Senate Bill No. 98

CHAPTER 358

An act to amend Sections 11155, 11322.85, 11450.025, 14186.11, 14199.1, 17600.15, 17600.50, 17600.60, 17601.75, 17603, 17604, 17606.10, 17610, 17610.5, 17612.1, 17612.2, 17612.3, 17612.5, 17612.6, 17613.1, 17613.2, 17613.3, 17613.4, and 18901.2 of, and to repeal Section 17612.21 of, the Welfare and Institutions Code, relating to public health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor September 26, 2013. Filed with Secretary of State September 26, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 98, Committee on Budget and Fiscal Review. Public health.

Existing law imposes limits on the amount of income and personal and real property an individual or family may possess in order to be eligible for public aid, including under the CalFresh program, and specifies the allowable value of a licensed vehicle retained by an applicant for, or recipient of, that aid.

This bill would change the term "licensed vehicle" to "motor vehicle" for these purposes.

Under existing law, every individual, as a condition of eligibility for aid under the CalWORKs program, is required to participate in certain welfare-to-work activities for a period of 24 months, except as provided. Existing law provides that any month in which certain conditions exist shall not be counted as one of the 24 months of participation.

This bill would make a clarifying change to these provisions. This bill would also make a nonsubstantive technical change to these provisions.

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 requires, to the extent that federal financial participation is available, and pursuant to a demonstration project or waiver of federal law, the department to establish specified pilot projects in up to 8 counties, known as Coordinated Care Initiative counties.

This bill would correct an erroneous cross-reference with respect to a provision of law relating to Coordinated Care Initiative counties.

Existing law establishes the Local Revenue Fund, a continuously appropriated fund that allocates Vehicle License Fund moneys and sales tax moneys. Existing law creates various accounts within the Local Revenue

Fund, including the Sales Tax Account and the Sales Tax Growth Account, which each contain various subaccounts.

Existing law, for the 2013–14 fiscal year and subsequent fiscal years, allocates funds to the Social Services Subaccount, Health Subaccount, and Mental Health Subaccount of the Sales Tax Account using specified calculations.

This bill would modify the calculations used to allocate moneys to the above-described subaccounts, and would also require the Controller to transfer funds between the Social Services Subaccount and the Health Subaccount in an amount not to exceed $300 million for the 2013–14 fiscal year, or $1 billion in any subsequent fiscal year, as specified, thereby making an appropriation.

Existing law requires counties, through a choice of methodologies, to provide specified health services to eligible county residents who are indigent. Existing law authorizes counties to receive funding for this program from the Health Subaccount by either proving actual costs or by electing to receive 60% of the funds that would otherwise have been allocated to them, and would establish a default contribution for counties that fail to make a choice or to inform the Director of Health Care Services by a specified date. Existing law places the difference between prior fiscal year contributions to counties from the Health Subaccount and the new contributions to counties in the Family Support Subaccount, which is established within the Sales Tax Account, to be used by counties for the CalWORKs program, as specified.

With respect to the redirection of funds to the Family Support Subaccount, existing law requires counties to determine the amount or percentage of funding to be redirected and to provide that calculation to the department by a specified date. Existing law provides a specified process to be used if the department disagrees with a county's determination. Existing law authorizes the county to submit a petition to the County Health Care Funding Resolution Committee if no agreement between the parties is reached by a specified date. Existing law also establishes an expedited formal appeal process by which a county may contest the determinations, as specified.

This bill would make technical changes to these provisions and revise the deadlines by which counties must comply with the provisions described above.

Existing law requires the department, in consultation with the counties, to determine the historical low-income shortfall between Medi-Cal and uninsured revenues and the costs incurred by county public hospital health systems for health services to Medi-Cal beneficiaries and uninsured patients. In determining this shortfall, the department is required to apply against that shortfall county indigent realignment amounts, special local health funds specifically restricted for indigent care, amounts from other specified sources of funding, including unrestricted health care funds and one-time funds received or carried forward by a county public hospital health system, and then gains from all other payers.

This bill would require the department, once the department has accounted for amounts for county indigent realignment and special local health funds specifically restricted for indigent care, to determine and apply against the shortfall amounts for special local health funds that are not restricted for indigent care, amounts imputed for county low-income health, and one-time and carry-forward revenues, as defined. The bill would require the department to determine these amounts on a historical basis for the 2008–09 to 2011–12 fiscal years, inclusive.

This bill would also make technical, nonsubstantive changes to these provisions.

Existing law states the Legislature's intent to create a program in California that provides a Low-Income Home Energy Assistance Program (LIHEAP) service benefit, through the LIHEAP block grant, to all recipient households of CalFresh, as specified.

Existing law requires that, if the demand for the nominal LIHEAP service benefit exceeds allocated funding, the Department of Community Services and Development and the State Department of Social Services report that information to the Legislature and develop a plan to maintain the program as intended.

This bill would delete those provisions. The bill would require that the nominal LIHEAP services benefit be funded through the LIHEAP grant allocated for outreach activities in accordance with state and federal requirements.

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

Appropriation: yes.

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

SECTION 1. Section 11155 of the Welfare and Institutions Code, as added by Section 13 of Chapter 21 of the Statutes of 2013, is amended to read:

11155. (a) Notwithstanding Section 11257, in addition to the personal property or resources permitted by other provisions of this part, and to the extent permitted by federal law, an applicant or recipient for aid under this chapter including an applicant or recipient under Chapter 2 (commencing with Section 11200) may retain countable resources in an amount equal to the amount permitted under federal law for qualification for the federal Supplemental Nutrition Assistance Program, administered in California as CalFresh.

(b) The county shall determine the value of exempt personal property other than motor vehicles in conformance with methods established under CalFresh.

(c) (1) (A) The value of each motor vehicle that is not exempt under paragraph (4) shall be the equity value of the vehicle, which shall be the fair market value less encumbrances.

(B) Any motor vehicle with an equity value of nine thousand five hundred dollars ($9,500) or less shall not be attributed to the family's resource level.

(C) For each motor vehicle with an equity value of more than nine thousand five hundred dollars ($9,500), the equity value that exceeds nine thousand five hundred dollars ($9,500) shall be attributed to the family's resource level.

(2) The equity threshold described in paragraph (1) of nine thousand five hundred dollars ($9,500) shall be adjusted upward annually by the increase, if any, in the United States Transportation Consumer Price Index for All Urban Consumers published by the United States Department of Labor, Bureau of Labor Statistics.

(3) The county shall determine the fair market value of the vehicle in accordance with a methodology determined by the department. The applicant or recipient shall self-certify the amount of encumbrance, if any.

(4) The entire value of any motor vehicle shall be exempt if any of the following apply:

(A) It is used primarily for income-producing purposes.

(B) It annually produces income that is consistent with its fair market value, even if used on a seasonal basis.

(C) It is necessary for long distance travel, other than daily commuting, that is essential for the employment of a family member.

(D) It is used as the family's residence.

(E) It is necessary to transport a physically disabled family member, including an excluded disabled family member, regardless of the purpose of the transportation.

(F) It would be exempted under any of subparagraphs (A) to (D), inclusive, but the vehicle is not in use because of temporary unemployment.

(G) It is used to carry fuel for heating for home use, when the transported fuel or water is the primary source of fuel or water for the family.

(H) Ownership of the vehicle was transferred through a gift, donation, or family transfer, as defined by the Department of Motor Vehicles.

(d) This section shall become operative on January 1, 2014.

SEC. 2. Section 11322.85 of the Welfare and Institutions Code, as amended by Section 26 of Chapter 21 of the Statutes of 2013, is amended to read:

11322.85. (a) Unless otherwise exempt, an applicant or recipient shall participate in welfare-to-work activities.

(1) For 24 cumulative months during a recipient's lifetime, these activities may include the activities listed in Section 11322.6 that are consistent with the assessment performed in accordance with Section 11325.4 and that are included in the individual's welfare-to-work plan, as described in Section 11325.21, to meet the hours required in Section 11322.8. These 24 months need not be consecutive.

(2) Any month in which the recipient meets the requirements of Section 11322.8, through participation in an activity or activities described in paragraph (3), shall not count as a month of activities for purposes of the 24-month time limit described in paragraph (1).

(3) After a total of 24 months of participation in welfare-to-work activities pursuant to paragraph (1), an aided adult shall participate in one or more of the following welfare-to-work activities, in accordance with Section 607(c) and (d) of Title 42 of the United States Code as of the operative date of this section, that are consistent with the assessment performed in accordance with Section 11325.4, and included in the individual's welfare-to-work plan, described in Section 11325.21:

(A) Unsubsidized employment.

(B) Subsidized private sector employment.

(C) Subsidized public sector employment.

(D) Work experience, including work associated with the refurbishing of publicly assisted housing, if sufficient private sector employment is not available.

(E) On-the-job training.

(F) Job search and job readiness assistance.

(G) Community service programs.

(H) Vocational educational training (not to exceed 12 months with respect to any individual).

(I) Job skills training directly related to employment.

(J) Education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency.

(K) Satisfactory attendance at a secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate.

(L) The provision of child care services to an individual who is participating in a community service program.

(b) Any month in which any of the following conditions exists shall not be counted as one of the 24 months of participation allowed under paragraph (1) of subdivision (a):

(1) The recipient is participating in job search or assessment pursuant to subdivision (a) or (b) of Section 11320.1, is in the process of appraisal as described in Section 11325.2, or is participating in the development of a welfare-to-work plan, as described in Section 11325.21.

(2) The recipient is no longer receiving aid, pursuant to Sections 11327.4 and 11327.5.

(3) The recipient has been excused from participation for good cause, pursuant to Section 11320.3.

(4) The recipient is exempt from participation pursuant to subdivision (b) of Section 11320.3.

(5) The recipient is only required to participate in accordance with subdivision (d) of Section 11320.3.

(c) County welfare departments shall provide each recipient who is subject to the requirements of paragraph (3) of subdivision (a) written notice describing the 24-month time limitation described in that paragraph and the process by which recipients may claim exemptions from, and extensions to, those requirements.

(d) The notice described in subdivision (c) shall be provided at the time the individual applies for aid, during the recipient's annual redetermination, and at least once after the individual has participated for a total of 18 months, and prior to the end of the 21st month, that count toward the 24-month time limit.

(e) The notice described in this section shall include, but shall not be limited to, all of the following:

(1) The number of remaining months the adult recipient may be eligible to receive aid.

(2) The requirements that the recipient must meet in accordance with paragraph (3) of subdivision (a) and the action that the county will take if the adult recipient does not meet those requirements.

(3) The manner in which the recipient may dispute the number of months counted toward the 24-month time limit.

(4) The opportunity for the recipient to modify his or her welfare-to-work plan to meet the requirements of paragraph (3) of subdivision (a).

(5) The opportunity for an exemption to, or extension of, the 24-month time limitation.

(f) For an individual subject to the requirements of paragraph (3) of subdivision (a), who is not exempt or granted an extension, and who does not meet those requirements, the provisions of Sections 11327.4, 11327.5, 11327.9, and 11328.2 shall apply to the extent consistent with the requirements of this section. For purposes of this section, the procedures referenced in this subdivision shall not be described as sanctions.

(g) (1) The department, in consultation with stakeholders, shall convene a workgroup to determine further details of the noticing and engagement requirements for the 24-month time limit, and shall instruct counties via an all-county letter, followed by regulations, no later than 18 months after the effective date of the act that added this section.

(2) The workgroup described in paragraph (1) may also make recommendations to refine or differentiate the procedures and due process requirements applicable to individuals as described in subdivision (f).

(h) (1) Notwithstanding paragraph (3) of subdivision (a) or any other law, an assistance unit that contains an eligible adult who has received assistance under this chapter, or from any state pursuant to the Temporary Assistance for Needy Families program (Part A (commencing with Section 401) of Title IV of the federal Social Security Act (42 U.S.C. Sec. 601 et seq.)) prior to January 1, 2013, may continue in a welfare-to-work plan that meets the requirements of Section 11322.6 for a cumulative period of 24 months commencing January 1, 2013, unless or until he or she exceeds the 48-month time limitation described in Section 11454.

(2) All months of assistance described in paragraph (1) prior to January 1, 2013, shall not be applied to the 24-month limitation described in paragraph (1) of subdivision (a).

(i) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 3. Section 11322.85 of the Welfare and Institutions Code, as added by Section 27 of Chapter 21 of the Statutes of 2013, is amended to read:

11322.85. (a) Unless otherwise exempt, an applicant or recipient shall participate in welfare-to-work activities.

(1) For 24 cumulative months during a recipient's lifetime, these activities may include the activities listed in Section 11322.6 that are consistent with the assessment performed in accordance with Section 11325.4 and that are included in the individual's welfare-to-work plan, as described in Section 11325.21, to meet the hours required in Section 11322.8. These 24 months need not be consecutive.

(2) Any month in which the recipient meets the requirements of Section 11322.8, through participation in an activity or activities described in paragraph (3), shall not count as a month of activities for purposes of the 24-month time limit described in paragraph (1).

(3) After a total of 24 months of participation in welfare-to-work activities pursuant to paragraph (1), an aided adult shall participate in one or more of the following welfare-to-work activities, in accordance with Section 607(c) and (d) of Title 42 of the United States Code as of the operative date of this section, that are consistent with the assessment performed in accordance with Section 11325.4, and included in the individual's welfare-to-work plan, described in Section 11325.21:

(A) Unsubsidized employment.

(B) Subsidized private sector employment.

(C) Subsidized public sector employment.

(D) Work experience, including work associated with the refurbishing of publicly assisted housing, if sufficient private sector employment is not available.

(E) On-the-job training.

(F) Job search and job readiness assistance.

(G) Community service programs.

(H) Vocational educational training (not to exceed 12 months with respect to any individual).

(I) Job skills training directly related to employment.

(J) Education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency.

(K) Satisfactory attendance at a secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate.

(L) The provision of child care services to an individual who is participating in a community service program.

(b) Any month in which any of the following conditions exists shall not be counted as one of the 24 months of participation allowed under paragraph (1) of subdivision (a):

(1) The recipient is participating in job search in accordance with Section 11325.22, assessment pursuant to Section 11325.4, is in the process of

appraisal as described in Section 11325.2, or is participating in the development of a welfare-to-work plan as described in Section 11325.21.

(2) The recipient is no longer receiving aid, pursuant to Sections 11327.4 and 11327.5.

(3) The recipient has been excused from participation for good cause, pursuant to Section 11320.3.

(4) The recipient is exempt from participation pursuant to subdivision (b) of Section 11320.3.

(5) The recipient is only required to participate in accordance with subdivision (d) of Section 11320.3.

(6) The recipient is participating in family stabilization pursuant to Section 11325.24, and the recipient would meet the criteria for good cause pursuant to Section 11320.3. This paragraph may apply to a recipient for no more than six cumulative months.

(c) County welfare departments shall provide each recipient who is subject to the requirements of paragraph (3) of subdivision (a) written notice describing the 24-month time limitation described in that paragraph and the process by which recipients may claim exemptions from, and extensions to, those requirements.

(d) The notice described in subdivision (c) shall be provided at the time the individual applies for aid, during the recipient's annual redetermination, and at least once after the individual has participated for a total of 18 months, and prior to the end of the 21st month, that count toward the 24-month time limit.

(e) The notice described in this section shall include, but shall not be limited to, all of the following:

(1) The number of remaining months the adult recipient may be eligible to receive aid.

(2) The requirements that the recipient must meet in accordance with paragraph (3) of subdivision (a) and the action that the county will take if the adult recipient does not meet those requirements.

(3) The manner in which the recipient may dispute the number of months counted toward the 24-month time limit.

(4) The opportunity for the recipient to modify his or her welfare-to-work plan to meet the requirements of paragraph (3) of subdivision (a).

(5) The opportunity for an exemption to, or extension of, the 24-month time limitation.

(f) For an individual subject to the requirements of paragraph (3) of subdivision (a), who is not exempt or granted an extension, and who does not meet those requirements, the provisions of Sections 11327.4, 11327.5, 11327.9, and 11328.2 shall apply to the extent consistent with the requirements of this section. For purposes of this section, the procedures referenced in this subdivision shall not be described as sanctions.

(g) (1) The department, in consultation with stakeholders, shall convene a workgroup to determine further details of the noticing and engagement requirements for the 24-month time limit, and shall instruct counties via an

all-county letter, followed by regulations, no later than 18 months after the effective date of the act that added this section.

(2) The workgroup described in paragraph (1) may also make recommendations to refine or differentiate the procedures and due process requirements applicable to individuals as described in subdivision (f).

(h) (1) Notwithstanding paragraph (3) of subdivision (a) or any other law, an assistance unit that contains an eligible adult who has received assistance under this chapter, or from any state pursuant to the Temporary Assistance for Needy Families program (Part A (commencing with Section 401) of Title IV of the federal Social Security Act (42 U.S.C. Sec. 601 et seq.)) prior to January 1, 2013, may continue in a welfare-to-work plan that meets the requirements of Section 11322.6 for a cumulative period of 24 months commencing January 1, 2013, unless or until he or she exceeds the 48-month time limitation described in Section 11454.

(2) All months of assistance described in paragraph (1) prior to January 1, 2013, shall not be applied to the 24-month limitation described in paragraph (1) of subdivision (a).

(i) This section shall become operative on January 1, 2014.

SEC. 4. Section 11450.025 of the Welfare and Institutions Code is amended to read:

11450.025. (a) Notwithstanding any other law, effective on March 1, 2014, the maximum aid payments in effect on July 1, 2012, as specified in subdivision (b) of Section 11450.02, shall be increased by 5 percent.

(b) Commencing in 2014 and annually thereafter, on or before January 10 and on or before May 14, the Director of Finance shall do all of the following:

(1) Estimate the amount of growth revenues pursuant to subdivision (f) of Section 17606.10 that will be deposited in the Child Poverty and Family Supplemental Support Subaccount of the Local Revenue Fund for the current fiscal year and the following fiscal year and the amounts in the subaccount carried over from prior fiscal years.

(2) For the current fiscal year and the following fiscal year, determine the total cost of providing the increase described in subdivision (a), as well as any other increase in the maximum aid payments subsequently provided only under this section, after adjusting for updated projections of CalWORKs costs associated with caseload changes, as reflected in the local assistance subvention estimates prepared by the State Department of Social Services and released with the annual Governor's Budget and subsequent May Revision update.

(3) If the amount estimated in paragraph (1) plus the amount projected to be deposited for the current fiscal year into the Child Poverty and Family Supplemental Support Subaccount pursuant to subparagraph (3) of subdivision (e) of Section 17600.15 is greater than the amount determined in paragraph (2), the difference shall be used to calculate the percentage increase to the CalWORKs maximum aid payment standards that could be fully funded on an ongoing basis beginning the following fiscal year.

(4) If the amount estimated in paragraph (1) plus the amount projected to be deposited for the current fiscal year into the Child Poverty and Family Supplemental Support Subaccount pursuant to subparagraph (3) of subdivision (e) of Section 17600.15 is equal to or less than the amount determined in paragraph (2), no additional increase to the CalWORKs maximum aid payment standards shall be provided in the following fiscal year in accordance with this section.

(5) (A) Commencing with the 2014–15 fiscal year and for all fiscal years thereafter, if changes to the estimated amounts determined in paragraphs (1) or (2), or both, as of the May Revision, are enacted as part of the final budget, the Director of Finance shall repeat, using the same methodology used in the May Revision, the calculations described in paragraphs (3) and (4) using the revenue projections and grant costs assumed in the enacted budget.

(B) If a calculation is required pursuant to subparagraph (A), the Department of Finance shall report the result of this calculation to the appropriate policy and fiscal committees of the Legislature upon enactment of the Budget Act.

(c) An increase in maximum aid payments calculated pursuant to paragraph (3) of subdivision (b), or pursuant to paragraph (5) of subdivision (b) if applicable, shall become effective on October 1 of the following fiscal year.

(d) (1) An increase in maximum aid payments provided in accordance with this section shall be funded with growth revenues from the Child Poverty and Family Supplemental Support Subaccount in accordance with paragraph (3) of subdivision (e) of Section 17600.15 and subdivision (f) of Section 17606.10, to the extent funds are available in that subaccount.

(2) If funds received by the Child Poverty and Family Supplemental Support Subaccount in a particular fiscal year are insufficient to fully fund any increases to maximum aid payments made pursuant to this section, the remaining cost for that fiscal year will be addressed through existing provisional authority included in the annual Budget Act. Additional grant increases shall not be provided until and unless the ongoing cumulative costs of all prior grant increases provided pursuant to this section are fully funded by the Child Poverty and Family Supplemental Support Subaccount.

(e) Notwithstanding Section 15200, counties shall not be required to contribute a share of cost to cover the costs of increases to maximum aid payments made pursuant to this section.

SEC. 5. Section 14186.11 of the Welfare and Institutions Code is amended to read:

14186.11. Section 14182.17 shall apply to the provision of CBAS, MSSP, skilled nursing facility, and IHSS services in Coordinated Care Initiative counties as set forth in this article.

SEC. 6. Section 14199.1 of the Welfare and Institutions Code is amended to read:

14199.1. (a) The Legislature finds and declares the following:

(1) Beginning January 1, 2014, many low-income individuals will be eligible for Medi-Cal coverage pursuant to federal law, as part of health care reform.

(2) In implementing this expansion of Medi-Cal coverage, it is critical to maintain the role of county public hospital health systems that have traditionally served Medi-Cal and uninsured beneficiaries to ensure adequate access to care is available for the new Medi-Cal members, and to preserve the policy goal to support and strengthen traditional safety net providers who treat a high volume of uninsured and Medi-Cal patients.

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

(1) "County public hospital health system" shall have the meaning provided in subdivision (f) of Section 17612.2.

(2) "Default members" means newly eligible beneficiaries enrolled in each Medi-Cal managed care plan who do not affirmatively select a primary care provider as part of the enrollment process.

(3) "Enrollment target" means the number of newly eligible beneficiaries assigned to primary care providers within a county public hospital health system, not to exceed the number of unduplicated Low Income Health Program and uninsured patient count in the county public hospital health system. The unduplicated patient count shall be certified by the county public hospital health system and provided to the department, along with its proposed enrollment target, by November 30, 2013. The county public hospital health system may notify the department of a proposed reduction to its enrollment target based on its capacity to accept new patients. A standardized protocol for determining the target shall be developed by the department in consultation with the public hospital health system counties.

(4) "Low Income Health Program" shall mean the LIHP as defined in subdivision (c) of Section 15909.1.

(5) "Medi-Cal managed care plan" means an organization or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.91 (commencing with Section 14089), or Chapter 8 (commencing with Section 14200).

(6) "Newly eligible beneficiaries" shall have the meaning provided in subdivision (s) of Section 17612.2.

(7) "Primary care provider" means a primary care physician or nonphysician medical practitioner, medical group, clinic, or a medical home.

(8) "Public hospital health system county" shall have the meaning provided in subdivision (u) of Section 17612.2.

(c) Subject to subdivision (d), default members who reside in a public hospital health system county shall be assigned by each Medi-Cal managed care plan in the county to a primary care provider in accordance with the following:

(1) Throughout the three-year period ending on December 31, 2016, at least 75 percent of default members shall be assigned by each Medi-Cal managed care plan to primary care providers within the county public

hospital health system until the county public hospital health system meets its enrollment target.

(2) Following the expiration of the three-year period set forth in paragraph (1), at least 50 percent of default members shall be assigned by each Medi-Cal managed care plan to primary care providers within the county public hospital health system until the county public hospital health system meets its applicable enrollment target.

(3) Paragraphs (1) and (2) shall not apply with respect to a county public hospital health system during any time period in which the county public hospital health system meets or exceeds its applicable target. For time periods during which paragraphs (1) and (2) do not apply, default members shall be assigned to primary care providers in the same manner as other Medi-Cal members of the Medi-Cal managed care plan who do not affirmatively select primary care providers. Medi-Cal managed care plans shall not modify the assignment procedures due to the default assignment requirements of this section with respect to primary care providers within the county public hospital health system.

(4) In implementing the assignment process set forth in paragraphs (1) and (2), to the extent legally permissible and consistent with federal and state privacy and patient confidentiality laws, each Medi-Cal managed care plan shall first assign to a primary care provider within the county public hospital health system those default members who have accessed care within the county public hospital health system two or more times within the past 12 months. The department and the county public hospital health systems shall work together to share patient information in order to provide the Medi-Cal managed care plans with data demonstrating which default members have accessed the county public hospital health system providers prior to assignment to a primary care provider.

(5) If at any time a county public hospital health system notifies a contracted Medi-Cal managed care plan that it has reached its maximum capacity for the assignment of default members, the requirements set forth in paragraphs (1) and (2) shall not apply to the Medi-Cal managed care plan so notified. Once the county public hospital health system notifies a Medi-Cal managed care plan that it has capacity to accept assignment of default members, the requirements set forth in paragraphs (1) and (2) shall apply effective on the first day of the month following that notice.

(6) A Medi-Cal managed care plan shall not assign default members to a primary care provider within the county public hospital health system if that primary care provider has notified the Medi-Cal managed care plan that it does not have capacity to accept new patients.

(d) The default process described in this section shall not apply to Low Income Health Program enrollees subject to Section 14005.61.

(e) Nothing set forth in this section shall alter, reduce, or modify in any manner the way in which Medi-Cal managed care plans assign other Medi-Cal members to the county public hospital health systems.

(f) (1) The department shall modify its contracts with the Medi-Cal managed care plans in public hospital health system counties to include the assignment requirements set forth in this section.

(2) Each Medi-Cal managed care plan shall demonstrate and certify that it has contracts or other arrangements in place with county public hospital health systems that provide for implementing the requirements of this section. To the extent a Medi-Cal managed care plan is not compliant with any of the requirements of this section, the department shall reduce by 25 percent the default assignment into the Medi-Cal managed care plan with respect to all Medi-Cal beneficiaries, as long as the other Medi-Cal managed care plan or plans in that county have the capacity to receive the additional default membership.

(g) Nothing in this section shall modify the ability of newly eligible beneficiaries to select or change their primary care providers.

(h) The department shall seek any necessary federal approvals to implement the provisions of this section.

SEC. 7. Section 17600.15 of the Welfare and Institutions Code is amended to read:

17600.15. (a) Of the sales tax proceeds from revenues collected in the 1991–92 fiscal year which are deposited to the credit of the Local Revenue Fund, 51.91 percent shall be credited to the Mental Health Subaccount, 36.17 percent shall be credited to the Social Services Subaccount, and 11.92 percent shall be credited to the Health Subaccount of the Sales Tax Account.

(b) For the 1992–93 fiscal year to the 2011–12 fiscal year, inclusive, of the sales tax proceeds from revenues deposited to the credit of the Local Revenue Fund, the Controller shall make monthly deposits to the Mental Health Subaccount, the Social Services Subaccount, and the Health Subaccount of the Sales Tax Account until the deposits equal the amounts that were allocated to counties, cities, and cities and counties mental health accounts, social services accounts, and health accounts, respectively, of the local health and welfare trust funds in the prior fiscal year pursuant to this chapter from the Sales Tax Account and the Sales Tax Growth Account. Any excess sales tax revenues received pursuant to Sections 6051.2 and 6201.2 of the Revenue and Taxation Code shall be deposited in the Sales Tax Growth Account of the Local Revenue Fund.

(c) (1) For the 2012–13 fiscal year, of the sales tax proceeds from revenues deposited to the credit of the Local Revenue Fund, the Controller shall make monthly deposits to the Social Services Subaccount and the Health Subaccount of the Sales Tax Account until the deposits equal the amounts that were allocated to counties', cities', and city and counties social services accounts and health accounts, respectively, of the local health and welfare trust funds in the prior fiscal year pursuant to this chapter from the Sales Tax Account and the Sales Tax Growth Account.

(2) For the 2012–13 fiscal year, of the sales tax proceeds from revenues deposited to the credit of the Local Revenue Fund, the Controller shall make monthly deposits to the Mental Health Subaccount of the Sales Tax Account until the deposits equal the amounts that were allocated to counties', cities',

and city and counties CalWORKs Maintenance of Effort Subaccounts pursuant to subdivision (a) of Section 17601.25, and any additional amounts above the amount specified in subdivision (a) of Section 17601.25, of the local health and welfare trust funds in the prior fiscal year pursuant to this chapter from the Sales Tax Account and the Sales Tax Growth Account. The Controller shall not include in this calculation any funding deposited in the Mental Health Subaccount from the Support Services Growth Subaccount pursuant to Section 30027.9 of the Government Code or funds described in subdivision (c) of Section 17601.25.

(3) Any excess sales tax revenues received pursuant to Sections 6051.2 and 6201.2 of the Revenue and Taxation Code after the allocations required by paragraphs (1) and (2) are made shall be deposited in the Sales Tax Growth Account of the Local Revenue Fund.

(d) (1) For the 2013–14 fiscal year, of the sales tax proceeds from revenues deposited to the credit of the Local Revenue Fund, the Controller shall make monthly deposits pursuant to a schedule provided by the Department of Finance, which shall provide deposits to the Social Services Subaccount and the Health Subaccount of the Sales Tax Account until the deposits equal the amounts that were allocated to counties', cities', and city and counties' social services accounts and health accounts, respectively, of the local health and welfare trust funds in the prior fiscal year pursuant to this chapter from the Sales Tax Account and the Sales Tax Growth Account.

(2) For the 2013–14 fiscal year, of the sales tax proceeds from revenues deposited to the credit of the Local Revenue Fund, the Controller shall make monthly deposits to the Mental Health Subaccount of the Sales Tax Account until the deposits equal the amounts that were allocated to counties', cities', and cities and counties' CalWORKs Maintenance of Effort Subaccounts pursuant to subdivision (a) of Section 17601.25, and any additional amounts above the amount specified in subdivision (a) of Section 17601.25, of the local health and welfare trust funds in the prior fiscal year pursuant to this chapter from the Sales Tax Account and the Sales Tax Growth Account. The Controller shall not include in this calculation any funding deposited in the Mental Health Subaccount from the Support Services Growth Subaccount pursuant to Section 30027.9 of the Government Code or funds described in subdivision (c) of Section 17601.25.

(3) Any excess sales tax revenues received pursuant to Sections 6051.2 and 6201.2 of the Revenue and Taxation Code after the allocations required by paragraphs (1) and (2) are made shall be deposited in the Sales Tax Growth Account of the Local Revenue Fund.

(4) On a monthly basis, pursuant to a schedule provided by the Department of Finance, the Controller shall transfer funds from the Social Services Subaccount to the Health Subaccount in an amount that shall not exceed three hundred million dollars ($300,000,000) for the 2013–14 fiscal year. The funds so transferred shall not be used in calculating future year deposits to the Social Services Subaccount or the Health Subaccount.

(e) For the 2014–15 fiscal year and fiscal years thereafter, of the sales tax proceeds from revenues deposited to the credit of the Local Revenue Fund, the Controller shall make the following monthly deposits:

(1) To the Social Services Subaccount of the Sales Tax Account, until the deposits equal the total amount that was deposited to the Social Services Subaccount in the prior fiscal year pursuant to this section, in addition to the amounts that were allocated to the social services accounts of the local health and welfare trust funds in the prior fiscal year pursuant to this chapter from the Sales Tax Growth Account.

(2) To the Health Subaccount of the Sales Tax Account, until the deposits equal the total amount that was deposited to the Health Subaccount in the prior year from the Sales Tax Account in addition to the amounts that were allocated to the health accounts of the local health and welfare trust funds in the prior fiscal year pursuant to this chapter from the Sales Tax Growth Account.

(3) To the Child Poverty and Family Supplemental Support Subaccount until the deposits equal the amounts that were deposited in the prior fiscal year from the Sales Tax Account and the Sales Tax Growth Account.

(4) To the Mental Health Subaccount of the Sales Tax Account until the deposits equal the amounts that were allocated to counties', cities', and cities and counties' CalWORKs Maintenance of Effort Subaccounts pursuant to subdivision (a) of Section 17601.25, and any additional amounts above the amount specified in subdivision (a) of Section 17601.25 of the local health and welfare trust funds in the prior fiscal year pursuant to this chapter from the Sales Tax Account and the Sales Tax Growth Account. The Controller shall not include in this calculation any funding deposited in the Mental Health Subaccount from the Support Services Growth Subaccount pursuant to Section 30027.9 of the Government Code or funds described in subdivision (c) of Section 17601.25.

(5) Any excess sales tax revenues received pursuant to Sections 6051.2 and 6201.2 of the Revenue and Taxation Code after the allocations required by paragraphs (1) to (4), inclusive, are made shall be deposited in the Sales Tax Growth Account of the Local Revenue Fund.

(6) On a monthly basis, pursuant to a schedule provided by the Department of Finance, the Controller shall transfer funds from the Social Services Subaccount to the Health Subaccount in an amount that shall not exceed one billion dollars ($1,000,000,000) in any fiscal year. The transfer schedule shall be based on the amounts that each county is receiving in vehicle license fees pursuant to this chapter. The funds so transferred shall not be used in calculating future year deposits to the Social Services Subaccount or the Health Subaccount.

SEC. 8. Section 17600.50 of the Welfare and Institutions Code is amended to read:

17600.50. (a) A county that participated in the County Medical Services Program in the 2011–12 fiscal year, including the Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino,

Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, and Yuba and the Governing Board of the County Medical Services Program, shall adopt resolutions by January 22, 2014, that confirm acceptance for the following approach to determining payments to the Family Support Subaccount:

(1) The amount of payments to the Family Support Subaccount shall be equal to 60 percent of the sum of the following:

(A) The 1991 health realignment funds that would have otherwise been allocated to the counties listed above pursuant to Sections 17603, 17604, and 17606.20 and the maintenance of effort in subdivision (a) of Section 17608.10 for these counties, as those sections read on January 1, 2012, and Section 17606.10 as it read on July 1, 2013.

(B) The 1991 health realignment funds that would have otherwise been allocated to the County Medical Services Program pursuant to Sections 17603, 17604, 17605.07, and 17606.20, as those sections read on January 1, 2012.

(2) The payment computed in paragraph (1) shall be achieved through the following:

(A) Each county listed in subdivision (a) shall pay the amounts otherwise payable to the County Medical Services Program pursuant to subparagraph (B) of paragraph (2) of subdivision (j) of Section 16809 to the Family Support Subaccount.

(B) The County Medical Services Program shall pay the difference between the total computed in paragraph (1) and the amount calculated in subparagraph (A) from funds provided pursuant to the Welfare and Institutions Code.

(b) The Counties of Fresno, Merced, Orange, Placer, Sacramento, San Diego, San Luis Obispo, Santa Barbara, Santa Cruz, Stanislaus, Tulare, and Yolo shall each tentatively inform the state by November 1, 2013, which of the following options it selects for determining its payments to the Family Support Subaccount. On or before January 22, 2014, the board of supervisors of each county and city and county may adopt a resolution informing the state of the county's or city and county's final selection of the option for determining its payments to the Family Support Subaccount:

(1) The formula detailed in Article 13 (commencing with Section 17613.1).

(2) (A) A calculation of 60 percent of the total of 1991 health realignment funds that would have otherwise been allocated to that county or city and county pursuant to Sections 17603, 17604, and 17606.20, as those sections read on January 1, 2012, and Section 17606.10, as it read on July 1, 2013, and 60 percent of the maintenance of effort in subdivision (a) of Section 17608.10, as it read on January 1, 2012.

(B) If a county's maintenance of effort in subdivision (a) of Section 17608.10 is greater than 14.6 percent of the total value of the county's 2010–11 allocation pursuant to Sections 17603, 17604, 17606.10, and 17606.20 and subdivision (a) of Section 17608.10, the value of the

maintenance of effort used in the calculation in subparagraph (A) shall be limited to 14.6 percent.

(c) The Counties of Alameda, Contra Costa, Kern, Los Angeles, Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, and Ventura shall each tentatively inform the state by November 1, 2013, which of the following options it selects for determining its payments to the Family Support Subaccount. On or before January 22, 2014, the board of supervisors of each county and city and county may adopt a resolution informing the state of the county's or city and county's final selection of the option for determining its payments to the Family Support Subaccount:

(1) The formula detailed in Article 12 (commencing with Section 17612.1).

(2) (A) A calculation of 60 percent of the total of 1991 health realignment funds that would have otherwise been allocated to that county or city and county pursuant to Sections 17603, 17604, and 17606.20, as those sections read on January 1, 2012, and Section 17606.10, as it read on July 1, 2013, and 60 percent of the maintenance of effort in subdivision (a) of Section 17608.10, as it read on January 1, 2012.

(B) If a county's maintenance of effort in subdivision (a) of Section 17608.10 is greater than 25.9 percent of the total value of the county's 2010–11 fiscal year allocation pursuant to Sections 17603, 17604, 17606.10, and 17606.20, and subdivision (a) of Section 17608.10, the value of the maintenance of effort used in the calculation in subparagraph (A) shall be limited to 25.9 percent.

(d) (1) If the board of supervisors of a county or city and county fails to adopt a resolution pursuant to subdivision (b) or (c), as applicable, or fails to inform the Director of Health Care Services of the city and county or county's final selection, by January 22, 2014, the calculation shall be 62.5 percent of the total of 1991 health realignment funds that would have otherwise been allocated to that county or city and county pursuant to Sections 17603, 17604, and 17606.20, as those sections read on January 1, 2012, and Section 17606.10, as it read on July 1, 2013, and 62.5 percent of the maintenance of effort in subdivision (a) of Section 17608.10, as it read on January 1, 2012.

(2) If the County Medical Services Program governing board or the board of supervisors of a county that participates in the County Medical Services Program fails to adopt a resolution pursuant to subdivision (a), or fails to inform the Director of Health Care Services of the county's final selection, by January 22, 2014, then paragraphs (1) and (2) of subdivision (a) apply to the applicable counties and to the County Medical Services Program.

SEC. 9. Section 17600.60 of the Welfare and Institutions Code is amended to read:

17600.60. (a) The County Health Care Funding Resolution Committee is hereby created to do all of the following:

(1) Determine whether the calculation of the historical percentage or amount to be applied in calculations in Sections 17612.3 and 17613.3

complies with those sections, taking into account the data and calculations provided by the county and any alternative data and calculations submitted by the department.

(2) Hear and determine petitions from certain counties, as defined, to make particularized changes in what provisions of Section 17600.50 are controlling.

(3) Hear and determine petitions for an alternative cost calculation to the cost per person calculation in subdivision (c) of Section 17613.2.

(b) The committee shall consist of the following members:

(1) One person selected by the California State Association of Counties.

(2) One person selected by the State Department of Health Care Services.

(3) One person selected by the Director of Finance.

(c) (1) The committee is not subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code) and shall be exempt from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The Department of Finance shall provide staff for the committee.

(2) Pursuant to paragraph (2) of subdivision (b) of Section 3 of Article I of the California Constitution, the Legislature finds and declares that the public interest in affordable and accessible health care outweighs the public interest in access to these proceedings.

(d) (1) A county or city and county, that chose to be subject to paragraph (2) of subdivision (b) or paragraph (2) of subdivision (c) of Section 17600.50 may submit a petition to the committee to be subject to paragraph (1) of subdivision (b) or paragraph (1) of subdivision (c) of Section 17600.50, as applicable, if the county or city and county demonstrates and provides sufficient evidence of both of the following criteria:

(A) There have been changes in expenditures related to state and federal law, regulation and rulemaking, or court decisions that have a material impact on the provision of health care services to indigent adults.

(B) All of the data necessary to participate in Article 12 (commencing with Section 17612.1) or Article 13 (commencing with Section 17613.1), as appropriate.

(2) The form of petition shall be determined by the committee by January 31, 2014.

(3) If the committee approves the petition the county or city and county shall be subject to paragraph (1) of subdivision (b) or paragraph (1) of subdivision (c) of Section 17600.50, as applicable, at the start of the next fiscal year.

(e) (1) A county that chose to be subject to Article 13 (commencing with Section 17613.1) may submit a petition to the committee for an alternative cost calculation to the cost per person calculation in subdivision (c) of Section 17613.2 with the documentation of extraordinary circumstances, including circumstances related to the local health care marketplace, provider, and provider contracts.

(2) The county shall submit all necessary data to support its submission.

(f) The committee shall make decisions within 45 days of hearing any petition.

SEC. 10. Section 17601.75 of the Welfare and Institutions Code is amended to read:

17601.75. (a) On or before the 27th day of the month, the Controller shall allocate to the family support account in the local health and welfare trust fund of each county and city and county the amounts deposited and remaining unexpended and unreserved on the 15th day of the month in the Family Support Subaccount of the Local Revenue Fund, pursuant to schedules developed by the Department of Finance in conjunction with the appropriate state departments and in consultation with the California State Association of Counties.

(b) All of the funds deposited in the family support account shall be used by each county and city and county that receives an allocation of those funds to pay an increased county contribution toward the costs of CalWORKs grants. Each county's total annual contribution pursuant to this section shall equal the total amount of funds deposited in each county's and city and county's family support account during that fiscal year. The family support account shall not be subject to the transferability provisions of Section 17600.20. Each county's contribution pursuant to this section and Section 17601.25 shall be in addition to the shares of cost required pursuant to Section 15200.

SEC. 11. Section 17603 of the Welfare and Institutions Code is amended to read:

17603. This paragraph shall only apply until the end of the 2012–13 fiscal year. On or before the 27th day of each month, the Controller shall allocate to the local health and welfare trust fund health accounts the amounts deposited and remaining unexpended and unreserved on the 15th day of the month in the Health Subaccount of the Sales Tax Account of the Local Revenue Fund, in accordance with subdivisions (a) and (b):

(a) For the 1991–92 fiscal year, allocations shall be made in accordance with the following schedule:

Jurisdiction	Allocation Percentage
Alameda	4.5046
Alpine	0.0137
Amador	0.1512
Butte	0.8131
Calaveras	0.1367
Colusa	0.1195
Contra Costa	2.2386
Del Norte	0.1340
El Dorado	0.5228
Fresno	2.3531
Glenn	0.1391
Humboldt	0.8929

Imperial	0.8237
Inyo	0.1869
Kern	1.6362
Kings	0.4084
Lake	0.1752
Lassen	0.1525
Los Angeles	37.2606
Madera	0.3656
Marin	1.0785
Mariposa	0.0815
Mendocino	0.2586
Merced	0.4094
Modoc	0.0923
Mono	0.1342
Monterey	0.8975
Napa	0.4466
Nevada	0.2734
Orange	5.4304
Placer	0.2806
Plumas	0.1145
Riverside	2.7867
Sacramento	2.7497
San Benito	0.1701
San Bernardino	2.4709
San Diego	4.7771
San Francisco	7.1450
San Joaquin	1.0810
San Luis Obispo	0.4811
San Mateo	1.5937
Santa Barbara	0.9418
Santa Clara	3.6238
Santa Cruz	0.6714
Shasta	0.6732
Sierra	0.0340
Siskiyou	0.2246
Solano	0.9377
Sonoma	1.6687
Stanislaus	1.0509
Sutter	0.4460
Tehama	0.2986
Trinity	0.1388
Tulare	0.7485
Tuolumne	0.2357
Ventura	1.3658
Yolo	0.3522
Yuba	0.3076
Berkeley	0.0692

Long Beach	0.2918
Pasadena	0.1385

(b) For the 1992–93 fiscal year and fiscal years thereafter until the commencement of the 2013–14 fiscal year, the allocations to each county and city and county shall equal the amounts received in the prior fiscal year by each county, city, and city and county from the Sales Tax Account and the Sales Tax Growth Account of the Local Revenue Fund into the health and welfare trust fund.

(c) (1) For the 2013–14 fiscal year, on the 27th day of each month, the Controller shall allocate, in the same proportion as funds in subdivision (b) were allocated, to each county's and city and county's local health and welfare trust fund health accounts, the amounts deposited and remaining unexpended and unreserved on the 15th day of the month in the Health Subaccount of the Sales Tax Account of the Local Revenue Fund.

(2) (A) Beginning January 2014 and for the remainder of the 2013–14 fiscal year, on or before the 27th of each month, the Controller shall transfer to the Family Support Subaccount from the Health Subaccount amounts determined pursuant to a schedule prepared by the Department of Finance in consultation with the California State Association of Counties. Cumulatively, no more than three hundred million dollars ($300,000,000) shall be transferred.

(B) Every month, after the transfers in subparagraph (A) have occurred, the remainder shall be allocated to the counties and cities and counties in the same proportions as funds in subdivision (b) were allocated.

(C) For counties participating in the County Medical Services Program, transfers from each county shall not be greater than the monthly amount the county would otherwise pay pursuant to paragraph (2) of subdivision (j) of Section 16809 for participation in the County Medical Services Program. Any difference between the amount paid by these counties and the proportional share of the three hundred million dollars ($300,000,000) calculated as payable by these counties and the County Medical Services Program shall be paid from the funds available for allocation to the County Medical Services Program in accordance with the Welfare and Institutions Code.

(3) For the 2013–14 fiscal year, the Controller, using the same timing and criteria used in paragraph (1), shall allocate to each city, not to include a city and county, funds that shall equal the amounts received in the prior fiscal year by each city from the Sales Tax Account and the Sales Tax Growth Account of the Local Revenue Fund into the health and welfare trust fund.

(d) (1) (A) For the 2014–15 fiscal year and for every fiscal year thereafter, the Department of Finance, in consultation with the California State Association of Counties, shall calculate the amount each county or city and county shall contribute to the Family Support Subaccount in accordance with Section 17600.50.

(B) On or before the 27th of each month, the Controller shall transfer, based on a schedule prepared the Department of Finance in consultation with the California State Association of Counties, from the funds deposited and remaining unexpended and unreserved on the 15th day of the month in the Health Subaccount of the Sales Tax Account of the Local Revenue Fund to the Family Support Subaccount, funds that equal, over the course of the year, the amount determined in subparagraph (A) pursuant to a schedule provided by the Department of Finance.

(C) After the transfer in subparagraph (B) has occurred, the State Controller shall allocate on or before the 27th of each month to health account in the local health and welfare trust fund of every county and city and county from a schedule prepared by the Department of Finance, in consultation with the California State Association of Counties, any funds remaining in the Health Account from the funds deposited and remaining unexpended and unreserved on the 15th day of the month in the Health Subaccount of the Sales Tax Account of the Local Revenue Fund. The schedule shall be prepared as the allocations would have been distributed pursuant to subdivision (b).

(D) For the 2014–15 fiscal year and for every fiscal year thereafter, the Controller, using the same timing and criteria as had been used in subdivision (b), shall allocate to each city, not to include a city and county, funds that equal the amounts received in the prior fiscal year by each city from the Sales Tax Account and the Sales Tax Growth Account of the Local Revenue Fund into the health and welfare trust fund.

SEC. 12. Section 17604 of the Welfare and Institutions Code is amended to read:

17604. (a) All motor vehicle license fee revenues collected in the 1991–92 fiscal year that are deposited to the credit of the Local Revenue Fund shall be credited to the Vehicle License Fee Account of that fund.

(b) (1) For the 1992–93 fiscal year and fiscal years thereafter, from vehicle license fee proceeds from revenues deposited to the credit of the Local Revenue Fund, the Controller shall make monthly deposits to the Vehicle License Fee Account of the Local Revenue Fund until the deposits equal the amounts that were allocated to counties, cities, and cities and counties as general purpose revenues in the prior fiscal year pursuant to this chapter from the Vehicle License Fee Account in the Local Revenue Fund and the Vehicle License Fee Account and the Vehicle License Fee Growth Account in the Local Revenue Fund.

(2) Any excess vehicle fee revenues deposited into the Local Revenue Fund pursuant to Section 11001.5 of the Revenue and Taxation Code shall be deposited in the Vehicle License Fee Growth Account of the Local Revenue Fund.

(3) The Controller shall calculate the difference between the total amount of vehicle license fee proceeds deposited to the credit of the Local Revenue Fund, pursuant to paragraph (1) of subdivision (a) of Section 11001.5 of the Revenue and Taxation Code, and deposited into the Vehicle License Fee Account for the period of July 16, 2009, to July 15, 2010, inclusive,

and the amount deposited for the period of July 16, 2010, to July 15, 2011, inclusive.

(4) Of vehicle license fee proceeds deposited to the Vehicle License Fee Account after July 15, 2011, an amount equal to the difference calculated in paragraph (3) shall be deemed to have been deposited during the period of July 16, 2010, to July 15, 2011, inclusive, and allocated to cities, counties, and a city and county as if those proceeds had been received during the 2010–11 fiscal year.

(c) (1) On or before the 27th day of each month, the Controller shall allocate to each county, city, or city and county, as general purpose revenues the amounts deposited and remaining unexpended and unreserved on the 15th day of the month in the Vehicle License Fee Account of the Local Revenue Fund, in accordance with paragraphs (2) and (3).

(2) For the 1991–92 fiscal year, allocations shall be made in accordance with the following schedule:

Jurisdiction	Allocation Percentage
Alameda	4.5046
Alpine	0.0137
Amador	0.1512
Butte	0.8131
Calaveras	0.1367
Colusa	0.1195
Contra Costa	2.2386
Del Norte	0.1340
El Dorado	0.5228
Fresno	2.3531
Glenn	0.1391
Humboldt	0.8929
Imperial	0.8237
Inyo	0.1869
Kern	1.6362
Kings	0.4084
Lake	0.1752
Lassen	0.1525
Los Angeles	37.2606
Madera	0.3656
Marin	1.0785
Mariposa	0.0815
Mendocino	0.2586
Merced	0.4094
Modoc	0.0923
Mono	0.1342
Monterey	0.8975
Napa	0.4466
Nevada	0.2734

Orange	5.4304
Placer	0.2806
Plumas	0.1145
Riverside	2.7867
Sacramento	2.7497
San Benito	0.1701
San Bernardino	2.4709
San Diego	4.7771
San Francisco	7.1450
San Joaquin	1.0810
San Luis Obispo	0.4811
San Mateo	1.5937
Santa Barbara	0.9418
Santa Clara	3.6238
Santa Cruz	0.6714
Shasta	0.6732
Sierra	0.0340
Siskiyou	0.2246
Solano	0.9377
Sonoma	1.6687
Stanislaus	1.0509
Sutter	0.4460
Tehama	0.2986
Trinity	0.1388
Tulare	0.7485
Tuolumne	0.2357
Ventura	1.3658
Yolo	0.3522
Yuba	0.3076
Berkeley	0.0692
Long Beach	0.2918
Pasadena	0.1385

(3) For the 1992–93, 1993–94, and 1994–95 fiscal year and fiscal years thereafter, allocations shall be made in the same amounts as were distributed from the Vehicle License Fee Account and the Vehicle License Fee Growth Account in the prior fiscal year.

(4) For the 1995–96 fiscal year, allocations shall be made in the same amounts as distributed in the 1994–95 fiscal year from the Vehicle License Fee Account and the Vehicle License Fee Growth Account after adjusting the allocation amounts by the amounts specified for the following counties:

Alpine	$(11,296)
Amador	25,417
Calaveras	49,892
Del Norte	39,537
Glenn	(12,238)

Lassen	17,886
Mariposa	(6,950)
Modoc	(29,182)
Mono	(6,950)
San Benito	20,710
Sierra	(39,537)
Trinity	(48,009)

(5) For the 1996–97 fiscal year and fiscal years thereafter, allocations shall be made in the same amounts as were distributed from the Vehicle License Fee Account and the Vehicle License Fee Growth Account in the prior fiscal year.

Initial proceeds deposited in the Vehicle License Fee Account in the 2003–04 fiscal year in the amount that would otherwise have been transferred pursuant to Section 10754 of the Revenue and Taxation Code for the period June 20, 2003, to July 15, 2003, inclusive, shall be deemed to have been deposited during the period June 16, 2003, to July 15, 2003, inclusive, and allocated to cities, counties, and a city and county during the 2002–03 fiscal year.

(d) The Controller shall make monthly allocations from the amount deposited in the Vehicle License Collection Account of the Local Revenue Fund to each county in accordance with a schedule to be developed by the State Department of Mental Health in consultation with the California Mental Health Directors Association, which is compatible with the intent of the Legislature expressed in the act adding this subdivision.

(e) Prior to making the monthly allocations in accordance with paragraph (5) of subdivision (c) and subdivision (d), and pursuant to a schedule provided by the Department of Finance, the Controller shall adjust the monthly distributions from the Vehicle License Fee Account to reflect an equal exchange of sales and use tax funds from the Social Services Subaccount to the Health Subaccount, as required by subdivisions (d) and (e) of Section 17600.15, and of Vehicle License Fee funds from the Health Account to the Social Services Account. Adjustments made to the Vehicle License Fee distributions pursuant to this subdivision shall not be used in calculating future year allocations to the Vehicle License Fee Account.

SEC. 13. Section 17606.10 of the Welfare and Institutions Code is amended to read:

17606.10. (a) For the 1992–93 fiscal year and subsequent fiscal years, the Controller shall allocate funds, on a monthly basis from the General Growth Subaccount in the Sales Tax Growth Account to the appropriate accounts in the local health and welfare trust fund of each county, city, and city and county in accordance with a schedule setting forth the percentage of total state resources received in the 1990–91 fiscal year, including State Legalization Impact Assistance Grants distributed by the state under Part 4.5 (commencing with Section 16700), funding provided for purposes of implementation of Division 5 (commencing with Section 5000), for the organization and financing of community mental health services, including

the Cigarette and Tobacco Products Surtax proceeds which are allocated to county mental health programs pursuant to Chapter 1331 of the Statutes of 1989, Chapter 51 of the Statutes of 1990, and Chapter 1323 of the Statutes of 1990, and state hospital funding and funding distributed for programs administered under Sections 1794, 10101.1, and 11322.2, as annually adjusted by the Department of Finance, in conjunction with the appropriate state department to reflect changes in equity status from the base percentages. However, for the 1992–93 fiscal year, the allocation for community mental health services shall be based on the following schedule:

Jurisdiction	Percentage of Statewide Resource Base
Alameda	4.3693
Alpine	0.0128
Amador	0.0941
Butte	0.7797
Calaveras	0.1157
Colusa	0.0847
Contra Costa	2.3115
Del Norte	0.1237
El Dorado	0.3966
Fresno	3.1419
Glenn	0.1304
Humboldt	0.6175
Imperial	0.5425
Inyo	0.1217
Kern	1.8574
Kings	0.4229
Lake	0.2362
Lassen	0.1183
Los Angeles	27.9666
Madera	0.3552
Marin	0.9180
Mariposa	0.0792
Mendocino	0.4099
Merced	0.8831
Modoc	0.0561
Mono	0.0511
Monterey	1.1663
Napa	0.3856
Nevada	0.2129
Orange	5.3423
Placer	0.5034
Plumas	0.1134
Riverside	3.6179
Sacramento	4.1872

San Benito	0.1010
San Bernardino	4.5494
San Diego	7.8773
San Francisco	3.5335
San Joaquin	2.4690
San Luis Obispo	0.6652
San Mateo	2.5169
Santa Barbara	1.0745
Santa Clara	5.0488
Santa Cruz	0.7960
Shasta	0.5493
Sierra	0.0345
Siskiyou	0.2051
Solano	0.6694
Sonoma	1.1486
Stanislaus	1.4701
Sutter/Yuba	0.6294
Tehama	0.2384
Trinity	0.0826
Tulare	1.4704
Tuolumne	0.1666
Ventura	1.9311
Yolo	0.5443
Berkeley	0.2688
Tri-City	0.2347

(b) The Department of Finance shall recalculate the resource base used in determining the General Growth Subaccount allocations to the Health Account, Mental Health Account, and Social Services Account of the local health and welfare trust fund of each city, county, and city and county for the 1994–95 fiscal year general growth allocations according to subdivisions (c) and (d). For the 1995–96 fiscal year and annually until the end of the 2012–13 fiscal year, the Department of Finance shall prepare the schedule of allocations of growth based upon the recalculation of the resource base as provided by subdivision (c).

(c) For the Mental Health Account, the Department of Finance shall do all of the following:

(1) Use the following sources as reported by the State Department of Mental Health:

(A) The final December 1992 distribution of resources associated with Institutes for Mental Disease.

(B) The 1990–91 fiscal year state hospitals and community mental health allocations.

(C) Allocations for services provided for under Chapter 1294 of the Statutes of 1989.

(2) Expand the resource base with the following nonrealigned funding sources as allocated among the counties:

(A) Tobacco surtax allocations made under Chapter 1331 of the Statutes of 1989 and Chapter 51 of the Statutes of 1990.

(B) For the 1994–95 allocation year only, Chapter 1323 of the Statutes of 1990.

(C) 1993–94 fiscal year federal homeless block grant allocation.

(D) 1993–94 fiscal year Mental Health Special Education allocations.

(E) 1993–94 fiscal year allocations for the system of care for children, in accordance with Chapter 1229 of the Statutes of 1992.

(F) 1993–94 fiscal year federal Substance Abuse and Mental Health Services Administration block grant allocations pursuant to Subchapter 1 (commencing with Section 10801) of Chapter 114 of Title 42 of the United States Code.

(d) Until the end of the 2012–13 fiscal year, for the Health Account, the Department of Finance shall use the historical resource base of state funds as allocated among the counties, cities, and city and county as reported by the State Department of Health Services in a September 17, 1991, report of Indigent and Community Health Resources.

(e) The Department of Finance shall use these adjusted resource bases for the Health Account and Mental Health Account to calculate what the 1994–95 fiscal year General Growth Subaccount allocations would have been, and together with 1994–95 fiscal year Base Restoration Subaccount allocations, CMSP subaccount allocations, equity allocations to the Health Account and Mental Health Account as adjusted by subparagraph (E) of paragraph (2) of subdivision (c) of Section 17606.05, and special equity allocations to the Health Account and Mental Health Account as adjusted by subdivision (e) of Section 17606.15 reconstruct the 1994–95 fiscal year General Growth Subaccount resource base for the 1995–96 allocation year for each county, city, and city and county. Notwithstanding any other provision of law, the actual 1994–95 general growth allocations shall not become part of the realignment base allocations to each county, city, and city and county. The total amounts distributed by the Controller for general growth for the 1994–95 allocation year shall be reallocated among the counties, cities, and city and county in the 1995–96 allocation year according to this paragraph, and shall be included in the general growth resource base for the 1996–97 allocation year and each fiscal year thereafter. For the 1996–97 allocation year and fiscal years thereafter, the Department of Finance shall update the base with actual growth allocations to the Health Account, Mental Health Account, and Social Services Account of each county, city, and city and county local health and welfare trust fund in the prior year, and adjust for actual changes in nonrealigned funds specified in subdivision (c) in the year prior to the allocation year.

(f) For the 2013–14 fiscal year and every fiscal year thereafter, the Controller shall do all of the following:

(1) Allocate to the mental health account of each county, city, or city and county based on a schedule provided by the Department of Finance. The Department of Finance shall recalculate the resource base used in determining the General Growth Subaccount allocations to mental health

account in accordance with subdivision (c) and allocate based on that recalculation.

(2) Allocate 18.4545 percent of the total General Growth Subaccount to the Health Account.

(3) Allocate to the Child Poverty and Family Supplemental Support Subaccount in the Sales Tax Account the remainder of the funds in the General Growth Subaccount.

SEC. 14. Section 17610 of the Welfare and Institutions Code is amended to read:

17610. (a) In June 2016 and for every fiscal year thereafter, for every county or city and county that selected the option pursuant to paragraph (1) of subdivision (b) or paragraph (1) of subdivision (c) of Section 17600.50, the Director of Finance shall make a final determination of the amount of the allocation attributable to each county and city and county should have been pursuant to subdivision (d) of Section 17603 for the penultimate fiscal year.

(b) The amount of the final determination amount for each county or city and county shall be subtracted from the amount attributable to each county or city and county that was actually transferred in the applicable fiscal year. This calculation shall be made at the same time as the final determination in subdivision (a).

(c) The Director of Finance shall promptly notify every affected county or city and county and the Joint Legislative Budget Committee of the determinations made pursuant to subdivisions (a) and (b).

(d) If the difference calculated in subdivision (b) is negative, the state shall pay the applicable county or city and county, the difference and those funds shall be deposited in that county's or city and county's health account of the local health and welfare trust fund. Notwithstanding Section 13340 of the Government Code, there is hereby continuously appropriated to the Director of Finance the funds necessary to pay any amounts owed pursuant to this subdivision.

(e) If the difference determined in subdivision (b) is positive, the applicable county or city and county shall pay the difference to the family support account within the health and welfare trust fund of that county or city and county. If within three months of receipt of the determination made in subdivision (b), the county or city and county has failed to make the payment, then the Director of Finance shall provide a supplemental schedule to the Controller to have 1.5 times the amount of the determination transferred from the next Health Subaccount allocations of the applicable county or city and county to the Family Support Subaccount until 1.5 times the amount owed has been deposited in the family support account.

(f) Solely for the June 2016 final determination, the amount redirected pursuant to this article shall not exceed the amount determined for the county or city and county for the 2013–14 fiscal year under subdivision (c) of Section 17603, as that amount may have been reduced by the application of Section 17610.5.

SEC. 15. Section 17610.5 of the Welfare and Institutions Code is amended to read:

17610.5. (a) There is hereby created a 2013–14 Special Holding Account in the Family Support Subaccount. Starting January 1, 2014, until the end of the 2013–14 fiscal year, funds transferred to the Family Support Subaccount that are attributable to every county or city and county that chose to be subject to paragraph (1) of subdivision (b), or paragraph (1) of subdivision (c), of Section 17600.50 shall be placed in the 2013–14 Special Holding Account.

(b) No later than April 20, 2014, the State Department of Health Care Services shall provide an updated savings estimate for every county and city and county that chose to be subject to paragraph (1) of subdivision (b), or paragraph (1) of subdivision (c) of Section 17600.50 to the Department of Finance. On or before May 14, 2014, the Department of Finance shall, for each county or city and county described in subdivision (a), determine whether the actual savings for each county or city and county is greater or lesser than the amount of funds deposited into the Special Holding Account.

(c) If the revised estimate of savings is greater than the funds estimated by the Department of Finance to be deposited in the Special Holding Account, the funds shall be transferred back to the Family Support Subaccount by the end of the 2013–14 fiscal year, for allocation.

(d) If the revised estimate of savings is less than the funds estimated by the Department of Finance to be deposited in the Special Holding Account, the difference between the amount estimated to be transferred and the revised estimated savings amount shall be transferred to the health account of the local health and welfare trust fund of every affected county or city and county pursuant to a schedule prepared by the Director of Finance in consultation with the California State Association of Counties and provided to the Controller.

(e) This section shall remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date.

SEC. 16. Section 17612.1 of the Welfare and Institutions Code is amended to read:

17612.1. (a) For the 2013–14 fiscal year and each fiscal year thereafter, for each public hospital health system county that selected the option in paragraph (1) of subdivision (c) of Section 17600.50, the total amount that would be payable for the fiscal year from 1991 Health Realignment funds under Sections 17603, 17604, and 17606.20, as those sections read on January 1, 2012, and Section 17606.10, as it read on July 1, 2013, and deposited by the Controller into the local health and welfare trust fund health account of the county in the absence of this section shall be determined.

(b) The redirected amount determined for the public hospital health system county pursuant to Section 17612.3 shall be divided by the total determined in subdivision (a), except that, with respect to the County of Los Angeles, the redirected amount shall be determined by taking into account the adjustments required in Section 17612.5.

(c) The resulting fraction determined in subdivision (b) shall be the percentage of 1991 Health Realignment funds under Sections 17603, 17604, and 17606.20, as those sections read on January 1, 2012, and Section 17606.10, as it read on July 1, 2013, to be deposited each month into the Family Support Subaccount.

(d) The total amount deposited into the Family Support Subaccount under subdivision (c) with respect to a public hospital health system county for a fiscal year shall not exceed the redirected amount determined pursuant to Section 17612.3, and shall be subject to the appeal processes, and judicial review as described in subdivision (d) of Section 17612.3.

(e) The Legislature finds and declares that this article is not intended to change the local obligation pursuant to Section 17000.

SEC. 17. Section 17612.2 of the Welfare and Institutions Code is amended to read:

17612.2. For purposes of this article, the following definitions shall apply:

(a) "Adjusted patient day" means a county public hospital health system's total number of patient census days, as defined by the Office of Statewide Health Planning and Development, multiplied by the following fraction: the numerator that is the sum of the county public hospital health system's total gross revenue for all services provided to all patients, including nonhospital services, and the denominator that is the sum of the county public hospital health system's gross inpatient revenue. The adjusted patient days shall pertain to those services that are provided by the county public hospital health system and shall exclude services that are provided by contract or out-of-network clinics or hospitals.

(b) "Base year" means the fiscal year ending three years prior to the fiscal year for which the redirected amount is calculated.

(c) "Blended CPI trend factor" means the blended percent change applicable for the fiscal year that is derived from the nonseasonally adjusted Consumer Price Index for All Urban Consumers (CPI-U), United States City Average, for Hospital and Related Services, weighted at 75 percent, and for Medical Care Services, weighted at 25 percent, all as published by the United States Bureau of Labor Statistics, computed as follows:

(1) For each prior fiscal year within the period to be trended through the current fiscal year, the annual average of the monthly index amounts shall be determined separately for the Hospital and Related Services Index and the Medical Care Services Index.

(2) The year-to-year percentage changes in the annual averages determined in paragraph (1) for each of the Hospital and Related Services Index and the Medical Care Services Index shall be calculated.

(3) A weighted average annual percentage change for each year-to-year period shall be calculated from the determinations made in paragraph (2), with the percentage changes in the Hospital and Related Services Index weighted at 75 percent, and the percentage changes in the Medical Care Services Index weighted at 25 percent. The resulting average annual percentage changes shall be expressed as a fraction, and increased by 1.00.

(4) The product of the successive year-to-year amounts determined in paragraph (3) shall be the blended CPI trend factor.

(d) "Cost containment limit" means the public hospital health system county's Medi-Cal costs and uninsured costs determined for the 2014–15 fiscal year and each subsequent fiscal year, adjusted as follows:

(1) Notwithstanding paragraphs (2) to (4), inclusive, at the public hospital health system county's option it shall be deemed to comply with the cost containment limit if the county demonstrates that its total health care costs, including nursing facility, mental health, and substance use disorder services, that are not limited to Medi-Cal and uninsured patients, for the fiscal year did not exceed its total health care costs in the base year, multiplied by the blended CPI trend factor for the fiscal year. A county electing this option shall elect by November 1 following the end of the fiscal year, and submit its supporting reports for meeting this requirement, including the annual report of financial transactions required to be submitted to the Controller pursuant to Section 53891 of the Government Code.

(2) (A) The public hospital health system county's Medi-Cal costs, uninsured costs, and other entity intergovernmental transfer amounts for the fiscal year shall be added together. Medi-Cal costs, uninsured costs, and other entity intergovernmental transfer amounts for purposes of this paragraph are as defined in subdivisions (q), (t), and (y) for the relevant fiscal period.

(B) The public hospital health system county's Medi-Cal costs, uninsured costs, and imputed other entity intergovernmental transfer amounts for the base year shall be added together and multiplied by the blended CPI trend factor. The base year costs used shall not reflect any adjustments under this subdivision.

(C) The fiscal year amount determined in subparagraph (A) shall be compared to the trended amount in subparagraph (B). If the amount in subparagraph (B) exceeds the amount in subparagraph (A), the public hospital health system county shall be deemed to have satisfied the cost containment limit. If the amount in subparagraph (A) exceeds the amount in subparagraph (B), the calculation in paragraph (3) shall be performed.

(3) (A) If the number of adjusted patient days of service provided by the county public hospital health system for the fiscal year exceeds its number of adjusted patient days of service rendered in the base year by at least 10 percent, the excess adjusted patient days above the base year for the fiscal year shall be multiplied by the cost per adjusted patient day of the county public hospital health system for the base year. The result shall be added to the trended base year amount determined in subparagraph (B) of paragraph (2), yielding the applicable cost containment limit, subject to paragraph (4).

(B) If the number of adjusted patient days of service provided by a county's public hospital health system for the fiscal year does not exceed its number of adjusted patient days of service rendered in the base year by 10 percent, the applicable cost containment limit is the trended base year

amount determined in subparagraph (B) of paragraph (2), subject to paragraph (4).

(4) If a public hospital health system county's costs, as determined in subparagraph (A) of paragraph (2), exceeds the amount determined in subparagraph (B) of paragraph (2) as adjusted by paragraph (3), the portion of the following cost increases incurred in providing services to Medi-Cal beneficiaries and uninsured patients shall be added to and reflected in any cost containment limit:

(A) Electronic Health Records and related implementation and infrastructure costs.

(B) Costs related to state or federally mandated activities, requirements, or benefit changes.

(C) Costs resulting from a court order or settlement.

(D) Costs incurred in response to seismic concerns, including costs necessary to meet facility seismic standards.

(E) Costs incurred as a result of a natural disaster or act of terrorism.

(5) If a public hospital health system county's costs, as determined in subparagraph (A) of paragraph (2), exceeds the amount determined in subparagraph (B) of paragraph (2) as adjusted by paragraphs (3) and (4), the county may request that the department consider other costs as adjustments to the cost containment limit, including, but not limited to, transfer amounts in excess of the imputed other entity intergovernmental transfer amount trended by the blended CPI trend factor, costs related to case mix index increases, pension costs, expanded medical education programs, increased costs in response to delivery system changes in the local community, and system expansions, including capital expenditures necessary to ensure access to and the quality of health care. Costs approved by the department shall be added to and reflected in any cost containment limit.

(e) "County indigent care health realignment amount" means the product of the health realignment amount times the health realignment indigent care percentage, as computed on a county-specific basis.

(f) "County public hospital health system" means a designated public hospital identified in paragraphs (6) to (20), inclusive, and paragraph (22) of subdivision (d) of Section 14166.1, and its affiliated governmental entity clinics, practices, and other health care providers that do not provide predominantly public health services. A county public hospital health system does not include a health care service plan, as defined in subdivision (f) of Section 1345 of the Health and Safety Code. The Alameda County Medical Center and County of Alameda shall be considered affiliated governmental entities.

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

(h) "Health realignment amount" means the amount that, in the absence of this article, would be payable to a public hospital health system county under Sections 17603, 17604, and 17606.20, as those sections read on January 1, 2012, and Section 17606.10, as it read on July 1, 2013, for the

fiscal year that is deposited by the Controller into the local health and welfare trust fund health account of the public hospital health system county.

(i) "Health realignment indigent care percentage" means the county-specific percentage determined in accordance with the following, and established in accordance with the procedures described in subdivision (c) of Section 17612.3.

(1) Each public hospital health system county shall identify the portion of that county's health realignment amount that was used to provide health services to the indigent, including Medi-Cal beneficiaries and the uninsured, for each of the historical fiscal years along with verifiable data in support thereof.

(2) The amounts identified in paragraph (1) shall be expressed as a percentage of the health realignment amount of that county for each historical fiscal year.

(3) The average of the percentages determined in paragraph (2) shall be the county's health realignment indigent care percentage.

(4) To the extent a county does not provide the information required in paragraph (1) or the department determines that the information provided is insufficient, the amount under this subdivision shall be 85 percent.

(j) "Historical fiscal years" means the state 2008–09 to 2011–12, inclusive, fiscal years.

(k) "Hospital fee direct grants" means the direct grants described in Section 14169.7 that are funded by the Private Hospital Quality Assurance Fee Act of 2011 (Article 5.229 (commencing with Section 14169.31) of Chapter 7 of Part 3), or direct grants made in support of health care expenditures funded by a successor statewide hospital fee program.

(*l*) "Imputed county low-income health amount" means the predetermined, county-specific amount of county general purpose funds assumed, for purposes of the calculation in Section 17612. 3, to be available to the county public hospital health system for services to Medi-Cal and uninsured patients. County general purpose funds shall not include any other revenues, grants, or funds otherwise defined in this section. The imputed county low-income health amount shall be determined as follows and established in accordance with subdivision (c) of Section 17612.3.

(1) For each of the historical fiscal years, an amount determined to be the annual amount of county general fund contribution provided for health services to Medi-Cal beneficiaries and the uninsured, which does not include funds provided for nursing facility, mental health, and substance use disorder services, shall be determined through methodologies described in subdivision (ab).

(2) If a year-to-year percentage increase in the amount determined in paragraph (1) was present, an average annual percentage trend factor shall be determined.

(3) The annual amounts determined in paragraph (1) shall be averaged, and multiplied by the percentage trend factor, if applicable, determined in paragraph (2), for each fiscal year after the 2011–12 fiscal year through the applicable fiscal year. However, if the percentage trend factor determined

in paragraph (2) is greater than the applicable percentage change for any year of the same period in the blended CPI trend factor, the percentage change in the blended CPI trend factor for that year shall be used. The resulting determination is the imputed county low-income health amount for purposes of Section 17612.3.

(m) "Imputed gains from other payers" means the predetermined, county-specific amount of revenues in excess of costs generated from all other payers for health services that is assumed to be available to the county public hospital health system for services to Medi-Cal and uninsured patients, which shall be determined as follows and established in accordance with subdivision (c) of Section 17612.3.

(1) For each of the historical fiscal years, the gains from other payers shall be determined in accordance with methodologies described in subdivision (ab).

(2) The amounts determined in paragraph (1) shall be averaged, yielding the imputed gains from other payers.

(n) "Imputed other entity intergovernmental transfer amount" means the predetermined average historical amount of the public hospital health system county's other entity intergovernmental transfer amount, determined as follows and established in accordance with subdivision (c) of Section 17612.3.

(1) For each of the historical fiscal years, the other entity intergovernmental transfer amount shall be determined based on the records of the public hospital health system county.

(2) The annual amounts in paragraph (1) shall be averaged.

(o) "Medicaid demonstration revenues" means payments paid or payable to the county public hospital health system for the fiscal year pursuant to the Special Terms and Conditions of the federal Medicaid demonstration project authorized under Section 1115 of the federal Social Security Act entitled the "Bridge to Health Care Reform" (waiver number 11-W-00193/9), for uninsured care services from the Safety Net Care Pool or as incentive payments from the Delivery System Reform Improvement Pool, or pursuant to mechanisms that provide funding for similar purposes under the subsequent demonstration project. Medicaid demonstration revenues do not include the nonfederal share provided by county public hospital health systems as certified public expenditures, and are reduced by any intergovernmental transfer by county public hospital health systems or affiliated governmental entities that is for the nonfederal share of Medicaid demonstration payments to the county public hospital health system or payments to a Medi-Cal managed care plan for services rendered by the county public hospital health system, and any related fees imposed by the state on those transfers; and by any reimbursement of costs, or payment of administrative or other processing fees imposed by the state relating to payments or other Medicaid demonstration program functions. Medicaid demonstration revenues shall not include Safety Net Care Pool revenues for nursing facility, mental health, and substance use disorder services, as determined from the pro rata share of eligible certified public expenditures

for such services, or revenues that are otherwise included as Medi-Cal revenues.

(p) "Medi-Cal beneficiaries" means individuals eligible to receive benefits under Chapter 7 (commencing with Section 14000) of Part 3, except for: individuals who are dual eligibles, as defined in paragraph (4) of subdivision (c) of Section 14132.275, and individuals for whom Medi-Cal benefits are limited to cost sharing or premium assistance for Medicare or other insurance coverage as described in Section 1396d(a) of Title 42 of the United States Code.

(q) "Medi-Cal costs" means the costs incurred by the county public hospital health system for providing Medi-Cal services to Medi-Cal beneficiaries during the fiscal year, which shall be determined in a manner consistent with the cost claiming protocols developed for Medi-Cal cost-based reimbursement for public providers and under Section 14166.8, and, in consultation with each county, shall be based on other cost reporting and statistical data necessary for an accurate determination of actual costs as required in Section 17612.4. Medi-Cal costs shall include all fee-for-service and managed care hospital and nonhospital components, managed care out-of-network costs, and related administrative costs. The Medi-Cal costs determined under this paragraph shall exclude costs incurred for nursing facility, mental health, and substance use disorder services.

(r) "Medi-Cal revenues" means total amounts paid or payable to the county public hospital health system for medical services provided under the Medi-Cal State Plan that are rendered to Medi-Cal beneficiaries during the state fiscal year, and shall include payments from Medi-Cal managed care plans for services rendered to Medi-Cal managed care plan members, Medi-Cal copayments received from Medi-Cal beneficiaries, but only to the extent actually received, supplemental payments for Medi-Cal services, and Medi-Cal disproportionate share hospital payments for the state fiscal year, but shall exclude Medi-Cal revenues paid or payable for nursing facility, mental health, and substance use disorder services. Medi-Cal revenues do not include the nonfederal share provided by county public hospital health systems as certified public expenditures. Medi-Cal revenues shall be reduced by all of the following:

(1) Intergovernmental transfers by the county public hospital health system or its affiliated governmental entities that are for the nonfederal share of Medi-Cal payments to the county public hospital health system, or Medi-Cal payments to a Medi-Cal managed care plan for services rendered by the county public hospital health system for the fiscal year.

(2) Related fees imposed by the state on the transfers specified in paragraph (1).

(3) Administrative or other fees, payments, or transfers imposed by the state, or voluntarily provided by the county public hospital health systems or affiliated governmental entities, relating to payments or other Medi-Cal program functions for the fiscal year.

(s) "Newly eligible beneficiaries" means individuals who meet the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of

the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)) such that expenditures for services provided to the individual are eligible for the enhanced federal medical assistance percentage described in that section.

(t) "Other entity intergovernmental transfer amount" means the amount of intergovernmental transfers by a county public hospital health system or affiliated governmental entities, and accepted by the department, that are for the nonfederal share of Medi-Cal payments or Medicaid demonstration payments for the fiscal year to any Medi-Cal provider other than the county public hospital health system, or to a Medi-Cal managed care plan for services rendered by those other providers, and any related fees imposed by the state on those transfers.

(u) "Public hospital health system county" means a county in which a county public hospital health system is located.

(v) "Redirected amount" means the amount to be redirected in accordance with Section 17612.1, as calculated pursuant to subdivision (a) of Section 17612.3.

(w) "Special local health funds" means the amount of the following county funds received by the county public hospital health system for health services during the fiscal year:

(1) Assessments and fees restricted for health-related purposes. The amount of the assessment or fee for this purpose shall be the greater of subparagraph (A) or (B). If, because of restrictions and limitations applicable to the assessment or fee, the county public hospital health system cannot expend this amount, this amount shall be reduced to the amount actually expended.

(A) The amount of the assessment or fee expended by the county public hospital health system for the provision of health services to Medi-Cal and uninsured beneficiaries during the fiscal year.

(B) The amount of the assessment or fee multiplied by the average of the percentages of the amount of assessment or fees that were allocated to and expended by the county public hospital health system for health services to Medi-Cal and uninsured beneficiaries during the historical fiscal years. The percentages for the historical fiscal years shall be determined by dividing the amount allocated in each fiscal year as described in subparagraphs (B) and (C) of paragraph (2) of subdivision (ab) by the actual amount of assessment or fee expended in the fiscal year.

(2) Funds available pursuant to the Master Settlement Agreement and related documents entered into on November 23, 1998, by the state and leading United States tobacco product manufacturers during a fiscal year. The amount of the tobacco settlement funds that may be used for this purpose shall be the greater of subparagraph (A) or (B), less any bond payments and other costs of securitization related to the funds described in this paragraph.

(A) The amount of the funds expended by the county public hospital health system for the provision of health services to Medi-Cal and uninsured beneficiaries during the fiscal year.

(B) The amount of the tobacco settlement funds multiplied by the average of the percentages of the amount of tobacco settlement funds that were allocated to and expended by the county public hospital health system for health services to Medi-Cal and uninsured beneficiaries during the historical fiscal years. The percentages for the historical fiscal years shall be determined by dividing the amount allocated in each fiscal year as described in subparagraphs (B) and (C) of paragraph (2) of subdivision (ab) by the actual amount of tobacco settlement funds expended in the fiscal year.

(x) "Subsequent demonstration project" means the federally approved Medicaid demonstration project implemented after the termination of the federal Medicaid demonstration project authorized under Section 1115 of the federal Social Security Act entitled the "Bridge to Health Care Reform" (waiver number 11-W-00193/9), the extension of that demonstration project, or the material amendment to that demonstration project.

(y) "Uninsured costs" means the costs incurred by the public hospital health system county and its affiliated government entities for purchasing, providing, or ensuring the availability of services to uninsured patients during the fiscal year. Uninsured costs shall be determined in a manner consistent with the cost-claiming protocols developed for the federal Medicaid demonstration project authorized under Section 1115 of the federal Social Security Act entitled the "Bridge to Health Care Reform" (waiver number 11-W-00193/9), including protocols pending federal approval, and under Section 14166.8, and, in consultation with each county, shall be based on any other cost reporting and statistical data necessary for an accurate determination of actual costs incurred. For this purpose, no reduction factor applicable to otherwise allowable costs under the demonstration project or the subsequent demonstration project shall apply. Uninsured costs shall exclude costs for nursing facility, mental health, and substance use disorder services.

(z) "Uninsured patients" means individuals who have no source of third-party coverage for the specific service furnished, as further defined in the reporting requirements established pursuant to Section 17612.4.

(aa) "Uninsured revenues" means self-pay payments made by or on behalf of uninsured patients to the county public hospital health system for the services rendered in the fiscal year, but shall exclude revenues received for nursing facility, mental health, and substance use disorder services. Uninsured revenues do not include the health realignment amount or imputed county low-income health amount and shall not include any other revenues, grants, or funds otherwise defined in this section.

(ab) "Historical allocation" means the allocation for the amounts in the historical years described in subdivisions (*l*), (m), and (w) for health services to Medi-Cal beneficiaries and uninsured patients. The allocation of those amounts in the historical years shall be done in accordance with a process to be developed by the department, in consultation with the counties, which includes the following required parameters:

(1) For each of the historical fiscal years, the Medi-Cal costs, uninsured costs, and costs of other entity intergovernmental transfer amounts, as

defined in subdivisions (q), (t), and (y), and the Medicaid demonstration, Medi-Cal and uninsured revenues, and hospital fee direct grants with respect to the services as defined in subdivisions (k), (o), (r), and (aa), shall be determined. For these purposes, Medicaid demonstration revenues shall include applicable payments as described in subdivision (o) paid or payable to the county public hospital health system under the prior demonstration project defined in subdivision (c) of Section 14166.1, under the Low Income Health Program (Part 3.6 (commencing with Section 15909)), and under the Health Care Coverage Initiative (Part 3.5 (commencing with Section 15900)), none of which shall include the nonfederal share of the Medicaid demonstration payments. The revenues shall be subtracted from the costs, yielding the initial low-income shortfall for each of the historical fiscal years.

(2) The following shall be applied in sequential order against, but shall not exceed in the aggregate, the initial low-income shortfall determined in paragraph (1) for each of the historical fiscal years:

(A) First, the county indigent care health realignment amount shall be applied 100 percent against the initial low-income shortfall.

(B) Second, special local health funds specifically restricted for indigent care shall be applied 100 percent against the initial low-income shortfall.

(C) Third, the sum of clauses (iv), (v), and (vi). Clause (iv) is the special local health funds, as defined in subdivision (w) and not otherwise identified as restricted special local health funds under subparagraph (B), clause (v) is the imputed county low-income health amount defined in subdivision (*l*), and clause (vi) is the one-time and carry-forward revenues as defined in subdivision (aj), all allocated to the historical low-income shortfall. These amounts shall be calculated as follows:

(i) Determine the sum of the special local health funds, as defined in subdivision (w) and not otherwise identified as restricted special local health funds under subparagraph (B), the imputed county low-income health amount defined in subdivision (*l*), and one-time and carry-forward revenues as defined in subdivision (aj).

(ii) Divide the historical total shortfall defined in subdivision (ah) by the sum in clause (i) to get the historical usage of funds percentage defined in subdivision (ai). If this calculation produces a percentage above 100 percent in a given historical fiscal year, then the historical usage of funds percentage in that historical fiscal year shall be deemed to be 100 percent.

(iii) Multiply the historical usage of funds percentage defined in subdivision (ai) and calculated in clause (ii) by each of the following funds:

(I) Special local health funds, as defined in subdivision (w) and not otherwise identified as restricted special local health funds under subparagraph (B).

(II) The imputed county low-income health amount defined in subdivision (*l*).

(III) One-time and carry-forward revenues as defined in subdivision (aj).

(iv) Multiply the product of subclause (I) of clause (iii) by the historical low-income shortfall percentage defined in subdivision (af) to determine

the amount of special local health funds, as defined in subdivision (w) and not otherwise identified as restricted special local health funds under subparagraph (B), allocated to the historical low-income shortfall.

(v) Multiply the product of subclause (II) of clause (iii) by the historical low-income shortfall percentage defined in subdivision (af) to determine the amount of the imputed county low-income health amount defined in subdivision (*l*) allocated to the historical low-income shortfall.

(vi) Multiply the product of subclause (III) of clause (iii) by the historical low-income shortfall percentage defined in subdivision (af) to determine the amount of one-time and carry-forward revenues as defined in subdivision (aj) allocated to the historical low-income shortfall.

(D) Finally, to the extent that the process above does not result in completely allocating revenues up to the amount necessary to address the initial low-income shortfall in the historical years, gains from other payers shall be allocated to fund those costs only to the extent that such other payer gains exist.

(ac) "Gains from other payers" means the county-specific amount of revenues in excess of costs generated from all other payers for health services. For purposes of this subdivision, patients with other payer coverage are patients who are identified in all other financial classes, including, but not limited to, commercial coverage and dual eligible, other than allowable costs and associated revenues for Medi-Cal and the uninsured.

(ad) "New mandatory other entity intergovernmental transfer amounts" means other entity intergovernmental transfer amounts required by the state after July 1, 2013.

(ae) "Historical low-income shortfall" means, for each of the historical fiscal years described in subdivision (j), the initial low-income shortfall for Medi-Cal and uninsured costs determined in paragraph (1) of subdivision (ab), less amounts identified in subparagraphs (A) and (B) of paragraph (2) of subdivision (ab).

(af) "Historical low-income shortfall percentage" means, for each of the historical fiscal years described in subdivision (j), the historical low-income shortfall described in subdivision (ae) divided by the historical total shortfall described in subdivision (ah).

(ag) "Historical other shortfall" means, for each of the historical fiscal years described in subdivision (j), the shortfall for all other types of costs incurred by the public hospital health system that are not Medi-Cal or uninsured costs, and is determined as total costs less total revenues, excluding any costs and revenue amounts used in the calculation of the historical low-income shortfall, and also excluding those costs and revenues related to mental health and substance use disorder services. If the amount of historical other shortfall in a given historical fiscal year is less than zero, then the historical other shortfall for that historical fiscal year shall be deemed to be zero.

(ah) "Historical total shortfall" means, for each of the historical fiscal years described in subdivision (j), the sum of the historical low-income

shortfall described in subdivision (ae) and the historical other shortfall described in subdivision (ag).

(ai) "Historical usage of funds percentage" means, for each of the historical fiscal years described in subdivision (j), the historical total shortfall described in subdivision (ah) divided by the sum of special local health funds as defined in subdivision (w) and not otherwise identified as restricted special local health funds under subparagraph (B) of paragraph (2) of subdivision (ab), the imputed county low-income health amount defined in subdivision (*l*), and one-time and carry-forward revenues as defined in subdivision (aj). If this calculation produces a percentage above 100 percent in a given historical fiscal year, then the historical usage of funds percentage in that historical fiscal year shall be deemed to be 100 percent.

(aj) "One-time and carry-forward revenues" mean, for each of the historical fiscal years described in subdivision (j), revenues and funds that are not attributable to services provided or obligations in the applicable historical fiscal year, but were available and utilized during the applicable historical fiscal year by the public hospital health system.

SEC. 18. Section 17612.21 of the Welfare and Institutions Code is repealed.

SEC. 19. Section 17612.3 of the Welfare and Institutions Code is amended to read:

17612.3. (a) For each fiscal year, commencing with the 2013–14 fiscal year, the amount to be redirected in accordance with Section 17612.1 shall be determined for each public hospital health system county as follows:

(1) The public hospital health system county's revenues and other funds paid or payable for the state fiscal year shall be comprised of the total of the following:

(A) Medi-Cal revenues.

(B) Uninsured revenues.

(C) Medicaid demonstration revenues.

(D) Hospital fee direct grants.

(E) Special local health funds.

(F) The county indigent care health realignment amount.

(G) The imputed county low-income health amount.

(H) Imputed gains from other payers.

(I) The amount by which the public hospital health system county's costs exceeded the cost containment limit for the fiscal year, expressed as a negative number, multiplied by 0.50.

(2) The following, incurred by the public hospital health system county for the fiscal year, not to exceed in total the cost containment limit, shall be subtracted from the sum in paragraph (1):

(A) Medi-Cal costs.

(B) Uninsured costs.

(C) The lesser of the other entity intergovernmental transfer amount or the imputed other entity intergovernmental transfer amounts.

(D) New mandatory other entity intergovernmental transfer amounts.

(3) The resulting amount determined in paragraph (2) shall be multiplied by 0.80, except that for the 2013–14 fiscal year the resulting amount determined in paragraph (2) shall be multiplied by 0.70.

(4) If the amount in paragraph (3) is a positive number, that amount, subject to paragraph (5), shall be redirected in accordance with Section 17612.1, except that for the 2013–14 fiscal year the amount to be redirected shall not exceed the amount determined for the county for the 2013–14 fiscal year under subdivision (c) of Section 17603, as that amount may have been reduced by the application of Section 17610.5. If the amount determined in paragraph (3) is a negative number, the redirected amount shall be zero.

(5) Notwithstanding any other law, the amount to be redirected as determined in paragraph (4) for any fiscal year shall not exceed the county indigent care health realignment amount for that fiscal year.

(6) (A) The redirected amount shall be applied until the later of the following:

(i) June 30, 2023.

(ii) The beginning of the fiscal year following a period of two consecutive fiscal years in which both of the following occur:

(aa) The total interim amount determined under subdivision (b) of Section 17612.3 in May of the previous fiscal year is within 10 percent of the final, reconciled amount in subdivision (d) of that section.

(bb) The final, reconciled amounts under subdivision (d) of Section 17612.3 are within 5 percent of each other.

(B) After the redirected amount ceases as provided in subparagraph (A), a permanent redirected amount shall be established to be an amount determined by calculating the percentage that the redirected amount was in the last fiscal year of the operation of this article of the county's health realignment amount of that same fiscal year, multiplied by the county's health realignment amount of all subsequent years.

(b) Commencing with the 2014–15 fiscal year, the department shall calculate an interim redirected amount for each public hospital health system county under subdivision (a) by the January immediately prior to the starting fiscal year, using the most recent and accurate data available. For purposes of the interim determinations, the cost containment limit shall not be applied. The interim redirected amount shall be updated in the May before the start of the fiscal year in consultation with each public hospital health system county and based on any more recent and accurate data available at that time. During the fiscal year, the interim redirected amount will be applied pursuant to Section 17612.1.

(c) The predetermined amounts or historical percentages described in subdivisions (i), (*l*), (m), (n), and (w) of Section 17612.2 shall each be established in accordance with the following procedure:

(1) By October 31, 2013, each public hospital health system county shall determine the amount or percentage described in the applicable subdivision, and shall provide this calculation to the department, supported by verifiable data and a description of how the determination was made.

(2) If the department disagrees with the public hospital health system county's determination, the department shall confer with the public hospital health system county by December 15, 2013, and shall issue its determination by January 31, 2014.

(3) If no agreement between the parties has been reached by January 31, 2014, the department shall apply the county's determination when making the interim calculations pursuant to subdivision (b), until a decision is issued pursuant to paragraph (6).

(4) If no agreement between the parties has been reached by January 31, 2014, the public hospital health system county shall submit a petition by February 28, 2014, to the County Health Care Funding Resolution Committee, established pursuant to Section 17600.60, to seek a decision regarding the historical percentage or amount to be applied in calculations under this section.

(5) The County Health Care Funding Resolution Committee shall hear and make a determination as to whether the county's proposed percentage or amount complies with the requirements of this section taking into account the data and calculations of the county and any alternative data and calculations submitted by the department.

(6) The committee shall issue its final determination within 45 days of the petition. If the county chooses to contest the final determination, the final determination of the committee will be applied for purposes of any interim calculation under subdivision (b) until a final decision is issued pursuant to de novo administrative review pursuant to paragraph (2) of subdivision (d).

(d) (1) The data for the final calculations under subdivision (a) for the fiscal year shall be submitted by public hospital health system counties within 12 months after the conclusion of each fiscal year as required in Section 17612.4. The data shall be the most recent and accurate data from the public hospital health system county's books and records pertaining to the revenues paid or payable, and the costs incurred, for services provided in the subject fiscal year. After consulting with the county, the department shall make final calculations using the data submitted pursuant to this paragraph by December 15 of the following fiscal year, and shall provide its final determination to the county. The final determination will also reflect the application of the cost containment limit, if any. If the county and the department agree, a revised recalculation and reconciliation may be completed by the department within six months thereafter.

(2) The director shall establish an expedited formal appeal process for a public hospital health system county to contest final determinations made under this article. No appeal shall be available for interim determinations made under subdivision (b). The appeals process shall include all of the following:

(A) The public hospital health system county shall have 30 calendar days, following the issuance of a final determination made under paragraph (6) of subdivision (c) or paragraph (1) of this subdivision, to file an appeal with the Director of Health Care Services. All appeals shall be governed by

Section 100171 of the Health and Safety Code, except for those provisions of paragraph (1) of subdivision (d) of Section 100171 of the Health and Safety Code relating to accusations, statements of issues, statement to respondent, and notice of defense, and except as otherwise set forth in this section. All appeals shall be in writing and shall be filed with the State Department of Health Care Service's Office of Administrative Hearings and Appeals. An appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals.

(i) An appeal shall specifically set forth each issue in dispute, which may include any component of the determination, and include the public hospital health system county's contentions as to those issues. A formal hearing before an Office of Administrative Hearings and Appeals Administrative Law Judge shall commence within 60 days of the filing of the appeal requesting a formal hearing. A final decision under this paragraph shall be adopted no later than six months following the filing of the appeal.

(ii) If the public hospital health system county fails to file an appeal within 30 days of the issuance of a determination made under this section, the determination of the department shall be deemed final and not appealable either administratively or to a court of general jurisdiction, except that a county may elect to appeal a determination under subdivision (c) within 30 days of the issuance of the County Health Care Funding Resolution Committee's final determination under paragraph (6) of subdivision (c) or as a component of an appeal of the department's final determination under paragraph (1) of this subdivision for the 2013–14 fiscal year.

(B) If a final decision under this paragraph is not issued by the department within two years of the last day of the subject fiscal year, the public hospital health system county shall be deemed to have exhausted its administrative remedies and shall not be precluded from pursuing any available judicial review. However, the time period in this subdivision shall be extended by either of the following:

(i) Undue delay caused by the public hospital health system county.

(ii) An extension of time granted to a public hospital health system county at its sole request, or following the joint request of the public hospital health system county and the department.

(C) If the final decision issued by the department pursuant to this paragraph results in a different determination than that originally determined by the department, then the Department of Finance shall adjust the original determination by that amount, pursuant to a process developed by the Department of Finance and in consultation with the public hospital health system counties.

(e) For purposes of this article, all references to "health services" or "health care services," unless specified otherwise, shall exclude nursing facility, mental health, and substance use disorder services.

SEC. 20. Section 17612.5 of the Welfare and Institutions Code is amended to read:

17612.5. (a) For the 2013–14 fiscal year and each year thereafter, the amount to be redirected in accordance with Section 17612.1 for the County

of Los Angeles shall be determined in accordance with Section 17612.3, except that the formula in subdivision (a) of Section 17612.3 shall be replaced with the following formula:

(1) The total revenues as defined in paragraph (7) of subdivision (b) paid or payable to the County of Los Angeles, Department of Health Services, for the fiscal year, which shall include special local health funds and as adjusted in accordance with Section 17612.6, shall be added together.

(2) The sum of three hundred twenty-three million dollars ($323,000,000), which represents the imputed county low-income health amount trended annually by 1 percent from the 2012–13 fiscal year through the applicable fiscal year, and the county indigent care health realignment amount, as determined in accordance with subdivision (e) of Section 17612.2 for the fiscal year.

(3) The amount by which the county's total costs exceeded the cost containment limit for the fiscal year, expressed as a negative number, multiplied by 0.50.

(4) (A) The total costs as defined in paragraph (6) of subdivision (b) incurred by or on behalf of the County of Los Angeles, Department of Health Services, for the fiscal year shall be added together, but shall not exceed the cost containment limit determined in accordance with paragraph (3) of subdivision (b).

(B) The costs in paragraph (A) shall be subtracted from the sum of paragraphs (1) to (3), inclusive.

(5) The resulting amount determined in subparagraph (B) of paragraph (4) shall be multiplied by 0.80, except that for the 2013–14 fiscal year, the resulting amount determined in subparagraph (B) of paragraph (4) shall be multiplied by 0.70.

(6) If the amount in paragraph (5) is a positive number, that amount, subject to paragraph (7), shall be redirected in accordance with Section 17612.1 of this article, except that for the 2013–14 fiscal year the amount to be redirected shall not exceed the amount determined for the County of Los Angeles for the 2013–14 fiscal year under subdivision (c) of Section 17603, as that amount may have been reduced by the application of Section 17610.5. If the amount determined in paragraph (5) is a negative number, the redirected amount shall be zero.

(7) Notwithstanding any other provision of law, the amount to be redirected as determined in paragraph (6) for any fiscal year shall not exceed the county indigent care health realignment amount for that fiscal year.

(8) (A) The redirected amount shall be applied until the later of:

(i) June 30, 2023.

(ii) The beginning of fiscal year following a period of two consecutive fiscal years that both of the following occur:

(aa) The total interim amount determined under subdivision (b) of Section 17612.3 in May of the previous fiscal year is within 10 percent of the final, reconciled amount in subdivision (d) of that section.

(bb) The final, reconciled amounts under subdivision (d) of Section 17612.3 are within 5 percent of each other.

(B) After the redirected amount ceases as provided in subparagraph (A), a permanent redirected amount shall be established to be an amount determined by calculating the percentage that the redirected amount was in the last fiscal year of the operation of this article of the county's health realignment amount of that same fiscal year, multiplied by the county's health realignment amount of all subsequent years.

(b) Except as otherwise provided in this section, the definitions in Section 17612.2 shall apply. For purposes of this section, and for purposes the calculations in Section 17612.3 that apply to the County of Los Angeles, the following definitions shall apply:

(1) "Adjusted patient day" means LA County DHS's total number of patient days multiplied by the following fraction: the numerator that is the sum of the county public hospital health system's total gross revenue for all services provided to all patients, including nonhospital services, and the denominator that is the sum of the county public hospital health system's gross inpatient revenue. The adjusted patient days shall pertain to those services that are provided by the LA County DHS, and shall exclude services that are provided by contract or out-of-network clinics or hospitals. For purposes of this paragraph, gross revenue shall be adjusted as necessary to reflect the relationship between inpatient costs and charges and outpatient costs and charges.

(2) "Blended CPI trend factor" means the blended percent change applicable for the state fiscal year that is derived from the nonseasonally adjusted Consumer Price Index for All Urban Consumers (CPI-U), United States City Average, for Hospital and Related Services, weighted at 90 percent, and for Medical Care Services, weighted at 10 percent, all as published by the United States Bureau of Labor Statistics, computed as follows:

(A) For each prior fiscal year, within the period to be trended through the fiscal year, the annual average of the monthly index amounts shall be determined separately for the Hospital and Related Services Index and the Medical Care Services Index.

(B) The year-to-year percentage changes in the annual averages determined in subparagraph (A) for each of the Hospital and Related Services Index and the Medical Care Services Index shall be determined.

(C) A weighted average annual percentage change for each year-to-year period shall be calculated from the determinations made in subparagraph (B), with the percentage changes in the Hospital and Related Services Index weighted at 90 percent, and the percentage changes in the Medical Care Services Index weighted at 10 percent. The resulting average annual percentage changes shall be expressed as a fraction, and increased by 1.00.

(D) The product of the successive year-to-year amounts determined in subparagraph (C) shall be the blended CPI trend factor.

(3) "Cost containment limit" means the LA County DHS's total costs determined for the 2014–15 fiscal year and each subsequent fiscal year adjusted as follows:

(A) The County of Los Angeles will be deemed to comply with the cost containment limit if the county demonstrates that its total costs for the fiscal year did not exceed its total costs in the base year, multiplied by the blended CPI trend factor for the fiscal year as reflected in the annual report of financial transactions required to be submitted to the Controller pursuant to Section 53891 of the Government Code. If the total costs for the fiscal year exceeded the total cost in the base year, multiplied by the blended CPI trend factor for the fiscal year, the calculation in subparagraph (B) shall be performed.

(B) (i) If the number of adjusted patient days of service provided by LA County DHS for the fiscal year exceeds its number of adjusted patient days of service rendered in the base year by at least 10 percent, the excess adjusted patient days above the base year for the fiscal year shall be multiplied by the cost per adjusted patient day of the public hospital health system for the base year. The result shall be added to the trended base year amount determined in subparagraph (A), yielding the applicable cost containment limit, subject to subparagraph (C). Costs per adjusted patient day shall be based upon only those LA County DHS costs incurred for patient care services.

(ii) If the number of adjusted patient days of service provided by LA County DHS for the fiscal year does not exceed its number of adjusted patient days of service rendered in the base year by at least 10 percent, the applicable limit is the trended base year amount determined in subparagraph (A) subject to subparagraph (C).

(C) If LA County DHS's total costs for the fiscal year in as determined in subparagraph (A) exceeds the trended cost as determined in subparagraph (A) as adjusted by subparagraph (B), the following cost increases shall be added to and reflected in any cost containment limit:

(i) Electronic health records and related implementation and infrastructure costs.

(ii) Costs related to state or federally mandated activities, requirements, or benefit changes.

(iii) Costs resulting from a court order or settlement.

(iv) Costs incurred in response to seismic concerns, including costs necessary to meet facility seismic standards.

(v) Costs incurred as a result of a natural disaster or act of terrorism.

(vi) The total amount of any intergovernmental transfer for the nonfederal share of Medi-Cal payments to the hospital facility described in subdivision (f) of Section 14165.50.

(D) If LA County DHS's total costs for the fiscal year exceed the trended costs as adjusted by subparagraphs (B) and (C), the county may request that the department consider other costs as adjustments to the cost containment limit, including, but not limited to, transfer amounts in excess of the imputed other entity intergovernmental transfer amount trended by the blended CPI trend factor, costs related to case mix index increases, pension costs, expanded medical education programs, increased costs in response to delivery system changes in the local community, and system expansions,

including capital expenditures necessary to ensure access to and the quality of health care. Costs approved by the department shall be added to and reflected in the cost containment limit.

(4) "Health realignment indigent care percentage" means 83 percent.

(5) "Special local health funds" means both of the following:

(A) The total amount of assessments and fees restricted for health-related purposes that are received by LA County DHS and expended for health services during the fiscal year.

(B) Ninety-one percent of the funds actually received by the County of Los Angeles during the fiscal year pursuant to the Master Settlement Agreement and related documents entered into on November 23, 1998, by the state and leading United States tobacco product manufacturers, less any bond payments and other costs of securitization related to the funds described in this paragraph.

(6) "Total costs" means the actual net expenditures, excluding encumbrances, for all operating budget units of the LA County DHS. Operating budget units consist of four Hospital Enterprise Funds plus the LA County DHS's budget units within the county general fund. Net expenditures, excluding encumbrances, are those recognized within LA County DHS, net of intrafund transfers, expenditure distributions, and all other billable services recorded from and to the LA County DHS enterprise funds and the LA County DHS general fund budget units, determined based on its central accounting system known as eCAPS, as of November 30 of the year following the fiscal year, and shall include the new mandatory other entity intergovernmental transfer amounts, as defined in subdivision (ad) of Section 17612.2, and the lesser of other entity intergovernmental transfer amounts or the imputed other entity intergovernmental transfer amounts.

(7) "Total revenues" means the sum of the revenue paid or payable for all operating budget units of the LA County DHS determined based on its central accounting system known as eCAPS, as of November 30 of the year following the fiscal year.

(8) "LA County DHS" means operating budget units consisting of four hospital enterprise funds plus the DHS budget units within the county's general fund.

SEC. 21. Section 17612.6 of the Welfare and Institutions Code is amended to read:

17612.6. (a) For purposes of this section, the following definitions shall apply:

(1) "Type A payers" means the following sources of revenue for amounts paid to the County of Los Angeles, Department of Health Services:

(A) Title XVIII of the federal Social Security Act, known as the Medicare program.

(B) Commercial health insurance.

(C) Health care coverage for providers of in-home supportive services, consistent with Article 7 (commencing with Section 12300) of Chapter 3 and Chapter 7 (commencing with Section 14000) of Part 3 of Division 9.

(2) "Type B payers" means the following sources of revenue for amounts paid to the County of Los Angeles, Department of Health Services:

(A) Patient care revenues received for services provided to other county departments.

(B) State payments for patient financial services workers.

(C) Other federal payers, not including federal grants, Medicare, Medicaid, and payments pursuant to Section 1011 of the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173).

(3) "Historical Base Type A revenues" means revenues from Type A payers in the historical fiscal years, calculated as follows:

(A) For each historical fiscal year, the actual revenue received from Type A payers.

(B) Calculate the average of the historical year's amounts in subparagraph (A). This average shall be considered the historical Base Type A revenues.

(4) "Historical Base Type B revenues" means revenues from Type B payers in the historical fiscal years, calculated as follows:

(A) For each historical fiscal year, the actual revenue received from Type B payers.

(B) Calculate the average of the historical years amounts in subparagraph (A). This average shall be considered the historical Base Type B revenues.

(5) "Type A payer revenue" means the amount of revenue that is the greater of the following:

(A) The amount of the revenue received from Type A payers for services rendered during the fiscal year.

(B) The historical Base Type A revenues, as adjusted by the Type A adjustment, defined in paragraph (8).

(6) "Type B payer revenue" means the amount of revenue that is the greater of the following:

(A) The amount of the revenue received from Type B payers for services rendered during the fiscal year.

(B) The historical Base Type B revenues.

(7) "Baseline Type A payer costs" means the average of the costs of services provided to Type A payer patients rendered in each of the four historical fiscal years to be determined as follows:

(A) For each historical year, the actual costs incurred in providing services to Type A payer patients.

(B) Calculate the average of the historical fiscal year amounts in subparagraph (A), this average shall be considered the baseline Type A payer costs.

(8) "Type A adjustment" means the value of the revenue adjustment to historical base Type A revenues as defined in paragraph (3).

(A) This adjustment will occur only if the Type A payer revenue for the fiscal year is less than historical base, otherwise the adjustment is considered to be zero.

(B) If the requirement in subparagraph (A) is met, then there will only be an adjustment if one or more of the specified Type A payers' data meets all of the following conditions:

(i) The Type A payer revenue for the fiscal year is less than the historical base.

(ii) The Type A payer costs for the fiscal year are less than the historical base trended by the blended CPI trend factor.

(iii) The Type A payer volume for the fiscal year is less than the historical base.

(C) For each Type A payer that meets all the conditions in subparagraph (B) the adjustment to the Type A payer revenue for that Type A payer will be as follows:

(i) Calculate the percentage decrease in cost from the baseline Type A payer cost as trended by the blended CPI trend factor as defined in paragraph (2) of subdivision (b) of Section 17612.5 and applied from the 2010–11 fiscal year to the subject fiscal year.

(ii) Calculate the percentage decrease in volume, based on the adjusted patient days, from the baseline Type A payer volume to the subject fiscal year.

(iii) Calculate the average of the percentages in clauses (i) and (ii).

(iv) The percentage reduction in clause (iii) shall be applied to the historical Base Type A payer revenue for the individual Type A payer.

(b) The Type A payer revenues included in the total revenues in subdivision (a) of Section 17612.5 shall be the greater of the adjusted historical Type A baseline or the actual revenues received from Type A payers for services rendered in the subject fiscal year.

(c) The Type B payer revenues included in the total revenues in subdivision (a) of Section 17612.5 shall be the greater of the historical Base Type B revenues or the actual revenues received from Type B payers for services rendered in the subject fiscal year.

SEC. 22. Section 17613.1 of the Welfare and Institutions Code is amended to read:

17613.1. (a) For the 2013–14 fiscal year and each fiscal year thereafter, for each county, the total amount that would be payable for the fiscal year from 1991 Health Realignment funds under Sections 17603, 17604, and 17606.20, as those sections read on January 1, 2012, and Section 17606.10, as it read on July 1, 2013, and deposited by the Controller into the local health and welfare trust fund health account of the county in the absence of this section, shall be determined.

(b) The redirected amount determined for the county pursuant to Section 17613.3 shall be divided by the total determined in subdivision (a).

(c) The resulting fraction determined in subdivision (b) shall be the percentage of 1991 Health Realignment funds under Sections 17603, 17604, and 17606.20, as those sections read on January 1, 2012, and Section 17606.10, as it read on July 1, 2013, to be deposited each month into the Family Support Subaccount.

(d) The total amount deposited pursuant to subdivision (c) with respect to a county for a fiscal year shall not exceed the redirected amount determined pursuant to Section 17613.3, and shall be subject to the appeal processes, and judicial review as described in subdivision (d) of Section 17613.3.

(e) The Legislature finds and declares that this article is not intended to change the local obligation pursuant to Section 17000.

SEC. 23. Section 17613.2 of the Welfare and Institutions Code is amended to read:

17613.2. For purposes of this article, the following definitions shall apply:

(a) "Base year" means the fiscal year ending three years prior to the fiscal year for which the redirected amount is calculated.

(b) "Blended CPI trend factor" means the blended percent change applicable for the fiscal year that is derived from the nonseasonally adjusted Consumer Price Index for All Urban Consumers (CPI-U), United States City Average, for Hospital and Related Services, weighted at 75 percent, and for Medical Care Services, weighted at 25 percent, all as published by the United States Bureau of Labor Statistics, computed as follows:

(1) For each prior fiscal year within the period to be trended through the state fiscal year, the annual average of the monthly index amounts shall be determined separately for the Hospital and Related Services Index and the Medical Care Services Index.

(2) The year-to-year percentage changes in the annual averages determined in paragraph (1) for each of the Hospital and Related Services Index and the Medical Care Services Index shall be determined.

(3) A weighted average annual percentage change for each year-to-year period shall be calculated from the determinations made in paragraph (2), with the percentage changes in the Hospital and Related Services Index weighted at 75 percent, and the percentage changes in the Medical Care Services Index weighted at 25 percent. The resulting average annual percentage changes shall be expressed as a fraction, and increased by 1.00.

(4) The product of the successive year-to-year amounts determined in paragraph (3) shall be the blended CPI trend factor.

(c) "Calculated cost per person" is determined by dividing county indigent program costs by the number of indigent program individuals for the applicable fiscal year. If a county expands eligibility, the enrollment count is limited to those indigent program individuals who would have been eligible for services under the eligibility requirements in existence on July 1, 2013, except if approved as an exception allowed pursuant to subparagraph (3) of paragraph (C) of subdivision (d).

(d) "Cost containment limit" means the county's indigent program costs determined for the 2014–15 fiscal year and each subsequent fiscal year, to be adjusted as follows:

(1) (A) The county's indigent program costs for the state fiscal year shall be determined as indigent program costs for purposes of this paragraph for the relevant fiscal period.

(B) The county's calculated costs per person for the base year will be multiplied by the blended CPI trend factor and then multiplied by the county's fiscal year indigent program individuals. The base year costs used shall not reflect any adjustments under this subdivision.

(C) The fiscal year amount determined in subparagraph (A) shall be compared to the trended amount in subparagraph (B). If the amount in subparagraph (B) exceeds the amount in subparagraph (A), the county will be deemed to have satisfied the cost containment limit. If the amount in subparagraph (A) exceeds the amount in subparagraph (B), the calculation in paragraph (2) shall be performed.

(2) If a county's costs as determined in subparagraph (A) of paragraph (1) exceeds the amount determined in subparagraph (B) of paragraph (1), the following costs, as allocated to the county's indigent care program, shall be added to the cost and reflected in any containment limit:

(A) Costs related to state or federally mandated activities, requirements, or benefit changes.

(B) Costs resulting from a court order or settlement.

(C) Costs incurred as a result of a natural disaster or act of terrorism.

(3) If a county's costs as determined in subparagraph (A) of paragraph (1) exceed the amount determined in subparagraph (B) of paragraph (1), as adjusted by paragraph (2), the county may request that the department consider other costs as adjustments to the cost containment limit. These costs would require departmental approval.

(e) "County" for purposes of this article means the following counties: Fresno, Merced, Orange, Placer, Sacramento, San Diego, San Luis Obispo, Santa Barbara, Santa Cruz, Stanislaus, Tulare, and Yolo.

(f) "County indigent care health realignment amount" means the product of the health realignment amount times the health realignment indigent care percentage, as computed on a county-specific basis.

(g) "County savings determination process" means the process for determining the amount to be redirected in accordance with Section 17613.1, as calculated pursuant to subdivision (a) of Section 17613.3.

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

(i) "Health realignment amount" means the amount that, in the absence of this article, would be payable to a county under Sections 17603, 17604, and 17606.20, as those sections read on January 1, 2012, and Section 17606.10, as it read on July 1, 2013, for the fiscal year that is deposited by the Controller into the local health and welfare trust fund health account of the county.

(j) "Health realignment indigent care percentage" means the county-specific percentage determined in accordance with the following, and established in accordance with the procedures described in subdivision (c) of Section 17613.3:

(1) Each county shall identify the portion of that county's health realignment amount that was used to provide health services to the indigent, including the indigent program individuals, for each of the historical fiscal years, along with verifiable data in support thereof.

(2) The amounts identified in paragraph (1) shall be expressed as a percentage of the health realignment amount of that county for each fiscal year of the historical fiscal years.

(3) The average of the percentages determined in paragraph (2) shall be the county's health realignment indigent care percentage.

(4) To the extent a county does not provide the information required in paragraph (1) or the department determines that the information required is insufficient, the amount under this subdivision shall be considered to be 85 percent.

(k) All references to "health services" or "health care services," unless specified otherwise, shall exclude mental health and substance use disorder services.

(*l*) "Historical fiscal years" means the fiscal years 2008–09 to 2011–12, inclusive.

(m) "Imputed county low-income health amount" means the predetermined, county-specific amount of county general purpose funds assumed, for purposes of the calculation in Section 17613.3, to be available to the county for services to indigent program individuals. The imputed county low-income health amount shall be determined as set forth below and established in accordance with subdivision (c) of Section 17613.3.

(1) For each of the historical fiscal years, an amount shall be determined as the annual amount of county general fund contribution provided for health services to the indigent, which does not include funds provided for mental health and substance use disorder services, through a methodology to be developed by the department, in consultation with the California State Association of Counties.

(2) If a year-to-year percentage increase in the amount determined in paragraph (1) was present, an average annual percentage trend factor shall be determined.

(3) The annual amounts determined in paragraph (1) shall be averaged and multiplied by the percentage trend factor, if applicable, determined in paragraph (2), for each fiscal year after the 2011–12 fiscal year through the applicable fiscal year. Notwithstanding the foregoing, if the percentage trend factor determined in paragraph (2) is greater than the applicable percentage change for any year of the same period in the blended CPI trend factor, the percentage change in the blended CPI trend factor for that year shall be used. The resulting determination is the imputed county low-income health amount for purposes of Section 17613.3.

(n) "Indigent program costs" means the costs incurred by the county for purchasing, providing, or ensuring the availability of services to indigent program individuals during the fiscal year. The costs for mental health and substance use disorder services shall not be included in these costs.

(o) "Indigent program individuals" means all individuals enrolled in a county indigent health care program at any point throughout the fiscal year. If a county does not enroll individuals into an indigent health care program, indigent program individuals shall mean all individuals who used services offered through the county indigent health care program in the fiscal year.

(p) "Indigent program revenues" means self-pay payments made by or on behalf of indigent program individuals to the county for the services rendered in the fiscal year, but shall exclude revenues received for mental health and substance use disorder services.

(q) "Redirected amount" means the amount to be redirected in accordance with Section 17613.1, as calculated pursuant to subdivision (a) of Section 17613.3.

(r) "Special local health funds" means the amount of the following county funds received by the county for health services to indigent program individuals during the fiscal year and shall include funds available pursuant to the Master Settlement Agreement and related documents entered into on November 23, 1998, by the state and leading United States tobacco product manufacturers during a fiscal year. The amount of the tobacco settlement funds to be used for this purpose shall be the greater of paragraph (1) or (2), less any bond payments and other costs of securitization related to the funds described in this subdivision.

(1) The amount of the funds expended by the county for the provision of health services to indigent program individuals during the fiscal year.

(2) The amount of the tobacco settlement funds multiplied by the average of the percentages of the amount of tobacco settlement funds that were allocated to and expended by the county for health services to indigent program individuals during the historical fiscal years.

SEC. 24. Section 17613.3 of the Welfare and Institutions Code is amended to read:

17613.3. (a) For each fiscal year commencing with the 2013–14 fiscal year, the amount to be redirected in accordance with Section 17613.1 shall be determined for each county as set forth in this section.

(1) The county's revenues and other funds paid or payable for the fiscal year shall be comprised of the total of the following:

(A) Indigent program revenues.

(B) Special local health funds.

(C) The county indigent care health realignment amount.

(D) The imputed county low-income health amount.

(2) Indigent program costs incurred by the county for the fiscal year, not to exceed in total the cost containment limit, shall be subtracted from the sum in paragraph (1).

(3) The resulting amount shall be multiplied by 0.80, except that for the 2013–14 fiscal year where the resulting amount shall be multiplied by 0.70.

(4) If the amount in paragraph (3) is a positive number, that amount, subject to paragraph (5), shall be redirected in accordance with Section 17613.1, except that for the 2013–14 fiscal year, the amount to be redirected shall not exceed the amount determined for the county for the 2013–14 fiscal year under subdivision (c) of Section 17603, as that amount may have been reduced by the application of Section 17610.5. If the amount determined in paragraph (3) is a negative number, the redirected amount shall be zero.

(5) Notwithstanding any other law, the amount to be redirected as determined in paragraph (4) for a fiscal year shall not exceed the county indigent care health realignment amount for that fiscal year.

(6) (A) The redirected amount shall be applied until the later of the following:

(i) June 30, 2023.

(ii) The beginning of the fiscal year following a period of two consecutive fiscal years in which both of the following occur:

(aa) The total interim amount determined under subdivision (b) in May of the previous fiscal year is within 10 percent of the final, reconciled amount in subdivision (d).

(bb) The final, reconciled amounts under subdivision (d) are within 5 percent of each other.

(B) After the redirected amount ceases as provided in subparagraph (A), a permanent redirected amount shall be established to be the amount determined by calculating the percentage that the redirected amount was in the last fiscal year of the operation of this article of the county's health realignment amount of that same fiscal year, multiplied by the county's health realignment amount of all subsequent years.

(b) Starting with the 2014–15 fiscal year, the department shall calculate an interim redirected amount for each county under subdivision (a) by the January immediately prior to the starting fiscal year, using the most recent and accurate data available. For purposes of the interim determinations, the cost containment limit shall not be applied. The interim redirected amount shall be updated in the May before the start of the fiscal year in consultation with each county and based on any more recent and accurate data available at that time. During the fiscal year, the interim redirected amount will be applied pursuant to Section 17613.1.

(c) The predetermined amounts or historical percentages described in subdivisions (j), (m), and (r) of Section 17613.2 shall each be established in accordance with the following procedure:

(1) By October 31, 2013, each county shall determine the amount or percentage described in the applicable subdivision, and shall provide this calculation to the department, supported by verifiable data and a description of how the determination was made.

(2) If the department disagrees with the county's determination, the department shall confer with the county by December 15, 2013, and shall issue its determination by January 31, 2014.

(3) If no agreement between the parties has been reached by January 31, 2014, the department shall apply the county's determination when making the interim calculations pursuant to subdivision (b), until a decision is issued pursuant to paragraph (6).

(4) If no agreement between the parties has been reached by January 31, 2014, the county shall submit a petition by February 28, 2014, to the County Health Care Funding Resolution Committee, established pursuant to Section 17600.60, to seek a decision regarding the historical percentage or amount to be applied in calculations under this section.

(5) The County Health Care Funding Resolution Committee shall hear and make a determination as to whether the county's proposed percentage or amount complies with the requirements of this section based on the data and calculations of the county and any alternative data and calculations submitted by the department.

(6) The County Health Care Funding Resolution Committee shall issue its final determination within 45 days of the petition. If the county chooses to contest the final determination, the final determination of the committee will be applied for purposes of any interim calculation under subdivision (b) until a final decision is issued pursuant to de novo administrative review under paragraph (2) of subdivision (d).

(d) (1) The data for the final calculations under subdivision (a) for the fiscal year shall be submitted by counties within 12 months after the conclusion of each fiscal year as required in Section 17613.4. The data shall be the most recent and accurate data from the county's books and records pertaining to the revenues paid or payable, and the costs incurred, for services provided in the subject fiscal year. After consulting with the county, the department shall make final calculations using the data submitted pursuant to this paragraph by December 15 of the following fiscal year, and shall provide its final determination to the county. The final determination will also reflect the application of the cost containment limit, if any. If the county and the department agree, a revised recalculation and reconciliation may be completed by the department within six months thereafter.

(2) The Director of Health Care Services shall establish an expedited formal appeal process for a county to contest final determinations made under this article. No appeal shall be available for interim determinations made under subdivision (b). The appeals process shall include all of the following:

(A) The county shall have 30 calendar days, following the issuance of a final determination made under paragraph (6) of subdivision (c) or paragraph (1) of this subdivision, to file an appeal with the director. All appeals shall be governed by Section 100171 of the Health and Safety Code, except for those provisions of paragraph (1) of subdivision (d) of Section 100171 of the Health and Safety Code relating to accusations, statements of issues, statement to respondent, and notice of defense, and except as otherwise set forth in this section. All appeals shall be in writing and shall be filed with the State Department of Health Care Service's Office of Administrative Hearings and Appeals. An appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals.

(i) An appeal shall specifically set forth each issue in dispute, including, but not limited to, any component of the determination, and include the county's contentions as to those issues. A formal hearing before an Office of Administrative Hearings and Appeals Administrative Law Judge shall commence within 60 days of the filing of the appeal requesting a formal hearing. A final decision under this paragraph shall be adopted no later than six months following the filing of the appeal.

(ii) If the county fails to file an appeal within 30 days of the issuance of a determination made under this section, the determination of the department shall be deemed final and not appealable either administratively or to a court of general jurisdiction, except that a county may elect to appeal a determination under subdivision (c) within 30 days of the issuance of the County Health Care Funding Resolution Committee's final determination under paragraph (6) of subdivision (c) or as a component of an appeal of the department's final determination under paragraph (1) for the 2013–14 fiscal year.

(B) If a final decision under this paragraph is not issued by the department within two years of the last day of the subject fiscal year, the county shall be deemed to have exhausted its administrative remedies, and shall not be precluded from pursuing any available judicial review. However, the time period in this subdivision shall be extended by either of the following:

(i) Undue delay caused by the county.

(ii) An extension of time granted to a county at its sole request, or following the joint request of the county and the department.

(C) If the final decision issued by the department pursuant to this paragraph results in a different determination than that originally made by the department, then the Department of Finance shall adjust the original determination by that amount, pursuant to a process developed by the Department of Finance and in consultation with the California State Association of Counties.

SEC. 25. Section 17613.4 of the Welfare and Institutions Code is amended to read:

17613.4. (a) Beginning with the 2013–14 fiscal year, each county that has elected to participate in the County Savings Determination Process shall, within five months after the end of each fiscal year, be required to submit initial reports on both of the following:

(1) All revenue data required for the operation of Section 17613.3, including both of the following:

(A) Indigent program revenues.

(B) Special local health funds.

(2) All cost data required for the operation of Section 17613.3, including indigent program costs.

(b) Counties shall submit final reports of cost and revenue data identified in subdivision (a) to the department for the each fiscal year no later than June 30 of the fiscal year ending one year after the subject fiscal year.

(c) The department shall develop, in consultation with California State Association of Counties, the methodologies used to determine the costs and revenues required to be reported and the format of the submissions.

(d) Reports submitted under this section shall be accompanied by a certification by an appropriate public official attesting to the accuracy of the reports.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or

make specific this article by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions.

SEC. 26. Section 18901.2 of the Welfare and Institutions Code is amended to read:

18901.2. (a) It is the intent of the Legislature to create a program in California that provides a nominal Low-Income Home Energy Assistance Program (LIHEAP) service benefit, through the LIHEAP block grant, to all recipient households of CalFresh so that they are made aware of services available under LIHEAP and so that some households may experience an increase in federal Supplemental Nutrition Assistance Program benefits, as well as benefit from paperwork reduction.

(b) To the extent permitted by federal law, the State Department of Social Services (DSS) shall, in conjunction with the Department of Community Services and Development (CSD), design, implement, and maintain a utility assistance initiative: the "Heat and Eat" program.

(1) The nominal LIHEAP service benefit shall be funded through the LIHEAP block grant allocated for outreach activities in accordance with state and federal requirements, and shall be provided by the CSD to the DSS after receipt by the CSD of the LIHEAP block grant funds from the federal funding authorities.

(2) The total amount transferred shall be the product of the nominal LIHEAP service benefit established by the CSD in the LIHEAP state plan multiplied by the number of CalFresh recipient households as agreed upon annually by the CSD and the DSS.

(3) The total amount transferred shall be reduced by any unexpended or reinvested amounts remaining from prior transfers for the nominal LIHEAP service benefits as provided in subparagraph (C) of paragraph (1) of subdivision (c).

(c) In implementing and maintaining the utility assistance initiative, the State Department of Social Services shall do all of the following:

(1) (A) Grant recipient households of CalFresh benefits pursuant to this chapter a nominal LIHEAP service benefit out of the federal LIHEAP block grant (42 U.S.C. Sec. 8621 et seq.).

(B) In establishing the nominal LIHEAP service benefit amount, the department shall take into consideration that the benefit level need not provide significant utility assistance.

(C) Any funds allocated for this purpose not expended by CalFresh recipient households shall be recouped through the "Heat and Eat" program and reinvested into the program on an annual basis as determined by both departments.

(2) Provide the nominal LIHEAP service benefit without requiring the applicant or recipient to provide additional paperwork or verification.

(3) To the extent permitted by federal law and to the extent federal funds are available, provide the nominal LIHEAP service benefit annually to each recipient of CalFresh benefits.

(4) (A) Deliver the nominal LIHEAP service benefit using the Electronic Benefit Transfer (EBT) system or other nonpaper delivery system.

(B) Notification of a recipient's impending EBT dormant account status shall not be required when the remaining balance in a recipient's account at the time the account becomes inactive is ninety-nine cents ($0.99) or less of LIHEAP service benefits.

(5) Ensure that receipt of the nominal LIHEAP service benefit pursuant to this section shall not adversely affect a CalFresh recipient household's eligibility, reduce a household's CalFresh benefits, or disqualify the applicant or recipient of CalFresh benefits from receiving other nominal LIHEAP service benefits or other utility benefits for which they may qualify.

(d) Recipients of the nominal LIHEAP service benefit pursuant to this section shall remain subject to the additional eligibility requirements for LIHEAP assistance as outlined in the California LIHEAP state plan, developed by the CSD.

(e) (1) To the extent permitted by federal law, a CalFresh household receiving or anticipating receipt of nominal LIHEAP service benefits pursuant to the utility assistance initiative or any other law shall be entitled to use the full standard utility allowance (SUA) for the purposes of calculating CalFresh benefits. A CalFresh household shall be entitled to use the full SUA regardless of whether the nominal LIHEAP service benefit is actually redeemed.

(2) If use of the full SUA, instead of the homeless shelter deduction, results in a lower amount of CalFresh benefits for a homeless household, the homeless household shall be entitled to use the homeless shelter deduction instead of the full SUA.

(f) The department shall implement the initiative by January 1, 2013.

SEC. 27. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

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