

Senate Bill No. 1352

CHAPTER 46

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.

[Approved by Governor June 23, 2014. Filed with
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LEGISLATIVE COUNSEL'S DIGEST

SB 1352, 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 5. ALAMEDA HEALTH SYSTEM HOSPITAL AUTHORITY

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

101850. The Legislature finds and declares the following:

(a) (1) Due to the challenges facing the Alameda Health System arising from changes in the public and private health industries, the Alameda County Board of Supervisors has determined that a transfer of governance of the Alameda Health System to an independent governing body, a hospital

authority, is needed to improve the efficiency, effectiveness, and economy of the community health services provided at the medical center. The board of supervisors has further determined that the creation of an independent hospital authority strictly and exclusively dedicated to the management, administration, and control of the medical center, in a manner consistent with the county's obligations under Section 17000 of the Welfare and Institutions Code, is the best way to fulfill its commitment to the medically indigent, special needs, and general populations of Alameda County. To accomplish this, it is necessary that the board of supervisors be given authority to create a hospital authority. Because there is no general law under which this authority could be formed, the adoption of a special act and the formation of a special authority is required.

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

(A) "The county" means the County of Alameda.

(B) "Governing board" means the governing body of the hospital authority.

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

(D) "Medical center" means the Alameda Health System, which was formerly known as the Alameda County Medical Center.

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

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

(d) The mission of the hospital authority shall be the management, administration, and other control, as determined by the board of supervisors, of the group of public hospitals, clinics, and programs that comprise the medical center, in a manner that ensures appropriate, quality, and cost-effective medical care as required of counties by Section 17000 of the

Welfare and Institutions Code, and, to the extent feasible, other populations, including special populations in the County of Alameda.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(k) (1) Any contract executed by and between the county and the hospital authority shall provide that liabilities or obligations of the hospital authority with respect to its activities pursuant to the contract shall be the liabilities or obligations of the hospital authority, and shall not become the liabilities or obligations of the county.

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

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

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

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

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

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

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

(2) A transfer of maintenance, operation, and management or ownership to the hospital authority may be made with or without the payment of a purchase price by the hospital authority and otherwise upon the terms and conditions that the parties may mutually agree, which terms and conditions shall include those found necessary by the board of supervisors to ensure that the transfer will constitute an ongoing material benefit to the county and its residents.

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) The timeframe for which the transfer of personnel shall occur. The timeframe shall be subject to modification by the board of supervisors as appropriate, but in no event shall it exceed one year from the effective date of transfer of governance from the board of supervisors to the hospital authority.

(ii) A specified period of time during which employees of the county impacted by the transfer of governance may elect to be appointed to vacant positions with the Alameda County Health Care Services Agency for which they have tenure.

(iii) A specified period of time during which employees of the county impacted by the transfer of governance may elect to be considered for

reinstatement into positions with the county for which they are qualified and eligible.

(iv) Compensation for vacation leave and compensatory leave accrued while employed with the county in a manner that grants affected employees the option of either transferring balances or receiving compensation to the degree permitted employees laid off from service with the county.

(v) A transfer of sick leave accrued while employed with the county to hospital authority employment.

(vi) The recognition by the hospital authority of service with the county in determining the rate at which vacation accrues.

(vii) The possible preservation of seniority, pensions, health benefits, and other applicable accrued benefits of employees of the county impacted by the transfer of governance.

(2) Nothing in this subdivision shall be construed as prohibiting the hospital authority from determining the number of employees, the number of full-time equivalent positions, the job descriptions, and the nature and extent of classified employment positions.

(3) Employees of the hospital authority are public employees for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code relating to claims and actions against public entities and public employees.

(x) Any hospital authority created pursuant to this section shall be bound by the terms of the memorandum of understanding executed by and between the county and health care and management employee organizations that is in effect as of the date this legislation becomes operative in the county. Upon the expiration of the memorandum of understanding, the hospital authority shall have sole authority to negotiate subsequent memorandums of understanding with appropriate employee organizations. Subsequent memorandums of understanding shall be approved by the hospital authority.

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

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

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

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

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

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

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

(3) The records of the hospital authority, whether paper records, records maintained in the management information system, or records in any other form, that relate to trade secrets or to payment rates or the determination thereof, or which relate to contract negotiations with providers of health care, shall not be subject to disclosure pursuant to the California Public Records Act (Chapter 5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). The transmission of the records, or the information contained therein in an alternative form, to the board of supervisors shall not constitute a waiver of exemption from disclosure, and the records and information once transmitted shall be subject to this same exemption. The information, if compelled pursuant to an order of a court of competent jurisdiction or administrative body in a manner permitted by law, shall be limited to in-camera review, which, at the discretion of the court, may include the parties to the proceeding, and shall not be made a part of the court file unless sealed.

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

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

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

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

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

(ah) Contracts by and between the hospital authority and the state and contracts by and between the hospital authority and providers of health care, goods, or services may be let on a nonbid basis and shall be exempt from

Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

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

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

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

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

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

(am) (1) The county shall establish baseline data reporting requirements for the medical center consistent with the Medically Indigent Health Care Reporting System (MICRS) program established pursuant to Section 16910 of the Welfare and Institutions Code and shall collect that data for at least one year prior to the final transfer of the medical center to the hospital authority established pursuant to this chapter. The baseline data shall include, but not be limited to, all of the following:

(A) Inpatient days by facility by quarter.

(B) Outpatient visits by facility by quarter.

(C) Emergency room visits by facility by quarter.

(D) Number of unduplicated users receiving services within the medical center.

(2) Upon transfer of the medical center, the county shall establish baseline data reporting requirements for each of the medical center inpatient facilities consistent with data reporting requirements of the Office of Statewide Health

Planning and Development, including, but not limited to, monthly average daily census by facility for all of the following:

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

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

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

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

14085.53. (a) The Alameda Health System may revise plans submitted in accordance with subparagraph (C) of paragraph (1) of subdivision (b) of Section 14085.5 for the Alameda Health System capital project and submit those revised plans pursuant to this section. The revised capital project plans shall qualify for supplemental reimbursement under Section 14085.5 for the revised capital project as described in the revised plans, notwithstanding the assignment of a different permit number, if all of the following conditions are met:

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

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

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

(b) The revised capital project plan for the Alameda Health System may provide for any or all or any combination of the following:

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

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

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

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

(c) The revised capital project plans for the Alameda Health System, as described in this section, shall qualify for supplemental reimbursement as calculated pursuant to subdivision (c) of Section 14085.5, as limited by this section. The initial Medi-Cal inpatient utilization rate for the Alameda Health System, for purposes of calculating the supplemental reimbursement, shall

be that which was established at the point of the original project plan submission. The supplemental reimbursement shall be based on actual costs of the revised capital project eligible for reimbursement under Section 14085.5. However, in no event shall the supplemental reimbursement for the revised capital project exceed 85 percent of the supplemental reimbursement for that portion of the original Alameda Health System capital project that qualified for the supplemental reimbursement, the original qualifying amount that was sixty-two million six hundred ninety-six thousand three hundred forty dollars (\$62,696,340), as indicated by the budgetary estimate as prepared and submitted by Alameda County to the department July 11, 1994.

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

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

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

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

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

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

- (1) UC Davis Medical Center.
- (2) UC Irvine Medical Center.
- (3) UC San Diego Medical Center.
- (4) UC San Francisco Medical Center.
- (5) UC Los Angeles Medical Center, including Santa Monica/UCLA Medical Center.
- (6) LA County Harbor/UCLA Medical Center.
- (7) LA County Martin Luther King Jr.-Harbor Hospital.

- (8) LA County Olive View UCLA Medical Center.
- (9) LA County Rancho Los Amigos National Rehabilitation Center.
- (10) LA County University of Southern California Medical Center.
- (11) Alameda Health System.
- (12) Arrowhead Regional Medical Center.
- (13) Contra Costa Regional Medical Center.
- (14) Kern Medical Center.
- (15) Natividad Medical Center.
- (16) Riverside County Regional Medical Center.
- (17) San Francisco General Hospital.
- (18) San Joaquin General Hospital.
- (19) San Mateo Medical Center.
- (20) Santa Clara Valley Medical Center.
- (21) Tuolumne General Hospital.
- (22) Ventura County Medical Center.

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

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

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

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

(i) “Prior supplemental funds” means the Emergency Services and Supplemental Payments Fund, the Medi-Cal Medical Education Supplemental Payment Fund, the Large Teaching Emphasis Hospital and Children’s Hospital Medi-Cal Medical Education Supplemental Payment Fund, and the Small and Rural Hospital Supplemental Payments Fund, established under Sections 14085.6, 14085.7, 14085.8, and 14085.9, respectively.

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 6. 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 Health System 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.