

AMENDED IN SENATE APRIL 21, 2014

AMENDED IN SENATE MARCH 25, 2014

SENATE BILL

No. 1352

Introduced by Senator Hancock

(Coauthor: Senator Corbett)

(Coauthors: Assembly Members Bonta, Quirk, and Skinner)

February 21, 2014

An act to amend Section 101850 of, and to amend the heading of Chapter 5 (commencing with Section 101850) of Part 4 of Division 101 of, the Health and Safety Code, *and to amend Sections 14085.53, 14166.1, and 17612.2 of the Welfare and Institutions Code*, relating to the Alameda Health System.

LEGISLATIVE COUNSEL'S DIGEST

SB 1352, as amended, Hancock. Alameda Health System.

Existing law authorizes the board of supervisors of Alameda County to establish an independent hospital authority strictly and exclusively dedicated to the management, administration, and control of the group of public hospitals, clinics, and programs that comprise the Alameda County Medical Center.

This bill would instead authorize the board to establish an independent hospital authority for the Alameda Health System, which was formerly known as the Alameda County Medical Center. The bill would make conforming changes with regard to legislative findings and declarations and would include additional legislative findings and declarations relating to the Alameda Health System. *The bill would also make other conforming changes in existing law.*

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

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:

3 (a) The Alameda County Medical Center has evolved to include
4 additional facilities that have expanded services and the quality of
5 care to the residents of the County of Alameda.

6 (b) In order to better reflect the regional availability of services
7 to the residents of the County of Alameda, the Alameda County
8 Medical Center is doing business as the Alameda Health System
9 and it is appropriate that the name change be reflected statutorily
10 to ensure that there is no confusion in the administration of state
11 programs.

12 (c) The Alameda Health System is a major public health care
13 provider and medical training institution recognized for its world
14 class patient and family-centered system of care.

15 (d) The Alameda Health System provides comprehensive,
16 high-quality medical treatment, health promotion, disease
17 prevention, and health maintenance in an integrated system of
18 hospitals, clinics, and health services.

19 (e) As a training institution, the Alameda Health System
20 maintains an environment that is supportive of a wide range of
21 educational programs and activities, including the education of
22 medical students, interns, residents, and continuing education for
23 medical nursing, and other staff, along with medical research.

24 (f) The Alameda Health System is a regional provider of health
25 care services, and includes the following facilities:

26 (1) Highland Hospital, located in Oakland, is a major regional
27 trauma center and teaching hospital that delivers primary, specialty,
28 and multispecialty care. Within the Highland campus are centers
29 of excellence in maternity services, gastroenterology, surgery,
30 orthopedics, geriatrics and senior care, and trauma.

31 (2) John George Psychiatric Hospital, located in San Leandro,
32 provides psychiatric emergency and acute care services to adults
33 experiencing severe and disabling mental illnesses.

34 (3) San Leandro Hospital, located in San Leandro, is a 93-bed
35 facility in central Alameda County acquired in late 2013 and
36 provides a wide range of medical services, including 24-hour
37 emergency services, critical care, a full complement of skilled
38 surgeons, rehabilitation services, and ancillary services.

1 (4) Fairmont Hospital, located in San Leandro, is an acute
2 rehabilitation center that is one of the foremost providers of acute
3 rehabilitation services in northern California, treating severe
4 injuries such as stroke, brain, and multiple-trauma injuries.

5 (5) Wellness Centers, in Oakland, Hayward, and Newark form
6 a network of community-based wellness centers that expand access
7 to primary care and Alameda Health System medical specialties.
8 All primary services are offered at the Wellness Centers to provide
9 continuity of care for patients. These services include pediatrics,
10 immunizations, family planning, HIV/AIDS, breast health, dental,
11 podiatry, tuberculosis, minor surgery, social work, and health
12 education.

13 SEC. 2. The heading of Chapter 5 (commencing with Section
14 101850) of Part 4 of Division 101 of the Health and Safety Code
15 is amended to read:

16
17 CHAPTER 5. ALAMEDA HEALTH SYSTEM HOSPITAL AUTHORITY
18

19 SEC. 3. Section 101850 of the Health and Safety Code is
20 amended to read:

21 101850. The Legislature finds and declares the following:

22 (a) (1) Due to the challenges facing the Alameda Health System
23 arising from changes in the public and private health industries,
24 the Alameda County Board of Supervisors has determined that a
25 transfer of governance of the Alameda Health System to an
26 independent governing body, a hospital authority, is needed to
27 improve the efficiency, effectiveness, and economy of the
28 community health services provided at the medical center. The
29 board of supervisors has further determined that the creation of an
30 independent hospital authority strictly and exclusively dedicated
31 to the management, administration, and control of the medical
32 center, in a manner consistent with the county's obligations under
33 Section 17000 of the Welfare and Institutions Code, is the best
34 way to fulfill its commitment to the medically indigent, special
35 needs, and general populations of Alameda County. To accomplish
36 this, it is necessary that the board of supervisors be given authority
37 to create a hospital authority. Because there is no general law under
38 which this authority could be formed, the adoption of a special act
39 and the formation of a special authority is required.

1 (2) The following definitions shall apply for purposes of this
2 section:

3 (A) “The county” means the County of Alameda.

4 (B) “Governing board” means the governing body of the hospital
5 authority.

6 (C) “Hospital authority” means the separate public agency
7 established by the Board of Supervisors of Alameda County to
8 manage, administer, and control the Alameda Health System.

9 (D) “Medical center” means the Alameda Health System, which
10 was formerly known as the Alameda County Medical Center.

11 (b) The board of supervisors of the county may, by ordinance,
12 establish a hospital authority separate and apart from the county
13 for the purpose of effecting a transfer of the management,
14 administration, and control of the medical center in accordance
15 with Section 14000.2 of the Welfare and Institutions Code. A
16 hospital authority established pursuant to this chapter shall be
17 strictly and exclusively dedicated to the management,
18 administration, and control of the medical center within parameters
19 set forth in this chapter, and in the ordinance, bylaws, and contracts
20 adopted by the board of supervisors that shall not be in conflict
21 with this chapter, Section 1442.5 of this code, or Section 17000
22 of the Welfare and Institutions Code.

23 (c) A hospital authority established pursuant to this chapter shall
24 be governed by a board that is appointed, both initially and
25 continually, by the Board of Supervisors of the County of Alameda.
26 This hospital authority governing board shall reflect both the
27 expertise necessary to maximize the quality and scope of care at
28 the medical center in a fiscally responsible manner and the diverse
29 interest that the medical center serves. The enabling ordinance
30 shall specify the membership of the hospital authority governing
31 board, the qualifications for individual members, the manner of
32 appointment, selection, or removal of governing board members,
33 their terms of office, and all other matters that the board of
34 supervisors deems necessary or convenient for the conduct of the
35 hospital authority’s activities.

36 (d) The mission of the hospital authority shall be the
37 management, administration, and other control, as determined by
38 the board of supervisors, of the group of public hospitals, clinics,
39 and programs that comprise the medical center, in a manner that
40 ensures appropriate, quality, and cost-effective medical care as

1 required of counties by Section 17000 of the Welfare and
2 Institutions Code, and, to the extent feasible, other populations,
3 including special populations in the County of Alameda.

4 (e) The board of supervisors shall adopt bylaws for the medical
5 center that set forth those matters related to the operation of the
6 medical center by the hospital authority that the board of
7 supervisors deems necessary and appropriate. The bylaws shall
8 become operative upon approval by a majority vote of the board
9 of supervisors. Any changes or amendments to the bylaws shall
10 be by majority vote of the board of supervisors.

11 (f) The hospital authority created and appointed pursuant to this
12 section is a duly constituted governing body within the meaning
13 of Section 1250 and Section 70035 of Title 22 of the California
14 Code of Regulations as currently written or subsequently amended.

15 (g) Unless otherwise provided by the board of supervisors by
16 way of resolution, the hospital authority is empowered, or the
17 board of supervisors is empowered on behalf of the hospital
18 authority, to apply as a public agency for one or more licenses for
19 the provision of health care pursuant to statutes and regulations
20 governing licensing as currently written or subsequently amended.

21 (h) In the event of a change of license ownership, the governing
22 body of the hospital authority shall comply with the obligations
23 of governing bodies of general acute care hospitals generally as
24 set forth in Section 70701 of Title 22 of the California Code of
25 Regulations, as currently written or subsequently amended, as well
26 as the terms and conditions of the license. The hospital authority
27 shall be the responsible party with respect to compliance with these
28 obligations, terms, and conditions.

29 (i) (1) Any transfer by the county to the hospital authority of
30 the administration, management, and control of the medical center,
31 whether or not the transfer includes the surrendering by the county
32 of the existing general acute care hospital license and corresponding
33 application for a change of ownership of the license, shall not
34 affect the eligibility of the county, or in the case of a change of
35 license ownership, the hospital authority, to do any of the
36 following:

37 (A) Participate in, and receive allocations pursuant to, the
38 California Healthcare for the Indigents Program (CHIP).

1 (B) Receive supplemental reimbursements from the Emergency
2 Services and Supplemental Payments Fund created pursuant to
3 Section 14085.6 of the Welfare and Institutions Code.

4 (C) Receive appropriations from the Medi-Cal Inpatient Payment
5 Adjustment Fund without relieving the county of its obligation to
6 make intergovernmental transfer payments related to the Medi-Cal
7 Inpatient Payment Adjustment Fund pursuant to Section 14163 of
8 the Welfare and Institutions Code.

9 (D) Receive Medi-Cal capital supplements pursuant to Section
10 14085.5 of the Welfare and Institutions Code.

11 (E) Receive any other funds that would otherwise be available
12 to a county hospital.

13 (2) Any transfer described in paragraph (1) shall not otherwise
14 disqualify the county, or in the case of a change in license
15 ownership, the hospital authority, from participating in any of the
16 following:

17 (A) Other funding sources either specific to county hospitals or
18 county ambulatory care clinics or for which there are special
19 provisions specific to county hospitals or to county ambulatory
20 care clinics.

21 (B) Funding programs in which the county, on behalf of the
22 medical center and the Alameda County Health Care Services
23 Agency, had participated prior to the creation of the hospital
24 authority, or would otherwise be qualified to participate in had the
25 hospital authority not been created, and administration,
26 management, and control not been transferred by the county to the
27 hospital authority, pursuant to this chapter.

28 (j) A hospital authority created pursuant to this chapter shall be
29 a legal entity separate and apart from the county and shall file the
30 statement required by Section 53051 of the Government Code.
31 The hospital authority shall be a government entity separate and
32 apart from the county, and shall not be considered to be an agency,
33 division, or department of the county. The hospital authority shall
34 not be governed by, nor be subject to, the charter of the county
35 and shall not be subject to policies or operational rules of the
36 county, including, but not limited to, those relating to personnel
37 and procurement.

38 (k) (1) Any contract executed by and between the county and
39 the hospital authority shall provide that liabilities or obligations
40 of the hospital authority with respect to its activities pursuant to

1 the contract shall be the liabilities or obligations of the hospital
2 authority, and shall not become the liabilities or obligations of the
3 county.

4 (2) Any liabilities or obligations of the hospital authority with
5 respect to the liquidation or disposition of the hospital authority's
6 assets upon termination of the hospital authority shall not become
7 the liabilities or obligations of the county.

8 (3) Any obligation of the hospital authority, statutory,
9 contractual, or otherwise, shall be the obligation solely of the
10 hospital authority and shall not be the obligation of the county or
11 the state.

12 (l) (1) Notwithstanding any other provision of this section, any
13 transfer of the administration, management, or assets of the medical
14 center, whether or not accompanied by a change in licensing, shall
15 not relieve the county of the ultimate responsibility for indigent
16 care pursuant to Section 17000 of the Welfare and Institutions
17 Code or any obligation pursuant to Section 1442.5 of this code.

18 (2) Any contract executed by and between the county and the
19 hospital authority shall provide for the indemnification of the
20 county by the hospital authority for liabilities as specifically set
21 forth in the contract, except that the contract shall include a
22 provision that the county shall remain liable for its own negligent
23 acts.

24 (3) Indemnification by the hospital authority shall not be
25 construed as divesting the county from its ultimate responsibility
26 for compliance with Section 17000 of the Welfare and Institutions
27 Code.

28 (m) Notwithstanding the provisions of this section relating to
29 the obligations and liabilities of the hospital authority, a transfer
30 of control or ownership of the medical center shall confer onto the
31 hospital authority all the rights and duties set forth in state law
32 with respect to hospitals owned or operated by a county.

33 (n) (1) A transfer of the maintenance, operation, and
34 management or ownership of the medical center to the hospital
35 authority shall comply with the provisions of Section 14000.2 of
36 the Welfare and Institutions Code.

37 (2) A transfer of maintenance, operation, and management or
38 ownership to the hospital authority may be made with or without
39 the payment of a purchase price by the hospital authority and
40 otherwise upon the terms and conditions that the parties may

1 mutually agree, which terms and conditions shall include those
2 found necessary by the board of supervisors to ensure that the
3 transfer will constitute an ongoing material benefit to the county
4 and its residents.

5 (3) A transfer of the maintenance, operation, and management
6 to the hospital authority shall not be construed as empowering the
7 hospital authority to transfer any ownership interest of the county
8 in the medical center except as otherwise approved by the board
9 of supervisors.

10 (o) The board of supervisors shall retain control over the use of
11 the medical center physical plant and facilities except as otherwise
12 specifically provided for in lawful agreements entered into by the
13 board of supervisors. Any lease agreement or other agreement
14 between the county and the hospital authority shall provide that
15 county premises shall not be sublet without the approval of the
16 board of supervisors.

17 (p) The statutory authority of a board of supervisors to prescribe
18 rules that authorize a county hospital to integrate its services with
19 those of other hospitals into a system of community service that
20 offers free choice of hospitals to those requiring hospital care, as
21 set forth in Section 14000.2 of the Welfare and Institutions Code,
22 shall apply to the hospital authority upon a transfer of maintenance,
23 operation, and management or ownership of the medical center by
24 the county to the hospital authority.

25 (q) The hospital authority shall have the power to acquire and
26 possess real or personal property and may dispose of real or
27 personal property other than that owned by the county, as may be
28 necessary for the performance of its functions. The hospital
29 authority shall have the power to sue or be sued, to employ
30 personnel, and to contract for services required to meet its
31 obligations. Before January 1, 2024, the hospital authority shall
32 not enter into a contract with any private person or entity to replace
33 services being provided by physicians and surgeons who are
34 employed by the hospital authority and in a recognized collective
35 bargaining unit as of March 31, 2013, with services provided by
36 a private person or entity without clear and convincing evidence
37 that the needed medical care can only be delivered cost effectively
38 by a private contractor. Prior to entering into a contract for any of
39 those services, the authority shall negotiate with the representative
40 of the recognized collective bargaining unit of its physician and

1 surgeon employees over the decision to privatize and, if unable to
2 resolve any dispute through negotiations, shall submit the matter
3 to final binding arbitration.

4 (r) Any agreement between the county and the hospital authority
5 shall provide that all existing services provided by the medical
6 center shall continue to be provided to the county through the
7 medical center subject to the policy of the county and consistent
8 with the county’s obligations under Section 17000 of the Welfare
9 and Institutions Code.

10 (s) A hospital authority to which the maintenance, operation,
11 and management or ownership of the medical center is transferred
12 shall be a “district” within the meaning set forth in the County
13 Employees Retirement Law of 1937 (Chapter 3 (commencing with
14 Section 31450) of Part 3 of Division 4 of Title 3 of the Government
15 Code). Employees of a hospital authority are eligible to participate
16 in the County Employees Retirement System to the extent
17 permitted by law, except as described in Section 101851.

18 (t) Members of the governing board of the hospital authority
19 shall not be vicariously liable for injuries caused by the act or
20 omission of the hospital authority to the extent that protection
21 applies to members of governing boards of local public entities
22 generally under Section 820.9 of the Government Code.

23 (u) The hospital authority shall be a public agency subject to
24 the Meyers-Miliias-Brown Act (Chapter 10 (commencing with
25 Section 3500) of Division 4 of Title 1 of the Government Code).

26 (v) Any transfer of functions from county employee
27 classifications to a hospital authority established pursuant to this
28 section shall result in the recognition by the hospital authority of
29 the employee organization that represented the classifications
30 performing those functions at the time of the transfer.

31 (w) (1) In exercising its powers to employ personnel, as set
32 forth in subdivision (p), the hospital authority shall implement,
33 and the board of supervisors shall adopt, a personnel transition
34 plan. The personnel transition plan shall require all of the
35 following:

36 (A) Ongoing communications to employees and recognized
37 employee organizations regarding the impact of the transition on
38 existing medical center employees and employee classifications.

39 (B) Meeting and conferring on all of the following issues:

- 1 (i) The timeframe for which the transfer of personnel shall occur.
2 The timeframe shall be subject to modification by the board of
3 supervisors as appropriate, but in no event shall it exceed one year
4 from the effective date of transfer of governance from the board
5 of supervisors to the hospital authority.
- 6 (ii) A specified period of time during which employees of the
7 county impacted by the transfer of governance may elect to be
8 appointed to vacant positions with the Alameda County Health
9 Care Services Agency for which they have tenure.
- 10 (iii) A specified period of time during which employees of the
11 county impacted by the transfer of governance may elect to be
12 considered for reinstatement into positions with the county for
13 which they are qualified and eligible.
- 14 (iv) Compensation for vacation leave and compensatory leave
15 accrued while employed with the county in a manner that grants
16 affected employees the option of either transferring balances or
17 receiving compensation to the degree permitted employees laid
18 off from service with the county.
- 19 (v) A transfer of sick leave accrued while employed with the
20 county to hospital authority employment.
- 21 (vi) The recognition by the hospital authority of service with
22 the county in determining the rate at which vacation accrues.
- 23 (vii) The possible preservation of seniority, pensions, health
24 benefits, and other applicable accrued benefits of employees of
25 the county impacted by the transfer of governance.
- 26 (2) Nothing in this subdivision shall be construed as prohibiting
27 the hospital authority from determining the number of employees,
28 the number of full-time equivalent positions, the job descriptions,
29 and the nature and extent of classified employment positions.
- 30 (3) Employees of the hospital authority are public employees
31 for purposes of Division 3.6 (commencing with Section 810) of
32 Title 1 of the Government Code relating to claims and actions
33 against public entities and public employees.
- 34 (x) Any hospital authority created pursuant to this section shall
35 be bound by the terms of the memorandum of understanding
36 executed by and between the county and health care and
37 management employee organizations that is in effect as of the date
38 this legislation becomes operative in the county. Upon the
39 expiration of the memorandum of understanding, the hospital
40 authority shall have sole authority to negotiate subsequent

1 memorandums of understanding with appropriate employee
2 organizations. Subsequent memorandums of understanding shall
3 be approved by the hospital authority.

4 (y) The hospital authority created pursuant to this section may
5 borrow from the county and the county may lend the hospital
6 authority funds or issue revenue anticipation notes to obtain those
7 funds necessary to operate the medical center and otherwise provide
8 medical services.

9 (z) The hospital authority shall be subject to state and federal
10 taxation laws that are applicable to counties generally.

11 (aa) The hospital authority, the county, or both, may engage in
12 marketing, advertising, and promotion of the medical and health
13 care services made available to the community at the medical
14 center.

15 (ab) The hospital authority shall not be a “person” subject to
16 suit under the Cartwright Act (Chapter 2 (commencing with Section
17 16700) of Part 2 of Division 7 of the Business and Professions
18 Code).

19 (ac) Notwithstanding Article 4.7 (commencing with Section
20 1125) of Chapter 1 of Division 4 of Title 1 of the Government
21 Code related to incompatible activities, a member of the hospital
22 authority administrative staff shall not be considered to be engaged
23 in activities inconsistent and incompatible with his or her duties
24 as a result of employment or affiliation with the county.

25 (ad) (1) The hospital authority may use a computerized
26 management information system in connection with the
27 administration of the medical center.

28 (2) Information maintained in the management information
29 system or in other filing and records maintenance systems that is
30 confidential and protected by law shall not be disclosed except as
31 provided by law.

32 (3) The records of the hospital authority, whether paper records,
33 records maintained in the management information system, or
34 records in any other form, that relate to trade secrets or to payment
35 rates or the determination thereof, or which relate to contract
36 negotiations with providers of health care, shall not be subject to
37 disclosure pursuant to the California Public Records Act (Chapter
38 5 (commencing with Section 6250) of Division 7 of Title 1 of the
39 Government Code). The transmission of the records, or the
40 information contained therein in an alternative form, to the board

1 of supervisors shall not constitute a waiver of exemption from
2 disclosure, and the records and information once transmitted shall
3 be subject to this same exemption. The information, if compelled
4 pursuant to an order of a court of competent jurisdiction or
5 administrative body in a manner permitted by law, shall be limited
6 to in-camera review, which, at the discretion of the court, may
7 include the parties to the proceeding, and shall not be made a part
8 of the court file unless sealed.

9 (ae) (1) Notwithstanding any other law, the governing board
10 may order that a meeting held solely for the purpose of discussion
11 or taking action on hospital authority trade secrets, as defined in
12 subdivision (d) of Section 3426.1 of the Civil Code, shall be held
13 in closed session. The requirements of making a public report of
14 actions taken in closed session and the vote or abstention of every
15 member present may be limited to a brief general description
16 devoid of the information constituting the trade secret.

17 (2) The governing board may delete the portion or portions
18 containing trade secrets from any documents that were finally
19 approved in the closed session that are provided to persons who
20 have made the timely or standing request.

21 (3) Nothing in this section shall be construed as preventing the
22 governing board from meeting in closed session as otherwise
23 provided by law.

24 (af) Open sessions of the hospital authority shall constitute
25 official proceedings authorized by law within the meaning of
26 Section 47 of the Civil Code. The privileges set forth in that section
27 with respect to official proceedings shall apply to open sessions
28 of the hospital authority.

29 (ag) The hospital authority shall be a public agency for purposes
30 of eligibility with respect to grants and other funding and loan
31 guarantee programs. Contributions to the hospital authority shall
32 be tax deductible to the extent permitted by state and federal law.
33 Nonproprietary income of the hospital authority shall be exempt
34 from state income taxation.

35 (ah) Contracts by and between the hospital authority and the
36 state and contracts by and between the hospital authority and
37 providers of health care, goods, or services may be let on a nonbid
38 basis and shall be exempt from Chapter 2 (commencing with
39 Section 10290) of Part 2 of Division 2 of the Public Contract Code.

1 (ai) (1) Provisions of the Evidence Code, the Government Code,
2 including the Public Records Act (Chapter 5 (commencing with
3 Section 6250) of Division 7 of Title 1 of the Government Code),
4 the Civil Code, the Business and Professions Code, and other
5 applicable law pertaining to the confidentiality of peer review
6 activities of peer review bodies shall apply to the peer review
7 activities of the hospital authority. Peer review proceedings shall
8 constitute an official proceeding authorized by law within the
9 meaning of Section 47 of the Civil Code and those privileges set
10 forth in that section with respect to official proceedings shall apply
11 to peer review proceedings of the hospital authority. If the hospital
12 authority is required by law or contractual obligation to submit to
13 the state or federal government peer review information or
14 information relevant to the credentialing of a participating provider,
15 that submission shall not constitute a waiver of confidentiality.
16 The laws pertaining to the confidentiality of peer review activities
17 shall be together construed as extending, to the extent permitted
18 by law, the maximum degree of protection of confidentiality.

19 (2) Notwithstanding any other law, Section 1461 shall apply to
20 hearings on the reports of hospital medical audit or quality
21 assurance committees.

22 (aj) The hospital authority shall carry general liability insurance
23 to the extent sufficient to cover its activities.

24 (ak) In the event the board of supervisors determines that the
25 hospital authority should no longer function for the purposes as
26 set forth in this chapter, the board of supervisors may, by ordinance,
27 terminate the activities of the hospital authority and expire the
28 hospital authority as an entity.

29 (al) A hospital authority which is created pursuant to this section
30 but which does not obtain the administration, management, and
31 control of the medical center or which has those duties and
32 responsibilities revoked by the board of supervisors shall not be
33 empowered with the powers enumerated in this section.

34 (am) (1) The county shall establish baseline data reporting
35 requirements for the medical center consistent with the Medically
36 Indigent Health Care Reporting System (MICRS) program
37 established pursuant to Section 16910 of the Welfare and
38 Institutions Code and shall collect that data for at least one year
39 prior to the final transfer of the medical center to the hospital

1 authority established pursuant to this chapter. The baseline data
2 shall include, but not be limited to, all of the following:

- 3 (A) Inpatient days by facility by quarter.
- 4 (B) Outpatient visits by facility by quarter.
- 5 (C) Emergency room visits by facility by quarter.
- 6 (D) Number of unduplicated users receiving services within the
7 medical center.

8 (2) Upon transfer of the medical center, the county shall
9 establish baseline data reporting requirements for each of the
10 medical center inpatient facilities consistent with data reporting
11 requirements of the Office of Statewide Health Planning and
12 Development, including, but not limited to, monthly average daily
13 census by facility for all of the following:

- 14 (A) Acute care, excluding newborns.
- 15 (B) Newborns.
- 16 (C) Skilled nursing facility, in a distinct part.

17 (3) From the date of transfer of the medical center to the hospital
18 authority, the hospital authority shall provide the county with
19 quarterly reports specified in paragraphs (1) and (2) and any other
20 data required by the county. The county, in consultation with health
21 care consumer groups, shall develop other data requirements that
22 shall include, at a minimum, reasonable measurements of the
23 changes in medical care for the indigent population of Alameda
24 County that result from the transfer of the administration,
25 management, and control of the medical center from the county
26 to the hospital authority.

27 (an) A hospital authority established pursuant to this section
28 shall comply with the requirements of Sections 53260 and 53261
29 of the Government Code.

30 *SEC. 4. Section 14085.53 of the Welfare and Institutions Code*
31 *is amended to read:*

32 14085.53. (a) The ~~Alameda County Medical Center Health~~
33 ~~System~~ may revise plans submitted in accordance with
34 subparagraph (C) of paragraph (1) of subdivision (b) of Section
35 14085.5 for the ~~Alameda County Medical Center Health System~~
36 capital project and submit those revised plans pursuant to this
37 section. The revised capital project plans shall qualify for
38 supplemental reimbursement under Section 14085.5 for the revised
39 capital project as described in the revised plans, notwithstanding

1 the assignment of a different permit number, if all of the following
2 conditions are met:

3 (1) The revised capital project continues to meet all other
4 requirements for eligibility as specified in Section 14085.5.

5 (2) The revised plans are submitted to the Office of Statewide
6 Health Planning and Development prior to June 30, 1997.

7 (3) The modifications do not involve a deviation from the
8 original capital project plan's stated architectural building footprint.

9 (b) The revised capital project plan for *the Alameda County*
10 ~~Medical Center Health System~~ may provide for any or all or any
11 combination of the following:

12 (1) A reduction in size and scope of the original project plan.

13 (2) Tenant interior improvements for the entire building not
14 specified in the original project plan.

15 (3) Modifications to the foundation, structural frame, and
16 building exterior shell, commonly known as the shell and core.

17 (4) Modifications necessary to comply with current seismic
18 safety standards.

19 (c) The revised capital project plans for the *Alameda County*
20 ~~Medical Center Health System~~, as described in this section, shall
21 qualify for supplemental reimbursement as calculated pursuant to
22 subdivision (c) of Section 14085.5, as limited by this section. The
23 initial Medi-Cal inpatient utilization rate for the *Alameda County*
24 ~~Medical Center Health System~~, for purposes of calculating the
25 supplemental reimbursement, shall be that which was established
26 at the point of the original project plan submission. The
27 supplemental reimbursement shall be based on actual costs of the
28 revised capital project eligible for reimbursement under Section
29 14085.5. However, in no event shall the supplemental
30 reimbursement for the revised capital project exceed 85 percent
31 of the supplemental reimbursement for that portion of the original
32 ~~Alameda County Medical Center Health System~~ capital project
33 that qualified for the supplemental reimbursement, the original
34 qualifying amount ~~which~~ *that* was sixty-two million six hundred
35 ninety-six thousand three hundred forty dollars (\$62,696,340), as
36 indicated by the budgetary estimate as prepared and submitted by
37 Alameda County to the department July 11, 1994.

38 *SEC. 5. Section 14166.1 of the Welfare and Institutions Code*
39 *is amended to read:*

1 14166.1. For purposes of this article, the following definitions
2 shall apply:

3 (a) “Allowable costs” means those costs recognized as allowable
4 under Medicare reasonable cost principles and additional costs
5 recognized under the demonstration project and successor
6 demonstration project, including those expenditures identified in
7 Appendix D to the Special Terms and Conditions for the
8 demonstration project and successor demonstration project.
9 Allowable costs under this subdivision shall be determined in
10 accordance with the Special Terms and Conditions and
11 implementation documents for the demonstration project and
12 successor demonstration project approved by the federal Centers
13 for Medicare and Medicaid Services.

14 (b) “Base year private DSH hospital” means a nonpublic
15 hospital, nonpublic-converted hospital, or converted hospital, as
16 those terms are defined in paragraphs (26), (27), and (28),
17 respectively, of subdivision (a) of Section 14105.98, that was an
18 eligible hospital under paragraph (3) of subdivision (a) of Section
19 14105.98 for the 2004–05 state fiscal year.

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

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

32 (1) UC Davis Medical Center.

33 (2) UC Irvine Medical Center.

34 (3) UC San Diego Medical Center.

35 (4) UC San Francisco Medical Center.

36 (5) UC Los Angeles Medical Center, including Santa
37 Monica/UCLA Medical Center.

38 (6) LA County Harbor/UCLA Medical Center.

39 (7) LA County Martin Luther King Jr.-Harbor Hospital.

40 (8) LA County Olive View UCLA Medical Center.

- 1 (9) LA County Rancho Los Amigos National Rehabilitation
2 Center.
- 3 (10) LA County University of Southern California Medical
4 Center.
- 5 (11) ~~Alameda County Medical Center~~ *Health System*.
- 6 (12) Arrowhead Regional Medical Center.
- 7 (13) Contra Costa Regional Medical Center.
- 8 (14) Kern Medical Center.
- 9 (15) Natividad Medical Center.
- 10 (16) Riverside County Regional Medical Center.
- 11 (17) San Francisco General Hospital.
- 12 (18) San Joaquin General Hospital.
- 13 (19) San Mateo Medical Center.
- 14 (20) Santa Clara Valley Medical Center.
- 15 (21) Tuolumne General Hospital.
- 16 (22) Ventura County Medical Center.
- 17 (e) “Federal medical assistance percentage” means the federal
18 medical assistance percentage applicable for federal financial
19 participation purposes for medical services under the Medi-Cal
20 state plan pursuant to Section 1396b(a) of Title 42 of the United
21 States Code.
- 22 (f) “Nondesignated public hospital” means a public hospital
23 defined in paragraph (25) of subdivision (a) of Section 14105.98,
24 excluding designated public hospitals.
- 25 (g) “Project year” means the applicable state fiscal year of the
26 Medi-Cal Hospital/Uninsured Care Demonstration Project through
27 October 31, 2010.
- 28 (h) “Project year private DSH hospital” means a nonpublic
29 hospital, nonpublic-converted hospital, or converted hospital, as
30 those terms are defined in paragraphs (26), (27), and (28),
31 respectively, of subdivision (a) of Section 14105.98, that was an
32 eligible hospital under paragraph (3) of subdivision (a) of Section
33 14105.98, for the particular project year.
- 34 (i) “Prior supplemental funds” means the Emergency Services
35 and Supplemental Payments Fund, the Medi-Cal Medical Education
36 Supplemental Payment Fund, the Large Teaching Emphasis
37 Hospital and Children’s Hospital Medi-Cal Medical Education
38 Supplemental Payment Fund, and the Small and Rural Hospital
39 Supplemental Payments Fund, established under Sections 14085.6,
40 14085.7, 14085.8, and 14085.9, respectively.

1 (j) “Private hospital” means a nonpublic hospital,
2 nonpublic-converted hospital, or converted hospital, as those terms
3 are defined in paragraphs (26) to (28), inclusive, respectively, of
4 subdivision (a) of Section 14105.98.

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

10 (l) “Uninsured” shall have the same meaning as that term has
11 in the Special Terms and Conditions issued by the federal Centers
12 for Medicare and Medicaid Services for the demonstration project
13 and the successor demonstration project.

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

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

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

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

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

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

31 (5) Successor demonstration year 10 corresponds to July 1,
32 2014, through October 31, 2015.

33 (o) “Low Income Health Program” means the county-based
34 elective program to provide benefits for low-income individuals
35 that is authorized by the successor demonstration project and
36 implemented by Part 3.6 (commencing with Section 15909).

37 (p) “Delivery system reform incentive pool” means the separate
38 federal funding pool created within the safety net care pool under
39 the successor demonstration project that is available to support
40 programs of activity to enhance the quality of care and health of

1 patients served by designated public hospitals and nonhospital
2 clinics and other provider types with which they are affiliated, and,
3 under specified conditions and approval of the federal Centers for
4 Medicare and Medicaid Services, to private disproportionate share
5 hospitals and nondesignated public hospitals.

6 *SEC. 6. Section 17612.2 of the Welfare and Institutions Code*
7 *is amended to read:*

8 17612.2. For purposes of this article, the following definitions
9 shall apply:

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

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

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

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

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

38 (3) A weighted average annual percentage change for each
39 year-to-year period shall be calculated from the determinations
40 made in paragraph (2), with the percentage changes in the Hospital

1 and Related Services Index weighted at 75 percent, and the
2 percentage changes in the Medical Care Services Index weighted
3 at 25 percent. The resulting average annual percentage changes
4 shall be expressed as a fraction, and increased by 1.00.

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

7 (d) “Cost containment limit” means the public hospital health
8 system county’s Medi-Cal costs and uninsured costs determined
9 for the 2014–15 fiscal year and each subsequent fiscal year,
10 adjusted as follows:

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

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

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

35 (C) The fiscal year amount determined in subparagraph (A)
36 shall be compared to the trended amount in subparagraph (B). If
37 the amount in subparagraph (B) exceeds the amount in
38 subparagraph (A), the public hospital health system county shall
39 be deemed to have satisfied the cost containment limit. If the

1 amount in subparagraph (A) exceeds the amount in subparagraph
2 (B), the calculation in paragraph (3) shall be performed.

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

13 (B) If the number of adjusted patient days of service provided
14 by a county's public hospital health system for the fiscal year does
15 not exceed its number of adjusted patient days of service rendered
16 in the base year by 10 percent, the applicable cost containment
17 limit is the trended base year amount determined in subparagraph
18 (B) of paragraph (2), subject to paragraph (4).

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

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

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

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

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

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

35 (5) If a public hospital health system county's costs, as
36 determined in subparagraph (A) of paragraph (2), exceeds the
37 amount determined in subparagraph (B) of paragraph (2) as
38 adjusted by paragraphs (3) and (4), the county may request that
39 the department consider other costs as adjustments to the cost
40 containment limit, including, but not limited to, transfer amounts

1 in excess of the imputed other entity intergovernmental transfer
2 amount trended by the blended CPI trend factor, costs related to
3 case mix index increases, pension costs, expanded medical
4 education programs, increased costs in response to delivery system
5 changes in the local community, and system expansions, including
6 capital expenditures necessary to ensure access to and the quality
7 of health care. Costs approved by the department shall be added
8 to and reflected in any cost containment limit.

9 (e) “County indigent care health realignment amount” means
10 the product of the health realignment amount times the health
11 realignment indigent care percentage, as computed on a
12 county-specific basis.

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

23 (g) “Department” means the State Department of Health Care
24 Services.

25 (h) “Health realignment amount” means the amount that, in the
26 absence of this article, would be payable to a public hospital health
27 system county under Sections 17603, 17604, and 17606.20, as
28 those sections read on January 1, 2012, and Section 17606.10, as
29 it read on July 1, 2013, for the fiscal year that is deposited by the
30 Controller into the local health and welfare trust fund health
31 account of the public hospital health system county.

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

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

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

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

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

10 (j) “Historical fiscal years” means the state 2008–09 to 2011–12,
11 inclusive, fiscal years.

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

18 (l) “Imputed county low-income health amount” means the
19 predetermined, county-specific amount of county general purpose
20 funds assumed, for purposes of the calculation in Section 17612.
21 3, to be available to the county public hospital health system for
22 services to Medi-Cal and uninsured patients. County general
23 purpose funds shall not include any other revenues, grants, or funds
24 otherwise defined in this section. The imputed county low-income
25 health amount shall be determined as follows and established in
26 accordance with subdivision (c) of Section 17612.3.

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

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

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

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

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

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

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

19 (n) “Imputed other entity intergovernmental transfer amount”
20 means the predetermined average historical amount of the public
21 hospital health system county’s other entity intergovernmental
22 transfer amount, determined as follows and established in
23 accordance with subdivision (c) of Section 17612.3.

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

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

28 (o) “Medicaid demonstration revenues” means payments paid
29 or payable to the county public hospital health system for the fiscal
30 year pursuant to the Special Terms and Conditions of the federal
31 Medicaid demonstration project authorized under Section 1115 of
32 the federal Social Security Act entitled the “Bridge to Health Care
33 Reform” (waiver number 11-W-00193/9), for uninsured care
34 services from the Safety Net Care Pool or as incentive payments
35 from the Delivery System Reform Improvement Pool, or pursuant
36 to mechanisms that provide funding for similar purposes under
37 the subsequent demonstration project. Medicaid demonstration
38 revenues do not include the nonfederal share provided by county
39 public hospital health systems as certified public expenditures,
40 and are reduced by any intergovernmental transfer by county public

1 hospital health systems or affiliated governmental entities that is
2 for the nonfederal share of Medicaid demonstration payments to
3 the county public hospital health system or payments to a Medi-Cal
4 managed care plan for services rendered by the county public
5 hospital health system, and any related fees imposed by the state
6 on those transfers; and by any reimbursement of costs, or payment
7 of administrative or other processing fees imposed by the state
8 relating to payments or other Medicaid demonstration program
9 functions. Medicaid demonstration revenues shall not include
10 Safety Net Care Pool revenues for nursing facility, mental health,
11 and substance use disorder services, as determined from the pro
12 rata share of eligible certified public expenditures for such services,
13 or revenues that are otherwise included as Medi-Cal revenues.

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

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

36 (r) “Medi-Cal revenues” means total amounts paid or payable
37 to the county public hospital health system for medical services
38 provided under the Medi-Cal State Plan that are rendered to
39 Medi-Cal beneficiaries during the state fiscal year, and shall include
40 payments from Medi-Cal managed care plans for services rendered

1 to Medi-Cal managed care plan members, Medi-Cal copayments
2 received from Medi-Cal beneficiaries, but only to the extent
3 actually received, supplemental payments for Medi-Cal services,
4 and Medi-Cal disproportionate share hospital payments for the
5 state fiscal year, but shall exclude Medi-Cal revenues paid or
6 payable for nursing facility, mental health, and substance use
7 disorder services. Medi-Cal revenues do not include the nonfederal
8 share provided by county public hospital health systems as certified
9 public expenditures. Medi-Cal revenues shall be reduced by all of
10 the following:

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

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

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

23 (s) “Newly eligible beneficiaries” means individuals who meet
24 the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of
25 Title XIX of the federal Social Security Act (42 U.S.C. Sec.
26 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described
27 in Section 1905(y) of the federal Social Security Act (42 U.S.C.
28 Sec. 1396d(y)) such that expenditures for services provided to the
29 individual are eligible for the enhanced federal medical assistance
30 percentage described in that section.

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

1 (u) “Public hospital health system county” means a county in
2 which a county public hospital health system is located.

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

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

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

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

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

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

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

37 (B) The amount of the tobacco settlement funds multiplied by
38 the average of the percentages of the amount of tobacco settlement
39 funds that were allocated to and expended by the county public
40 hospital health system for health services to Medi-Cal and

1 uninsured beneficiaries during the historical fiscal years. The
2 percentages for the historical fiscal years shall be determined by
3 dividing the amount allocated in each fiscal year as described in
4 subparagraphs (B) and (C) of paragraph (2) of subdivision (ab) by
5 the actual amount of tobacco settlement funds expended in the
6 fiscal year.

7 (x) “Subsequent demonstration project” means the federally
8 approved Medicaid demonstration project implemented after the
9 termination of the federal Medicaid demonstration project
10 authorized under Section 1115 of the federal Social Security Act
11 entitled the “Bridge to Health Care Reform” (waiver number
12 11-W-00193/9), the extension of that demonstration project, or
13 the material amendment to that demonstration project.

14 (y) “Uninsured costs” means the costs incurred by the public
15 hospital health system county and its affiliated government entities
16 for purchasing, providing, or ensuring the availability of services
17 to uninsured patients during the fiscal year. Uninsured costs shall
18 be determined in a manner consistent with the cost-claiming
19 protocols developed for the federal Medicaid demonstration project
20 authorized under Section 1115 of the federal Social Security Act
21 entitled the “Bridge to Health Care Reform” (waiver number
22 11-W-00193/9), including protocols pending federal approval, and
23 under Section 14166.8, and, in consultation with each county, shall
24 be based on any other cost reporting and statistical data necessary
25 for an accurate determination of actual costs incurred. For this
26 purpose, no reduction factor applicable to otherwise allowable
27 costs under the demonstration project or the subsequent
28 demonstration project shall apply. Uninsured costs shall exclude
29 costs for nursing facility, mental health, and substance use disorder
30 services.

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

35 (aa) “Uninsured revenues” means self-pay payments made by
36 or on behalf of uninsured patients to the county public hospital
37 health system for the services rendered in the fiscal year, but shall
38 exclude revenues received for nursing facility, mental health, and
39 substance use disorder services. Uninsured revenues do not include
40 the health realignment amount or imputed county low-income

1 health amount and shall not include any other revenues, grants, or
2 funds otherwise defined in this section.

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

10 (1) For each of the historical fiscal years, the Medi-Cal costs,
11 uninsured costs, and costs of other entity intergovernmental transfer
12 amounts, as defined in subdivisions (q), (t), and (y), and the
13 Medicaid demonstration, Medi-Cal and uninsured revenues, and
14 hospital fee direct grants with respect to the services as defined in
15 subdivisions (k), (o), (r), and (aa), shall be determined. For these
16 purposes, Medicaid demonstration revenues shall include
17 applicable payments as described in subdivision (o) paid or payable
18 to the county public hospital health system under the prior
19 demonstration project defined in subdivision (c) of Section
20 14166.1, under the Low Income Health Program (Part 3.6
21 (commencing with Section 15909)), and under the Health Care
22 Coverage Initiative (Part 3.5 (commencing with Section 15900)),
23 none of which shall include the nonfederal share of the Medicaid
24 demonstration payments. The revenues shall be subtracted from
25 the costs, yielding the initial low-income shortfall for each of the
26 historical fiscal years.

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

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

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

36 (C) Third, the sum of clauses (iv), (v), and (vi). Clause (iv) is
37 the special local health funds, as defined in subdivision (w) and
38 not otherwise identified as restricted special local health funds
39 under subparagraph (B), clause (v) is the imputed county
40 low-income health amount defined in subdivision (l), and clause

- 1 (vi) is the one-time and carry-forward revenues as defined in
2 subdivision (aj), all allocated to the historical low-income shortfall.
3 These amounts shall be calculated as follows:
- 4 (i) Determine the sum of the special local health funds, as
5 defined in subdivision (w) and not otherwise identified as restricted
6 special local health funds under subparagraph (B), the imputed
7 county low-income health amount defined in subdivision (l), and
8 one-time and carry-forward revenues as defined in subdivision
9 (aj).
- 10 (ii) Divide the historical total shortfall defined in subdivision
11 (ah) by the sum in clause (i) to get the historical usage of funds
12 percentage defined in subdivision (ai). If this calculation produces
13 a percentage above 100 percent in a given historical fiscal year,
14 then the historical usage of funds percentage in that historical fiscal
15 year shall be deemed to be 100 percent.
- 16 (iii) Multiply the historical usage of funds percentage defined
17 in subdivision (ai) and calculated in clause (ii) by each of the
18 following funds:
- 19 (I) Special local health funds, as defined in subdivision (w) and
20 not otherwise identified as restricted special local health funds
21 under subparagraph (B).
- 22 (II) The imputed county low-income health amount defined in
23 subdivision (l).
- 24 (III) One-time and carry-forward revenues as defined in
25 subdivision (aj).
- 26 (iv) Multiply the product of subclause (I) of clause (iii) by the
27 historical low-income shortfall percentage defined in subdivision
28 (af) to determine the amount of special local health funds, as
29 defined in subdivision (w) and not otherwise identified as restricted
30 special local health funds under subparagraph (B), allocated to the
31 historical low-income shortfall.
- 32 (v) Multiply the product of subclause (II) of clause (iii) by the
33 historical low-income shortfall percentage defined in subdivision
34 (af) to determine the amount of the imputed county low-income
35 health amount defined in subdivision (l) allocated to the historical
36 low-income shortfall.
- 37 (vi) Multiply the product of subclause (III) of clause (iii) by the
38 historical low-income shortfall percentage defined in subdivision
39 (af) to determine the amount of one-time and carry-forward

1 revenues as defined in subdivision (aj) allocated to the historical
2 low-income shortfall.

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

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

15 (ad) “New mandatory other entity intergovernmental transfer
16 amounts” means other entity intergovernmental transfer amounts
17 required by the state after July 1, 2013.

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

23 (af) “Historical low-income shortfall percentage” means, for
24 each of the historical fiscal years described in subdivision (j), the
25 historical low-income shortfall described in subdivision (ae)
26 divided by the historical total shortfall described in subdivision
27 (ah).

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

39 (ah) “Historical total shortfall” means, for each of the historical
40 fiscal years described in subdivision (j), the sum of the historical

1 low-income shortfall described in subdivision (ae) and the historical
2 other shortfall described in subdivision (ag).
3 (ai) “Historical usage of funds percentage” means, for each of
4 the historical fiscal years described in subdivision (j), the historical
5 total shortfall described in subdivision (ah) divided by the sum of
6 special local health funds as defined in subdivision (w) and not
7 otherwise identified as restricted special local health funds under
8 subparagraph (B) of paragraph (2) of subdivision (ab), the imputed
9 county low-income health amount defined in subdivision (l), and
10 one-time and carry-forward revenues as defined in subdivision
11 (aj). If this calculation produces a percentage above 100 percent
12 in a given historical fiscal year, then the historical usage of funds
13 percentage in that historical fiscal year shall be deemed to be 100
14 percent.
15 (aj) “One-time and carry-forward revenues” mean, for each of
16 the historical fiscal years described in subdivision (j), revenues
17 and funds that are not attributable to services provided or
18 obligations in the applicable historical fiscal year, but were
19 available and utilized during the applicable historical fiscal year
20 by the public hospital health system.