the hospital-specific disproportionate share hospital payment limits required by Section 1396r-4(g) of Title 42 of the United States Code for the hospitals described in paragraph (1).~~

~~(4) The distribution of the federal disproportionate share hospital allotment to hospitals described in paragraph (1) shall satisfy the state's payment obligations, if any, with respect to those hospitals under Section 1396r-4 of Title 42 of the United States Code.~~

~~(d) Eligible hospitals, as determined pursuant to Section 14105.98 for each project year and each successor demonstration year, which are nonpublic hospitals, nonpublic-converted hospitals, and converted hospitals, as those terms are defined in paragraphs (26), (27) and (28), respectively, of subdivision (a) of Section 14105.98, shall receive Medi-Cal disproportionate share hospital replacement payment adjustments pursuant to Section 14166.11 and other provisions of this chapter. The payment adjustments so provided shall satisfy the state's payment obligations, if any, with respect to those hospitals under Section 1396r-4 of Title 42 of the United States Code. The federal share of these payments shall not be claimed from the federal disproportionate share hospital allotment described in subdivision (c).~~

~~(e) The nonfederal share of payments described in subdivisions (c) and (d) shall be derived from the following sources:~~

~~(1) With respect to the payments described in paragraph (1) of subdivision (c) that are made to designated public hospitals, the nonfederal share shall consist of certified public expenditures described in subparagraphs (A) and (C) of paragraph (2) of subdivision (a) of Section 14166.9, and intergovernmental transfer amounts described in paragraph (2) of subdivision (d) of Section 14166.6.~~

~~(2) With respect to the payments described in paragraph (1) of subdivision (c) that are made to nondesignated public hospitals, the nonfederal share shall consist solely of state General Fund appropriations.~~

~~(3) With respect to the payments described in subdivision (d), the nonfederal share shall consist of state General Fund appropriations.~~

~~(f) (1) During the terms of the demonstration project and successor demonstration project, for the 2005–06 state fiscal year and any subsequent state fiscal years, no public entity shall be obligated to make any intergovernmental transfer pursuant to Section 14163, and all transfer amount determinations for those state fiscal years shall be suspended. However, during the demonstration project and successor demonstration project terms, intergovernmental transfers shall be made with respect to the disproportionate share hospital payment adjustments made in accordance with paragraph (2) of subdivision (d) of Section~~

~~14166.6, or paragraph (2) of subdivision (d) of Section 14166.61, as applicable.~~

~~(2) During the terms of the demonstration project and successor demonstration project, for the 2005–06 state fiscal year and any subsequent state fiscal years, transfer amounts from the Medi-Cal Inpatient Payment Adjustment Fund to the Health Care Deposit Fund, as provided for pursuant to paragraph (2) of subdivision (d) of Section 14163, are hereby reduced to zero. Unless otherwise specified in this article, this paragraph shall be disregarded for purposes of the calculations made under Section 14105.98 during the demonstration project and successor demonstration project.~~

SEC. 3. Section 14166.3 of the Welfare and Institutions Code is amended to read:

14166.3. (a) During the demonstration project ~~term~~ *and successor demonstration project terms*, payment adjustments to disproportionate share hospitals shall not be made pursuant to Section 14105.98. Payment adjustments to disproportionate share hospitals shall be made solely in accordance with this article.

(b) Except as otherwise provided in this article, the department shall continue to make all eligibility determinations and perform all payment adjustment amount computations under the disproportionate share hospital payment adjustment program pursuant to Section 14105.98 and pursuant to the disproportionate share hospital provisions of the Medicaid state plan in effect as of the ~~2004-05~~ *2004–05* state fiscal year. *For purposes of these determinations and computations, services that are rendered under the Health Care Coverage Initiative authorized pursuant to Part 3.5 (commencing with Section 15900) or the Low Income Health Program authorized pursuant to Part 3.6 (commencing with Section 15909) shall be included.*

(c) (1) Notwithstanding Section 14105.98, the federal disproportionate share hospital allotment specified for California under Section 1396r-4(f) of Title 42 of the United States Code for each of federal fiscal years 2006 to ~~2010, inclusive,~~ *2015, inclusive, and federal fiscal year 2016 with respect to the pro rata portion of the allotment that will apply during successor demonstration year 10 pursuant to paragraph (2),* shall be distributed solely among the following hospitals:

(A) Eligible hospitals, as determined pursuant to Section 14105.98 for each project year *and successor demonstration year*

in which the particular federal fiscal year commences, which meet the definition of a public hospital as specified in paragraph (25) of subdivision (a) of Section 14105.98.

(B) Hospitals that are licensed to the University of California, which meet the requirements set forth in Section 1396r-4(d) of Title 42 of the United States Code.

(2) The federal disproportionate share hospital allotment for each of the federal fiscal years 2006 to ~~2010~~ *2015*, inclusive, shall be aligned with the project year *or successor demonstration year* in which the applicable federal fiscal year commences. The payment adjustment year, as used within the meaning of paragraph (6) of subdivision (a) of Section 14105.98, shall be the corresponding project year *or successor demonstration year. With respect to successor demonstration year 10, the period of July 1, 2015, through October 31, 2015, shall be aligned with a pro rata portion of the federal disproportionate share hospital allotment for federal fiscal year 2016*.

(3) Uncompensated Medi-Cal and uninsured costs as reported pursuant to Section 14166.8, shall be used by the department as the basis for determining the hospital-specific disproportionate share hospital payment limits required by Section 1396r-4(g) of Title 42 of the United States Code for the hospitals described in paragraph (1).

(4) The distribution of the federal disproportionate share hospital allotment to hospitals described in paragraph (1) shall satisfy the state's payment obligations, if any, with respect to those hospitals under Section 1396r-4 of Title 42 of the United States Code.

(d) Eligible hospitals, as determined pursuant to Section 14105.98 for each project year *and each successor demonstration year*, which are nonpublic hospitals, nonpublic-converted hospitals, and converted hospitals, as those terms are defined in paragraphs (26), (27) and (28), respectively, of subdivision (a) of Section 14105.98, shall receive Medi-Cal disproportionate share hospital replacement payment adjustments pursuant to Section 14166.11~~.~~ *and other provisions of this chapter*. The payment adjustments so provided shall satisfy the state's payment obligations, if any, with respect to those hospitals under Section 1396r-4 of Title 42 of the United States Code. The federal share of these payments shall not be claimed from the federal disproportionate share hospital allotment described in subdivision (c).

(e) The nonfederal share of payments described in subdivisions (c) and (d) shall be derived from the following sources:

(1) With respect to the payments described in paragraph (1) of subdivision (c) that are made to designated public hospitals, the nonfederal share shall consist of certified public expenditures described in subparagraphs (A) and (C) of paragraph (2) of subdivision (a) of Section 14166.9, and intergovernmental transfer amounts described in paragraph (2) of subdivision (d) of Section 14166.6.

(2) With respect to the payments described in paragraph (1) of subdivision (c) that are made to nondesignated public hospitals, the nonfederal share shall consist solely of state General Fund appropriations.

(3) With respect to the payments described in subdivision (d), the nonfederal share shall consist of state General Fund appropriations.

(f) (1) During the ~~term~~ *terms* of the demonstration project *and successor demonstration project*, for the ~~2005-06~~ *2005–06* state fiscal year and any subsequent state fiscal years, no public entity shall be obligated to make any intergovernmental transfer pursuant to Section 14163, and all transfer amount determinations for those state fiscal years shall be suspended. However, during the demonstration project ~~term~~ *and successor demonstration project terms*, intergovernmental transfers shall be made with respect to the disproportionate share hospital payment adjustments made in accordance with paragraph (2) of subdivision (d) of Section 14166.6, *or paragraph (2) of subdivision (d) of Section 14166.61, as applicable*.

(2) During the ~~term~~ *terms* of the demonstration project *and successor demonstration project*, for the ~~2005-06~~ *2005–06* state fiscal year and any subsequent state fiscal years, transfer amounts from the Medi-Cal Inpatient Payment Adjustment Fund to the Health Care Deposit Fund, as provided for pursuant to paragraph (2) of subdivision (d) of Section 14163, are hereby reduced to zero. Unless otherwise specified in this article, this paragraph shall be disregarded for purposes of the calculations made under Section 14105.98 during the demonstration project *and successor demonstration project*.

SEC. 4. Section 14166.35 of the Welfare and Institutions Code is amended to read:

14166.35. (a) For each project year through October 31, 2010, designated public hospitals shall be eligible to receive the following:

(1) Payments for Medi-Cal inpatient hospital services and supplemental payments for physician and nonphysician practitioner services, as specified in Section 14166.4.

(2) Disproportionate share hospital payment adjustments, as specified in Section 14166.6.

(3) Safety net care pool funding, as specified in Section 14166.7.

(4) Stabilization funding, as specified in Section 14166.75.

(5) Grants to distressed hospitals as negotiated by the California Medical Assistance Commission pursuant to Section 14166.23.

(b) For each successor demonstration year, designated public hospitals shall be eligible to receive the following:

(1) Payments for Medi-Cal inpatient hospital services and supplemental payments for physician and nonphysician practitioner services, as specified in Section 14166.4.

(2) Disproportionate share hospital payment adjustments, as specified in Section 14166.61.

(3) Safety net care pool funding, as specified in Section 14166.71.

(4) Delivery system reform incentive pool payments, as specified in Section 14166.77.

(5) Grants to distressed hospitals as negotiated by the California Medical Assistance Commission to the extent the funding is available pursuant to Section 14166.23 or any other provisions of this article.

(c) Payments under this section shall be in addition to other payments that may be made in accordance with law.

SEC. 5. Section 14166.4 of the Welfare and Institutions Code is amended to read:

14166.4. (a) Notwithstanding Article 2.6 (commencing with Section 14081), and any other provision of law, fee-for-service payments to the designated public hospitals for inpatient services to Medi-Cal beneficiaries shall be governed by this section. Each of the designated public hospitals shall receive as payment for inpatient hospital services provided to Medi-Cal beneficiaries during any project year or successor demonstration year, the hospital's allowable costs incurred in providing those services, multiplied by the federal medical assistance percentage. These

costs shall be determined, certified, and claimed in accordance with Sections 14166.8 and 14166.9. All Medicaid federal financial participation received by the state for the certified public expenditures of the hospital, or the governmental entity with which the hospital is affiliated, for inpatient hospital services rendered to Medi-Cal beneficiaries shall be paid to the hospital.

(b) With respect to each project year and successor demonstration year, each of the designated public hospitals shall receive an interim payment for each day of inpatient hospital services rendered to Medi-Cal beneficiaries based upon claims filed by the hospital in accordance with the claiming process set forth in Division 3 (commencing with Section 50000) of Title 22 of the California Code of Regulations. The interim per diem payment amount shall be based on estimated costs, which shall be derived from statistical data from the following sources and which shall be multiplied by the federal medical assistance percentage:

(1) For allowable costs reflected in the Medicare cost report, the cost report most recently audited by the hospital's Medicare fiscal intermediary adjusted by a trend factor to reflect increased costs, as approved by the federal Centers for Medicare and Medicaid Services for the demonstration project.

(2) For allowable costs not reflected in the Medicare cost report, each hospital shall provide hospital-specific cost data requested by the department. The department shall adjust the data by a trend factor as necessary to reflect project year allowable costs.

(c) Until the department commences making payments pursuant to subdivision (b), the department may continue to make fee-for-service, per diem payments to the designated public hospitals, pursuant to the selective provider contracting program in accordance with Article 2.6 (commencing with Section 14081), for services rendered on and after July 1, 2005, for a period of 120 days following the award of this demonstration. Per diem payments shall be adjusted retroactively to the amounts determined under the payment methodology prescribed in this article.

(d) No later than April 1 following the end of the relevant reporting period for the project year or successor demonstration year, the department shall undertake an interim reconciliation of payments made pursuant to subdivisions (a) to (c), inclusive, based on Medicare and other cost and statistical data submitted by the

hospital for the year and shall adjust payments to the hospital accordingly.

(e) (1) The designated public hospitals shall receive supplemental reimbursement for the costs incurred for physician and nonphysician practitioner services provided to Medi-Cal beneficiaries who are patients of the hospital, to the extent that those services are not claimed as inpatient hospital services by the hospital and the costs of those services are not otherwise recognized under subdivision (a).

(2) Expenditures made by the designated public hospital, or a governmental entity with which it is affiliated, for the services identified in paragraph (1) shall be reduced by any payments received pursuant to Article 7 (commencing with Section 51501) of Title 22 of the California Code of Regulations. The remainder shall be certified by the appropriate public official and claimed by the department in accordance with Sections 14166.8 and 14166.9. These expenditures may include any of the following:

(A) Compensation to physicians or nonphysician practitioners pursuant to contracts with the designated public hospital.

(B) Salaries and related costs for employed physicians and nonphysician practitioners.

(C) The costs of interns, residents, and related teaching physician and supervision costs.

(D) Administrative costs associated with the services described in subparagraphs (A) to (C), inclusive, including billing costs.

(3) Designated public hospitals shall receive federal funding based on the expenditures identified and certified in paragraph (2). All federal financial participation received by the department for the certified public expenditures identified in paragraph (2) shall be paid to the designated public hospital, or a governmental entity with which it is affiliated.

(4) To the extent that the supplemental reimbursement received under this subdivision relates to services provided to hospital inpatients, the reimbursement shall be applied in determining whether the designated public hospital has received full baseline payments for purposes of paragraph (1) of subdivision (b) of Section 14166.21.

(5) Supplemental reimbursement under this subdivision may be distributed as part of the interim payments under subdivision

(b), on a per-visit basis, on a per-procedure basis, or on any other federally permissible basis.

(6) The department shall submit for federal approval, by September 30, 2005, a proposed amendment to the Medi-Cal state plan to implement this subdivision, retroactive to July 1, 2005, to the extent permitted by the federal Centers for Medicare and Medicaid Services. If necessary to obtain federal approval, the department may limit the application of this subdivision to costs determined allowable by the federal Centers for Medicare and Medicaid Services. If federal approval is not obtained, this subdivision shall not be implemented.

SEC. 6. Section 14166.5 of the Welfare and Institutions Code is amended to read:

14166.5. (a) With respect to each project year through October 31, 2010, the director shall determine a baseline funding amount for each designated public hospital. A hospital's baseline funding amount shall be an amount equal to the total amount paid to the hospital for inpatient hospital services rendered to Medi-Cal beneficiaries during the 2004–05 fiscal year, including the following Medi-Cal payments, but excluding payments received under the Medi-Cal Specialty Mental Health Services Consolidation Program:

(1) Base payments under the selective provider contracting program as provided for under Article 2.6 (commencing with Section 14081).

(2) Emergency Services and Supplemental Payments Fund payments as provided for under Section 14085.6.

(3) Medi-Cal Medical Education Supplemental Payment Fund payments and Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund payments as provided for under Sections 14085.7 and 14085.8, respectively.

(4) Disproportionate share hospital payment adjustments as provided for under Section 14105.98.

(5) Administrative day payments as provided for under Section 51542 of Title 22 of the California Code of Regulations.

(b) The baseline funding amount for each designated public hospital shall reflect a reduction for the total amount of intergovernmental transfers made pursuant to Sections 14085.6, 14085.7, 14085.8, 14085.9, and 14163 for the 2004–05 state fiscal

year by the designated public hospital, or the governmental entity with which it is affiliated.

(c) With respect to each project year beginning after the 2005–06 project year through October 31, 2010, the department shall determine an adjusted baseline funding amount for each designated public hospital to reflect any increase or decrease in volume. The adjustment for designated public hospitals shall be calculated as follows:

(1) Applying the cost-finding methodology approved under the demonstration project, and applying accounting and reporting practices consistent with those applied in paragraph (2), the department shall determine the total allowable costs incurred by the hospital, or the governmental entity with which it is affiliated, in rendering hospital services that would be recognized under the demonstration project to Medi-Cal beneficiaries and the uninsured during the 2004–05 state fiscal year.

(2) Applying the cost-finding methodology approved under the demonstration project, and applying accounting and reporting practices consistent with those applied in paragraph (1), the department shall determine the total allowable costs incurred by the hospital, or the governmental entity with which it is affiliated, in rendering hospital services under the demonstration project to Medi-Cal beneficiaries and the uninsured during the state fiscal year preceding the project year for which the volume adjustment is being calculated.

(3) The department shall:

(A) Calculate the difference between the amount determined under paragraph (1) and the amount determined under paragraph (2).

(B) Determine the percentage increase or decrease by dividing the difference in subparagraph (A) by the amount in paragraph (1).

(C) Apply the percentage determined in subparagraph (B) to that amount that results from the hospital's baseline funding amount determined under subdivision (a) as adjusted by subdivision (b), except for the reduction for the amount of intergovernmental transfers made pursuant to Section 14163, minus the amount of disproportionate share hospital payments in paragraph (4) of subdivision (a).

(4) The designated public hospital's adjusted baseline for the project year is the amount determined for the hospital in subdivision (a) as adjusted by subdivision (b), plus the amount in subparagraph (C) of paragraph (3).

(5) Notwithstanding paragraphs (3) and (4), when, as determined by the department, in consultation with the designated public hospital, there has been a material reduction in patient services at the designated public hospital during the project year, and the reduction has resulted in a diminution of access for Medi-Cal and uninsured patients and a related reduction in total costs at the designated public hospital of at least 20 percent, the department may utilize current or adjusted data that are reflective of the diminution of access, even if the data are not annual data, to determine the hospital's adjusted baseline amount.

(d) The aggregate designated public hospital baseline funding amount for each project year through October 31, 2010, shall be the sum of all baseline funding amounts determined under subdivisions (a) and (b), as adjusted in subdivision (c), as appropriate, for all designated public hospitals.

(e) (1) If, with respect to any project year, the difference between the percentage adjustment in subparagraph (B) of paragraph (3) of subdivision (c) of this section, computed in the aggregate for designated public hospitals, excluding the percentage adjustment for any designated public hospital that was not in operation for the full project year, is greater than five percentage points more than the aggregate percentage adjustment for private DSH hospitals determined under subparagraph (B) of paragraph (3) of subdivision (c) of Section 14166.13, then the aggregate percentage adjustment for designated public hospitals shall be reduced in the amount necessary to reduce the difference to five percentage points. The reduction required by the previous sentence shall be allocated among designated public hospitals pro rata based on the relationship between each hospital's percentage determined under subparagraph (B) of paragraph (3) of subdivision (c) of this section and the aggregate percentage for designated public hospitals.

(2) Notwithstanding paragraph (1), the department may apply the adjustments set forth in paragraph (5) of subdivision (c).

(f) The provisions of this section shall apply only with respect to the demonstration project term, and shall not apply with respect

to the successor demonstration project term. All references to baseline funding amounts and adjusted baseline funding amounts with respect to designated public hospitals shall be disregarded for purposes of successor demonstration year determinations.

SEC. 7. Section 14166.6 of the Welfare and Institutions Code is amended to read:

14166.6. (a) For the 2005–06 project year and subsequent project years through October 31, 2010, each designated public hospital described in subdivision (c) of Section 14166.3 shall be eligible to receive an allocation of federal Medicaid funding from the applicable federal disproportionate share hospital allotment pursuant to this section. The department shall establish the allocations in a manner that maximizes federal Medicaid funding to the state during the term of the demonstration project, and shall consider, at a minimum, all of the following factors, taking into account all other payments to each hospital under this article:

(1) The optimal use of intergovernmental transfer-funded payments described in subdivision (d).

(2) Each hospital's pro rata share of the applicable aggregate designated public hospital baseline funding amount described in subdivision (d) of Section 14166.5.

(3) That the allocation under this section, in combination with the federal share of certified public expenditures for Medicaid inpatient hospital services for the project year determined under subdivision (a) of Section 14166.4, any supplemental reimbursement for professional services rendered to hospital inpatients determined for the project year under subdivision (e) of Section 14166.4, and the distribution of safety net care pool funds from the Health Care Support Fund determined under subdivision (a) of Section 14166.7, shall not exceed the baseline funding amount or adjusted baseline funding amount, as appropriate, for the hospital.

(4) Minimizing the need to redistribute federal funds that are based on the certified public expenditures of designated public hospitals as described in subdivision (c).

(b) Each designated public hospital shall receive its allocation of federal disproportionate share hospital payments in one or both of the following forms:

(1) Distributions from the Demonstration Disproportionate Share Hospital Fund established pursuant to subdivision (d) of Section

14166.9, consisting of federal funds claimed and received by the department, pursuant to subparagraphs (A) and (C) of paragraph (2) of subdivision (a) of Section 14166.9 based on designated public hospitals' certified public expenditures up to 100 percent of uncompensated Medi-Cal and uninsured costs.

(2) Intergovernmental transfer-funded payments, as described in subdivision (d). For purposes of determining whether the hospital has received its allocation of federal disproportionate share hospital payments established under this section, only the federal share of intergovernmental transfer-funded payments shall be considered.

(c) The distributions described in paragraph (1) of subdivision (b) may be made to a designated public hospital independent of the amount of uncompensated Medi-Cal and uninsured costs certified as public expenditures by that hospital pursuant to Section 14166.8, provided that, in accordance with the Special Terms and Conditions for the demonstration project, the recipient hospital does not return any portion of the funds received to any unit of government, excluding amounts recovered by the state or federal government.

(d) Designated public hospitals that meet the requirement of Section 1396r-4(b)(1)(A) of Title 42 of the United States Code regarding the Medicaid inpatient utilization rate or Section 1396r-4(b)(1)(B) of Title 42 of the United States Code regarding the low-income utilization rate, may receive intergovernmental transfer-funded disproportionate share hospital payments as follows:

(1) The department shall establish the amount of the hospital's intergovernmental transfer-funded disproportionate share hospital payment. The total amount of that payment, consisting of the federal and nonfederal components, shall in no case exceed that amount equal to 75 percent of the hospital's uncompensated Medi-Cal and uninsured costs of hospital services, determined in accordance with the Special Terms and Conditions for the demonstration project.

(2) A transfer amount shall be determined for each hospital that is subject to this subdivision, equal to the nonfederal share of the payment amount established for the hospital pursuant to paragraph (1). The transfer amount so determined shall be paid by the hospital, or the public entity with which the hospital is affiliated, and deposited into the Medi-Cal Inpatient Payment Adjustment

Fund established pursuant to subdivision (b) of Section 14163. The sources of funds utilized for the transfer amount shall not include impermissible provider taxes or donations as defined under Section 1396b(w) of Title 42 of the United States Code or other federal funds. For this purpose, federal funds do not include patient care revenue received as payment for services rendered under programs such as Medicare or Medicaid.

(3) The department shall pay the amounts established pursuant to paragraph (1) to each hospital using the transfer amounts deposited pursuant to paragraph (2) as the nonfederal share of those payments. The total intergovernmental transfer-funded payment amount, consisting of the federal and nonfederal share, paid to a hospital shall be retained by the hospital in accordance with the Special Terms and Conditions for the demonstration project.

(e) The total federal disproportionate share hospital funds allocated under this section to designated public hospitals with respect to each project year, in combination with the federal share of disproportionate share hospital payment adjustments made to nondesignated public hospitals pursuant to Section 14166.16 for the same project year, shall not exceed the applicable federal disproportionate share hospital allotment.

(f) (1) Each designated public hospital shall receive quarterly interim payments of its disproportionate share hospital allocation during the project year. The determinations set forth in subdivisions (a) to (e), inclusive, shall be made on an interim basis prior to the start of each project year, except that, with respect to the 2005–06 project year, the interim determinations shall be made prior to January 1, 2006. The department shall use the same cost and statistical data used in determining the interim payments for Medi-Cal inpatient hospital services under Section 14166.4, and available payments and uncompensated and uninsured cost data, including data from the Medi-Cal paid claims file and the hospital's books and records, for the corresponding period.

(2) Prior to the distribution of payments in accordance with paragraph (1) and with subdivision (g) to a designated public hospital that is part of a hospital system containing multiple designated public hospitals licensed to the same governmental entity, the department shall consult with the applicable governmental entity. The department shall implement any

adjustments to the payment distributions for the hospitals in that hospital system as requested by the governmental entity if the net effect of the requested adjustments for those hospitals is zero. These payment redistributions shall recognize the level of care provided to Medi-Cal and uninsured patients and shall maintain the viability and effectiveness of the hospital system. The adjustments made pursuant to this paragraph with respect to an affected hospital shall be disregarded in the application of the limitations described in paragraph (3) of subdivision (a), and in paragraph (1) of subdivision (a) of Section 14166.7.

(g) No later than April 1 following the end of the relevant reporting period for the project year, the department shall undertake an interim reconciliation of payments based on Medicare and other cost, payment, and statistical data submitted by the hospital for the project year, and shall adjust payments to the hospital accordingly.

(h) Each designated public hospital shall receive its disproportionate share hospital allocation, as computed pursuant to subdivisions (a) to (e), inclusive, subject to final audits of all applicable Medicare and other cost, payment, and statistical data for the project year.

(i) The provisions of this section shall apply only with respect to the demonstration project term, and shall not apply with respect to the successor demonstration project term.

SEC. 8. Section 14166.61 is added to the Welfare and Institutions Code, to read:

14166.61. (a) For successor demonstration year 6 and subsequent successor demonstration years, each designated public hospital described in subdivision (c) of Section 14166.3 shall be eligible to receive an allocation of federal Medicaid funding from the applicable federal disproportionate share hospital allotment pursuant to this section. The department shall establish the allocations and claim the federal funding in a manner that maximizes federal Medicaid funding to the state during the term of the successor demonstration project, and shall consider, at a minimum, all of the following factors:

(1) The optimal use of intergovernmental transfer-funded payments described in subdivision (d).

(2) Minimizing the need to redistribute federal funds that are based on the certified public expenditures of designated public hospitals as described in paragraph (1) of subdivision (c).

(b) Disproportionate share hospital allocations for designated public hospitals shall be determined for each successor demonstration year as set forth below. With respect to successor demonstration year 10, allocations shall be determined separately for each of the periods of July 1, 2014, through June 30, 2015, and July 1, 2015 through October 31, 2015.

(1) The department shall determine the maximum federal disproportionate share hospital allotment that is available under this section for the successor demonstration year.

(2) An initial allocation shall be made to Kern Medical Center for the periods and in the amounts specified below:

(A) For successor demonstration year 6, the amount of eight million dollars ($8,000,000).

(B) For successor demonstration years 7 through 9, the amount of twelve million dollars ($12,000,000).

(C) For the period of July 1, 2014, through June 30, 2015, the amount of twelve million dollars ($12,000,000);

(D) For the period of July 1, 2015, through October 31, 2015, the amount of four million dollars ($4,000,000).

(3) Each designated public hospital shall be allocated an amount per hospital discharge as specified in this paragraph. The number of discharges per category occurring in the relevant period shall be derived from each hospital's data as reported pursuant to Section 14166.8. The reported discharges shall relate to the same hospital services for which costs are calculated for purposes of this section.

(A) One thousand one hundred dollars ($1,100) per hospital discharge with respect to an uninsured individual.

(B) Nine hundred dollars ($900) per hospital discharge with respect to an individual enrolled in the Low Income Health Program.

(C) Seven hundred fifty dollars ($750) per hospital discharge with respect to a Medi-Cal beneficiary, excluding discharges for which Medicare payments were received.

(4) The remaining available federal disproportionate share hospital allotment, after the allocations are made pursuant to paragraphs (2) and (3), shall be allocated to designated public hospitals as follows:

(A) The department shall calculate for each designated public hospital an initial DSH claiming ability amount. For the purposes of this article, the "initial DSH claiming ability amount" means the total sum of the hospital's uncompensated Medi-Cal, Low Income Health Program, and uninsured costs of hospital services that are reported as eligible certified public expenditures for disproportionate share hospital payments pursuant to Section 14166.8. For hospitals described in subdivision (d), the total sum shall be multiplied by 175 percent.

(B) The remaining available federal disproportionate share hospital allotment shall be allocated pro rata among the designated public hospitals based upon each hospital's initial DSH claiming ability amount as determined pursuant to subparagraph (A).

(c) Each designated public hospital shall receive its allocation of federal disproportionate share hospital payments in one or both of the following forms:

(1) Distributions from the Demonstration Disproportionate Share Hospital Fund established pursuant to subdivision (d) of Section 14166.9, consisting of federal funds claimed and received by the department, pursuant to clauses (ii) and (iii) of subparagraph (A) paragraph (2) of subdivision (a) of Section 14166.9 based on designated public hospitals' certified public expenditures up to 100 percent of uncompensated Medi-Cal and uninsured costs. These distributions may be made to a designated public hospital independent of the amount of uncompensated Medi-Cal and uninsured costs certified as public expenditures by that hospital pursuant to Section 14166.8.

(2) Intergovernmental transfer-funded payments, as described in subdivision (d). For purposes of determining whether the hospital has received its allocation of federal disproportionate share hospital payments established under this section, only the federal share of intergovernmental transfer-funded payments shall be considered.

(d) Designated public hospitals that meet the requirements of Section 1396r-4(b)(1)(A) of Title 42 of the United States Code regarding the Medicaid inpatient utilization rate or Section 1396r-4 (b)(1)(B) of Title 42 of the United States Code regarding the low-income utilization rate, may receive intergovernmental transfer-funded disproportionate share hospital payments as follows:

(1) The department shall establish the amount of the hospital's intergovernmental transfer-funded disproportionate share hospital payment. The total amount of that payment, consisting of the federal and nonfederal components, shall in no case exceed an amount equal to 75 percent of the hospital's uncompensated Medi-Cal, Low Income Health Program, and uninsured costs of hospital services, determined in accordance with the Special Terms and Conditions for the successor demonstration project and the applicable provisions of the Medi-Cal State Plan.

(2) A transfer amount shall be determined for each hospital that is subject to this subdivision, equal to the nonfederal share of the payment amount established for the hospital pursuant to paragraph (1). The transfer amount determined shall be paid by the hospital, or the public entity with which the hospital is affiliated, and deposited into the Medi-Cal Inpatient Payment Adjustment Fund established pursuant to subdivision (b) of Section 14163. The sources of funds utilized for the transfer amount shall not include impermissible provider taxes or donations as defined under Section 1396b(w) of Title 42 of the United States Code or other federal funds. For this purpose, federal funds do not include delivery system reform incentive pool payments or patient care revenue received as payment for services rendered under programs such as designated state health programs, the Low Income Health Program, Medicare, or Medicaid.

(3) The department shall pay the amounts established pursuant to paragraph (1) to each hospital using the transfer amounts deposited pursuant to paragraph (2) as the nonfederal share of those payments.

(e) The total federal disproportionate share hospital funds allocated under this section to designated public hospitals with respect to each successor demonstration year, in combination with the federal share of disproportionate share hospital payment adjustments made to nondesignated public hospitals pursuant to Section 14166.16 and applicable provisions of the Medi-Cal State Plan for the same successor demonstration year, shall not exceed the applicable federal disproportionate share hospital allotment.

(f) (1) Each designated public hospital shall receive quarterly interim payments of its disproportionate share hospital allocation during the successor demonstration year, except that, with respect to the period of July 1, 2015, through October 31, 2015, the interim

payment shall be made in October 2015. The determinations set forth in subdivisions (a) to (e), inclusive, shall be made on an interim basis prior to the start of each successor demonstration year. The department shall use the same cost and statistical data used in determining the interim payments for Medi-Cal inpatient hospital services under Section 14166.4, and available payments and uncompensated and uninsured cost data, including data from the Medi-Cal paid claims file and the hospital's books and records, for the corresponding period.

(2) Prior to the distribution of payments in accordance with paragraph (1) and subdivisions (g) and (h) to a designated public hospital that is part of a hospital system containing multiple designated public hospitals licensed to the same governmental entity, the department shall consult with the applicable governmental entity. The department shall implement any adjustments to the payment distributions for the hospitals in that hospital system as requested by the governmental entity if the net effect of the requested adjustments for those hospitals is zero. These payment redistributions shall recognize the level of care provided to Medi-Cal and uninsured patients and shall maintain the viability and effectiveness of the hospital system.

(g) No later than April 1 following the end of the relevant reporting period for the successor demonstration year, the department shall undertake an interim reconciliation of payments based on Medicare and other cost, payment, discharge, and statistical data submitted by the hospital for the successor demonstration year, and shall adjust payments to the hospital accordingly.

(h) Each designated public hospital shall receive its disproportionate share hospital allocation, as computed pursuant to subdivisions (a) to (e), inclusive, subject to final audits of all applicable Medicare and other cost, payment, discharge, and statistical data for the successor demonstration year.

SEC. 9. Section 14166.7 of the Welfare and Institutions Code is amended to read:

14166.7. (a) (1) With respect to each project year through October 31, 2010, designated public hospitals, or governmental entities with which they are affiliated, shall be eligible to receive safety net care pool payments from the Health Care Support Fund established pursuant to Section 14166.21. The total amount of

these payments, in combination with the federal share of certified public expenditures for Medicaid inpatient hospital services determined for the project year under subdivision (a) of Section 14166.4, any supplemental reimbursement for physician and nonphysician practitioner services rendered to hospital inpatients determined for the project year under subdivision (e) of Section 14166.4, and the federal disproportionate share hospital allocation determined under Section 14166.6, shall not exceed the hospital's baseline funding amount or adjusted baseline funding amount, as appropriate.

(2) The department shall establish the amount of the safety net care pool payment described in paragraph (1) for each designated public hospital in a manner that maximizes federal Medicaid funding to the state during the term of the demonstration project.

(3) A safety net care pool payment amount may be paid to a designated public hospital, or governmental entity with which it is affiliated, pursuant to this section independent of the amount of uncompensated Medi-Cal and uninsured costs that is certified as public expenditures pursuant to Section 14166.8, provided that, in accordance with the Special Terms and Conditions for the demonstration project, the recipient hospital does not return any portion of the funds received to any unit of government, excluding amounts recovered by the state or federal government.

(4) In establishing the amount to be paid to each designated public hospital under this subdivision, the department shall minimize to the extent possible the redistribution of federal funds that are based on certified public expenditures as described in paragraph (3).

(b) (1) Each designated public hospital, or governmental entity with which it is affiliated, shall receive the amount established pursuant to subdivision (a) in quarterly interim payments during the project year. The determination of the interim payments shall be made on an interim basis prior to the start of each project year, except that, with respect to the 2005–06 project year, the determination of the interim payments shall be made prior to January 1, 2006. The department shall use the same cost and statistical data that is used in determining the interim payments for Medi-Cal inpatient hospital services under Section 14166.4 and for the disproportionate share hospital allocations under Section 14166.6, for the corresponding period.

(2) Prior to the distribution of payments in accordance with paragraph (1) and with subdivision (c) to a designated public hospital that is part of a hospital system containing multiple designated public hospitals licensed to the same governmental entity, the department shall consult with the applicable governmental entity. The department shall implement any adjustments to the payment distributions for the hospitals in that hospital system as requested by the governmental entity if the net effect of the requested adjustments for those hospitals is zero. These payment redistributions shall recognize the level of care provided to Medi-Cal and uninsured patients and shall maintain the viability and effectiveness of the hospital system. The adjustments made pursuant to this paragraph with respect to an affected hospital shall be disregarded in the application of the limitations described in paragraph (1) of subdivision (a), and in paragraph (3) of subdivision (a) of Section 14166.6.

(c) (1) No later than April 1 following the end of the project year, the department shall undertake an interim reconciliation of the payment amount established pursuant to subdivision (a) for each designated public hospital using Medicare and other cost, payment, and statistical data submitted by the hospital for the project year, and shall adjust payments to the hospital accordingly.

(2) The final payment to a designated public hospital for purposes of subdivision (b) and paragraph (1) of this subdivision, shall be subject to final audits of all applicable Medicare and other cost, payment, and statistical data for the project year, and the distribution priorities set forth in Section 14166.20.

(d) (1) Each designated public hospital, or governmental entity with which it is affiliated, shall be eligible to receive additional safety net care pool payments above the baseline funding amount or adjusted baseline funding amount, as appropriate, from the Health Care Support Fund, established pursuant to Section 14166.21, for the project year through October 31, 2010, in accordance with the stabilization funding determination for the hospital made pursuant to Section 14166.75.

(2) Payment of the additional safety net care pool amounts shall be subject to the distribution priorities set forth in Section 14166.21.

(3) The provisions of this section shall apply only with respect to the demonstration project term, and shall not apply with respect to the successor demonstration project term.

SEC. 10. Section 14166.71 is added to the Welfare and Institutions Code, to read:

14166.71. (a) (1) With respect to each successor demonstration year, designated public hospitals, or governmental entities with which they are affiliated, shall be eligible to receive safety net care pool payments for uncompensated care from the Health Care Support Fund established pursuant to Section 14166.21. Safety net care pool payments for uncompensated care shall be allocated to designated public hospitals as follows:

(A) The department shall determine the maximum amount of safety net pool payments for uncompensated care that is available to designated public hospitals for the successor demonstration year.

(B) The department shall calculate for each designated public hospital an initial SNCP claiming ability amount. For the purposes of this article, "initial SNCP claiming ability amount" means the total sum of the uncompensated Medi-Cal, Low Income Health Program, and uninsured costs of services incurred by the designated public hospital, the governmental entity, nonhospital clinics, and other provider types with which it is affiliated, that are reported as eligible certified public expenditures for safety net care pool uncompensated care claiming pursuant to Section 14166.8.

(C) The available safety net pool payments shall be allocated pro rata among the designated public hospitals based upon each hospital's initial SNCP claiming ability amount as determined pursuant to subparagraph (B).

(2) The department shall establish the amount of the safety net care pool payment described in paragraph (1) for each designated public hospital in a manner that maximizes federal Medicaid funding to the state during the term of the successor demonstration project.

(3) A safety net care pool payment amount may be paid to a designated public hospital, or governmental entity with which it is affiliated, pursuant to this section independent of the amount of uncompensated Medi-Cal and uninsured costs that is certified as public expenditures pursuant to Section 14166.8, provided that, in accordance with the Special Terms and Conditions for the

successor demonstration project, the recipient hospital does not return any portion of the funds received to any unit of government, excluding amounts recovered by the state or federal government.

(4) In establishing the amount to be paid to each designated public hospital under this subdivision, the department shall minimize to the extent possible the redistribution of federal funds that are based on certified public expenditures as described in paragraph (3).

(b) (1) Each designated public hospital, or governmental entity with which it is affiliated, shall receive the amount established pursuant to subdivision (a) in quarterly interim payments during the successor demonstration year. The determination of the interim payments shall be made on an interim basis prior to the start of each successor demonstration year. The department shall use the same cost and statistical data that is used in determining the interim payments for Medi-Cal inpatient hospital services under Section 14166.4 and for the disproportionate share hospital allocations under Section 14166.61, for the corresponding period.

(2) Prior to the distribution of payments in accordance with paragraph (1) and subdivision (c) to a designated public hospital that is part of a hospital system containing multiple designated public hospitals licensed to the same governmental entity, the department shall consult with the applicable governmental entity. The department shall implement any adjustments to the payment distributions for the hospitals in that hospital system as requested by the governmental entity if the net effect of the requested adjustments for those hospitals is zero. These payment redistributions shall recognize the level of care provided to Medi-Cal and uninsured patients and shall maintain the viability and effectiveness of the hospital system.

(c) (1) No later than April 1 following the end of the relevant reporting period for the successor demonstration year, the department shall undertake an interim reconciliation of the payment amount established pursuant to subdivision (a) for each designated public hospital using Medicare and other cost, payment, and statistical data submitted by the hospital for the successor demonstration year, and shall adjust payments to the hospital accordingly.

(2) The final payment to a designated public hospital for purposes of subdivision (b) and paragraph (1) of this subdivision,

shall be subject to final audits of all applicable Medicare and other cost, payment, discharge, and statistical data for the successor demonstration year.

SEC. 11. Section 14166.75 of the Welfare and Institutions Code is amended to read:

14166.75. (a) For services provided during the 2005–06 and 2006–07 project years, the amount allocated to designated public hospitals pursuant to subparagraph (A) of paragraph (2) and subparagraph (A) of paragraph (5) of subdivision (b) of Section 14166.20 shall be allocated, in accordance with this section, among the designated public hospitals. For services provided during the 2007–08, 2008–09, and 2009–10 project years through October 31, 2010, amounts allocated to designated public hospitals as stabilization funding pursuant to any provision of this article, unless otherwise specified, shall be allocated among the designated public hospitals in accordance with this section. All amounts allocated to designated public hospitals in accordance with this section shall be paid as direct grants, which shall not constitute Medi-Cal payments.

(b) The baseline funding amount, as determined under Section 14166.5, for San Mateo Medical Center shall be increased by eight million dollars ($8,000,000) for purposes of this section.

(c) The following payments shall be made from the amount identified in subdivision (a), in addition to any other payments due to the University of California hospitals and health system and County of Los Angeles hospitals under this section:

(1) The lower of eleven million dollars ($11,000,000) or 3.67 percent of the amount identified in subdivision (a) to the University of California hospitals and health system.

(2) For each of the 2005–06 and 2006–07 project years, in the event that the one hundred eighty million dollars ($180,000,000) identified in paragraph 41 of the Special Terms and Conditions for the demonstration project is available in the safety net care pool for the project year, the lower of twenty-three million dollars ($23,000,000) or 7.67 percent of the amount identified in subdivision (a) to the County of Los Angeles, Department of Health Services, hospitals. If an amount less than the one hundred eighty million dollars ($180,000,000) is available during the project year, the amount determined under this paragraph shall be reduced proportionately.

(d) For the 2005–06 and 2006–07 project years, the amount identified in subdivision (a), as reduced by the amounts identified in subdivision (c), shall be distributed among the designated public hospitals pursuant to this subdivision.

(1) Designated public hospitals that are donor hospitals, and their associated donated certified public expenditures, shall be identified as follows:

(A) An initial pro rata allocation of the amount subject to this subdivision shall be made to each designated public hospital, based upon the hospital's baseline funding amount determined pursuant to Section 14166.5, and as further adjusted in subdivision (b). This initial allocation shall be used for purposes of the calculations under subparagraph (C) and paragraph (3).

(B) The federal financial participation amount arising from the certified public expenditures of each designated public hospital, including the expenditures of the governmental entity, nonhospital clinics, and other provider types with which it is affiliated, that were claimed by the department from the federal disproportionate share hospital allotment pursuant to subparagraphs (A) and (C) of paragraph (2) of subdivision (a) of Section 14166.9, and from the safety net care pool funds pursuant to paragraph (3) of subdivision (a) of Section 14166.9, shall be determined.

(C) The amount of federal financial participation received by each designated public hospital, and by the governmental entity, nonhospital clinics, and other provider types with which it is affiliated, based on certified public expenditures from the federal disproportionate share hospital allotment pursuant to paragraph (1) of subdivision (b) of Section 14166.6, and from the safety net care pool payments pursuant to subdivision (a) of Section 14166.7 shall be identified. With respect to this identification, if a payment adjustment for a hospital has been made pursuant to paragraph (2) of subdivision (f) of Section 14166.6, or paragraph (2) of subdivision (b) of Section 14166.7, the amount of federal financial participation received by the hospital based on certified public expenditures shall be determined as though no such payment adjustment had been made. The resulting amount shall be increased by amounts distributed to the hospital pursuant to subdivision (c) of this section, paragraph (1) of subdivision (b) of Section 14166.20, and the initial allocation determined for the hospitals in subparagraph (A).

(D) If the amount in subparagraph (B) is greater than the amount determined in subparagraph (C), the hospital is a donor hospital, and the difference between the two amounts is deemed to be that donor hospital's associated donated certified public expenditures amount.

(2) Seventy percent of the total amount subject to this subdivision shall be allocated pro rata among the designated public hospitals based upon each hospital's baseline funding amount determined pursuant to Section 14166.5, and as further adjusted in subdivision (b).

(3) The lesser of the remaining 30 percent of the total amount subject to this subdivision or the total amounts of donated certified public expenditures for all donor hospitals, shall be distributed pro rata among the donor hospitals based upon the donated certified public expenditures amount determined for each donor hospital. Any amounts not distributed pursuant to this paragraph shall be distributed in the same manner as set forth in paragraph (2).

(e) For the 2007–08 and subsequent project years through October 31, 2010, the amount identified in subdivision (a), as reduced by the amounts identified in subdivision (c), shall be distributed among the designated public hospitals pursuant to this subdivision.

(1) Each designated public hospital that renders inpatient hospital services under the health care coverage initiative program authorized pursuant to Part 3.5 (commencing with Section 15900) shall be allocated an amount equal to the amount of the federal safety net pool funds claimed and received with respect to the services rendered by the hospital, including services rendered to enrollees of a managed care organization, to the extent the amount was included in the determination of total stabilization funding for the project year pursuant to Section 14166.20.

(2) Each designated public hospital for which, during the project year, the sum of the allowable costs incurred in rendering inpatient hospital services to Medi-Cal beneficiaries and the allowable costs incurred with respect to supplemental reimbursement for physician and nonphysician practitioner services rendered to Medi-Cal hospital inpatients, as specified in Section 14166.4, exceeds the allowable costs incurred for those services rendered in the prior year, shall be allocated an amount equal to 60 percent of the difference in the allowable costs, multiplied by the applicable

federal medical assistance percentage. The allocations under this paragraph, however, shall be reduced pro rata as necessary to ensure that the total of those allocations does not exceed 80 percent of the amount subject to this subdivision after the allocations in paragraph (1). For purposes of this paragraph, the most recent cost data that are available at the time of the department's determinations for the project year pursuant to Section 14166.20 shall be used.

(3) The remaining amount subject to this subdivision that is not otherwise allocated pursuant to paragraphs (1) and (2) shall be allocated as set forth below:

(A) Designated public hospitals that are donor hospitals, and their associated donated certified public expenditures, shall be identified as follows:

(i) An initial pro rata allocation of the amount subject to this paragraph shall be made to each designated public hospital, based upon the total allowable costs incurred by each hospital, or governmental entity with which it is affiliated, in rendering hospital services to the uninsured during the project year as reported pursuant to Section 14166.8. This initial allocation shall be used for purposes of the calculations under clause (iii) and subparagraph (C).

(ii) The federal financial participation amount arising from the certified public expenditures of each designated public hospital, including the expenditures of the governmental entity, nonhospital clinics, and other provider types with which it is affiliated, that were claimed by the department from the federal disproportionate share hospital allotment pursuant to subparagraphs (A) and (C) of paragraph (2) of subdivision (a) of Section 14166.9, and from the safety net care pool funds pursuant to paragraph (3) of subdivision (a) of Section 14166.9, shall be determined.

(iii) The amount of federal financial participation received by each designated public hospital, and by the governmental entity, nonhospital clinics, and other provider types with which it is affiliated, based on certified public expenditures from the federal disproportionate share hospital allotment pursuant to paragraph (1) of subdivision (b) of Section 14166.6, and from the safety net care pool payments pursuant to subdivision (a) of Section 14166.7 shall be identified. With respect to this identification, if a payment adjustment for a hospital has been made pursuant to paragraph (2)

of subdivision (f) of Section 14166.6, or paragraph (2) of subdivision (b) of Section 14166.7, the amount of federal financial participation received by the hospital based on certified public expenditures shall be determined as though no payment adjustment had been made. The resulting amount shall be increased by amounts distributed to the hospital pursuant to subdivision (c), paragraphs (1) and (2) of this subdivision, paragraph (1) of subdivision (b) of Section 14166.20, and the initial allocation determined for the hospitals in clause (i).

(iv) If the amount in clause (ii) is greater than the amount determined in clause (iii), the hospital is a donor hospital, and the difference between the two amounts is deemed to be that donor hospital's associated donated certified public expenditures amount.

(B) Fifty percent of the total amount subject to this paragraph shall be allocated pro rata among the designated public hospitals in the same manner described in clause (i) of subparagraph (A).

(C) The lesser of the remaining 50 percent of the total amount subject to this paragraph, the total amounts of donated certified public expenditures for all donor hospitals or that amount that is 30 percent of the amount subject to this subdivision after the allocations in paragraph (1), shall be distributed pro rata among the donor hospitals based upon the donated certified public expenditures amount determined for each donor hospital. Any amounts not distributed pursuant to this subparagraph shall be distributed in the same manner as set forth in subparagraph (B).

(D) The federal financial participation amount arising from the certified public expenditures that has been paid to designated public hospitals, or the governmental entities with which they are affiliated, pursuant to subdivision (g) of Section 14166.221 shall be disregarded for purposes of this paragraph.

(f) The department shall consult with designated public hospital representatives regarding the appropriate distribution of stabilization funding before stabilization funds are allocated and paid to hospitals. No later than 30 days after this consultation, the department shall issue a final allocation of stabilization funding under this section that shall not be modified for any reason other than mathematical errors or mathematical omissions on the part of the department.

(g) The provisions of this section shall apply only with respect to the demonstration project term, and shall not apply with respect to the successor demonstration project term.

SEC. 12. Section 14166.77 is added to the Welfare and Institutions Code, to read:

14166.77. (a) *(1)* The amount of delivery system reform incentive pool funding, consisting of both the federal and nonfederal share of payments, that is made available to each designated public hospital system in the aggregate for the term of the successor demonstration project shall be based initially on the delivery system reform proposals that are submitted by the designated public hospitals to the department for review and submission to the federal Centers for Medicare and Medicaid Services for final approval. The initial percentages of delivery system reform incentive pool funding among the designated public hospital systems for each successor demonstration year shall be determined based on the annual components as contained in the approved proposals.

~~(b)~~

(2) The actual receipt of funds shall be conditioned on the designated public hospital system's progress towards, and achievement of, the specified milestones and other metrics established in its approved delivery system reform incentive pool proposal. A designated public hospital system may carry forward available incentive pool funding associated with milestones and metrics from one year to a subsequent period as authorized by the Special Terms and Conditions and the final delivery system reform incentive pool protocol.

~~(c)~~

(3) The department may reallocate incentive pool funding under conditions specified, and as authorized by, the Special Terms and Conditions and the final delivery system reform incentive pool protocol.

(b) Each designated public hospital system shall be individually responsible for progress towards, and achievement of, milestones and other metrics in its proposal, as well as other applicable requirements specified in the Special Terms and Conditions and the final delivery system reform incentive pool protocol, in order to receive its specified allocation of incentive pool funding under this section.

(1) The designated public hospital system shall submit semiannual reports and requests for payment to the department by March 31 and the September 30 following the end of the second and fourth quarters of the successor demonstration year, or comply with such other process as approved by the federal Centers for Medicare and Medicaid Services. A standardized report form shall be developed jointly by the department and designated public hospital systems for this purpose.

(2) Within 14 days after the semiannual report due date, the designated public hospital system or its affiliated governmental entity shall make an intergovernmental transfer of funds equal to the nonfederal share that is necessary to draw down the federal funding for the pool payment related to the achievement or progress metric that is certified. The intergovernmental transfers shall be deposited into the Public Hospital Investment, Improvement, and Incentive Fund, established pursuant to Section 14182.4.

(3) The department shall draw down the federal funding and pay both the nonfederal and federal shares of the incentive payment to the designated public hospital system or other affiliated governmental provider as applicable. If the intergovernmental transfer is made within the appropriate 14-day timeframe, the incentive payment shall be disbursed within seven days with the expedited payment process as approved by the federal Centers for Medicare and Medicaid Services, otherwise the payment shall be disbursed within 20 days of when the transfer is made.

(4) Notwithstanding any other provision of this subdivision, payment requests for successor demonstration year 6 shall be submitted, processed, and paid in accordance with the expedited payment process as approved by the federal Centers for Medicare and Medicaid Services.

(5) The designated public hospital system or other affiliated governmental provider is responsible for any fee or cost required to implement the expedited payment process in accordance with Section 8422.1 of the State Administrative Manual.

(c) In the event of a conflict between any provision of this section and the Special Terms and Conditions for the successor demonstration project and the final delivery system reform incentive pool protocol, the Special Terms and Conditions and the final delivery system reform incentive pool protocol shall control.

SEC. 13. Section 14166.8 of the Welfare and Institutions Code is amended to read:

14166.8. (a) Within five months after the end of each project year or successor demonstration year, each of the designated public hospitals shall submit to the department all of the following reports:

(1) The hospital's Medicare cost report for the project year or successor demonstration year.

(2) Other cost reporting and statistical data necessary for the determination of amounts due the hospital under the demonstration project or successor demonstration project, as requested by the department.

(b) For each project year or successor demonstration year, the reports shall identify all of the following:

(1) The costs incurred in providing inpatient hospital services to Medi-Cal beneficiaries on a fee-for-service basis and physician and nonphysician practitioner services costs, as identified in subdivision (e) of Section 14166.4.

(2) The amount of uncompensated costs incurred in providing hospital services to Medi-Cal beneficiaries, including managed care enrollees.

(3) The costs incurred in providing hospital services to uninsured individuals.

(4) (A) Discharge data, commencing with successor demonstration year 6, and retrospectively for prior periods as necessary to establish interim payment determinations, for the following patient categories:

(i) Uninsured patients.

(ii) Low Income Health Program patients.

(iii) Medi-Cal patients, excluding discharges for which Medicare payments were received.

(B) The department shall consult with the designated public hospitals regarding a methodology for adjusting prior period discharge data to reflect the projected number of discharges relating to Low Income Health Program patients for the period at issue.

(c) Each designated public hospital, or governmental entity with which it is affiliated, that operates nonhospital clinics or provides physician, nonphysician practitioner, or other health care services that are not identified as hospital services under the Special Terms and Conditions for the demonstration project and successor demonstration project, may report and certify all, or a portion, of

the uncompensated Medi-Cal and uninsured costs of the services furnished. The amount of these uncompensated costs to be claimed by the department shall be determined by the department in consultation with the governmental entity so as to optimize the level of claimable federal Medicaid funding.

(d) Reports submitted under this section shall include all allowable costs.

(e) The appropriate public official shall certify to all of the following:

(1) The accuracy of the reports required under this section.

(2) That the expenditures to meet the reported costs comply with Section 433.51 of Title 42 of the Code of Federal Regulations.

(3) That the sources of funds used to make the expenditures certified under this section do not include impermissible provider taxes or donations as defined under Section 1396b(w) of Title 42 of the United States Code or other federal funds. For this purpose, federal funds do not include delivery system reform incentive pool payments, patient care revenue received as payment for services rendered under programs such as designated state health programs, the Low Income Health Program, Medicare, or Medicaid.

(f) The certification of public expenditures made pursuant to this section shall be based on a schedule established by the department. The director may require the designated public hospitals to submit quarterly estimates of anticipated expenditures, if these estimates are necessary to obtain interim payments of federal Medicaid funds. All reported expenditures shall be subject to reconciliation to allowable costs, as determined in accordance with applicable implementing documents for the demonstration project and successor demonstration project.

(g) Except as provided in subdivision (c), the director shall seek Medicaid federal financial participation for all certified public expenditures reported by the designated public hospitals and recognized under the demonstration project and successor demonstration project, to the extent consistent with Section 14166.9.

(h) Governmental or public entities other than those that operate a designated public hospital may, at the request of a governmental or public entity, certify uncompensated Medi-Cal and uninsured costs in accordance with this section, subject to the department's

discretion and prior approval of the federal Centers for Medicare and Medicaid Services.

(i) The timeframes for data submission and reporting periods may be adjusted as necessary with respect to the 2010–11 project year through October 31, 2010, and successor demonstration years 6 and 10.

SEC. 14. Section 14166.9 of the Welfare and Institutions Code is amended to read:

14166.9. (a) The department, in consultation with the designated public hospitals, shall determine the mix of sources of federal funds for payments to the designated public hospitals in a manner that provides baseline funding to hospitals as applicable during the demonstration project term and maximizes federal Medicaid funding to the state during the terms of the demonstration project and successor demonstration project.

(1) During the demonstration project term through October 31, 2010, federal funds shall be claimed according to the following priorities:

(A) The certified public expenditures of the designated public hospitals for inpatient hospital services and physician and nonphysician practitioner services, as identified in subdivision (e) of Section 14166.4, rendered to Medi-Cal beneficiaries.

(B) Federal disproportionate share hospital allotment, subject to the federal hospital-specific limit, in the following order:

(i) Those hospital expenditures that are eligible for federal financial participation only from the federal disproportionate share hospital allotment.

(ii) Payments funded with intergovernmental transfers, consistent with the requirements of the demonstration project, up to the hospital's baseline funding amount or adjusted baseline funding amount, as appropriate, for the project year.

(iii) Any other certified public expenditures for hospital services that are eligible for federal financial participation from the federal disproportionate share hospital allotment.

(C) Safety net care pool funds, using the optimal combination of hospital-certified public expenditures and certified public expenditures of a hospital, or governmental entity with which the hospital is affiliated, that operates nonhospital clinics or provides physician, nonphysician practitioner, or other health care services that are not identified as hospital services under the Special Terms

and Conditions for the demonstration project, except that certified public expenditures reported by the County of Los Angeles or its designated public hospitals shall be the exclusive source of certified public expenditures for claiming those federal funds deposited in the South Los Angeles Medical Services Preservation Fund under Section 14166.25.

(D) Health care expenditures of the state that represent alternate state funding mechanisms approved by the federal Centers for Medicare and Medicaid Services under the demonstration project as set forth in Section 14166.22.

(2) During each successor demonstration year, federal funds for payments to the designated public hospitals pursuant to Sections 14166.61 and 14166.71 shall be claimed according to the following priorities:

(A) With respect to the applicable federal disproportionate share hospital allotment, subject to the federal hospital-specific limit, in the following order:

(i) Payments funded with intergovernmental transfers, as determined pursuant to subdivision (d) of Section 14166.61.

(ii) Those hospital expenditures that are eligible for federal financial participation only from the federal disproportionate share hospital allotment.

(iii) Any other certified public expenditures for hospital services that are eligible for federal financial participation from the federal disproportionate share hospital allotment.

(B) With respect to safety net care pool payments for uncompensated care, in the following order:

(i) The certified public expenditures of the designated public hospitals, or the governmental entities with which they are affiliated that operate nonhospital clinics or provide physician, nonphysician practitioner, or other health care services, that are not identified as hospital services under the Special Terms and Conditions for the successor demonstration project and eligible for federal financial participation from the safety net care pool for uncompensated care.

(ii) The available certified public expenditures of designated public hospitals for hospital services that are eligible for federal financial participation from either the federal disproportionate share hospital allotment or safety net care pool for uncompensated

care, that were not otherwise claimed for purposes of subparagraph (A).

(b) The department shall implement these priorities, to the extent possible, in a manner that minimizes the redistribution of federal funds that are based on the certified public expenditures of the designated public hospitals.

(c) The department may adjust the claiming priorities to the extent that these adjustments result in additional federal medicaid funding during the term of the demonstration project and successor demonstration project, or facilitate the objectives of subdivision (b).

(d) There is hereby established in the State Treasury the "Demonstration Disproportionate Share Hospital Fund." All federal funds received by the department with respect to the certified public expenditures claimed pursuant to subparagraphs (A) and (C) of paragraph (2) of subdivision (a) shall be transferred to the fund. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department solely for the purposes specified in Sections 14166.6 and 14166.61.

(e) (1) Except as provided in Section 14166.25, all federal safety net care pool funds claimed and received by the department based on health care expenditures incurred by the designated public hospitals, or other governmental entities, shall be transferred to the Health Care Support Fund, established pursuant to Section 14166.21.

(2) The department shall separately identify and account for federal safety net care pool funds claimed and received by the department under the health care coverage initiative program authorized under Part 3.5 (commencing with Section 15900) and under paragraphs 43 and 44 of the Special Terms and Conditions for the demonstration project.

(3) With respect to those funds identified under paragraph (2), the department shall separately identify and account for federal safety net care pool funds claimed and received for inpatient hospital services rendered under the health care coverage initiative, including services rendered to enrollees of a managed care organization, by designated public hospitals, nondesignated public hospitals, and project year private DSH hospitals.

SEC. 15. Section 14166.20 of the Welfare and Institutions Code is amended to read:

14166.20. (a) With respect to each project year through October 31, 2010, the total amount of stabilization funding shall be the sum of the following:

(1) (A) Federal Medicaid funds available in the Health Care Support Fund, established pursuant to Section 14166.21, reduced by the amount necessary to meet the baseline funding amount, or the adjusted baseline funding amount, as appropriate, for project years after the 2005–06 project year for each designated public hospital, project year private DSH hospitals in the aggregate, and nondesignated public hospitals in the aggregate as determined in Sections 14166.5, 14166.13, and 14166.18, respectively, taking into account all other payments to each hospital under this article. This amount shall be not less than zero.

(B) For purposes of subparagraph (A), federal Medicaid funds available in the Health Care Support Fund shall not include health care coverage initiative amounts identified under paragraph (2) of subdivision (e) of Section 14166.9.

(C) The federal financial participation amount arising from the certified public expenditures that has been paid to designated public hospitals, or the governmental entities with which they are affiliated, pursuant to subdivision (g) of Section 14166.221, shall be disregarded for purposes of this section.

(2) The state general funds that were made available due to the receipt of federal funding for previously state-funded programs through the safety net care pool and any federal Medicaid hospital reimbursements resulting from these expenditures, unless otherwise recognized under paragraph (1), to the extent those funds are in excess of the amount necessary to meet the baseline funding amount, or the adjusted baseline funding amount, as appropriate, for project years after the 2005–06 project year for each designated public hospital, for project year private DSH hospitals in the aggregate, and for nondesignated public hospitals in the aggregate, as determined in Sections 14166.5, 14166.13, and 14166.18, respectively.

(3) To the extent not included in paragraph (1) or (2), the amount of the increase in state General Fund expenditures for Medi-Cal inpatient hospital services for the project year for project year private DSH hospitals and nondesignated public hospitals, including amounts expended in accordance with paragraph (1) of subdivision (c) of Section 14166.23, that exceeds the expenditure

amount for the same purpose and the same hospitals necessary to provide the aggregate baseline funding amounts applicable to the project determined pursuant to Sections 14166.13 and 14166.18, and any direct grants to designated public hospitals for services under the demonstration project.

(4) To the extent not included in paragraph (2), federal Medicaid funds received by the state as a result of the General Fund expenditures described in paragraph (3).

(5) The federal Medicaid funds received by the state as a result of federal financial participation with respect to Medi-Cal payments for inpatient hospital services made to project year private DSH hospitals and to nondesignated public hospitals for services rendered during the project year, the state share of which was derived from intergovernmental transfers or certified public expenditures of any public entity that does not own or operate a public hospital.

(6) Federal safety net care pool funds claimed and received for inpatient hospital services rendered under the health care coverage initiative identified under paragraph (3) of subdivision (e) of Section 14166.9.

(b) With respect to the 2005–06, 2006–07, and subsequent project years through October 31, 2010, the stabilization funding determined under subdivision (a) shall be allocated as follows:

(1) Eight million dollars ($8,000,000) shall be paid to San Mateo Medical Center. All or a portion of this amount may be paid as disproportionate share hospital payments in addition to the hospital's allocation that would otherwise be determined under Section 14166.6. The amount provided for in this paragraph shall be disregarded in the application of the limitations described in paragraph (3) of subdivision (a) of Section 14166.6, and in paragraph (1) of subdivision (a) of Section 14166.7.

(2) (A) Ninety-six million two hundred twenty-eight thousand dollars ($96,228,000) shall be allocated to designated public hospitals to be paid in accordance with Section 14166.75.

(B) Forty-two million two hundred twenty-eight thousand dollars ($42,228,000) shall be allocated to private DSH hospitals to be paid in accordance with Section 14166.14.

(C) Five hundred forty-four thousand dollars ($544,000) shall be allocated to nondesignated public hospitals to be paid in accordance with Section 14166.17.

(D) In the event that stabilization funding is less than one hundred forty-seven million dollars ($147,000,000), the amounts allocated to designated public hospitals, private DSH hospitals, and nondesignated public hospitals under this paragraph shall be reduced proportionately.

(3) (A) An amount equal to the lesser of 10 percent of the total amount determined under subdivision (a) or twenty-three million five hundred thousand dollars ($23,500,000), but at least fifteen million three hundred thousand dollars ($15,300,000), shall be made available for additional payments to distressed hospitals that participate in the selective provider contracting program under Article 2.6 (commencing with Section 14081), including designated public hospitals, in amounts to be determined by the California Medical Assistance Commission. The additional payments to designated public hospitals shall be negotiated by the California Medical Assistance Commission, but shall be paid by the department in the form of a direct grant rather than as Medi-Cal payments.

(B) Notwithstanding subparagraph (A) and solely for the 2006–07 fiscal year, if the amount that otherwise would be made available for additional payments to distressed hospitals under subparagraph (A) is equal to or greater than eighteen million three hundred thousand dollars ($18,300,000), that amount shall be reduced by eighteen million three hundred thousand dollars ($18,300,000) and the state's obligation to make these payments shall be reduced by this amount. In the event the amount that otherwise would be made available under subparagraph (A) is less than eighteen million three hundred thousand dollars ($18,300,000), but greater than or equal to the minimum amount of fifteen million three hundred thousand dollars ($15,300,000), then the amount available under this paragraph shall be zero and the state's obligation to make these payments shall be zero.

(C) Notwithstanding subparagraph (A) and solely for the 2008–09 and 2009–10 fiscal years, the amount to be made available shall be reduced by fifteen million three hundred thousand dollars ($15,300,000) in each of the two years. The funds generated from this reduction shall be retained in the General Fund.

(4) An amount equal to 0.64 percent of the total amount determined under subdivision (a), to nondesignated public hospitals to be paid in accordance with Section 14166.19.

(5) The amount remaining after subtracting the amount determined in paragraphs (1) and (2), subparagraph (A) of paragraph (3), and paragraph (4), without taking into account subparagraphs (B) and (C) of paragraph (3), shall be allocated as follows:

(A) Sixty percent to designated public hospitals to be paid in accordance with Section 14166.75.

(B) Forty percent to project year private DSH hospitals to be paid in accordance with Section 14166.14.

(c) By April 1 of the year following the project year for which the payment is made, and after taking into account final amounts otherwise paid or payable to hospitals under this article, the director shall calculate in accordance with subdivision (a), allocate in accordance with subdivision (b), and pay to hospitals in accordance with Sections 14166.75, 14166.14, and 14166.19, as applicable, the stabilization funding.

(d) For purposes of determining amounts paid or payable to hospitals under subdivision (c), the department shall apply the following:

(1) In determining amounts paid or payable to designated public hospitals that are based on allowable costs incurred by the hospital, or the governmental entity with which it is affiliated, the following shall apply:

(A) If the final payment amount is based on the hospital's Medicare cost report, the department shall rely on the cost report filed with the Medicare fiscal intermediary for the project year for which the calculation is made, reduced by a percentage that represents the average percentage change from total reported costs to final costs for the three most recent cost reporting periods for which final determinations have been made, taking into account all administrative and judicial appeals. Protested amounts shall not be considered in determining the average percentage change unless the same or similar costs are included in the project year cost report.

(B) If the final payment amount is based on costs not included in subparagraph (A), the reported costs as of the date the determination is made under subdivision (c), shall be reduced by 10 percent.

(C) In addition to adjustments required in subparagraphs (A) and (B), the department shall adjust amounts paid or payable to

designated public hospitals by any applicable deferrals or disallowances identified by the federal Centers for Medicare and Medicaid Services as of the date the determination is made under subdivision (c) not otherwise reflected in subparagraphs (A) and (B).

(2) Amounts paid or payable to project year private DSH hospitals and nondesignated public hospitals shall be determined by the most recently available Medi-Cal paid claims data increased by a percentage to reflect an estimate of amounts remaining unpaid.

(e) The department shall consult with hospital representatives regarding the appropriate calculation of stabilization funding before stabilization funds are paid to hospitals. The calculation may be comprised of multiple steps involving interim computations and assumptions as may be necessary to determine the total amount of stabilization funding under subdivision (a) and the allocations under subdivision (b). No later than 30 days after this consultation, the department shall establish a final determination of stabilization funding that shall not be modified for any reason other than mathematical errors or mathematical omissions on the part of the department.

(f) The department shall distribute 75 percent of the estimated stabilization funding on an interim basis throughout the project year.

(g) The allocation and payment of stabilization funding shall not reduce the amount otherwise paid or payable to a hospital under this article or any other provision of law, unless the reduction is required by the demonstration project's Special Terms and Conditions or by federal law.

(h) It is the intent of the Legislature that the amendments made to Sections 14166.12 and to this section by the act that added this subdivision in the 2007–08 Regular Session shall not be construed to amend or otherwise alter the ongoing structure of the department's Medicaid Demonstration Project and Waiver approved by the federal Centers for Medicare and Medicaid Services to begin on September 1, 2005.

(i) The provisions of this section shall only apply with respect to the demonstration project term, and shall not apply with respect to the successor demonstration project term.

SEC. 16. Section 14166.21 of the Welfare and Institutions Code is amended to read:

14166.21. (a) The Health Care Support Fund is hereby established in the State Treasury. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department for the purposes specified in this article. The fund shall include any interest that accrues on amounts in the fund.

(b) During the term of the demonstration project, amounts in the Health Care Support Fund shall be paid in the following order of priority:

(1) To hospitals for services rendered to Medi-Cal beneficiaries and the uninsured in an amount necessary to meet the aggregate baseline funding amount, or the adjusted aggregate baseline funding amount for project years after the 2005-06 project year, as specified in subdivision (d) of Section 14166.5, subdivision (b) of Section 14166.13, and Section 14166.18, taking into account all other payments to each hospital under this article, except payments made from the Distressed Hospital Fund pursuant to Section 14166.23 and payments made to distressed hospitals pursuant to paragraph (3) of subdivision (b) of Section 14166.20. If the amount in the Health Care Support Fund is inadequate to provide full aggregate baseline funding, or adjusted aggregate baseline funding, to all designated public hospitals, project year private DSH hospitals, and nondesignated public hospitals, each group's payments shall be reduced pro rata.

(2) To the extent necessary to maximize federal funding under the demonstration project and consistent with Section 14166.22, the department may claim safety net care pool funds based on health care expenditures incurred by the department for uncompensated medical care costs of medical services provided to uninsured individuals, as approved by the federal Centers for Medicare and Medicaid Services.

(3) Stabilization funding, allocated and paid in accordance with Sections 14166.75, 14166.14, and 14166.19, and paragraph (3) of subdivision (b) of Section 14166.20.

(4) Any amounts remaining after final reconciliation of all amounts due at the end of a project year shall remain available for payments in accordance with this section in the next project year.

(c) Subdivision (b) shall not apply to federal safety net care pool funds claimed and received for services rendered under the health care coverage initiative identified under paragraph (2) of

subdivision (e) of Section 14166.9, which shall be paid in accordance with Part 3.5 (commencing with Section 15900) and under paragraphs 43 and 44 of the Special Terms and Conditions for the demonstration project.

(d) During the term of the successor demonstration project, amounts in the Health Care Support Fund shall be paid as follows:

(1) To the department consistent with Section 14166.22, with respect to amounts claimed by the department based on health care expenditures incurred by the state for uncompensated medical care costs of medical services provided to uninsured individuals, or expenditures incurred by the state for uncompensated costs of state-funded workforce development programs, as approved by the federal Centers for Medicare and Medicaid Services.

(2) To designated public hospitals and the governmental entities with which they are affiliated pursuant to Section 14166.71, with respect to amounts claimed based on certified public expenditures as reported pursuant to Section 14166.8.

(3) Any amounts remaining after final reconciliation of all amounts due at the end of a successor demonstration year shall remain available for payments in accordance with this section in the next successor demonstration year, as authorized by the Special Terms and Conditions for the successor demonstration project.

SEC. 17. Section 14166.24 of the Welfare and Institutions Code is amended to read:

14166.24. (a) Any determination of the amount due a designated public hospital that is based in whole or in part on costs reported to or audited by a Medicare fiscal intermediary shall not be deemed final for purposes of this article unless the hospital has received a final determination of Medicare payment for the cost reporting for Medicare purposes. Designated public hospitals shall be entitled to pursue all administrative and judicial review available under the Medicare Program and any final determination shall be incorporated into the department's final determination of payment due the hospital under this article.

(b) If as a result of an audit performed by the department or any state or federal agency, the department determines that any hospital has been overpaid under the demonstration project or the successor demonstration project, the department shall recoup the overpayment in accordance with Section 14172.5 or 14115.5. The hospital may appeal the overpayment determinations and any related audit

determination in accordance with the appeal procedures set forth in Sections 51016 to 51047, inclusive, of Title 22 of the California Code of Regulations. The hospital may seek judicial review of the final administrative decision as set forth in Section 14171.

(c) The department shall promptly consult with the affected governmental entity regarding a dispute between a designated public hospital and the department regarding the validity of the hospital's certified public expenditures. If the department determines that the hospital's certification is valid, the department shall submit the claim to obtain federal reimbursement for the certified expenditure in question.

(d) (1) Upon receipt of a notice of disallowance or deferral from the federal government related to the certified public expenditures or intergovernmental transfers of any governmental entity participating in the demonstration project, the department shall promptly notify the affected governmental entity. The governmental entity that certified the public expenditure shall be the entity responsible for the federal portion of that expenditure.

(2) The department and the affected governmental entity shall promptly consult regarding the proposed disallowance or deferral.

(3) After consulting with the governmental entity, the department shall determine whether the disallowance or response to a deferral should be filed with the federal government. If the department determines the appeal or response has merit, the department shall timely appeal. If necessary, the department may request an extension of the deadline to file an appeal or response to a deferral. The affected governmental entity may provide the department with the legal and factual basis for the appeal or response.

(e) Notwithstanding any other provision of law, if the department has exercised the authority set forth in subdivision (g) of Section 14166.221 and subdivision (e) of Section 14167.5, then all of the following shall occur:

(1) (A) The state shall be solely responsible for the repayment of the federal portion of any federal disallowance associated with any certified public expenditures for the 2009, 2010, and 2011 project years through October 31, 2010, and paragraph (1) of subdivision (d) of Section 14166.24 shall be disregarded, up to the total amount of the grant funds retained by the state under subdivision (e) of Section 14167.5.

(B) If the hospitals have additional certified public expenditures for which federal funds have not been received but for which federal funds could have been received under the demonstration project had additional federal funds been available, including federal funds made available under an extension of the demonstration project, the state shall first be allowed to respond to a deferral or disallowance based on the certified public expenditures of designated public hospitals, or the governmental entities with which they are affiliated, by substituting the additional certified public expenditures for those deferred or disallowed.

(2) The department shall not recoup any overpayment from a designated public hospital, or a governmental entity with which it is affiliated, with respect to payments under this article for the 2009, 2010, and 2011 project years through October 31, 2010, until the state has repaid all federal funds due up to the amount of the grant funds retained by the state under subdivision (e) of Section 14167.5.

SEC. 18. Section 14166.26 of the Welfare and Institutions Code is amended to read:

14166.26. (a) Unless this article is repealed pursuant to subdivision (b) or (g) of Section 14166.2, this article shall become inoperative on the date that the director executes a declaration, which shall be retained by the director and provided to the fiscal and appropriate policy committees of the Legislature, stating that the federal demonstration project or the successor demonstration project provided for in this article has been terminated by the federal Centers for Medicare and Medicaid Services, and shall, six months after the date the declaration is executed, be repealed.

(b) In addition to the requirements specified in subdivision (a), the director shall post the declaration on the department's Internet Web site and the director shall send the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

SEC. 19. Section 14182 of the Welfare and Institutions Code is amended to read:

14182. (a) (1) In furtherance of the waiver or demonstration project developed pursuant to Section 14180, the department may require seniors and persons with disabilities who do not have other health coverage to be assigned as mandatory enrollees into new or existing managed care health plans. To the extent that enrollment

is required by the department, an enrollee's access to fee-for-service Medi-Cal shall not be terminated until the enrollee has been assigned to a managed care health plan.

(2) For purposes of this section:

(A) "Other health coverage" means health coverage providing the same full or partial benefits as the Medi-Cal program, health coverage under another state or federal medical care program, or health coverage under contractual or legal entitlement, including, but not limited to, a private group or indemnification insurance program.

(B) "Managed care health plan" means an individual, organization, or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.81 (commencing with Section 14087.96), Article 2.91 (commencing with Section 14089), or Chapter 8 (commencing with Section 14200).

(b) In exercising its authority pursuant to subdivision (a), the department shall do all of the following:

(1) Assess and ensure the readiness of the managed care health plans to address the unique needs of seniors or persons with disabilities pursuant to the applicable readiness evaluation criteria and requirements set forth in paragraphs (1) to (8), inclusive, of subdivision (b) of Section 14087.48.

(2) Ensure the managed care health plans provide access to providers that comply with applicable state and federal laws, including, but not limited to, physical accessibility and the provision of health plan information in alternative formats.

(3) Develop and implement an outreach and education program for seniors and persons with disabilities, not currently enrolled in Medi-Cal managed care, to inform them of their enrollment options and rights under the demonstration project. Contingent upon available private or public dollars other than moneys from the General Fund, the department or its designated agent for enrollment and outreach may partner or contract with community-based, nonprofit consumer or health insurance assistance organizations with expertise and experience in assisting seniors and persons with disabilities in understanding their health care coverage options. Contracts entered into or amended pursuant to this paragraph shall be exempt from Chapter 2 (commencing with Section 10290) of

Part 2 of Division 2 of the Public Contract Code and any implementing regulations or policy directives.

(4) At least three months prior to enrollment, inform beneficiaries who are seniors or persons with disabilities, through a notice written at no more than a sixth grade reading level, about the forthcoming changes to their delivery of care, including, at a minimum, how their system of care will change, when the changes will occur, and who they can contact for assistance with choosing a delivery system or with problems they encounter. In developing this notice, the department shall consult with consumer representatives and other stakeholders.

(5) Implement an appropriate cultural awareness and sensitivity training program regarding serving seniors and persons with disabilities for managed care health plans and plan providers and staff in the Medi-Cal Managed Care Division of the department.

(6) Establish a process for assigning enrollees into an organized delivery system for beneficiaries who do not make an affirmative selection of a managed care health plan. The department shall develop this process in consultation with stakeholders and in a manner consistent with the waiver or demonstration project developed pursuant to Section 14180. The department shall base plan assignment on an enrollee's existing or recent utilization of providers, to the extent possible. If the department is unable to make an assignment based on the enrollee's affirmative selection or utilization history, the department shall base plan assignment on factors, including, but not limited to, plan quality and the inclusion of local health care safety net system providers in the plan's provider network.

(7) Review and approve the mechanism or algorithm that has been developed by the managed care health plan, in consultation with their stakeholders and consumers, to identify, within the earliest possible timeframe, persons with higher risk and more complex health care needs pursuant to paragraph (11) of subdivision (c).

(8) Provide managed care health plans with historical utilization data for beneficiaries upon enrollment in a managed care health plan so that the plans participating in the demonstration project are better able to assist beneficiaries and prioritize assessment and care planning.

(9) Develop and provide managed care health plans participating in the demonstration project with a facility site review tool for use in assessing the physical accessibility of providers, including specialists and ancillary service providers that provide care to a high volume of seniors and persons with disabilities, at a clinic or provider site, to ensure that there are sufficient physically accessible providers. Every managed care health plan participating in the demonstration project shall make the results of the facility site review tool publicly available on their Internet Web site and shall regularly update the results to the department's satisfaction.

(10) Develop a process to enforce legal sanctions, including, but not limited to, financial penalties, withholding of Medi-Cal payments, enrollment termination, and contract termination, in order to sanction any managed care health plan in the demonstration project that consistently or repeatedly fails to meet performance standards provided in statute or contract.

(11) Ensure that managed care health plans provide a mechanism for enrollees 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 conditions of the enrollee.

(12) Ensure that managed care health plans participating in the demonstration project are able to provide communication access to seniors and persons with disabilities in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language interpreters, captioning, written communication, plain language or written translations and oral interpreters, including for those who are limited English-proficient, or non-English speaking, and that all managed care health plans are in compliance with applicable cultural and linguistic requirements.

(13) Ensure that managed care health plans participating in the demonstration project provide access to out-of-network providers for new individual members enrolled under this section who have an ongoing relationship with a provider if the provider will accept the health plan's rate for the service offered, or the applicable Medi-Cal fee-for-service rate, whichever is higher, and the health plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues.

(14) Ensure that managed care health plans participating in the demonstration project comply with continuity of care requirements in Section 1373.96 of the Health and Safety Code.

(15) Ensure that the medical exemption criteria applied in counties operating under Chapter 4.1 (commencing with Section 53800) or Chapter 4.5 (commencing with Section 53900) of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations are applied to seniors and persons with disabilities served under this section.

(16) Ensure that managed care health plans participating in the demonstration project take into account the behavioral health needs of enrollees and include behavioral health services as part of the enrollee's care management plan when appropriate.

(17) Develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the subset of enrollees who are seniors and persons with disabilities. These performance measures may include measures from the Healthcare Effectiveness Data and Information Set (HEDIS) or measures indicative of performance in serving special needs populations, such as the National Committee for Quality Assurance (NCQA) Structure and Process measures, or both.

(18) Conduct medical audit reviews of participating managed care health plans that include elements specifically related to the care of seniors and persons with disabilities. These medical audits shall include, but not be limited to, evaluation of the delivery model's policies and procedures, performance in utilization management, continuity of care, availability and accessibility, member rights, and quality management.

(19) Conduct financial audit reviews to ensure that a financial statement audit is performed on managed care health plans annually pursuant to the Generally Accepted Auditing Standards, and conduct other risk-based audits for the purpose of detecting fraud and irregular transactions.

(c) Prior to exercising its authority under this section and Section 14180, the department shall ensure that each managed care health plan participating in the demonstration project is able to do all of the following:

(1) Comply with the applicable readiness evaluation criteria and requirements set forth in paragraphs (1) to (8), inclusive, of subdivision (b) of Section 14087.48.

(2) Ensure and monitor an appropriate provider network, including primary care physicians, specialists, professional, allied, and medical supportive personnel, and an adequate number of accessible facilities within each service area. Managed care health plans shall maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients and shall make it available to enrollees, at a minimum, by phone, written material, and Internet Web site.

(3) Assess the health care needs of beneficiaries who are seniors or persons with disabilities and coordinate their care across all settings, including coordination of necessary services within and, where necessary, outside of the plan's provider network.

(4) Ensure that the provider network and informational materials meet the linguistic and other special needs of seniors and persons with disabilities, including providing information in an understandable manner in plain language, maintaining toll-free telephone lines, and offering member or ombudsperson services.

(5) Provide clear, timely, and fair processes for accepting and acting upon complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits. Each managed care health plan participating in the demonstration project shall have a grievance process that complies with Section 14450, and Sections 1368 and 1368.01 of the Health and Safety Code.

(6) Solicit stakeholder and member participation in advisory groups for the planning and development activities related to the provision of services for seniors and persons with disabilities.

(7) Contract with safety net and traditional providers as defined in subdivisions (hh) and (jj) of Section 53810, of Title 22 of the California Code of Regulations, to ensure access to care and services. The managed care health plan shall establish participation standards to ensure participation and broad representation of traditional and safety net providers within a service area.

(8) Inform seniors and persons with disabilities of procedures for obtaining transportation services to service sites that are offered by the plan or are available through the Medi-Cal program.

(9) Monitor the quality and appropriateness of care for children with special health care needs, including children eligible for, or enrolled in, the California Children Services Program, and seniors and persons with disabilities.

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

(11) At the time of enrollment apply the risk stratification mechanism or algorithm described in paragraph (7) of subdivision (b) approved by the department to determine the health risk level of beneficiaries.

(12) (A) Managed care health plans shall assess an enrollee's current health risk by administering a risk assessment survey tool approved by the department. This risk assessment survey shall be performed within the following timeframes:

(i) Within 45 days of plan enrollment for individuals determined to be at higher risk pursuant to paragraph (11).

(ii) Within 105 days of plan enrollment for individuals determined to be at lower risk pursuant to paragraph (11).

(B) Based on the results of the current health risk assessment, managed care health plans shall develop individual care plans for higher risk beneficiaries that shall include the following minimum components:

(i) Identification of medical care needs, including primary care, specialty care, durable medical equipment, medications, and other needs with a plan for care coordination as needed.

(ii) Identification of needs and referral to appropriate community resources and other agencies as needed for services outside the scope of responsibility of the managed care health plan.

(iii) Appropriate involvement of caregivers.

(iv) Determination of timeframes for reassessment and, if necessary, circumstances or conditions that require redetermination of risk level.

(13) (A) Establish medical homes to which enrollees are assigned that include, at a minimum, all of the following elements, which shall be considered in the provider contracting process:

(i) A primary care physician who is the primary clinician for the beneficiary and who provides core clinical management functions.

(ii) Care management and care coordination for the beneficiary across the health care system including transitions among levels of care.

(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 beneficiaries at the care site with chronic illness or other significant health issues.

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

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

(B) In implementing this section, and the Special Terms and Conditions of the demonstration project, the department may alter the medical home elements described in this paragraph 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.

(14) Perform, at a minimum, the following care management and care coordination functions and activities for enrollees who are seniors or persons with disabilities:

(A) Assessment of each new enrollee's risk level and health needs shall be conducted through a standardized risk assessment survey by means such as telephonic, Web-based, or in-person communication or by other means as determined by the department.

(B) Facilitation of timely access to primary care, specialty care, durable medical equipment, medications, and other health services needed by the enrollee, including referrals to address any physical or cognitive barriers to access.

(C) Active referral to community resources or other agencies for needed services or items outside the managed care health plans responsibilities.

(D) Facilitating communication among the beneficiaries' health care providers, including mental health and substance abuse providers when appropriate.

(E) Other activities or services needed to assist beneficiaries in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health status.

(d) Except in a county where Medi-Cal services are provided by a county organized health system, and notwithstanding any other provision of law, in any county in which fewer than two existing managed care health plans contract with the department to provide Medi-Cal services under this chapter, the department may contract with additional managed care health plans to provide Medi-Cal services for seniors and persons with disabilities and other Medi-Cal beneficiaries.

(e) Beneficiaries enrolled in managed care health plans pursuant to this section shall have the choice to continue an established patient-provider relationship in a managed care health plan participating in the demonstration project if his or her treating provider is a primary care provider or clinic contracting with the managed care health plan and agrees to continue to treat that beneficiary.

(f) The department may contract with existing managed care health plans to operate under the demonstration project to provide or arrange for services under this section. Notwithstanding any other provision of law, the department may enter into the contract without the need for a competitive bid process or other contract proposal process, provided the managed care health plan provides written documentation that it meets all qualifications and requirements of this section.

(g) This section shall be implemented only to the extent that federal financial participation is available.

(h) (1) The development of capitation rates for managed care health plan contracts shall include the analysis of data specific to the seniors and persons with disabilities population. For the purposes of developing capitation rates for payments to managed care health plans, the director may require managed care health

plans, including existing managed care health plans, to submit financial and utilization data in a form, time, and substance as deemed necessary by the department.

(2) (A) Notwithstanding Section 14301, the department may incorporate, on a one-time basis for a three-year period, a risk-sharing mechanism in a contract with the local initiative health plan in the county with the highest normalized fee-for-service risk score over the normalized managed care risk score listed in Table 1.0 of the Medi-Cal Acuity Study Seniors and Persons with Disabilities (SPD) report written by Mercer Government Human Services Consulting and dated September 28, 2010, if the local initiative health plan meets the requirements of subparagraph (B). The Legislature finds and declares that this risk-sharing mechanism will limit the risk of beneficial or adverse effects associated with a contract to furnish services pursuant to this section on an at-risk basis.

(B) The local initiative health plan shall pay the nonfederal share of all costs associated with the development, implementation, and monitoring of the risk-sharing mechanism established pursuant to subparagraph (A) by means of intergovernmental transfers. The nonfederal share includes the state costs of staffing, state contractors, or administrative costs directly attributable to implementing subparagraph (A).

(C) This subdivision shall be implemented only to the extent federal financial participation is not jeopardized.

(i) Persons meeting participation requirements for the Program of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter 8.75 (commencing with Section 14590), may select a PACE plan if one is available in that county.

(j) Persons meeting the participation requirements in effect on January 1, 2010, for a Medi-Cal primary care case management (PCCM) plan in operation on that date, may select that PCCM plan or a successor health care plan that is licensed pursuant to 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) to provide services within the same geographic area that the PCCM plan served on January 1, 2010.

(k) 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, plan or provider bulletins, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

(*l*) Consistent with state law that exempts Medi-Cal managed care contracts from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code, and in order to achieve maximum cost savings, the Legislature hereby determines that an expedited contract process is necessary for contracts entered into or amended pursuant to this section. The contracts and amendments entered into or amended pursuant to this section shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and the requirements of State Administrative Management Manual Memo 03-10. The department shall make the terms of a contract available to the public within 30 days of the contract's effective date.

(m) In the event of a conflict between the Special Terms and Conditions of the approved demonstration project, including any attachment thereto, and any provision of this part, the Special Terms and Conditions shall control. If the department identifies a specific provision of this article that conflicts with a term or condition of the approved waiver or demonstration project, or an attachment thereto, the term or condition shall control, and the department shall so notify the appropriate fiscal and policy committees of the Legislature within 15 business days.

(n) In the event of a conflict between the provisions of this article and any other provision of this part, the provisions of this article shall control.

(o) Any otherwise applicable provisions of this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14500) not in conflict with this article or with the terms and conditions of the demonstration project shall apply to this section.

(p) To the extent that the director utilizes state plan amendments or waivers to accomplish the purposes of this article in addition to waivers granted under the demonstration project, the terms of the state plan amendments or waivers shall control in the event of a conflict with any provision of this part.

(q) (1) Enrollment of seniors and persons with disabilities into a managed care health plan under this section shall be accomplished using a phased-in process to be determined by the department and shall not commence until necessary federal approvals have been acquired or until June 1, 2011, whichever is later.

(2) Notwithstanding paragraph (1), and at the director's discretion, enrollment in Los Angeles County of seniors and persons with disabilities may be phased-in over a 12-month period using a geographic region method that is proposed by Los Angeles County subject to approval by the department.

(r) A managed care health plan established pursuant to this section, or under the Special Terms and Conditions of the demonstration project pursuant to Section 14180, shall be subject to, and comply with, the requirement for submission of encounter data specified in Section 14182.1.

(s) (1) Commencing January 1, 2011, and until January 1, 2014, the department shall provide the fiscal and policy committees of the Legislature with semiannual updates regarding core activities for the enrollment of seniors and persons with disabilities into managed care health plans pursuant to the pilot program. The semiannual updates shall include key milestones, progress towards the objectives of the pilot program, relevant or necessary changes to the program, submittal of state plan amendments to the federal Centers for Medicare and Medicaid Services, submittal of any federal waiver documents, and other key activities related to the mandatory enrollment of seniors and persons with disabilities into managed care health plans. The department shall also include updates on the transition of individuals into managed care health plans, the health outcomes of enrollees, the care management and coordination process, and other information concerning the success or overall status of the pilot program.

(2) (A) The requirement for submitting a report imposed under paragraph (1) is inoperative on January 1, 2015, pursuant to Section 10231.5 of the Government Code.

(B) A report to be submitted pursuant to paragraph (1) shall be submitted in compliance with Section 9795 of the Government Code.

(t) The department, in collaboration with the State Department of Social Services and county welfare departments, shall monitor the utilization and caseload of the In-Home Supportive Services (IHSS) program before and during the implementation of the pilot program. This information shall be monitored in order to identify the impact of the pilot program on the IHSS program for the affected population.

(u) Services under Section 14132.95 or 14132.952, or Article 7 (commencing with Section 12300) of Chapter 3 that are provided to individuals assigned to managed care health plans under this section shall be provided through direct hiring of personnel, contract, or establishment of a public authority or nonprofit consortium, in accordance with and subject to the requirements of Section 12302 or 12301.6, as applicable.

(v) The department shall, at a minimum, monitor on a quarterly basis the adequacy of provider networks of the managed care health plans.

(w) The department shall suspend new enrollment of seniors and persons with disabilities into a managed care health plan if it determines that the managed care health plan does not have sufficient primary or specialty providers to meet the needs of their enrollees.

SEC. 20. Section 14182.3 of the Welfare and Institutions Code is amended to read:

14182.3. (a) To the extent the provisions of Article 5.2 (commencing with Section 14166) do not conflict with the provisions of this article or the Special Terms and Conditions of the new demonstration project created under this article, the provisions of Article 5.2 (commencing with Section 14166) shall continue to apply to the new demonstration project.

(b) In the event of a conflict between any provision of this article and the Special Terms and Conditions required by the federal Centers for Medicare and Medicaid Services for the approval of the demonstration project described in Section 14180, the Special Terms and Conditions shall control.

(c) (1) Under the demonstration project described in Section 14180, the state shall have priority to claim against and retain the

first five hundred million dollars ($500,000,000) in federal funds using expenditures incurred under state-only programs or other programs for which the state is authorized to claim under the Special Terms and Conditions of the demonstration project or federal Medicaid law, including state-only programs that serve special populations, such as those for which state savings were recognized in the Budget Act for the 2010–11 fiscal year.

(2) Notwithstanding paragraph (1), if the director determines that the amount of base funding available under the demonstration project described in Section 14180 is less than the six hundred eighty-one million six hundred forty thousand dollars ($681,640,000) available to public hospitals under the original demonstration project, the state may reallocate an amount from the five hundred million dollars ($500,000,000) described in paragraph (1) to increase the amount of base funding under the new demonstration project to six hundred eighty one million six hundred forty thousand dollars ($681,640,000).

(3) For purposes of this section, the term "base funding" includes funding for the safety net care pool or a similar pool or fund for health coverage expansion, and for an investment, incentive, or similar pool, but shall not include funds made available to hospitals or counties for inpatient or outpatient Medi-Cal reimbursements, expansion of managed care for seniors and persons with disabilities, or other expansions of systems of care for individuals who are eligible under the Medi-Cal state plan.

(4) If the state is unable to claim the full amount of the five hundred million dollars ($500,000,000) described in paragraph (1), any portion of the amount that remains unclaimed may be reallocated to be claimed based on the certified public expenditures of the designated public hospitals.

(d) The director shall have authority to maximize available federal financial participation under the demonstration project described in Section 14180, including, but not limited to, authorizing the use of intergovernmental transfers by district hospitals that are not reimbursed under a contract negotiated pursuant to the Selective Provider Contracting Program, to fund the nonfederal share of expenditures to the extent permitted by the Special Terms and Conditions of the demonstration project.

(e) Participation in intergovernmental transfers under this section is voluntary on the part of the transferring entity for purposes of

all applicable federal laws. As part of its voluntary participation in the nonfederal share of payments under this subdivision by means of intergovernmental transfers, the transferring entity agrees to reimburse the state for the nonfederal share of state staffing or administrative costs directly attributable to the state's implementation of these voluntary intergovernmental transfers. This subdivision shall be implemented only to the extent federal financial participation is not jeopardized.

(f) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may clarify, interpret, or implement the provisions of this section by means of provider bulletins or similar instructions. The department shall notify the fiscal and appropriate policy committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

SEC. 21. Section 14182.4 of the Welfare and Institutions Code is amended to read:

14182.4. (a) To the extent authorized under a federal waiver or demonstration project described in Section 14180 that is approved by the federal Centers for Medicare and Medicaid Services, the department shall establish a program of investment, improvement, and incentive payments for designated public hospitals to encourage and incentivize delivery system transformation and innovation in preparation for the implementation of federal health care reform.

(b) The Public Hospital Investment, Improvement, and Incentive Fund is hereby established in the State Treasury. Notwithstanding Section 13340 of the Government Code, moneys in the fund shall be continuously appropriated, without regard to fiscal years, to the department for the purposes specified in this section.

(c) The fund shall consist of any moneys that a county, other political subdivision of the state, or other governmental entity in the state that may elect to transfer to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.

(d) Moneys in the fund shall be used as the source for the nonfederal share of investment, improvement, and incentive payments as authorized under a federal waiver or demonstration

project to participating designated public hospitals defined in subdivision (d) of Section 14166.1, and the governmental entities with which they are affiliated, that provide the intergovernmental transfers for deposit into the fund, and to nondesignated public hospitals and private disproportionate share hospitals as authorized under Section 14182.45, as long as the payments are made to support and reward the pursuit of delivery system improvements.

(e) The department shall obtain federal financial participation for moneys in the fund to the full extent permitted by law. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with the Special Terms and Conditions of the waiver or demonstration project and Section 14167.77, and in accordance with Section 14182.45, as applicable. The moneys disbursed from the fund, and all associated federal financial participation, shall be distributed solely to the designated public hospitals and the governmental entities with which they are affiliated, and to other eligible hospitals as may be provided for under Section 14182.45.

(f) Participation under this section is voluntary on the part of the county or other political subdivision for purposes of all applicable federal laws. As part of its voluntary participation in the nonfederal share of payments under this section, the county or other political subdivision agrees to reimburse the state for the nonfederal share of state staffing or administrative costs directly attributable to implementation of this section. This section shall be implemented only to the extent federal financial participation is not jeopardized.

(g) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may clarify, interpret, or implement the provisions of this section by means of provider bulletins or similar instructions. The department shall notify the fiscal and appropriate policy committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

SEC. 22. Section 14182.45 is added to the Welfare and Institutions Code, to read:

14182.45. In consultation with the designated public hospitals, as defined in subdivision (d) of Section 14166.1, and to the extent it does not impede the ability of the designated public hospitals to

meet the requirements and conditions for delivery system reform incentive payments authorized under Sections 14166.77 and 14182.4, the state may provide for milestone incentive payments to private disproportionate share hospitals and nondesignated public disproportionate share hospitals to create incentives for improvement activities towards, and achievement of, delivery system transformation. The milestone incentive payments to private disproportionate share hospitals and nondesignated public disproportionate share hospitals shall be structured in accordance with the requirements and conditions for delivery system reform incentive payments set forth in the Special Terms and Conditions and as approved by the federal Centers for Medicare and Medicaid Services. Incentive payments may be funded by voluntary intergovernmental transfers made by the designated public hospitals and nondesignated public hospitals. All incentive pool funding, including any potential private and nondesignated public hospital subpools, shall be limited to the total amount of incentive pool funding allowed for delivery system reform incentive payments as set forth in the Special Terms and Conditions.

SEC. 23. Section 15908 of the Welfare and Institutions Code is amended to read:

15908. (a) This part shall become inoperative on the date that the director executes a declaration, which shall be retained by the director and provided to the fiscal and appropriate policy committees of the Legislature, stating that the ~~Low-Income~~ *Low Income* Health Program authorized under Part 3.6 (commencing with Section 15909) and under the Special Terms and Conditions of the demonstration project, as defined in Section 15909.1, has been implemented, and that each Health Care Coverage Initiative program approved under this part that has sought approval under Part 3.6 (commencing with Section 15909) has been transitioned to a ~~LowIncome~~ *Low Income* Health Program, if authorized under the demonstration project and Part 3.6 (commencing with Section 15909), and shall, six months after the date the declaration is executed, be repealed.

(b) In addition to the requirements specified in subdivision (a), the director shall post the declaration on the department's Internet Web site and the director shall send the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(c) Until the effective date of the repeal of this part pursuant to subdivision (a), the director may continue and administer any extensions, modifications, or continuation of the projects under this part approved by the federal Centers for Medicare and Medicaid Services.

SEC. 24. The heading of Part 3.6 (commencing with Section 15909) of Division 9 of the Welfare and Institutions Code is amended to read:

PART 3.6. LOW INCOME HEALTH PROGRAM

SEC. 25. Section 15909.1 of the Welfare and Institutions Code is amended to read:

15909.1. For purposes of this part, the following definitions shall apply:

(a) "Demonstration project" means a federal waiver or demonstration project described in Section 14180 approved by the federal Centers for Medicare and Medicaid Services that authorizes the implementation of a successor to the Health Care Coverage Initiative under Part 3.5 (commencing with Section 15900).

(b) "Eligible entity" means a county, city and county, consortium of counties serving a region consisting of more than one county, or health authority. For purposes of this section and to the extent allowed under the Special Terms and Conditions of the demonstration project, a County Medical Services Program shall be considered a consortium of counties serving a region consisting of more than one county.

(c) "LIHP" means a local Low Income Health Program authorized pursuant to this part that is comprised of the following populations:

(1) The Medicaid Coverage Expansion (MCE) population, which means low-income individuals 19 to 64~~, inclusive, years of age~~ *years of age, inclusive*, who are not pregnant, with family incomes at or below 133 percent of the federal poverty level, are not eligible for the~~ Medicare Program, the Medi-Cal program,~~ *Medi-Cal program* or the Children's Health Insurance Program, are United States citizens, nationals, or have satisfactory immigration status, and meet the county of residence requirements.

(2) The Health Care Coverage Initiative (HCCI) population, which means low-income individuals 19 to 64~~, inclusive, years of~~

~~age~~ *years of age, inclusive,* who are not pregnant, with family incomes above 133 percent through 200 percent of the federal poverty level, are not eligible for the Medicare Program, the Medi-Cal program, ~~or~~ the Children's Health Insurance Program, *or other third party coverage,* are United States citizens, nationals, or have satisfactory immigration status, and meet the county of residence requirements.

(d) "Participating entity" means an eligible entity that operates an approved LIHP.

SEC. 26. Section 15910 of the Welfare and Institutions Code is amended to read:

15910. (a) Subject to federal approval of a demonstration project effective on or after November 1, 2010, the department shall, by no later than July 1, 2011, authorize local LIHPs to provide scheduled health care services, consistent with the Special Terms and Conditions of the demonstration project, to eligible low-income individuals 19 to 6~~4, inclusive, years of age~~ *years of age, inclusive,* who are not otherwise eligible for the~~ Medicare program, the Medi-Cal Program,~~ *Medi-Cal program* or the Children's Health Insurance Program, with family incomes at or below 133 percent of the federal poverty level. To the extent federal financial participation is made available under the Special Terms and Conditions of the demonstration project pursuant to Section 15910.1, LIHP health care services may be made available to eligible individuals with family incomes above 133 percent through 200 percent of the federal poverty level.

(b) Eligible entities, consistent with the Special Terms and Conditions of the demonstration project, may perform outreach and enrollment activities to target populations, including, but not limited to, the people who are homeless, individuals who frequently use hospital inpatient or emergency department services for avoidable reasons, or people with mental health or substance abuse treatment needs.

(c) The LIHP shall be designed and implemented with the systems and program elements necessary to facilitate the transition of those eligible individuals to Medi-Cal coverage, or alternatively, to coverage through the California Health Benefit Exchange, by 2014, pursuant to state and federal law, and the Special Terms and Conditions of the demonstration project.

(d) The department shall authorize a LIHP that meets the requirements set forth in this part and the Special Terms and Conditions of the demonstration project.

(e) (1) By January 1, 2011, or alternatively, 60 days after federal approval of the demonstration project, whichever occurs later, the department shall notify all eligible entities of the opportunity to elect to implement a LIHP, the applicable requirements, and the process for submitting an application for department approval of a LIHP application.

(2) The director shall approve or deny an eligible entity's LIHP application within 60 days of receipt of the application. If the director denies an application, the denial shall be in writing and shall specify the reasons therefor.

(3) Within 10 days of a denial by the director under this subdivision, a participating entity may submit a written request for reconsideration. The director shall respond in writing to a request for reconsideration within 20 days, confirming or reversing the denial, and specifying the reasons for the reconsidered decision.

(f) If the eligible entity had in operation a Health Care Coverage Initiative program under Part 3.5 (commencing with Section 15900) as of November 1, 2010, and the eligible entity elects to continue funding the program, then the existing Health Care Coverage Initiative program shall, to the extent permitted by the Special Terms and Conditions of the demonstration project, remain in effect and receive federal reimbursement in accordance with the Special Terms and Conditions of the demonstration project until the LIHP is effective, but no later than July 1, 2011.

(g) Health care services provided pursuant to this part shall be available to those eligible, low-income individuals enrolled in the applicable LIHP, subject to the limitations of this part and the Special Terms and Conditions of the demonstration project. However, nothing in this part is intended to create an entitlement program of any kind.

(h) Each LIHP may establish an upper income limit for eligible MCE individuals to enroll in the LIHP, which shall be expressed as a percentage between 0 percent and up to, and including, 133 percent of the federal poverty level. If the LIHP elects to enroll HCCI-eligible individuals with family incomes above 133 percent through 200 percent of the federal poverty level, it may also establish an upper income limit between this range.

Notwithstanding any established upper income limit, the LIHP may impose a limit on enrollment in the LIHP, which shall be subject to all of the following provisions:

(1) The Special Terms and Conditions required by the federal Centers for Medicare and Medicaid Services for the approval of the demonstration project described in Section 14180 permit a limitation on enrollment in a LIHP.

(2) Any enrollment limitation by a LIHP shall be administered in accordance with the Special Terms and Conditions required by the federal Centers for Medicare and Medicaid Services.

(3) Any enrollment limitation by a LIHP is subject to approval by the director, and notification to the federal Centers for Medicare and Medicaid Services. A LIHP shall establish an income limit at a level that minimizes the need for imposing a limit on enrollment for the MCE population.

(4) Prior to applying for approval from the director, the LIHP shall submit to the director a resolution from its governing board approving the proposed limitation on enrollment by the LIHP.

(i) LIHPs shall be established and implemented only to the extent that federal financial participation is available and only to the extent that available federal financial participation is not jeopardized.

(j) For the purposes of operating a LIHP approved under this part, and notwithstanding Section 14181, participating entities shall be exempt from the provisions of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, shall not be considered Medi-Cal managed care health plans subject to the requirements applicable to the two-plan model and geographic managed care plans, as contained in Article 2.7 (commencing with Section 14087.3), Article 2.81 (commencing with Section 14087.96) and Article 2.91 (commencing with Section 14089) of Chapter 7 of Part 1 and the corresponding regulations, and shall not be considered prepaid health plans as defined in Section 14251.

SEC. 27. Section 15910.1 of the Welfare and Institutions Code is amended to read:

15910.1. (a) For LIHPs serving HCCI-eligible individuals , subject to federal funding limits or requirements that differ from the requirements for individuals described in subdivision (a) of Section 15910, the department shall, in consultation with

participating entities, develop a process for allocating the available federal funding to those approved LIHPs that elect to serve the additional group of individuals identified in this subdivision, if the participating entity voluntarily agrees to provide the nonfederal share of the LIHP expenditures for the additional group.

(b) To the extent permitted by the Special Terms and Conditions of the demonstration project, the allocation of funding under this section shall ensure that a Health Care Coverage Initiative program under Part 3.5 (commencing with Section 15900) as of November 1, 2010, that elects to continue as a participating entity under this part receives, at a minimum, an allocation in an amount adequate to ensure that their existing eligible enrollees can continue to receive services under their LIHP.

(c) If a LIHP elects to serve eligible persons with incomes above 133 percent through 200 percent of the federal poverty level, the LIHP shall also serve eligible persons with incomes up to 133 percent of the federal poverty level.

(d) Section 15910 and Section 15910.2 shall apply with respect to LIHPs funded under this section, as appropriate.

(e) Reimbursements to LIHPs approved under this section shall be made in accordance with Section 15910.3 or through another mechanism authorized under the Special Terms and Conditions for the demonstration project.

(f) The nonfederal share of funding for LIHP expenditures authorized under this section shall be provided in accordance with Section 15911 or through another mechanism authorized by the Special Terms and Conditions of the demonstration project.

(g) Any unused federal funds shall be distributed in accordance with the Special Terms and Conditions of the demonstration project.

SEC. 28. Section 15910.2 of the Welfare and Institutions Code is amended to read:

15910.2. (a) The eligible entity shall meet both of the following requirements and any additional requirements imposed by the Special Terms and Conditions of the demonstration project in order for the department to authorize the LIHP proposed by the eligible entity:

(1) The eligible entity shall voluntarily agree to commit, on an annual basis, to provide the nonfederal share of LIHP expenditures for health care services to eligible individuals for the LIHP.

(2) The LIHP proposed by the eligible entity shall include the LIHP elements set forth in subdivision (b).

(b) The LIHP elements shall include all of the following, subject to the Special Terms and Conditions of the demonstration project:

(1) Development of standardized eligibility and enrollment procedures that interface with Medi-Cal processes by December 31, 2013, according to the milestones developed in consultation with the counties, county health departments, public hospitals, and county human service departments. LIHPs shall migrate to the standardized procedures in accordance with the Special Terms and Conditions of the demonstration project and subdivision (c) of Section 15910.

(2) Eligibility for LIHP benefits may be provided retroactively for any of the three months prior to the enrollment date in which the individual would have been found eligible had he or she applied during that month. If an individual is determined to be retroactively eligible, LIHP coverage for the retroactive period shall be limited to those services provided within the approved LIHP network ~~as required~~ *or out of network emergency services as authorized* under the Special Terms and Conditions of the demonstration project.

(3) The LIHP shall perform annual eligibility redeterminations for persons participating in the LIHP to assess if they remain eligible for the LIHP or are eligible for Medi-Cal or the Healthy Families Program.

(4) (A) Assignment of eligible individuals to a medical home. For purposes of this paragraph and subject to the Special Terms and Conditions of the demonstration project, "medical home" means a single provider, facility, or health care team that maintains an individual's medical information, and coordinates health care services for enrolled individuals. The medical home shall provide, at a minimum, all of the following elements, which shall be considered in the contracting process:

(i) A primary health care contact who facilitates the enrollee's access to preventive, primary, specialty, mental health, or chronic illness treatment, as appropriate.

(ii) An intake assessment of each new enrollee's general health status.

(iii) Referrals to qualified professionals, community resources, or other agencies as needed.

(iv) Care coordination for the enrollees across the service delivery system, as agreed to between the medical home and the LIHP. This may include facilitating communication among enrollee's health care providers, including appropriate outreach to mental health providers.

(v) Care management, case management, and transitions among levels of care, if needed and as agreed to between the medical home and the LIHP.

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

(vii) Focus on continuous improvement in quality of care.

(viii) Timely access to qualified health care interpretation as needed and as appropriate for enrollees with limited English proficiency, as determined by applicable federal guidelines.

(ix) Health information, education, and support to beneficiaries and, where appropriate, their families, if and when needed, in a culturally competent manner.

(B) In implementing this section, and the Special Terms and Conditions of the demonstration project, the department may alter the medical home elements described in this paragraph 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.

(5) A minimum set of core benefits or services required under the Special Terms and Conditions of the demonstration project that shall be limited to those services provided within an approved LIHP provider network and service delivery system as required under the Special Terms and Conditions of the demonstration project.

(6) A provider network and service delivery system that seeks to promote the viability of the existing safety net health care system that serves the population to be covered by the LIHP. The provider network and service delivery system shall meet the standards established in the Special Terms and Conditions of the demonstration project.

(7) Development of an outreach and enrollment plan that reaches potential project enrollees and begins to prepare to transition eligible individuals to Medi-Cal coverage in 2014, or alternatively, to coverage through the California Health Benefit Exchange.

(8) A quality measurement and quality monitoring system.

(9) Data tracking systems to provide the department with required data for quality monitoring, quality improvement, and evaluation.

(10) Demonstration of how the LIHP will provide consumer assistance to individuals applying for, participating in, or accessing, services in the LIHP, including the availability of materials that provide information on all of the following:

(A) The scope of covered services.

(B) The exceptions, reductions, and limitations that apply to covered services.

(C) Any premium, copayment, or deductible requirements that may be incurred by the enrollee.

(D) The participating providers in the LIHP network.

(E) The medical homes within the LIHP network from which the enrollee may select.

(F) The LIHP telephone number or numbers that may be used by an enrollee to receive additional information about the covered services or participating providers.

(11) Ability to meet program requirements, standards, and performance measurements developed by the department, in consultation with participating entities for the LIHP.

SEC. 29. Section 15910.3 of the Welfare and Institutions Code is amended to read:

15910.3. (a) In consultation with participating entities, the department shall determine actuarially sound per enrollee capitation rates for LIHPs that are adequate and sufficient to ensure access to services for enrollees and to at least cover the projected cost of care. As part of the rate development process, each LIHP shall submit a detailed proposal to the department outlining proposed methodologies and rates that have been certified by county-employed or county-retained actuaries using state and federal Medicaid principles and the standards provided in this section.

(b) Rates determined under this section shall be based on utilization and cost data specific to the enrolled population or

comparable data, including where available, project- and county-specific data. In setting actuarially sound rates, the department shall apply appropriate factors to ensure sufficient access to primary and specialty care, and shall take into account the cost of the services specified under the approved LIHP, administrative costs, graduate medical education costs, the utilization and intensity of services expected for LIHP enrollees, and an appropriate case management fee.

(c) The department may include risk corridors to allow for adjustments to rates if the actual cost or utilization of a LIHP exceeds the projected cost.

(d) The department may develop additional payment mechanisms that provide for incentive payments to LIHPs that meet designated performance criteria for quality of and access to care.

(e) The rate shall be determined annually, and shall be effective either the first day of each LIHP year, or another date agreed upon by the participating entity and the department. Rates may be adjusted outside the annual determination process if there is a change in federal or state law or regulation that increases the cost of fulfilling the obligations of a LIHP.

(f) Notwithstanding any other provision of law, payments to LIHPs shall not be limited by an estimate of the reimbursement that would be available for program services if those services were provided to Medi-Cal beneficiaries under the Medi-Cal fee-for-service program.

(g) LIHPs shall be paid actuarially sound rates as determined under this section at the beginning of each quarter based on enrollment. If payments are based on estimated enrollment data, the payments shall be reconciled to actual enrollment on an annual basis.

SEC. 30. Section 15911 of the Welfare and Institutions Code is amended to read:

15911. (a) Funding for each LIHP shall be based on all of the following:

(1) The amount of funding that the participating entity voluntarily provides for the nonfederal share of LIHP expenditures.

(2) For a LIHP that had in operation a Health Care Coverage Initiative program under Part 3.5 (commencing with Section 15900) as of November 1, 2010, and elects to continue funding the

program, the amount of funds requested to ensure that eligible enrollees continue to receive health care services for persons enrolled in the Health Care Coverage Initiative program as of November 1, 2010.

(3) Any limitations imposed by the Special Terms and Conditions of the demonstration project.

(4) The total allocations requested by participating entities for Health Care Coverage Initiative eligible individuals.

(5) Whether funding under this part would result in the reduction of other payments under the demonstration project.

(b) Nothing in this part shall be construed to require a political subdivision of the state to participate in a LIHP as set forth in this part, and those local funds expended or transferred for the nonfederal share of LIHP expenditures under this part shall be considered voluntary contributions for purposes of 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 the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), as amended by the federal Patient Protection and Affordable Care Act.

(c) No state General Fund moneys shall be used to fund LIHP services, nor to fund any related administrative costs incurred by counties or any other political subdivision of the state.

(d) Subject to the Special Terms and Conditions of the demonstration project, if a participating entity elects to fund the nonfederal share of a LIHP, the nonfederal funding and payments to the LIHP shall be provided through one of the following mechanisms, at the options of the participating entity:

(1) On a quarterly basis, the participating entity shall transfer to the department for deposit in the LIHP Fund established for the participating counties and pursuant to subparagraph (A), the amount necessary to meet the nonfederal share of estimated payments to the LIHP for the next quarter under subdivision (g) Section 15910.3.

(A) The LIHP Fund is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, all moneys in the fund shall be continuously appropriated to the department for the purposes specified in this part. The fund shall

contain all moneys deposited into the fund in accordance with this paragraph.

(B) The department shall obtain the related federal financial participation and pay the rates established under Section 15910.3, provided that the intergovernmental transfer is transferred in accordance with the deadlines imposed under the Medi-Cal Checkwrite Schedule, no later than the next available warrant release date. This payment shall be a nondiscretionary obligation of the department, enforceable under a writ of mandate pursuant to Section 1085 of the Code of Civil Procedure. Participating entities may request expedited processing within seven business days of the transfer as made available by the State Controllers Office, provided that the participating entity prepay the department for the additional administrative costs associated with the expedited processing.

(C) Total quarterly payment amounts shall be determined in accordance with estimates of the number of enrollees in each rate category, subject to annual reconciliation to final enrollment data.

(2) If a participating entity operates its LIHP through a contract with another entity, the participating entity may pay the operating entity based on the per enrollee rates established under Section 15910.3 on a quarterly basis in accordance with estimates of the number of enrollees in each rate category, subject to annual reconciliation to final enrollment data.

(A) (i) On a quarterly basis, the participating entity shall certify the expenditures made under this paragraph and submit the report of certified public expenditures to the department.

(ii) The department shall report the certified public expenditures of a participating entity under this paragraph on the next available quarterly report as necessary to obtain federal financial participation for the expenditures. The total amount of federal financial participation associated with the participating entity's expenditures under this paragraph shall be reimbursed to the participating entity.

(B) At the option of the participating entity, the LIHP may be reimbursed on a cost basis in accordance with the methodology applied to Health Care Coverage Initiative programs established under Part 3.5 (commencing with Section 15900) including interim quarterly payments.

(e) Notwithstanding Section 15910.3 and subdivision (d) of this section, if the participating entity cannot reach an agreement with the department as to the appropriate rate to be paid under Section 15910.3, at the option of the participating entity, the LIHP shall be reimbursed on a cost basis in accordance with the methodology applied to Health Care Coverage Initiative programs established under Part 3.5 (commencing with Section 15900), including interim quarterly payments. If the participating entity and the department reach an agreement as to the appropriate rate, the rate shall be applied no earlier than the first day of the LIHP year in which the parties agree to the rate.

(f) If authorized under the Special Terms and Conditions of the demonstration project, pending the department's development of rates in accordance with Section 15910.3, the department shall make interim quarterly payments to approved LIHPs for expenditures based on estimated costs submitted for rate setting.

~~(f)~~

(g) Participating entities that operate a LIHP directly or through contract with another entity shall be entitled to any federal financial participation available for administrative expenditures incurred in the operation of the Medi-Cal program or the demonstration project, including, but not limited to, outreach, screening and enrollment, program development, data collection, reporting and quality monitoring, and contract administration, but only to the extent that the expenditures are allowable under federal law and only to the extent the expenditures are not taken into account in the determination of the per enrollee rates under Section 15910.3.

~~(g)~~

(h) On and after January 1, 2014, the state shall implement comprehensive health care reform for the populations targeted by the LIHP in compliance with federal health care reform law, regulation, and policy, including 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 subsequent amendments.

~~(h)~~

(i) Participation in the LIHP under this part is voluntary on the part of the eligible entity for purposes of all applicable federal laws. As part of its voluntary participation under this article, the eligible entity shall agree to reimburse the state for the nonfederal

share of state staffing and administrative costs directly attributable to the cost of administering that LIHP. This section shall be implemented only to the extent federal financial participation is not jeopardized.

SEC. 31. Section 15912 of the Welfare and Institutions Code is amended to read:

15912. (a) Subject to the Special Terms and Conditions of the demonstration project, the department shall ensure that the LIHPs established under this part are evaluated to determine to what extent the projects have met the standards and performance measures described in paragraph (9) of subdivision (b) of Section 15910.2, and the extent to which the LIHPs have complied with the department's program to implement the transition of eligible LIHP enrollees to Medi-Cal coverage, or alternatively, to coverage through the California Health Benefit Exchange, in 2014.

(b) The department may seek federal or private funds or enter into partnership with an independent, nonprofit group or foundation, an academic institution, or a governmental entity providing grants for health-related activities, to evaluate the programs funded under this part.

SEC. 32. Section 15914 of the Welfare and Institutions Code is amended to read:

15914. The application process used by the department to authorize entities to operate LIHPs and any agreements entered into by, or modified by, the department for purposes of this part shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

SEC. 33. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes to publicly funded health care programs at the earliest possible time, it is necessary that this act take effect immediately.

O