

AMENDED IN ASSEMBLY JUNE 2, 2016

AMENDED IN SENATE MAY 3, 2016

AMENDED IN SENATE APRIL 11, 2016

**SENATE BILL**

**No. 815**

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**Introduced by Senators Hernandez and De León**

January 4, 2016

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An act to add Article 5.5 (commencing with Section 14184) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to Medi-Cal, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 815, as amended, Hernandez. Medi-Cal: demonstration project.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits and services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides for a demonstration project, known as California's "Bridge to Reform" Medicaid demonstration project, under the Medi-Cal program until October 31, 2015, to implement specified objectives, including better care coordination for seniors and persons with disabilities and maximization of opportunities to reduce the number of uninsured individuals.

Existing law establishes the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, which revises hospital supplemental payment methodologies under the Medi-Cal program in order to maximize the use of federal funds consistent with federal Medicaid law and to stabilize

the distribution of funding for hospitals that provide care to Medi-Cal beneficiaries and uninsured patients. This act provides for funding, in supplementation of Medi-Cal reimbursement, to various hospitals, including designated public hospitals, nondesignated public hospitals, and private hospitals, as defined, in accordance with certain provisions relating to disproportionate share hospitals.

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

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

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

Existing law requires the department to seek a subsequent demonstration project to implement specified objectives, including maximizing federal Medicaid funding for county public hospitals health systems and components that maintain a comparable level of support for delivery system reform in the county public hospital health systems as was provided under California's "Bridge to Reform" Medicaid demonstration project.

This bill would establish the Medi-Cal 2020 Demonstration Project Act, under which the department is required to implement specified components of the subsequent demonstration project, referred to as California's Medi-Cal 2020 demonstration project, consistent with the Special Terms and Conditions approved by the federal Centers for Medicare and Medicaid Services.

The bill would distinguish which payment methodologies and requirements under the Medi-Cal Hospital/Uninsured Care Demonstration Project Act apply to the Medi-Cal 2020 Demonstration Project Act. The bill would, in this regard, retain the continuously appropriated Demonstration Disproportionate Share Hospital Fund, which will continue to consist of all federal funds received by the department as federal financial participation with respect to certified

public expenditures, and would require moneys in this fund to be continuously appropriated, thereby making an appropriation, to the department for disbursement to eligible designated public hospitals. The bill would provide for a reconciliation process for disproportionate share hospital payment allocations and safety net care pool payment allocations that were paid to certain designated public hospitals, as specified.

The bill would require the department to implement the Global Payment Program (GPP), under which GPP systems, as defined, would be eligible to receive global payments that are calculated using a value-based point methodology, to be developed by the department, based on the health care they provide to the uninsured. The bill would provide that these global payments payable to GPP systems are in lieu of the traditional disproportionate share hospital payments and the safety net care pool payments previously made available under the Medi-Cal Hospital/Uninsured Care Demonstration Project Act. The bill would establish the Global Payment Program Special Fund in the State Treasury, which would consist of moneys that a designated public hospital or affiliated governmental agency or entity elects to transfer to the department for deposit into the fund as a condition of participation in the program. The bill would provide that these funds shall be continuously appropriated, thereby making an appropriation, to the department to be used as the nonfederal share of global payment program payments authorized under California's Medi-Cal 2020 demonstration project.

The bill would require the department to establish and operate the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, under which participating PRIME entities, as defined, would be eligible to earn incentive payments by undertaking specified projects set forth in the Special Terms and Conditions, for which there are required project metrics and targets. The bill would require the department to provide participating PRIME entities the opportunity to earn the maximum amount of funds authorized for the PRIME program under the demonstration project. The bill would retain the continuously appropriated Public Hospital Investment, Improvement, and Incentive Fund for purposes of making PRIME payments to participating PRIME entities. The Public Hospital Investment, Improvement, and Incentive Fund would consist of moneys that a designated public hospital or affiliated governmental agency or entity, or a district and municipal public hospital-affiliated governmental agency or entity, elects to

transfer to the department for deposit into the fund. The bill would provide that these funds are continuously appropriated, thereby making an appropriation, to the department to be used as the nonfederal share of PRIME program payments authorized under California's Medi-Cal 2020 demonstration project.

~~The bill would require the department to establish and operate the Whole Person Care pilot program, under which counties, Medi-Cal managed care plans, and community providers that elect to participate in the pilot program are provided an opportunity to establish a new model for integrated care delivery that incorporates health care needs, behavioral needs, and social support, including housing and other supportive services, for the state's most high-risk, high-utilizing populations. The bill would establish Whole Person Care Pilot Special Fund in the State Treasury, which would consist of moneys that a participating governmental agency or entity elects to transfer to the department as a condition of participation in the pilot program. The bill would provide that these funds shall be continuously appropriated, thereby making an appropriation, to the department to be used to fund the nonfederal share of any payments of Whole Person Care pilot payments authorized under California's Medi-Cal 2020 demonstration project.~~

~~The bill would require the department to implement the Dental Transformation Initiative (DTI), under which DTI incentive payments, as defined, within specified domain categories would be made available to qualified providers who meet achievements within one or more of the project domains. The bill would provide that providers in either the dental fee-for-service or dental managed care Medi-Cal delivery systems would be eligible to participate in the DTI.~~

~~The bill would require the department to conduct, or arrange to have conducted, any study, report, assessment, evaluation, or other similar demonstration project activity required under the Special Terms and Conditions. The bill, in this regard, would require the department to amend its contract with its external quality review organization to complete an access assessment to, among other things, evaluate primary, core specialty, and facility access to care for managed care beneficiaries, as specified. The bill would require the department to establish an advisory committee to provide input into the structure of the access assessment, which would be comprised of specified stakeholders, including representatives from consumer advocacy organizations.~~

The bill would provide that these provisions shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized. The bill would require the department to seek any federal approvals it deems necessary to implement these provisions during the course of the demonstration term.

The bill would authorize the department to implement the Medi-Cal 2020 Demonstration Project Act by means of all-county letters, provider bulletins, or other similar instructions without taking regulatory action.

*This bill would become operative only if AB 1568 of the 2015–16 Regular Session is enacted and takes effect on or before January 1, 2017.*

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

Vote:  $\frac{2}{3}$ . Appropriation: yes. Fiscal committee: yes.  
State-mandated local program: no.

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

1 SECTION 1. Article 5.5 (commencing with Section 14184) is  
2 added to Chapter 7 of Part 3 of Division 9 of the Welfare and  
3 Institutions Code, to read:

4  
5 Article 5.5. Medi-Cal 2020 Demonstration Project Act  
6

7 14184. (a) This article shall be known, and may be cited, as  
8 the Medi-Cal 2020 Demonstration Project Act.

9 (b) The Legislature finds and declares all of the following:

10 (1) The implementation of the federal Patient Protection and  
11 Affordable Care Act (Public Law 111-148) and California’s  
12 “Bridge to Reform” Medicaid demonstration project have led to  
13 the expansion of Medi-Cal coverage to more than 13 million  
14 beneficiaries, driving health care delivery system reforms that  
15 support expanded access to care, as well as higher quality,  
16 efficiency, and beneficiary satisfaction.

17 (2) California’s “Medi-Cal 2020” Medicaid demonstration  
18 project, No. 11-W-00193/9, expands on these achievements by  
19 continuing to focus on expanded health care system capacity, better  
20 coordinated care, and aligned incentives within the Medi-Cal

1 program in order to improve health outcomes for Medi-Cal  
2 beneficiaries, while simultaneously containing health care costs.

3 (3) Public safety net providers, including designated public  
4 hospitals, and nondesignated public hospitals, which are also  
5 known as district and municipal public hospitals, play an essential  
6 role in the Medi-Cal program, providing high-quality care to a  
7 disproportionate number of low-income Medi-Cal and uninsured  
8 populations in the state. Because Medi-Cal covers approximately  
9 one-third of the state’s population, the strength of these essential  
10 health care systems and hospitals is of critical importance to the  
11 health and welfare of the people of California.

12 (4) As a component of the “Medi-Cal 2020” demonstration  
13 project, the Global Payment Program provides an opportunity to  
14 test an alternative payment model for the remaining uninsured that  
15 rewards value and supports providing care at the appropriate place  
16 and time, aligning incentives to enhance primary and preventive  
17 services for California’s remaining uninsured seeking care in  
18 participating public health care systems.

19 (5) As a component of the “Medi-Cal 2020” demonstration  
20 project, the Public Hospital Redesign and Incentives in Medi-Cal  
21 (PRIME) program seeks to improve health outcomes for patients  
22 served by participating entities by building on the delivery system  
23 transformation work from the “Bridge to Reform” demonstration  
24 project. Using evidence-based quality improvement methods, the  
25 PRIME program is intended to be ambitious in scope in order to  
26 accelerate transformation in care delivery and maximize value for  
27 patients, providers, and payers. The PRIME program also seeks  
28 to strengthen the ability of designated public hospitals to  
29 successfully perform under risk-based alternative payment models  
30 (APMs) in the long term.

31 (6) As a component of the “Medi-Cal 2020” demonstration  
32 project, the Whole Person Care pilot program creates an  
33 opportunity for counties, Medi-Cal managed care plans, and  
34 community providers to establish a new model for integrated care  
35 delivery that incorporates health care needs, behavioral health, and  
36 social support for the state’s most vulnerable, high-user  
37 populations. The Whole Person Care pilot program encourages  
38 coordination among local partners to address the root causes of  
39 poor health outcomes, including immediate health needs and other

1 factors, such as housing and recidivism, that impact a beneficiary’s  
2 health status.

3 (7) As a component of the “Medi-Cal 2020” demonstration  
4 project, the Dental Transformation Initiative creates innovative  
5 opportunities for the Medi-Cal Dental Program to improve access  
6 to dental care, continuity of care, and increase the utilization of  
7 preventive services aimed at reducing preventable dental conditions  
8 for Medi-Cal beneficiaries identified within the project.

9 (c) The implementation of the “Medi-Cal 2020” demonstration  
10 project, as set forth in this article, will support all of the following  
11 goals:

12 (1) Improving access to health care and health care quality for  
13 California’s Medi-Cal and uninsured populations.

14 (2) Promoting value and improving health outcomes for  
15 low-income populations.

16 (3) Supporting whole person care by better integrating physical  
17 health, behavioral health, and social support services for high-risk,  
18 high-utilizing Medi-Cal beneficiaries.

19 (4) Improving the capacity of public safety net providers that  
20 provide high-quality care to a disproportionate number of  
21 low-income patients with complex health needs in the state.

22 (5) Transitioning from a cost-based reimbursement system  
23 toward a reimbursement structure that incentivizes quality and  
24 value by financially rewarding alternative models of care that  
25 support providers’ ability to deliver care in the most appropriate  
26 and cost-effective manner to patients.

27 14184.10. For purposes of this article, the following definitions  
28 shall apply:

29 (a) “Demonstration project” means the California Medi-Cal  
30 2020 Demonstration, Number 11-W-00193/9, as approved by the  
31 federal Centers for Medicare and Medicaid Services, effective for  
32 the period from December 30, 2015, to December 31, 2020,  
33 inclusive, and any applicable extension period.

34 (b) “Demonstration term” means the entire period during which  
35 the demonstration project is in effect, as approved by the federal  
36 Centers for Medicare and Medicaid Services, including any  
37 applicable extension period.

38 (c) “Demonstration year” means the demonstration year as  
39 identified in the Special Terms and Conditions that corresponds  
40 to a specific period of time as set forth in paragraphs (1) to (6),

1 inclusive. Individual programs under the demonstration project  
2 may be operated on program years that differ from the  
3 demonstration years identified in paragraphs (1) to (6), inclusive.

4 (1) Demonstration year 11 corresponds to the period of January  
5 1, 2016, to June 30, 2016, inclusive.

6 (2) Demonstration year 12 corresponds to the period of July 1,  
7 2016, to June 30, 2017, inclusive.

8 (3) Demonstration year 13 corresponds to the period of July 1,  
9 2017, to June 30, 2018, inclusive.

10 (4) Demonstration year 14 corresponds to the period of July 1,  
11 2018, to June 30, 2019, inclusive.

12 (5) Demonstration year 15 corresponds to the period of July 1,  
13 2019, to June 30, 2020, inclusive.

14 (6) Demonstration year 16 corresponds to the period of July 1,  
15 2020, to December 31, 2020, inclusive.

16 (d) “Dental Transformation Initiative” or “DTI” means the  
17 waiver program intended to improve oral health services for  
18 children, as authorized under the Special Terms and Conditions  
19 and described in Section 14184.70.

20 (e) “Designated state health program” shall have the same  
21 meaning as set forth in the Special Terms and Conditions.

22 (f) (1) “Designated public hospital” means any one of the  
23 following hospitals, and any successor or differently named  
24 hospital, which is operated by a county, a city and county, the  
25 University of California, or special hospital authority described in  
26 Chapter 5 (commencing with Section 101850) or Chapter 5.5  
27 (commencing with Section 101852) of Part 4 of Division 101 of  
28 the Health and Safety Code, or any additional public hospital, to  
29 the extent identified as a “designated public hospital” in the Special  
30 Terms and Conditions. Unless otherwise provided for in law, in  
31 the Medi-Cal State Plan, or in the Special Terms and Conditions,  
32 all references in law to a designated public hospital as defined in  
33 subdivision (d) of Section 14166.1 shall be deemed to refer to a  
34 hospital described in this section effective as of January 1, 2016,  
35 except as provided in paragraph (2):

36 (A) UC Davis Medical Center.

37 (B) UC Irvine Medical Center.

38 (C) UC San Diego Medical Center.

39 (D) UC San Francisco Medical Center.

40 (E) UCLA Medical Center.

- 1 (F) Santa Monica/UCLA Medical Center, also known as the
- 2 Santa Monica-UCLA Medical Center and Orthopaedic Hospital.
- 3 (G) LA County Health System Hospitals:
- 4 (i) LA County Harbor/UCLA Medical Center.
- 5 (ii) LA County Olive View UCLA Medical Center.
- 6 (iii) LA County Rancho Los Amigos National Rehabilitation
- 7 Center.
- 8 (iv) LA County University of Southern California Medical
- 9 Center.
- 10 (H) Alameda Health System Hospitals, including the following:
- 11 (i) Highland Hospital, including the Fairmont and John George
- 12 Psychiatric facilities.
- 13 (ii) Alameda Hospital.
- 14 (iii) San Leandro Hospital.
- 15 (I) Arrowhead Regional Medical Center.
- 16 (J) Contra Costa Regional Medical Center.
- 17 (K) Kern Medical Center.
- 18 (L) Natividad Medical Center.
- 19 (M) Riverside University Health System-Medical Center.
- 20 (N) San Francisco General Hospital.
- 21 (O) San Joaquin General Hospital.
- 22 (P) San Mateo Medical Center.
- 23 (Q) Santa Clara Valley Medical Center.
- 24 (R) Ventura County Medical Center.
- 25 (2) For purposes of the following reimbursement methodologies,
- 26 the hospitals identified in clauses (ii) and (iii) of subparagraph (H)
- 27 of paragraph (1) shall be deemed to be a designated public hospital
- 28 as of the following effective dates:
- 29 (A) For purposes of the fee-for-service payment methodologies
- 30 established and implemented under Section 14166.4, the effective
- 31 date shall be the date described in paragraph (3) of subdivision (a)
- 32 of Section 14184.30.
- 33 (B) For purposes of Article 5.230 (commencing with Section
- 34 14169.50), the effective date shall be January 1, 2017.
- 35 (g) “Disproportionate share hospital provisions of the Medi-Cal
- 36 State Plan” means those applicable provisions contained in
- 37 Attachment 4.19-A of the California Medicaid state plan, approved
- 38 by the federal Centers for Medicare and Medicaid Services, that
- 39 implement the payment adjustment program for disproportionate
- 40 share hospitals.

1 (h) “Federal disproportionate share hospital allotment” means  
2 the amount specified for California under Section 1396r-4(f) of  
3 Title 42 of the United States Code for a federal fiscal year.

4 (i) “Federal medical assistance percentage” means the federal  
5 medical assistance percentage applicable for federal financial  
6 participation purposes for medical services under the Medi-Cal  
7 State Plan pursuant to Section 1396b(a)(1) of Title 42 of the United  
8 States Code.

9 (j) “Global Payment Program” or “GPP” means the payment  
10 program authorized under the demonstration project and described  
11 in Section 14184.40 that assists participating public health care  
12 systems that provide health care for the uninsured and that  
13 promotes the delivery of more cost-effective, higher-value health  
14 care services and activities.

15 (k) “Nondesignated public hospital” means a public hospital as  
16 that term is defined in paragraph (25) of subdivision (a) of Section  
17 14105.98, excluding designated public hospitals.

18 (l) “Nonfederal share percentage” means the difference between  
19 100 percent and the federal medical assistance percentage.

20 (m) “PRIME” means the Public Hospital Redesign and  
21 Incentives in Medi-Cal program authorized under the  
22 demonstration project and described in Section 14184.50.

23 (n) “Total computable disproportionate share hospital allotment”  
24 means the federal disproportionate share hospital allotment for a  
25 federal fiscal year, divided by the applicable federal medical  
26 assistance percentage with respect to that same federal fiscal year.

27 (o) “Special Terms and Conditions” means those terms and  
28 conditions issued by the federal Centers for Medicare and Medicaid  
29 Services, including all attachments to those terms and conditions  
30 and any subsequent amendments approved by the federal Centers  
31 for Medicare and Medicaid Services, that apply to the  
32 demonstration project.

33 (p) “Uninsured” means an individual for whom there is no  
34 source of third-party coverage for the health care services the  
35 individual receives, as determined pursuant to the Special Terms  
36 and Conditions.

37 (q) “Whole Person Care pilot program” means a local  
38 collaboration among local governmental agencies, Medi-Cal  
39 managed care plans, health care and behavioral health providers,  
40 or other community organizations, as applicable, that are approved

1 by the department to implement strategies to serve one or more  
2 identified target populations, pursuant to Section 14184.60 and  
3 the Special Terms and Conditions.

4 14184.20. (a) Consistent with federal law, the Special Terms  
5 and Conditions, and this article, the department shall implement  
6 the Medi-Cal 2020 demonstration project, including, but not limited  
7 to, all of the following components:

8 (1) The Global Payment Program, as described in Section  
9 14184.40.

10 (2) The Public Hospital Redesign and Incentives in Medi-Cal  
11 (PRIME) program, as described in Section 14184.50.

12 (3) The Whole Person Care pilot program, as described in  
13 Section 14184.60.

14 (4) The Dental Transformation Initiative, as described in Section  
15 14184.70.

16 (b) In the event of a conflict between any provision of this article  
17 and the Special Terms and Conditions, the Special Terms and  
18 Conditions shall control.

19 (c) The department, as appropriate, shall consult with the  
20 designated public hospitals, district and municipal public hospitals,  
21 and other local governmental agencies with regard to the  
22 implementation of the components of the demonstration project  
23 under subdivision (a) in which they will participate, including, but  
24 not limited to, the issuance of guidance pursuant to subdivision  
25 (d).

26 (d) Notwithstanding Chapter 3.5 (commencing with Section  
27 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
28 the department may implement, interpret, or make specific this  
29 article or the Special Terms and Conditions, in whole or in part,  
30 by means of all-county letters, plan letters, provider bulletins, or  
31 other similar instructions, without taking regulatory action. The  
32 department shall provide notification to the Joint Legislative  
33 Budget Committee and to the Senate Committees on  
34 Appropriations, Budget and Fiscal Review, and Health, and the  
35 Assembly Committees on Appropriations, Budget, and Health  
36 within 10 business days after the above-described action is taken.  
37 The department shall make use of appropriate processes to ensure  
38 that affected stakeholders are timely informed of, and have access  
39 to, applicable guidance issued pursuant to this authority, and that

1 this guidance remains publicly available until all payments related  
2 to the applicable demonstration component are finalized.

3 (e) For purposes of implementing this article or the Special  
4 Terms and Conditions, the department may enter into exclusive  
5 or nonexclusive contracts, or amend existing contracts, on a bid  
6 or negotiated basis. Contracts entered into or amended pursuant  
7 to this subdivision shall be exempt from Chapter 6 (commencing  
8 with Section 14825) of Part 5.5 of Division 3 of Title 2 of the  
9 Government Code and Part 2 (commencing with Section 10100)  
10 of Division 2 of the Public Contract Code, and shall be exempt  
11 from the review or approval of any division of the Department of  
12 General Services.

13 ~~(f) The department shall conduct, or arrange to have conducted,~~  
14 ~~any study, report, assessment, including the access assessment~~  
15 ~~described in Section 14184.80, evaluation, or other similar~~  
16 ~~demonstration project activity required under the Special Terms~~  
17 ~~and Conditions.~~

18 ~~(g)~~

19 (f) During the course of the demonstration term, the department  
20 shall seek any federal approvals it deems necessary to implement  
21 the demonstration project and this article. This shall include, but  
22 is not limited to, approval of any amendment, addition, or technical  
23 correction to the Special Terms and Conditions, and any associated  
24 state plan amendment, as deemed necessary. This article shall be  
25 implemented only to the extent that any necessary federal approvals  
26 are obtained and federal financial participation is available and is  
27 not otherwise jeopardized.

28 ~~(h)~~

29 (g) The director may modify any process or methodology  
30 specified in this article to the extent necessary to comply with  
31 federal law or the Special Terms and Conditions of the  
32 demonstration project, but only if the modification is consistent  
33 with the goals set forth in this article for the demonstration project,  
34 and its individual components, and does not significantly alter the  
35 relative level of support for participating entities. If the director,  
36 after consulting with those entities participating in the applicable  
37 demonstration project component and that would be affected by  
38 that modification, determines that the potential modification would  
39 not be consistent with the goals set forth in this article or would  
40 significantly alter the relative level of support for affected

1 participating entities, the modification shall not be made and the  
2 director shall execute a declaration stating that this determination  
3 has been made. The director shall retain the declaration and provide  
4 a copy, within five working days of the execution of the  
5 declaration, to the fiscal and appropriate policy committees of the  
6 Legislature, and shall work with the affected participating entities  
7 and the Legislature to make the necessary statutory changes. The  
8 director shall post the declaration on the department's Internet  
9 Web site and the director shall send the declaration to the Secretary  
10 of State and the Legislative Counsel.

11 (i)

12 (h) In the event of a determination that the amount of federal  
13 financial participation available under the demonstration project  
14 is reduced due to the application of penalties set forth in the Special  
15 Terms and Conditions, the enforcement of the demonstration  
16 project's budget neutrality limit, or other similar occurrence, the  
17 department shall develop the methodology by which payments  
18 under the demonstration project shall be reduced, in consultation  
19 with the potentially affected participating entities and consistent  
20 with the standards and process specified in subdivision (h). To the  
21 extent feasible, those reductions shall protect the ability to claim  
22 the full amount of the total computable disproportionate share  
23 allotment through the Global Payment Program.

24 (j)

25 (i) During the course of the demonstration term, the department  
26 may work to develop potential successor payment methodologies  
27 that could continue to support entities participating in the  
28 demonstration project following the expiration of the demonstration  
29 term and that further the goals set forth in this article and in the  
30 Special Terms and Conditions. The department shall consult with  
31 the entities participating in the payment methodologies under the  
32 demonstration project, affected stakeholders, and the Legislature  
33 in the development of any potential successor payment  
34 methodologies pursuant to this subdivision.

35 (k)

36 (j) The department may seek to extend the payment  
37 methodologies described in this article through demonstration year  
38 16 or to subsequent time periods by way of amendment or  
39 extension of the demonstration project, amendment to the Medi-Cal  
40 State Plan, or any combination thereof, consistent with the

1 applicable federal requirements. This subdivision shall only be  
2 implemented after consultation with the entities participating in,  
3 or affected by, those methodologies, and only to the extent that  
4 any necessary federal approvals are obtained and federal financial  
5 participation is available and is not otherwise jeopardized.

6 ~~(f)~~

7 (k) (1) Notwithstanding any other law, and to the extent  
8 authorized by the Special Terms and Conditions, the department  
9 may claim federal financial participation for expenditures  
10 associated with the designated state health programs identified in  
11 the Special Terms and Conditions for use solely by the department  
12 as specified in this subdivision.

13 (2) Any federal financial participation claimed pursuant to  
14 paragraph (1) shall be used to offset applicable General Fund  
15 expenditures. These amounts are hereby appropriated to the  
16 department and shall be available for transfer to the General Fund  
17 for this purpose.

18 (3) An amount of General Fund moneys equal to the federal  
19 financial participation that may be claimed pursuant to paragraph  
20 (1) is hereby appropriated to the Health Care Deposit Fund for use  
21 by the department.

22 14184.30. The following payment methodologies and  
23 requirements implemented pursuant to Article 5.2 (commencing  
24 with Section 14166) shall be applicable as set forth in this section.

25 (a) (1) For purposes of Section 14166.4, the references to  
26 “project year” and “successor demonstration year” shall include  
27 references to the demonstration term, as defined under this article,  
28 and to any extensions of the prior federal Medicaid demonstration  
29 project entitled “California Bridge to Reform Demonstration  
30 (Waiver No. 11-W-00193/9).”

31 (2) The fee-for-service payment methodologies established and  
32 implemented under Section 14166.4 shall continue to apply with  
33 respect to designated public hospitals approved under the Medi-Cal  
34 State Plan.

35 (3) For the hospitals identified in clauses (ii) and (iii) of  
36 subparagraph (H) of paragraph (1) of subdivision (f) of Section  
37 14184.10, the department shall seek any necessary federal  
38 approvals to apply the fee-for-service payment methodologies  
39 established and implemented under Section 14166.4 to these  
40 identified hospitals effective no earlier than the 2016–17 state

1 fiscal year. This paragraph shall be implemented only to the extent  
2 that any necessary federal approvals are obtained and federal  
3 financial participation is available and not otherwise jeopardized.  
4 Prior to the effective date of any necessary federal approval  
5 obtained pursuant to this paragraph, these identified hospitals shall  
6 continue to be considered nondesignated public hospitals for  
7 purposes of the fee-for-service methodology authorized pursuant  
8 to Section 14105.28 and the applicable provisions of the Medi-Cal  
9 State Plan.

10 (4) The department shall continue to make reimbursement  
11 available to qualifying hospitals that meet the eligibility  
12 requirements for participation in the supplemental reimbursement  
13 program for hospital facility construction, renovation, or  
14 replacement pursuant to Section 14085.5 and the applicable  
15 provisions of the Medi-Cal State Plan. The department shall  
16 continue to make inpatient hospital payments for services that were  
17 historically excluded from a hospital's contract under the Selective  
18 Provider Contracting Program established under Article 2.6  
19 (commencing with Section 14081) in accordance with the  
20 applicable provisions of the Medi-Cal State Plan. These payments  
21 shall not duplicate or supplant any other payments made under  
22 this article.

23 (b) During the 2015–16 state fiscal year, and subsequent state  
24 fiscal years that commence during the demonstration term, payment  
25 adjustments to disproportionate share hospitals shall not be made  
26 pursuant to Section 14105.98, except as otherwise provided in this  
27 article. Payment adjustments to disproportionate share hospitals  
28 shall be made solely in accordance with this article.

29 (1) Except as otherwise provided in this article, the department  
30 shall continue to make all eligibility determinations and perform  
31 all payment adjustment amount computations under the  
32 disproportionate share hospital payment adjustment program  
33 pursuant to Section 14105.98 and pursuant to the disproportionate  
34 share hospital provisions of the Medi-Cal State Plan. For purposes  
35 of these determinations and computations, which include those  
36 made pursuant to Sections 14166.11 and 14166.16, all of the  
37 following shall apply:

38 (A) The federal Medicaid DSH reductions pursuant to Section  
39 1396r-4(f)(7) of Title 42 of the United States Code shall be  
40 reflected as appropriate, including, but not limited to, the

1 calculations set forth in subparagraph (B) of paragraph (2) of  
2 subdivision (am) of Section 14105.98.

3 (B) Services that were rendered under the Low Income Health  
4 Program authorized pursuant to Part 3.6 (commencing with Section  
5 15909) shall be included.

6 (2) (A) Notwithstanding Section 14105.98, the federal  
7 disproportionate share hospital allotment specified for California  
8 under Section 1396r-4(f) of Title 42 of the United States Code for  
9 each of federal fiscal years 2016 to 2021, inclusive, shall be aligned  
10 with the state fiscal year in which the applicable federal fiscal year  
11 commences, and shall be distributed solely for the following  
12 purposes:

13 (i) As disproportionate share hospital payments under the  
14 methodology set forth in applicable disproportionate share hospital  
15 provisions of the Medi-Cal State Plan, which, to the extent  
16 permitted under federal law and the Special Terms and Conditions,  
17 shall be limited to the following hospitals:

18 (I) Eligible hospitals, as determined pursuant to Section  
19 14105.98 for each state fiscal year in which the particular federal  
20 fiscal year commences, that meet the definition of a public hospital,  
21 as specified in paragraph (25) of subdivision (a) of Section  
22 14105.98, and that are not participating as GPP systems under the  
23 Global Payment Program.

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

27 (ii) As a funding component for payments under the Global  
28 Payment Program, as described in subparagraph (A) of paragraph  
29 (1) of subdivision (c) of Section 14184.40 and the Special Terms  
30 and Conditions.

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

35 (3) (A) During the 2015–16 state fiscal year and subsequent  
36 state fiscal years that commence during the demonstration term,  
37 a public entity shall not be obligated to make any intergovernmental  
38 transfer pursuant to Section 14163, and all transfer amount  
39 determinations for those state fiscal years shall be suspended.  
40 However, intergovernmental transfers shall be made with respect

1 to the disproportionate share hospital payment adjustments made  
2 in accordance with clause (ii) of subparagraph (B) of paragraph  
3 (6), as applicable.

4 (B) During the 2015–16 state fiscal year and subsequent state  
5 fiscal years that commence during the demonstration term, transfer  
6 amounts from the Medi-Cal Inpatient Payment Adjustment Fund  
7 to the Health Care Deposit Fund, as described in paragraph (2) of  
8 subdivision (d) of Section 14163, are hereby reduced to zero.  
9 Unless otherwise specified in this article or the applicable  
10 provisions of Article 5.2 (commencing with Section 14166), this  
11 subparagraph shall be disregarded for purposes of the calculations  
12 made under Section 14105.98 during the 2015–16 state fiscal year  
13 and subsequent state fiscal years that commence during the  
14 demonstration term.

15 (4) (A) During the state fiscal years for which the Global  
16 Payment Program under Section 14184.40 is in effect, designated  
17 public hospitals that are participating GPP systems shall not be  
18 eligible to receive disproportionate share hospital payments  
19 pursuant to otherwise applicable disproportionate share hospital  
20 provisions of the Medi-Cal State Plan.

21 (B) Eligible hospitals described in clause (i) of subparagraph  
22 (A) of paragraph (2) that are nondesignated public hospitals shall  
23 continue to receive disproportionate share hospital payment  
24 adjustments as set forth in Section 14166.16.

25 (C) Hospitals described in clause (i) of subparagraph (A) of  
26 paragraph (2) that are licensed to the University of California shall  
27 receive disproportionate share hospital payments as follows:

28 (i) Subject to clause (iii), each hospital licensed to the University  
29 of California may draw and receive federal Medicaid funding from  
30 the applicable federal disproportionate share hospital allotment on  
31 the amount of certified public expenditures for the hospital's  
32 expenditures that are eligible for federal financial participation as  
33 reported in accordance with Section 14166.8 and the applicable  
34 disproportionate share hospital provisions of the Medi-Cal State  
35 Plan.

36 (ii) Subject to clause (iii) and to the extent the hospital meets  
37 the requirement in Section 1396r-4(b)(1)(A) of Title 42 of the  
38 United States Code regarding the Medicaid inpatient utilization  
39 rate or Section 1396r-4(b)(1)(B) of Title 42 of the United States  
40 Code regarding the low-income utilization rate, each hospital shall

1 receive intergovernmental transfer-funded direct disproportionate  
2 share hospital payments as provided for under the applicable  
3 disproportionate share hospital provisions of the Medi-Cal State  
4 Plan. The total amount of these payments to the hospital, consisting  
5 of the federal and nonfederal components, shall in no case exceed  
6 that amount equal to 75 percent of the hospital's uncompensated  
7 Medi-Cal and uninsured costs of hospital services as reported in  
8 accordance with Section 14166.8.

9 (iii) Unless the provisions of subparagraph (D) apply, the  
10 aggregate amount of the federal disproportionate share hospital  
11 allotment with respect to payments for an applicable state fiscal  
12 year to hospitals licensed to the University of California shall be  
13 limited to an amount calculated as follows:

14 (I) The maximum amount of federal disproportionate share  
15 hospital allotment for the state fiscal year, less the amounts of  
16 federal disproportionate share hospital allotment associated with  
17 payments to nondesignated public hospitals under subparagraph  
18 (B) and other payments, if any, required to be made from the  
19 federal disproportionate share hospital allotment, shall be  
20 determined.

21 (II) For the 2015–16 state fiscal year, the amount determined  
22 in subclause (I) shall be multiplied by 26.296 percent, resulting in  
23 the maximum amount of the federal disproportionate share hospital  
24 allotment available as disproportionate share hospital payments  
25 for the state fiscal year to hospitals that are licensed to the  
26 University of California.

27 (III) For the 2016–17 state fiscal year, the amount determined  
28 in subclause (I) shall be multiplied by 24.053 percent, resulting in  
29 the maximum amount of the federal disproportionate share hospital  
30 allotment available as disproportionate share hospital payments  
31 for the state fiscal year to hospitals that are licensed to the  
32 University of California.

33 (IV) For the 2017–18 state fiscal year, the amount determined  
34 in subclause (I) shall be multiplied by 23.150 percent, resulting in  
35 the maximum amount of the federal disproportionate share hospital  
36 allotment available as disproportionate share hospital payments  
37 for the state fiscal year to hospitals that are licensed to the  
38 University of California.

39 (V) For each of the 2018–19 and 2019–20 state fiscal years, the  
40 amount determined in subclause (I) shall be multiplied by 21.896

1 percent, resulting in the maximum amount of the federal  
2 disproportionate share hospital allotment available as  
3 disproportionate share hospital payments for the state fiscal year  
4 to hospitals that are licensed to the University of California.

5 (VI) To the extent the limitations set forth in this clause result  
6 in payment reductions for the applicable year, those reductions  
7 shall be applied pro rata, subject to clause (vii).

8 (iv) Each hospital licensed to the University of California shall  
9 receive quarterly interim payments of its disproportionate share  
10 hospital allocation during the applicable state fiscal year. The  
11 determinations set forth in clauses (i) to (iii), inclusive, shall be  
12 made on an interim basis prior to the start of each state fiscal year,  
13 except that the determinations for the 2015–16 state fiscal year  
14 shall be made as soon as practicable. The department shall use the  
15 same cost and statistical data used in determining the interim  
16 payments for Medi-Cal inpatient hospital services under Section  
17 14166.4, and available payments and uncompensated and uninsured  
18 cost data, including data from the Medi-Cal paid claims file and  
19 the hospital’s books and records, for the corresponding period, to  
20 the extent permitted under the Medi-Cal State Plan.

21 (v) No later than April 1 following the end of the relevant  
22 reporting period for the applicable state fiscal year, the department  
23 shall undertake an interim reconciliation of payments based on  
24 Medi-Cal, Medicare, and other cost, payment, discharge, and  
25 statistical data submitted by the hospital for the applicable state  
26 fiscal year, and shall adjust payments to the hospital accordingly.

27 (vi) Except as otherwise provided in this article, each hospital  
28 licensed to the University of California shall receive  
29 disproportionate share hospital payments subject to final audits of  
30 all applicable Medi-Cal, Medicare, and other cost, payment,  
31 discharge, and statistical data submitted by the hospital for the  
32 applicable state fiscal year.

33 (vii) Prior to the interim and final distributions of payments  
34 pursuant to clauses (iv) through (vi), inclusive, the department  
35 shall consult with the University of California, and implement any  
36 adjustments to the payment distributions for the hospitals as  
37 requested by the University of California, so long as the aggregate  
38 net effect of the requested adjustments for the affected hospitals  
39 is zero.

1 (D) With respect to any state fiscal year commencing during  
2 the demonstration term for which the Global Payment Program is  
3 not in effect, designated public hospitals that are eligible hospitals  
4 as determined pursuant to Section 14105.98, and hospitals  
5 described in clause (i) of subparagraph (A) of paragraph (2) that  
6 are licensed to the University of California, shall claim  
7 disproportionate share hospital payments in accordance with the  
8 applicable disproportionate share hospital provisions of the  
9 Medi-Cal State Plan. The allocation of federal Medicaid funding  
10 from the applicable federal disproportionate share hospital  
11 allotment shall be made in accordance with the methodology set  
12 forth in Section 14166.61.

13 (5) For each applicable state fiscal year during the demonstration  
14 term, eligible hospitals, as determined pursuant to Section  
15 14105.98, which are nonpublic hospitals, nonpublic-converted  
16 hospitals, and converted hospitals, as those terms are defined in  
17 paragraphs (26), (27), and (28), respectively, of subdivision (a) of  
18 Section 14105.98, shall continue to receive Medi-Cal  
19 disproportionate share hospital replacement payment adjustments  
20 pursuant to Section 14166.11 and other provisions of this article  
21 and applicable provisions of the Medi-Cal State Plan. The payment  
22 adjustments so provided shall satisfy the state's payment  
23 obligations, if any, with respect to those hospitals under Section  
24 1396r-4 of Title 42 of the United States Code. The provisions of  
25 subdivision (j) of Section 14166.11 shall continue to apply with  
26 respect to the 2015–16 state fiscal year and subsequent state fiscal  
27 years commencing during the demonstration term. Except as may  
28 otherwise be required by federal law, the federal share of these  
29 payments shall not be claimed from the federal disproportionate  
30 share hospital allotment.

31 (6) The nonfederal share of disproportionate share hospital  
32 payments and disproportionate share hospital replacement payment  
33 adjustments described in paragraphs (4) and (5) shall be derived  
34 from the following sources:

35 (A) With respect to the payments described in subparagraph  
36 (B) of paragraph (4) that are made to nondesignated public  
37 hospitals, the nonfederal share shall consist solely of state General  
38 Fund appropriations.

39 (B) With respect to the payments described in subparagraph (C)  
40 or (D), as applicable, of paragraph (4) that are made to designated

1 public hospitals, the nonfederal share shall consist of both of the  
2 following:

3 (i) Certified public expenditures incurred by the hospitals for  
4 hospital expenditures eligible for federal financial participation as  
5 reported in accordance with Section 14166.8.

6 (ii) Intergovernmental transfer amounts for direct  
7 disproportionate share hospital payments provided for under  
8 subparagraph (C) or (D) of paragraph (4) and the applicable  
9 disproportionate share hospital provisions of the Medi-Cal State  
10 Plan. A transfer amount shall be determined for each hospital that  
11 is eligible for these payments, equal to the nonfederal share of the  
12 payment amount established for the hospital. The transfer amount  
13 determined shall be paid by the hospital, or the public entity with  
14 which the hospital is affiliated, and deposited into the Medi-Cal  
15 Inpatient Payment Adjustment Fund established pursuant to  
16 subdivision (b) of Section 14163, as permitted under Section  
17 433.51 of Title 42 of the Code of Federal Regulations or any other  
18 applicable federal Medicaid laws.

19 (C) With respect to the payments described in paragraph (5),  
20 the nonfederal share shall consist of state General Fund  
21 appropriations.

22 (7) The Demonstration Disproportionate Share Hospital Fund  
23 established in the State Treasury pursuant to subdivision (d) of  
24 Section 14166.9 shall be retained during the demonstration term.  
25 All federal funds received by the department with respect to the  
26 certified public expenditures claimed pursuant to subparagraph  
27 (C), and, as applicable in subparagraph (D), of paragraph (4) shall  
28 be transferred to the fund and disbursed to the eligible designated  
29 public hospitals pursuant to those applicable provisions.  
30 Notwithstanding Section 13340 of the Government Code, moneys  
31 deposited in the fund shall be continuously appropriated, without  
32 regard to fiscal year, to the department solely for the purposes  
33 specified in this article.

34 (c) (1) Disproportionate share hospital payment allocations  
35 under Sections 14166.3 and 14166.61, and safety net care pool  
36 payment allocations under Section 14166.71, that were paid to  
37 designated public hospitals with respect to the period July 1, 2015,  
38 through October 31, 2015, or for subsequent periods pursuant to  
39 Section 14166.253, shall be reconciled to amounts payable to the  
40 hospitals under this article as set forth in this subdivision.

1 (2) The disproportionate share hospital payments and safety net  
2 care pool payments described in paragraph (1) that were paid to a  
3 designated public hospital participating in a GPP system under  
4 Section 14184.40 shall be deemed to be interim payments under  
5 the Global Payment Program for GPP program year 2015–16, and  
6 will be reconciled to and offset against the interim payment amount  
7 due to the GPP system under subparagraph (B) of paragraph (4)  
8 of subdivision (d) of Section 14184.40, consistent with the Special  
9 Terms and Conditions.

10 (3) The disproportionate share hospital payments described in  
11 paragraph (1) that were paid to designated public hospitals licensed  
12 to the University of California shall be reconciled to and offset  
13 against the disproportionate share hospital payments payable to  
14 the hospitals under subparagraph (C) of paragraph (4) of  
15 subdivision (b) for the 2015–16 state fiscal year.

16 (4) The safety net care pool payments described in paragraph  
17 (1) that were paid to designated public hospitals licensed to the  
18 University of California shall be recouped and included as available  
19 funding under the Global Payment Program for the 2015–16 GPP  
20 program year described in subparagraph (B) of paragraph (1) of  
21 subdivision (c) of Section 14184.40.

22 (d) During the 2015–16 state fiscal year, and subsequent state  
23 fiscal years that commence during the demonstration term, costs  
24 shall continue to be determined and reported for designated public  
25 hospitals in accordance with Sections 14166.8 and 14166.24,  
26 except as follows:

27 (1) (A) The provisions of subdivision (c) of Section 14166.8  
28 shall not apply.

29 (B) Notwithstanding subparagraph (A), the department may  
30 require the reporting of any data the department deems necessary  
31 to satisfy reporting requirements pursuant to the Special Terms  
32 and Conditions.

33 (2) The provisions of Sections 14166.221 and 15916 shall not  
34 apply with respect to any costs reported for the demonstration term  
35 pursuant to Section 14166.8.

36 (e) (1) Notwithstanding subdivision (h) of Section 14166.61  
37 and subdivision (c) of Section 14166.71, the disproportionate share  
38 hospital allocation and safety net care pool payment determinations  
39 and payments for the 2013–14 and 2014–15 state fiscal years shall  
40 be deemed final as of the April 30 that is 22 months following the

1 close of the respective state fiscal year, to the extent permitted  
2 under federal law and subject to recoupment pursuant to  
3 subdivision (f) if it is later determined that federal financial  
4 participation is not available for any portion of the applicable  
5 payments.

6 (2) The determinations and payments shall be finalized using  
7 the best available data, including unaudited data, and reasonable  
8 current estimates and projections submitted by the designated  
9 public hospitals. The department shall accept all appropriate  
10 revisions to the data, estimates, and projections previously  
11 submitted, including revised cost reports, for purposes of this  
12 subdivision, to the extent these revisions are submitted in a timely  
13 manner as determined by the department.

14 (f) Upon receipt of a notice of disallowance or deferral from  
15 the federal government related to the certified public expenditures  
16 or intergovernmental transfers of a designated public hospital or  
17 governmental entity with which it is affiliated for disproportionate  
18 share hospital payments or safety net care pool payments claimed  
19 and distributed pursuant to Section 14166.61, 14166.71, or 15916  
20 for the 2013–14 or 2014–15 state fiscal year, the department shall  
21 promptly notify the designated public hospitals and proceed as  
22 follows:

23 (1) To the extent there are additional certified public  
24 expenditures for the applicable state fiscal year for which federal  
25 funds have not been received, but for which federal funds could  
26 have been received had additional federal funds been available,  
27 including any subsequently allowable expenditures for designated  
28 state health programs, the department shall first respond to the  
29 deferral or disallowance by substituting the additional certified  
30 public expenditures or allowable expenditures for those deferred  
31 or disallowed, consistent with the claiming optimization priorities  
32 set forth in Section 14166.9, in consultation with the designated  
33 public hospitals, but only to the extent that any necessary federal  
34 approvals are obtained or these actions are otherwise permitted by  
35 federal law.

36 (2) The department shall consult with the designated public  
37 hospitals and proceed in accordance with paragraphs (2) and (3)  
38 of subdivision (d) of Section 14166.24.

39 (3) If the department elects to appeal pursuant to paragraph (3)  
40 of subdivision (d) of Section 14166.24, the department shall not

1 implement any recoupment of payments from the affected  
2 designated public hospitals, until a final disposition has been made  
3 regarding the deferral or disallowance, including the conclusion  
4 of applicable administrative and judicial review, if any.

5 (4) (A) Upon final disposition of the federal deferral or  
6 disallowance, the department shall determine the resulting  
7 aggregate repayment amount of federal funds for each affected  
8 state fiscal year.

9 (B) The department shall determine the ratio of the aggregate  
10 repayment amount to the total amount of the federal share of  
11 payments finalized and distributed pursuant to Sections 14166.61  
12 and 14166.71 and subdivision (e) for each affected state fiscal  
13 year, expressed as a percentage.

14 (5) Notwithstanding paragraph (1) of subdivision (d) of Section  
15 14166.24, the responsibility for repayment of the federal portion  
16 of any deferral of disallowance for each affected year shall be  
17 determined as follows:

18 (A) The provisions of subdivision (g) of Section 15916 shall be  
19 applied to determine the department's repayment responsibility  
20 amount with respect to any deferral or disallowance related to  
21 safety net care pool payments, which shall be in addition to  
22 amounts determined under subparagraph (E).

23 (B) Using the most recent data for the applicable fiscal year,  
24 and reflecting modifications to the applicable initial DSH claiming  
25 ability and initial SNCP claiming ability for individual hospitals  
26 resulting from the deferral or disallowance, the department shall  
27 perform the calculations and determinations for each designated  
28 public hospital as set forth in Sections 14166.61 and 14166.71.  
29 For this purpose, the calculations and determinations shall assume  
30 no reduction in the available federal disproportionate share hospital  
31 allotment or in the amount of available safety net care pool  
32 payments as a result of the deferral or disallowance.

33 (C) For each designated public hospital, the revised  
34 determinations of disproportionate share hospital and safety net  
35 care pool payment amounts under subparagraph (B) shall be  
36 combined and compared to the combined disproportionate share  
37 hospital and safety net care pool payment amounts determined and  
38 received by the hospital pursuant to subdivision (e). For this  
39 purpose and purposes of subparagraph (D), the applicable data for  
40 designated public hospitals described in subparagraph (G) of

1 paragraph (1) of subdivision (f) of Section 14184.10 shall be  
2 combined, and the applicable data for designated public hospitals  
3 described in subparagraphs (E) and (F) of paragraph (1) of  
4 subdivision (f) of Section 14184.10 shall be combined.

5 (D) (i) Subject to subparagraph (E), the repayment of the federal  
6 portion of the deferral of disallowance, less the department's  
7 responsibility amount for safety net care pool payments, if any,  
8 determined in subparagraph (A), shall be first allocated among  
9 each of those designated public hospitals for which the combined  
10 revised disproportionate share hospital and safety net care pool  
11 payments as determined in subparagraph (B) are less than the  
12 combined disproportionate share hospital and safety net care pool  
13 payment amounts determined and received pursuant to subdivision  
14 (e). Repayment shall be allocated under this initial stage among  
15 these hospitals pro rata on the basis of each hospital's relative  
16 reduction as reflected in the revised calculations performed under  
17 subparagraph (B), but in no case shall the allocation to a hospital  
18 exceed the limit in clause (iii). Repayment amounts that are not  
19 allocated due to this limitation shall be allocated pursuant to clause  
20 (ii).

21 (ii) Subject to subparagraph (E), any repayment amounts that  
22 were unallocated to hospitals due to the limitation in clause (iii)  
23 shall be allocated in a second stage among each of the remaining  
24 designated public hospitals that has not reached its applicable  
25 repayment limit, including the hospitals that were not subject to  
26 the allocations under clause (i), based pro rata on the amounts  
27 determined and received by the hospital pursuant to subdivision  
28 (e), except that no repayment amount for a hospital shall exceed  
29 the limitation under clause (iii). The pro rata allocation process  
30 will be repeated in subsequent stages with respect to any repayment  
31 amounts that cannot be allocated in a prior stage to hospitals due  
32 to the limitation under clause (iii), until the entire federal repayment  
33 amount has been allocated among the hospitals.

34 (iii) The repayment amount allocated to a designated public  
35 hospital pursuant to this subparagraph shall not exceed an amount  
36 equal to the percentage of the combined payments determined and  
37 received by the hospital pursuant to subdivision (e) that is twice  
38 the percentage computed in subparagraph (B) of paragraph (4).

39 (E) Notwithstanding any other law, if the affiliated governmental  
40 entity for the designated public hospital is a county subject to the

1 provisions of Article 12 (commencing with Section 17612.1) of  
2 Chapter 6 of Part 5, the department, in consultation with the  
3 affected designated public hospital, and the Department of Finance,  
4 shall determine how to account for whether any repayment amount  
5 determined for the designated public hospital pursuant to  
6 subparagraph (D) for the 2013–14 and 2014–15 state fiscal years  
7 would otherwise have affected, if at all, the applicable county’s  
8 redirection obligation for the applicable state fiscal year pursuant  
9 to paragraphs (4) and (5) of subdivision (a) of Section 17612.3  
10 and shall determine what adjustments, if any, are necessary to  
11 either the repayment amount or the applicable county’s redirection  
12 obligation. For purposes of this subparagraph, the provisions of  
13 subdivision (f) of Section 17612.2 and paragraph (7) of subdivision  
14 (e) of Section 101853 of the Health and Safety Code shall apply.

15 (g) The provisions of Article 5.2 (commencing with Section  
16 14166) shall remain in effect until all payments authorized pursuant  
17 to that article have been paid, finalized, and settled, and to the  
18 extent its provisions are retained for purposes of this article.

19 14184.40. (a) (1) The department shall implement the Global  
20 Payment Program authorized under the demonstration project to  
21 support participating public health care systems that provide health  
22 care services for the uninsured. Under the Global Payment  
23 Program, GPP systems receive global payments based on the health  
24 care they provide to the uninsured, in lieu of traditional  
25 disproportionate share hospital payments and safety net care pool  
26 payments previously made available pursuant to Article 5.2  
27 (commencing with Section 14166).

28 (2) The Global Payment Program is intended to streamline  
29 funding sources for care for California’s remaining uninsured  
30 population, creating a value-based mechanism to increase  
31 incentives to provide primary and preventive care services and  
32 other high-value services. The Global Payment Program supports  
33 GPP systems for their key role providing and promoting effective,  
34 higher value services to California’s remaining uninsured.  
35 Promoting more cost-effective and higher value care means that  
36 the payment structure rewards the provision of care in more  
37 appropriate venues for patients, and will support structural changes  
38 to the care delivery system that will improve the options for treating  
39 both Medi-Cal and uninsured patients.

1 (3) Under the Global Payment Program, GPP systems will  
2 receive Global Payment Program payments calculated using an  
3 innovative value-based point methodology that incorporates  
4 measures of value for the patient in conjunction with the  
5 recognition of costs. To receive the full amount of Global Payment  
6 Program payments, a GPP system shall provide a threshold level  
7 of services, as measured in the point methodology described in  
8 paragraph (2) of subdivision (c), and based on the GPP system’s  
9 historical volume, cost, and mix of services. This payment  
10 methodology is intended to support GPP systems that continue to  
11 provide services to the uninsured, while incentivizing the GPP  
12 systems to shift the overall delivery of services for the uninsured  
13 to provide more cost-effective, higher value care.

14 (4) The department shall implement and oversee the operation  
15 of the Global Payment Program in accordance with the Special  
16 Terms and Conditions and the requirements of this section, to  
17 maximize the amount of federal financial participation available  
18 to participating GPP systems.

19 (b) For purposes of this article, the following definitions shall  
20 apply:

21 (1) “GPP system” means a public health care system that  
22 consists of a designated public hospital, as defined in subdivision  
23 (f) of Section 14184.10 but excluding the hospitals operated by  
24 the University of California, and its affiliated and contracted  
25 providers. Multiple designated public hospitals operated by a single  
26 legal entity may belong to the same GPP system, to the extent set  
27 forth in the Special Terms and Conditions.

28 (2) “GPP program year” means a state fiscal year beginning on  
29 July 1 and ending on June 30 during which the Global Payment  
30 Program is authorized under the demonstration project, beginning  
31 with state fiscal year 2015–16, and, as applicable, each state fiscal  
32 year thereafter through 2019–20, and any years or partial years  
33 during which the Global Payment Program is authorized under an  
34 extension or successor to the demonstration.

35 (c) (1) For each GPP program year, the department shall  
36 determine the Global Payment Program’s aggregate annual limit,  
37 which is the maximum amount of funding available under the  
38 demonstration project for the Global Payment Program and which  
39 is the sum of the components described in subparagraphs (A) and  
40 (B). To the extent feasible, the aggregate annual limit shall be

1 determined and made available by the department prior to the  
2 implementation of a GPP program year, and shall be updated and  
3 adjusted as necessary to reflect changes or adjustments to the  
4 amount of funding available for the Global Payment Program.

5 (A) A portion of the federal disproportionate share allotment  
6 specified for California under Section 1396r-4(f) of Title 42 of the  
7 United States Code shall be included as a component of the  
8 aggregate annual limit for each GPP program year. The amount  
9 of this portion shall equal the state's total computable  
10 disproportionate share allotment reduced by the maximum amount  
11 of funding projected for payments pursuant to subparagraphs (B)  
12 and (C) of paragraph (4) of subdivision (b) of Section 14184.30  
13 to disproportionate share hospitals that are not participating in the  
14 Global Payment Program. For purposes of this determination, the  
15 federal disproportionate share allotment shall be aligned with the  
16 GPP program year in which the applicable federal fiscal year  
17 commences.

18 (B) The aggregate annual limit shall also include the amount  
19 authorized under the demonstration project for the uncompensated  
20 care component of the Global Payment Program for the applicable  
21 GPP program year, as determined pursuant to the Special Terms  
22 and Conditions.

23 (2) The department shall develop a methodology for valuing  
24 health care services and activities provided to the uninsured that  
25 achieves the goals of the Global Payment Program, including those  
26 values set forth in subdivision (a) and as expressed in the Special  
27 Terms and Conditions. The points assigned to a particular service  
28 or activity shall be the same across all GPP systems. Points for  
29 specific services or activities may be increased or decreased over  
30 time as the Global Payment Program progresses, to incentivize  
31 appropriate changes in the mix of services provided to the  
32 uninsured. To the extent necessary, the department shall obtain  
33 federal approval for the methodology and any applicable changes  
34 to the methodology.

35 (3) For each GPP system, the department shall perform a  
36 baseline analysis of the GPP system's historical volume, cost, and  
37 mix of services to the uninsured to establish an annual threshold  
38 for purposes of the Global Payment Program. The annual threshold  
39 shall be measured in points established through the methodology

1 developed pursuant to paragraph (2) and as set forth in the Special  
2 Terms and Conditions.

3 (4) The department shall determine a pro rata allocation  
4 percentage for each GPP system by dividing the GPP system's  
5 annual threshold determined in paragraph (3) by the sum of all  
6 GPP systems' thresholds.

7 (5) For each GPP system, the department shall determine an  
8 annual budget the GPP system will receive if it achieves its  
9 threshold. A GPP system's annual budget shall equal the allocation  
10 percentage determined in paragraph (4) for the GPP system,  
11 multiplied by the Global Payment Program's aggregate annual  
12 limit determined in paragraph (1).

13 (6) In the event of a change in the aggregate annual limit, the  
14 department shall adjust and recalculate each GPP system's annual  
15 threshold and annual budget in proportion to changes in the  
16 aggregate annual limit calculated in paragraph (1) in accordance  
17 with the Special Terms and Conditions.

18 (d) The amount of Global Payment Program funding payable  
19 to a GPP system for a GPP program year shall be calculated as  
20 follows, subject to the Special Terms and Conditions:

21 (1) The full amount of a GPP system's annual budget shall be  
22 payable to the GPP system if the services it provided to the  
23 uninsured during the GPP program year, as measured and scored  
24 using the point methodology described under paragraph (2) of  
25 subdivision (c), meets or exceeds its threshold for a given year.  
26 For GPP systems that do not achieve their threshold, the amount  
27 payable to the GPP system shall equal its annual budget reduced  
28 by the proportion by which it fell short of its threshold.

29 (2) The department shall develop a methodology to redistribute  
30 unearned Global Payment Program funds for a given GPP program  
31 year to those GPP systems that exceeded their respective threshold  
32 for that same year. To the extent sufficient funds are available for  
33 all qualifying GPP systems, the GPP system's redistributed amount  
34 shall equal the GPP system's annual budget multiplied by the  
35 percentage by which the GPP system exceeded its threshold, and  
36 any remaining amounts of unearned funds will remain  
37 undistributed. If sufficient funds are unavailable to make all these  
38 payments to qualifying GPP systems, the amounts of these  
39 additional payments will be reduced for all qualifying GPP systems  
40 by the same proportion, so that the full amount of unearned Global

1 Payment Program funds are redistributed. Redistributed payment  
2 amounts calculated pursuant to this paragraph shall be added to  
3 the amounts payable to a GPP system calculated pursuant to  
4 paragraph (1).

5 (3) The department shall specify a reporting schedule for  
6 participating GPP systems to submit an interim yearend report and  
7 a final reconciliation report for each GPP program year. The interim  
8 yearend report and the final reconciliation report shall identify the  
9 services the GPP system provided to the uninsured during the GPP  
10 program year, the associated point calculation, and the amount of  
11 payments earned by the GPP system prior to any redistribution.  
12 The method and format of the reporting shall be established by  
13 the department, consistent with the approved Special Terms and  
14 Conditions.

15 (4) Payments shall be made in the manner and within the  
16 timeframes as follows, except if one or more GPP systems fail to  
17 provide the intergovernmental transfer amount determined pursuant  
18 to subdivision (g) by the date specified in this paragraph, the  
19 timeframe for the associated payments shall be extended to the  
20 extent necessary to allow the department to timely process the  
21 payments. In no event, however, shall payment be delayed beyond  
22 21 days after all the necessary intergovernmental transfers have  
23 been made.

24 (A) Except as provided in subparagraph (B), for each of the first  
25 three quarters of a GPP program year the department shall notify  
26 GPP systems of their payment amounts and intergovernmental  
27 transfer amounts and make a quarterly interim payment equal to  
28 25 percent of each GPP system's annual global budget to the GPP  
29 system.

30 (i) For quarters ending September 30, the payment amount and  
31 intergovernmental transfer amount notice shall be sent by  
32 September 15, intergovernmental transfers shall be due by  
33 September 22, and payments shall be made by October 15.

34 (ii) For quarters ending December 31, the payment amount and  
35 intergovernmental transfer amount notice shall be sent by  
36 December 15, intergovernmental transfers shall be due by  
37 December 22, and payments shall be made by January 15.

38 (iii) For quarters ending March 31, the payment amount and  
39 intergovernmental transfer amount notice shall be sent by March

1 15, intergovernmental transfers shall be due by March 22, and  
2 payments shall be made by April 15.

3 (B) For the 2015–16 GPP program year, the department shall  
4 make the quarterly interim payments described in subdivision (a)  
5 in a single interim payment for the first three quarters as soon as  
6 practicable following approval of the Global Payment Program  
7 protocols as part of the Special Terms and Conditions and receipt  
8 of the associated intergovernmental transfers. The amount of this  
9 interim payment that is otherwise payable to a GPP system shall  
10 be reduced by the payments described in paragraph (2) of  
11 subdivision (c) of Section 14184.30 that were received by a  
12 designated public hospital affiliated with the GPP system.

13 (C) By September 15 following the end of each GPP program  
14 year, the department shall determine and notify each GPP system  
15 of the amount the GPP system earned for the GPP program year  
16 pursuant to paragraph (1) based on its interim yearend report, the  
17 amount of additional interim payments necessary to bring the GPP  
18 system’s aggregate interim payments for the GPP program year  
19 to that amount, and the transfer amounts calculated pursuant to  
20 subdivision (g). If the GPP system has earned less than 75 percent  
21 of its annual budget, no additional interim payment will be made  
22 for the GPP program year. Intergovernmental transfer amounts  
23 shall be due by September 22 following the end of the GPP  
24 program year, and interim payments shall be made by October 15  
25 following the end of each GPP program year. All interim payments  
26 shall be subject to reconciliation after the submission of the final  
27 reconciliation report.

28 (D) By June 30 following the end of each GPP program year,  
29 the department shall review the final reconciliation reports and  
30 determine and notify each GPP system of the final amounts earned  
31 by the GPP system for the GPP program year pursuant to paragraph  
32 (1), as well as the redistribution amounts, if any, pursuant to  
33 paragraph (2), the amount of the payment adjustments or  
34 recoupments necessary to reconcile interim payments to those  
35 amounts, and the transfer amount pursuant to subdivision (g).  
36 Intergovernmental transfer amounts shall be due by July 14  
37 following the notification, and final reconciliation payments for  
38 the GPP program year shall be made no later than August 15  
39 following this notification.

1 (e) The Global Payment Program provides a source of funding  
2 for GPP systems to support their ability to make health care  
3 activities and services available to the uninsured, and shall not be  
4 construed to constitute or offer health care coverage for individuals  
5 receiving services. Global Payment Program payments are not  
6 paid on behalf of specific individuals, and participating GPP  
7 systems may determine the scope, type, and extent to which  
8 services are available, to the extent consistent with the Special  
9 Terms and Conditions. The operation of the Global Payment  
10 Program shall not be construed to decrease, expand, or otherwise  
11 alter the scope of a county’s obligations to the medically indigent  
12 pursuant to Part 5 (commencing with Section 17000) of Division  
13 9.

14 (f) The nonfederal share of any payments under the Global  
15 Payment Program shall consist of voluntary intergovernmental  
16 transfers of funds provided by designated public hospitals or  
17 affiliated governmental agencies or entities, in accordance with  
18 this section.

19 (1) The Global Payment Program Special Fund is hereby  
20 established in the State Treasury. Notwithstanding Section 13340  
21 of the Government Code, moneys deposited in the Global Payment  
22 Program Special Fund shall be continuously appropriated, without  
23 regard to fiscal years, to the department for the purposes specified  
24 in this section. All funds derived pursuant to this section shall be  
25 deposited in the State Treasury to the credit of the Global Payment  
26 Program Special Fund.

27 (2) The Global Payment Program Special Fund shall consist of  
28 moneys that a designated public hospital or affiliated governmental  
29 agency or entity elects to transfer to the department for deposit  
30 into the fund as a condition of participation in the Global Payment  
31 Program, to the extent permitted under Section 433.51 of Title 42  
32 of the Code of Federal Regulations, the Special Terms and  
33 Conditions, and any other applicable federal Medicaid laws. Except  
34 as otherwise provided in paragraph (3), moneys derived from these  
35 intergovernmental transfers in the Global Payment Program Special  
36 Fund shall be used as the source for the nonfederal share of Global  
37 Payment Program payments authorized under the demonstration  
38 project. Any intergovernmental transfer of funds provided for  
39 purposes of the Global Payment Program shall be made as specified  
40 in this section. Upon providing any intergovernmental transfer of

1 funds, each transferring entity shall certify that the transferred  
2 funds qualify for federal financial participation pursuant to  
3 applicable federal Medicaid laws and the Special Terms and  
4 Conditions, and in the form and manner as required by the  
5 department.

6 (3) The department shall claim federal financial participation  
7 for GPP payments using moneys derived from intergovernmental  
8 transfers made pursuant to this section, and deposited in the Global  
9 Payment Program Special Fund to the full extent permitted by law.  
10 The moneys disbursed from the fund, and all associated federal  
11 financial participation, shall be distributed only to GPP systems  
12 and the governmental agencies or entities to which they are  
13 affiliated, as applicable. In the event federal financial participation  
14 is not available with respect to a payment under this section and  
15 either is not obtained, or results in a recoupment of payments  
16 already made, the department shall return any intergovernmental  
17 transfer fund amounts associated with the payment for which  
18 federal financial participation is not available to the applicable  
19 transferring entities within 14 days from the date of the associated  
20 recoupment or other determination, as applicable.

21 (4) As a condition of participation in the Global Payment  
22 Program, each designated public hospital or affiliated governmental  
23 agency or entity, agrees to provide intergovernmental transfer of  
24 funds necessary to meet the nonfederal share obligation as  
25 calculated under subdivision (g) for Global Payment Program  
26 payments made pursuant to this section and the Special Terms and  
27 Conditions. Any intergovernmental transfer of funds made pursuant  
28 to this section shall be considered voluntary for purposes of all  
29 federal laws. No state General Fund moneys shall be used to fund  
30 the nonfederal share of any Global Payment Program payment.

31 (g) For each scheduled quarterly interim payment, interim  
32 yearend payment, and final reconciliation payment pursuant to  
33 subdivision (d), the department shall determine the  
34 intergovernmental transfer amount for each GPP system as follows:

35 (1) The department shall determine the amount of the quarterly  
36 interim payment, interim yearend payment, or final reconciliation  
37 payment, as applicable, that is payable to each GPP system  
38 pursuant to subdivision (d). For purposes of these determinations,  
39 the redistributed amounts described in paragraph (2) of subdivision  
40 (d) shall be disregarded.

1 (2) The department shall determine the aggregate amount of  
2 intergovernmental transfers necessary to fund the nonfederal share  
3 of the quarterly interim payment, interim yearend payment, or final  
4 reconciliation payment, as applicable, identified in paragraph (1)  
5 for all the GPP systems.

6 (3) With respect to each quarterly interim payment, interim  
7 yearend payment, or final yearend reconciliation payment, as  
8 applicable, an initial transfer amount shall be determined for each  
9 GPP system, calculated as the amount for the GPP system  
10 determined in paragraph (1), multiplied by the nonfederal share  
11 percentage, as defined in Section 14184.10, and multiplied by the  
12 applicable GPP system-specific IGT factor as follows:

- 13 (A) Los Angeles County Health System: 1.100.
- 14 (B) Alameda Health System: 1.137.
- 15 (C) Arrowhead Regional Medical Center: 0.923.
- 16 (D) Contra Costa Regional Medical Center: 0.502.
- 17 (E) Kern Medical Center: 0.581.
- 18 (F) Natividad Medical Center: 1.183.
- 19 (G) Riverside University Health System-Medical Center: 0.720.
- 20 (H) San Francisco General Hospital: 0.507.
- 21 (I) San Joaquin General Hospital: 0.803.
- 22 (J) San Mateo Medical Center: 1.325.
- 23 (K) Santa Clara Valley Medical Center: 0.706.
- 24 (L) Ventura County Medical Center: 1.401.

25 (4) The initial transfer amount for each GPP system determined  
26 under paragraph (3) shall be further adjusted as follows to ensure  
27 that sufficient intergovernmental transfers are available to make  
28 payments to all GPP systems:

29 (A) With respect to each quarterly interim payment, interim  
30 yearend payment, or final reconciliation payment, as applicable,  
31 the initial transfer amounts for all GPP systems determined under  
32 paragraph (3) shall be added together.

33 (B) The sum of the initial transfer amounts in subparagraph (A)  
34 shall be subtracted from the aggregate amount of intergovernmental  
35 transfers necessary to fund the payments as determined in  
36 paragraph (2). The resulting positive or negative amount shall be  
37 the aggregate positive or negative intergovernmental transfer  
38 adjustment.

39 (C) Each GPP system-specific IGT factor, as specified in  
40 subparagraphs (A) to (L), inclusive, of paragraph (3) shall be

1 subtracted from 2.000, yielding an IGT adjustment factor for each  
2 GPP system.

3 (D) The IGT adjustment factor calculated in subparagraph (C)  
4 for each GPP system shall be multiplied by the positive or negative  
5 amount in subparagraph (B), and multiplied by the allocation  
6 percentage determined for the GPP system in paragraph (4) of  
7 subdivision (c), yielding the amount to be added or subtracted from  
8 the initial transfer amount determined in paragraph (3) for the  
9 applicable GPP system.

10 (E) The transfer amount to be paid by each GPP system with  
11 respect to the applicable quarterly interim payment, interim yearend  
12 payment, or final reconciliation payment, shall equal the initial  
13 transfer amount determined in paragraph (3) as adjusted by the  
14 amount determined in subparagraph (D).

15 (5) Upon the determination of the redistributed amounts  
16 described in paragraph (2) of subdivision (d) for the final  
17 reconciliation payment, the department shall, with respect to each  
18 GPP system that exceeded its respective threshold, determine the  
19 associated intergovernmental transfer amount equal to the  
20 nonfederal share that is necessary to draw down the additional  
21 payment, and shall include this amount in the GPP system's  
22 transfer amount.

23 (h) The department may initiate audits of GPP systems' data  
24 submissions and reports, and may request supporting  
25 documentation. Any audits conducted by the department shall be  
26 complete within 22 months of the end of the applicable GPP  
27 program year to allow for the appropriate finalization of payments  
28 to the participating GPP system, but subject to recoupment if it is  
29 later determined that federal financial participation is not available  
30 for any portion of the applicable payments.

31 (i) If the department determines, during the course of the  
32 demonstration term and in consultation with participating GPP  
33 systems, that the Global Payment Program should be terminated  
34 for subsequent years, the department shall terminate the Global  
35 Payment Program by notifying the federal Centers for Medicare  
36 and Medicaid Services in accordance with the timeframes specified  
37 in the Special Terms and Conditions. In the event of this type of  
38 termination, the department shall issue a declaration terminating  
39 the Global Payment Program and shall work with the federal  
40 Centers for Medicare and Medicaid Services to finalize all

1 remaining payments under the Global Payment Program.  
2 Subsequent to the effective date for any termination accomplished  
3 pursuant to this subdivision, the designated public hospitals that  
4 participated in the Global Payment Program shall claim and receive  
5 disproportionate share hospital payments, if eligible, as described  
6 in subparagraph (D) of paragraph (4) of subdivision (b) of Section  
7 14184.30, but only to the extent that any necessary federal  
8 approvals are obtained and federal financial participation is  
9 available and not otherwise jeopardized.

10 ~~(j) The department shall conduct, or arrange for, the two~~  
11 ~~evaluations of the Global Payment Program methodology required~~  
12 ~~pursuant to the Special Terms and Conditions.~~

13 14184.50. (a) (1) The department shall establish and operate  
14 the Public Hospital Redesign and Incentives in Medi-Cal (PRIME)  
15 program to build upon the foundational delivery system  
16 transformation work, expansion of coverage, and increased access  
17 to coordinated primary care achieved through the prior California's  
18 "Bridge to Reform" Medicaid demonstration project. The activities  
19 supported by the PRIME program are designed to accelerate efforts  
20 by participating PRIME entities to change care delivery to  
21 maximize health care value and strengthen their ability to  
22 successfully perform under risk-based alternative payment models  
23 in the long term and consistent with the demonstration's goals.  
24 Participating PRIME entities consist of two types of entities:  
25 designated public hospital systems and district and municipal  
26 public hospitals.

27 (2) Participating PRIME entities shall be eligible to earn  
28 incentive payments by undertaking projects set forth in the Special  
29 Terms and Conditions, for which there are required project metrics  
30 and targets. Additionally, a minimum number of required projects  
31 is specified for each designated public hospital system.

32 (3) The department shall provide participating PRIME entities  
33 the opportunity to earn the maximum amount of funds authorized  
34 for the PRIME program under the demonstration project. Under  
35 the demonstration project, funding is available for the designated  
36 public hospital systems and the district and municipal public  
37 hospitals through two separate pools. Subject to the Special Terms  
38 and Conditions, up to one billion four hundred million dollars  
39 (\$1,400,000,000) is authorized annually for the designated public  
40 hospital systems pool, and up to two hundred million dollars

1 (\$200,000,000) is authorized annually for the district and municipal  
2 public hospitals pool, during the first three years of the  
3 demonstration project, with reductions to these amounts in the  
4 fourth and fifth years. Except in those limited instances specifically  
5 authorized by the Special Terms and Conditions, the funding that  
6 is authorized for each respective pool shall only be available to  
7 participating PRIME entities within that pool.

8 (4) PRIME payments shall be incentive payments, and are not  
9 payments for services otherwise reimbursable under the Medi-Cal  
10 program, nor direct reimbursement for expenditures incurred by  
11 participating PRIME entities in implementing reforms. PRIME  
12 incentive payments shall not offset payment amounts otherwise  
13 payable by the Medi-Cal program, or to and by Medi-Cal managed  
14 care plans for services provided to Medi-Cal beneficiaries, or  
15 otherwise supplant provider payments payable to PRIME entities.

16 (b) For purposes of this article, the following definitions shall  
17 apply:

18 (1) “Alternative payment methodology” or “APM” means a  
19 payment made from a Medi-Cal managed care plan to a designated  
20 public hospital system for services covered for a beneficiary  
21 assigned to a designated public hospital system that meets the  
22 conditions set forth in the Special Terms and Conditions and  
23 approved by the department, as applicable.

24 (2) “Designated public hospital system” means a designated  
25 public hospital, as listed in the Special Terms and Conditions, and  
26 its affiliated governmental providers and contracted governmental  
27 and nongovernmental entities that constitute a system with an  
28 approved project plan under the PRIME program. A single  
29 designated public hospital system may include multiple designated  
30 public hospitals under common government ownership.

31 (3) “District and municipal public hospitals” means those  
32 nondesignated public hospitals, as listed in the Special Terms and  
33 Conditions, that have an approved project plan under the PRIME  
34 program.

35 (4) “Participating PRIME entity” means a designated public  
36 hospital system or district and municipal public hospital  
37 participating in the PRIME program.

38 (5) “PRIME program year” means the state fiscal year beginning  
39 on July 1 and ending on June 30 during which the PRIME program  
40 is authorized, except that the first PRIME program year shall

1 commence on January 1, 2016, and, as applicable, means each  
2 state fiscal year thereafter through the 2019–20 state fiscal year,  
3 and any years or partial years during which the PRIME program  
4 is authorized under an extension or successor to the demonstration.

5 (c) (1) Within 30 days following federal approval of the  
6 protocols setting forth the PRIME projects, metrics, and funding  
7 mechanics, each participating PRIME entity shall submit a  
8 five-year PRIME project plan containing the specific elements  
9 required in the Special Terms and Conditions. The department  
10 shall review all five-year PRIME project plans and take action  
11 within 60 days to approve or disapprove each five-year PRIME  
12 project plan.

13 (2) Participating PRIME entities may modify projects or metrics  
14 in their five-year PRIME project plan, to the extent authorized  
15 under the demonstration project and approved by the department.

16 (d) (1) Each participating PRIME entity shall submit reports  
17 to the department twice a year demonstrating progress toward  
18 required metric targets. A standardized report form shall be  
19 developed jointly by the department and participating PRIME  
20 entities for this purpose. The mid-year report shall be due March  
21 31 of each PRIME program year, except that, for the 2015–16  
22 project year only, the submission of an acceptable five-year PRIME  
23 project plan in accordance with the Special Terms and Conditions  
24 shall constitute the submission of the mid-year report. The yearend  
25 report shall be due September 30 following each PRIME program  
26 year.

27 (2) The submission of the project reports pursuant to paragraph  
28 (1) shall constitute a request for payment. Amounts payable to the  
29 participating PRIME entity shall be determined based on the  
30 achievement of the metric targets included in the mid-year report  
31 and yearend report, as applicable.

32 (3) Within 14 days following the submission of the mid-year  
33 and yearend reports, the department shall confirm the amounts  
34 payable to participating PRIME entities and shall issue requests  
35 to each participating PRIME entity for the intergovernmental  
36 transfer amounts necessary to draw down the federal funding for  
37 the applicable PRIME incentive payment to that entity.

38 (A) Any intergovernmental transfers provided for purposes of  
39 this section shall be deposited in the Public Hospital Investment,

1 Improvement, and Incentive Fund established pursuant to Section  
2 14182.4 and retained pursuant to paragraph (1) of subdivision (f).

3 (B) Participating PRIME entities or their affiliated governmental  
4 agencies or entities shall make the intergovernmental transfer to  
5 the department within seven days of receiving the department's  
6 request. In the event federal approval for a payment is not obtained,  
7 the department shall return the intergovernmental transfer funds  
8 to the transferring entity within 14 days.

9 (C) PRIME payments to a participating PRIME entity shall be  
10 conditioned upon the department's receipt of the intergovernmental  
11 transfer amount from the applicable entity. If the intergovernmental  
12 transfer is made within the appropriate timeframe, the incentive  
13 payment shall be disbursed in accordance with paragraph (4),  
14 otherwise the payment shall be disbursed within 14 days of when  
15 the intergovernmental transfer is provided.

16 (4) Subject to paragraph (3), and except with respect to the  
17 2015–16 project year, amounts payable based on the mid-year  
18 reports shall be paid no later than April 30, and amounts payable  
19 based on the yearend report shall be paid no later than October 31.  
20 In the event of insufficient or misreported data, these payment  
21 deadlines may be extended up to 60 days to allow time for the  
22 reports to be adequately corrected for approval for payment. If  
23 corrected data is not submitted to enable payment to be made  
24 within the extended timeframe, the participating entity shall not  
25 receive PRIME payment for the period in question. For the  
26 2015–16 project year only, 25 percent of the annual allocation for  
27 the participating PRIME entity shall be payable within 14 days  
28 following the approval of the five-year PRIME project plan. The  
29 remaining 75 percent of the participating PRIME entity's annual  
30 allocation shall be available following the 2015–16 yearend report,  
31 subject to the requirements in paragraph (2) of subdivision (e).

32 (5) The department shall draw down the federal funding and  
33 pay both the nonfederal and federal shares of the incentive payment  
34 to the participating PRIME entity, to the extent federal financial  
35 participation is available.

36 (e) The amount of PRIME incentive payments payable to a  
37 participating PRIME entity shall be determined as follows:

38 (1) The department shall allocate the full amount of annual  
39 funding authorized under the PRIME project pools across all  
40 domains, projects, and metrics undertaken in the manner set forth

1 in the Special Terms and Conditions. Separate allocations shall be  
2 determined for the designated public hospital system pool and the  
3 district and municipal hospital pool. The allocations shall determine  
4 the aggregate annual amount of funding that may be earned for  
5 each domain, project, and metric for all participating PRIME  
6 entities within the appropriate pool.

7 (A) The department shall allocate the aggregate annual amounts  
8 determined for each project and metric under the designated public  
9 hospital system pool among participating designated public hospital  
10 systems through an allocation methodology that takes into account  
11 available system-specific data, primarily based on the unique  
12 number of Medi-Cal beneficiaries treated, consistent with the  
13 Special Terms and Conditions. For the 2015–16 project year only,  
14 the approval of the five-year PRIME project plans for designated  
15 public hospital systems will be considered an appropriate metric  
16 target and will equal up to 25 percent of a designated public  
17 hospital system’s annual allocation for that year.

18 (B) The department shall allocate the aggregate annual amounts  
19 determined for each project and metric under the district and  
20 municipal public hospital system pool among participating district  
21 and municipal public hospital systems through an allocation  
22 methodology that takes into account available system-specific data  
23 that includes Medi-Cal and uninsured care, the number of projects  
24 being undertaken, and a baseline floor funding amount, consistent  
25 with the Special Terms and Conditions. For the 2015–16 project  
26 year only, the approval of the five-year PRIME project plans for  
27 district and municipal public hospital systems will be considered  
28 an appropriate metric target and will equal up to 25 percent of a  
29 district and municipal public hospital system’s annual allocation  
30 for that year.

31 (2) Amounts payable to each participating PRIME entity shall  
32 be determined using the methodology described in the Special  
33 Terms and Conditions, based on the participating PRIME entity’s  
34 progress toward and achievement of the established metrics and  
35 targets, as reflected in the mid-year and yearend reports submitted  
36 pursuant to paragraph (1) of subdivision (d).

37 (A) Each participating PRIME entity shall be individually  
38 responsible for progress toward and achievement of project specific  
39 metric targets during the reporting period.

1 (B) The amounts allocated pursuant to subparagraphs (A) and  
2 (B) of paragraph (1) shall represent the amounts the designated  
3 public hospital system or district and municipal public hospital,  
4 as applicable, may earn through achievement of a designated  
5 project metric target for the applicable year, prior to any  
6 redistribution.

7 (C) Participating PRIME entities shall earn reduced payment  
8 for partial achievement at both the mid-year and yearend reports,  
9 as described in the Special Terms and Conditions.

10 (3) If, at the end of a project year, a project metric target is not  
11 fully met by a participating PRIME entity and that entity is not  
12 able to fully claim funds that otherwise would have been earned  
13 for meeting the metric target, participating PRIME entities shall  
14 have the opportunity to earn unclaimed funds under the  
15 redistribution methodology established under the Special Terms  
16 and Conditions. Amounts earned by a participating PRIME entity  
17 through redistribution shall be payable in addition to the amounts  
18 earned pursuant to paragraph (2).

19 (f) The nonfederal share of payments under the PRIME program  
20 shall consist of voluntary intergovernmental transfers of funds  
21 provided by designated public hospitals or affiliated governmental  
22 agencies or entities, or district and municipal public hospitals or  
23 affiliated governmental agencies or entities, in accordance with  
24 this section.

25 (1) The Public Hospital Investment, Improvement, and Incentive  
26 Fund, established in the State Treasury pursuant to Section 14182.4,  
27 shall be retained during the demonstration term for purposes of  
28 making PRIME payments to participating PRIME entities.  
29 Notwithstanding Section 13340 of the Government Code, moneys  
30 deposited in the Public Hospital Investment, Improvement, and  
31 Incentive Fund shall be continuously appropriated, without regard  
32 to fiscal years, to the department for the purposes specified in this  
33 section. All funds derived pursuant to this section shall be deposited  
34 in the State Treasury to the credit of the Public Hospital Investment,  
35 Improvement, and Incentive Fund.

36 (2) The Public Hospital Investment, Improvement, and Incentive  
37 Fund shall consist of moneys that a designated public hospital or  
38 affiliated governmental agency or entity, or a district and municipal  
39 public hospital-affiliated governmental agency or entity, elects to  
40 transfer to the department for deposit into the fund as a condition

1 of participation in the PRIME program, to the extent permitted  
2 under Section 433.51 of Title 42 of the Code of Federal  
3 Regulations, the Special Terms and Conditions, and any other  
4 applicable federal Medicaid laws. Except as provided in paragraph  
5 (3), moneys derived from these intergovernmental transfers in the  
6 Public Hospital Investment, Improvement, and Incentive Fund  
7 shall be used as the nonfederal share of PRIME program payments  
8 authorized under the demonstration project. Any intergovernmental  
9 transfer of funds provided for purposes of the PRIME program  
10 shall be made as specified in this section. Upon providing any  
11 intergovernmental transfer of funds, each transferring entity shall  
12 certify that the transferred funds qualify for federal financial  
13 participation pursuant to applicable federal Medicaid laws and the  
14 Special Terms and Conditions, and in the form and manner as  
15 required by the department.

16 (3) The department shall claim federal financial participation  
17 for PRIME incentive payments using moneys derived from  
18 intergovernmental transfers made pursuant to this section and  
19 deposited in the Public Hospital Investment, Improvement, and  
20 Incentive Fund to the full extent permitted by law. The moneys  
21 disbursed from the fund, and all associated federal financial  
22 participation, shall be distributed only to participating PRIME  
23 entities and the governmental agencies or entities to which they  
24 are affiliated, as applicable. No moneys derived from  
25 intergovernmental transfers on behalf of district and municipal  
26 public hospitals, including any associated federal financial  
27 participation, shall be used to fund PRIME payments to designated  
28 public hospital systems, and likewise, no moneys derived from  
29 intergovernmental transfers provided by designated public hospitals  
30 or their affiliated governmental agencies or entities, including any  
31 associated federal financial participation, shall be used to fund  
32 PRIME payments to district and municipal public hospitals. In the  
33 event federal financial participation is not available with respect  
34 to a payment under this section that results in a recoupment of  
35 funds from one or more participating PRIME entities, the  
36 department shall return any intergovernmental transfer fund  
37 amounts associated with the payment for which federal financial  
38 participation is not available to the applicable transferring entities  
39 within 14 days from the date of the associated recoupment or other  
40 determination, as applicable.

1 (4) This section shall not be construed to require a designated  
2 public hospital, a district and municipal public hospital, or any  
3 affiliated governmental agency or entity to participate in the  
4 PRIME program. As a condition of participation in the PRIME  
5 program, each designated public hospital or affiliated governmental  
6 agency or entity, and each district and municipal public  
7 hospital-affiliated governmental agency or entity agrees to provide  
8 intergovernmental transfers of funds necessary to meet the  
9 nonfederal share obligation for any PRIME payments made  
10 pursuant to this section and the Special Terms and Conditions.  
11 Any intergovernmental transfers made pursuant to this section  
12 shall be considered voluntary for purposes of all federal laws.

13 ~~(g) The department shall conduct, or arrange to have conducted,~~  
14 ~~the evaluation of the PRIME program required by the Special~~  
15 ~~Terms and Conditions.~~

16 (h)

17 (g) (1) PRIME incentive payments are intended to support  
18 designated public hospital systems in their efforts to change care  
19 delivery and strengthen those systems' ability to participate under  
20 an alternate payment methodology (APM). APMs shift some level  
21 of risk to participating designated public hospital systems through  
22 capitation and other risk-sharing agreements. Contracts entered  
23 into, issued, or renewed between managed care plans and  
24 participating designated public hospital systems shall include  
25 language requiring the designated public hospital system to report  
26 on metrics to meet quality benchmark goals and to ensure improved  
27 patient outcomes, consistent with the Special Terms and  
28 Conditions.

29 (2) In order to promote and increase the level of value-based  
30 payments made to designated public hospital systems during the  
31 course of the demonstration term, the department shall issue an  
32 all-plan letter to Medi-Cal managed care plans that shall promote  
33 and encourage positive system transformation. The department  
34 shall issue an activities plan supporting designated public hospital  
35 system efforts to meet those aggregate APM targets and  
36 requirements as provided in the Special Terms and Conditions.

37 (3) Designated public hospital systems shall contract with at  
38 least one Medi-Cal managed care plan in the service area where  
39 they operate using an APM methodology by January 1, 2018. If a  
40 designated public hospital system is unable to meet this

1 requirement and can demonstrate that it has made a good faith  
2 effort to contract with a Medi-Cal managed care plan in the service  
3 area that it operates in or a gap in contracting period occurs, the  
4 department has the discretion to waive this requirement.

5 (4) Designated public hospital systems and Medi-Cal managed  
6 care plans shall seek to strengthen their data and information  
7 sharing for purposes of identifying and treating applicable  
8 beneficiaries, including the timely sharing and reporting of  
9 beneficiary data, assessment, and treatment information. Consistent  
10 with the Special Terms and Conditions and the goals of the  
11 demonstration project, and notwithstanding any other state law,  
12 the department shall provide guidelines, state-level infrastructure,  
13 and other mechanisms to support this data and information sharing.

14 ~~14184.60. (a) (1) The department shall establish and operate~~  
15 ~~the Whole Person Care pilot program as authorized under the~~  
16 ~~demonstration project to allow for the development of WPC pilots~~  
17 ~~focused on target populations of high-risk, high-utilizing Medi-Cal~~  
18 ~~beneficiaries in local geographic areas. The overarching goal of~~  
19 ~~the program is the coordination of health, behavioral health, and~~  
20 ~~social services, as applicable, in a patient-centered manner to~~  
21 ~~improve beneficiary health and well-being through a more efficient~~  
22 ~~and effective use of resources.~~

23 ~~(2) The Whole Person Care (WPC) pilots shall provide an option~~  
24 ~~to a county, a city and county, a health or hospital authority, or a~~  
25 ~~consortium of any of the above entities serving a county or region~~  
26 ~~consisting of more than one county, to receive support to integrate~~  
27 ~~care for particularly vulnerable Medi-Cal beneficiaries who have~~  
28 ~~been identified as high users of multiple systems and who continue~~  
29 ~~to have or are at risk of poor health outcomes. Through~~  
30 ~~collaborative leadership and systematic coordination among public~~  
31 ~~and private entities, pilot entities will identify common~~  
32 ~~beneficiaries, share data between systems, coordinate care in real~~  
33 ~~time, and evaluate individual and population progress in order to~~  
34 ~~meet the goal of providing comprehensive coordinated care for~~  
35 ~~the beneficiary resulting in better health outcomes.~~

36 ~~(3) Investments in the localized pilots will build and strengthen~~  
37 ~~relationships and systems infrastructure and will improve~~  
38 ~~collaboration among WPC lead entities and WPC participating~~  
39 ~~entities. The results of the WPC pilots will provide learnings for~~  
40 ~~potential future local efforts beyond the term of the demonstration.~~

1 ~~(4) WPC pilots shall include specific strategies to increase~~  
2 ~~integration among local governmental agencies, health plans,~~  
3 ~~providers, and other entities that serve high-risk, high-utilizing~~  
4 ~~beneficiaries; increase coordination and appropriate access to care~~  
5 ~~for the most vulnerable Medi-Cal beneficiaries; reduce~~  
6 ~~inappropriate inpatient and emergency room utilization; improve~~  
7 ~~data collection and sharing among local entities; improve health~~  
8 ~~outcomes for the WPC target population; and may include other~~  
9 ~~strategies to increase access to housing and supportive services.~~

10 ~~(5) WPC pilots shall be approved by the department through~~  
11 ~~the process outlined in the Special Terms and Conditions.~~

12 ~~(6) Receipt of Whole Person Care services is voluntary.~~  
13 ~~Individuals receiving these services shall agree to participate in~~  
14 ~~the WPC pilot, and may opt out at any time.~~

15 ~~(b) For purposes of this article, the following definitions shall~~  
16 ~~apply:~~

17 ~~(1) “Medi-Cal managed care plan” means an organization or~~  
18 ~~entity that enters into a contract with the department pursuant to~~  
19 ~~Article 2.7 (commencing with Section 14087.3), Article 2.8~~  
20 ~~(commencing with Section 14087.5), Article 2.81 (commencing~~  
21 ~~with Section 14087.96), Article 2.91 (commencing with Section~~  
22 ~~14089), or Chapter 8 (commencing with Section 14200).~~

23 ~~(2) “WPC community partner” means an entity or organization~~  
24 ~~identified as participating in the WPC pilot that has significant~~  
25 ~~experience serving the target population within the pilot’s~~  
26 ~~geographic area, including physician groups, community clinics,~~  
27 ~~hospitals, and community-based organizations.~~

28 ~~(3) “WPC lead entity” means the entity designated for a WPC~~  
29 ~~pilot to coordinate the Whole Person Care pilot and to be the single~~  
30 ~~point of contact for the department. WPC lead entities may be a~~  
31 ~~county, a city and county, a health or hospital authority, a~~  
32 ~~designated public hospital, a district and municipal public hospital,~~  
33 ~~or an agency or department thereof, a federally recognized tribe,~~  
34 ~~a tribal health program operated under a Public Law 93-638~~  
35 ~~contract with the federal Indian Health Service, or a consortium~~  
36 ~~of any of these entities.~~

37 ~~(4) “WPC participating entity” means those entities identified~~  
38 ~~as participating in the WPC pilot, other than the WPC lead entity,~~  
39 ~~including other local governmental entities, agencies within local~~

1 governmental entities, Medi-Cal managed care plans, and WPC  
2 community partners.

3 (5) “WPC target population” means the population or  
4 populations identified by a WPC pilot through a collaborative data  
5 approach across partnering entities that identifies common  
6 Medi-Cal high-risk, high-utilizing beneficiaries who frequently  
7 access urgent and emergency services, including across multiple  
8 systems. At the discretion of the WPC lead entity, and in  
9 accordance with guidance as may be issued by the department  
10 during the application process and approved by the department,  
11 the WPC target population may include individuals who are not  
12 Medi-Cal patients, subject to the funding restrictions in the Special  
13 Terms and Conditions regarding the availability of federal financial  
14 participation for services provided to these individuals.

15 (e) (1) WPC pilots shall have flexibility to develop financial  
16 and administrative arrangements to encourage collaboration with  
17 regard to pilot activities subject to the Special Terms and  
18 Conditions, the provisions of any WPC pilot agreements with the  
19 department, and the applicable provisions of state and federal law,  
20 and any other guidance issued by the department.

21 (2) The WPC lead entity shall be responsible for operating the  
22 WPC pilot, conducting ongoing monitoring of WPC participating  
23 entities, arranging for the required reporting, ensuring an  
24 appropriate financial structure is in place, and identifying and  
25 securing a permissible source of the nonfederal share for WPC  
26 pilot payments.

27 (3) Each WPC pilot shall include, at a minimum, all of the  
28 following entities as WPC participating entities in addition to the  
29 WPC lead entity. If a WPC lead entity cannot reach an agreement  
30 with a required participant, the WPC lead entity may request an  
31 exception to this requirement from the department.

32 (A) At least one Medi-Cal managed care plan operating in the  
33 geographic area of the WPC pilot to work in partnership with the  
34 WPC lead entity when implementing the pilot specific to Medi-Cal  
35 managed care beneficiaries.

36 (B) The health services agency or agencies or department or  
37 departments for the geographic region where the WPC pilot  
38 operates, or any other public entity operating in that capacity for  
39 the county or city and county.

1 ~~(C) The local entities, agencies, or departments responsible for~~  
2 ~~specialty mental health services for the geographic area where the~~  
3 ~~WPC pilot operates.~~

4 ~~(D) At least one other public agency or department, which may~~  
5 ~~include, but is not limited to, county alcohol and substance use~~  
6 ~~disorder programs, human services agencies, public health~~  
7 ~~departments, criminal justice or probation entities, and housing~~  
8 ~~authorities, regardless of how many of these fall under the same~~  
9 ~~agency head within the geographic area where the WPC pilot~~  
10 ~~operates.~~

11 ~~(E) At least two other community partners serving the target~~  
12 ~~population within the applicable geographic area.~~

13 ~~(4) The department shall enter into a pilot agreement with each~~  
14 ~~WPC lead entity approved for participation in the WPC pilot~~  
15 ~~program. The information and terms of the approved WPC pilot~~  
16 ~~application shall become the pilot agreement between the~~  
17 ~~department and the WPC lead entity submitting the application~~  
18 ~~and shall set forth, at a minimum, the amount of funding that will~~  
19 ~~be available to the WPC pilot and the conditions under which~~  
20 ~~payments will be made, how payments may vary or under which~~  
21 ~~the pilot program may be terminated or restricted. The pilot~~  
22 ~~agreement shall include a data sharing agreement that is sufficient~~  
23 ~~in scope for purposes of the WPC pilot, and an agreement regarding~~  
24 ~~the provision of the nonfederal share. The pilot agreement shall~~  
25 ~~specify reporting of universal and variant metrics that shall be~~  
26 ~~reported by the pilot on a timeline specified by the department and~~  
27 ~~projected performance on them. The pilot agreement may include~~  
28 ~~additional components and requirements as issued by the~~  
29 ~~department during the application process. Modifications to the~~  
30 ~~WPC pilot activities and deliverables may be made on an annual~~  
31 ~~basis in furtherance of WPC pilot objectives, to incorporate~~  
32 ~~learnings from the operation of the WPC pilot as approved by the~~  
33 ~~department.~~

34 ~~(5) Notwithstanding any other law, including, but not limited~~  
35 ~~to, Section 5328 of this code, and Sections 11812 and 11845.5 of~~  
36 ~~the Health and Safety Code, the sharing of health information,~~  
37 ~~records, and other data with and among WPC lead entities and~~  
38 ~~WPC participating entities shall be permitted to the extent~~  
39 ~~necessary for the activities and purposes set forth in this section.~~  
40 ~~This provision shall also apply to the sharing of health information,~~

1 records, and other data with and among prospective WPC lead  
2 entities and WPC participating entities in the process of identifying  
3 a proposed target population and preparing an application for a  
4 WPC pilot.

5 (d) WPC pilots may target the focus of their pilot on individuals  
6 at risk of or experiencing homelessness who have a demonstrated  
7 medical need, including behavioral health needs, for housing or  
8 supportive services, subject to the restrictions on funding contained  
9 in the Special Terms and Conditions. In these instances, WPC  
10 participating entities may include local housing authorities, local  
11 continuum of care (CoCs) programs, community-based  
12 organizations, and others serving the homeless population as  
13 entities collaborating and participating in the WPC pilot. WPC  
14 pilot housing interventions may include the following:

15 (1) Tenancy-based care management services. For purposes of  
16 this section, “tenancy-based care management services” means  
17 supports to assist the target population in locating and maintaining  
18 medically necessary housing. These services may include the  
19 following:

20 (A) Individual housing transition services, such as individual  
21 outreach and assessments.

22 (B) Individual housing and tenancy-sustaining services,  
23 including tenant and landlord education and tenant coaching.

24 (C) Housing-related collaborative activities, such as services  
25 that support collaborative efforts across public agencies and the  
26 private sector that assist WPC participating entities in identifying  
27 and securing housing for the target population.

28 (2) Countywide housing pools.

29 (A) WPC pilots may establish a countywide housing pool  
30 (housing pool) that will directly provide needed support for  
31 medically necessary housing services, with the goal of improving  
32 access to housing and reducing churn in the Medi-Cal population.

33 (B) The housing pool may be funded through WPC pilot  
34 payments or direct contributions from community entities, or from  
35 State or local government. WPC pilot payments for the operation  
36 of a housing pool shall be subject to the restrictions in the Special  
37 Terms and Conditions and other applicable provisions of federal  
38 law. Housing pool funds that are not WPC pilot payments shall  
39 be maintained separately from WPC pilot payments, and may be  
40 allocated to fund support for long-term housing, including rental

1 housing subsidies. The housing pool may leverage local resources  
2 to increase access to subsidized housing units. The housing pool  
3 may also incorporate a financing component to reallocate or  
4 reinvest a portion of the savings from the reduced utilization of  
5 health care services into the housing pool. As applicable to an  
6 approved WPC pilot, WPC investments in housing units or housing  
7 subsidies, including any payment for room and board, shall not be  
8 eligible for federal financial participation, unless recognized as  
9 reimbursable under federal Centers for Medicare and Medicaid  
10 Services policy.

11 (e) ~~(1)~~ Payments to WPC pilots shall be disbursed twice a year  
12 to the WPC lead entity following the submission of the reports  
13 required pursuant to subdivision (f), to the extent all applicable  
14 requirements are met. The amount of funding for each WPC pilot  
15 and the timing of the payments shall be specified by the department  
16 upon the department approving a WPC application, consistent with  
17 the Special Terms and Conditions. During the 2016 calendar year  
18 only, payments shall be available for the planning, development,  
19 and submission of a successful WPC pilot application, including  
20 the submission of deliverables as set forth in the WPC pilot  
21 application and the WPC pilot annual report, to the extent  
22 authorized under the demonstration project and approved by the  
23 department.

24 ~~(2)~~ The department shall issue a WPC pilot application and  
25 selection criteria consistent with the Special Terms and Conditions,  
26 under which applicants shall demonstrate the ability to meet the  
27 goals of the WPC pilots as outlined in this section and the Special  
28 Terms and Conditions. The department shall approve applicants  
29 that meet the WPC pilot selection criteria established by the  
30 department, and shall allocate available funding to those approved  
31 WPC pilots up to the full amount of federal financial participation  
32 authorized under the demonstration project for WPC pilots during  
33 each calendar year from 2016 to 2020, inclusive, to the extent there  
34 are sufficient numbers of applications that meet the applicable  
35 criteria. In the event that otherwise unallocated federal financial  
36 participation is available after the initial award of WPC pilots, the  
37 department may solicit applications for the remaining available  
38 funds from WPC lead entities of approved WPC pilots or from  
39 additional applicants, including applicants not approved during  
40 the initial application process.

1     ~~(3) In the event a WPC pilot does not receive its full annual~~  
2 ~~payment amount, the WPC lead entity may request that the~~  
3 ~~remaining funds be carried forward into the following calendar~~  
4 ~~year, or may amend the scope of the WPC pilot, including, services,~~  
5 ~~activities, or enrollment, for which this unallocated funding may~~  
6 ~~be made available, subject to the Special Terms and Conditions~~  
7 ~~and approval by the department. If the department denies a WPC~~  
8 ~~lead entity request to carry forward unused funds and funds are~~  
9 ~~not disbursed in this manner, the department may make the~~  
10 ~~unexpended funds available for other WPC pilots or additional~~  
11 ~~applicants not approved during the initial application process, to~~  
12 ~~the extent authorized in the Special Terms and Conditions.~~

13     ~~(4) Payments to the WPC pilot are intended to support~~  
14 ~~infrastructure to integrate services among local entities that serve~~  
15 ~~the WPC target population, to support the availability of services~~  
16 ~~not otherwise covered or directly reimbursed by Medi-Cal to~~  
17 ~~improve care for the WPC target population, and to foster other~~  
18 ~~strategies to improve integration, reduce unnecessary utilization~~  
19 ~~of health care services, and improve health outcomes. WPC pilot~~  
20 ~~payments shall not be considered direct reimbursement for~~  
21 ~~expenditures incurred by WPC lead entities or WPC participating~~  
22 ~~entities in implementing these strategies or reforms. WPC pilot~~  
23 ~~payments shall not be considered payments for services otherwise~~  
24 ~~reimbursable under the Medi-Cal program, and shall not offset or~~  
25 ~~otherwise supplant payment amounts otherwise payable by the~~  
26 ~~Medi-Cal program, including payments to and by Medi-Cal~~  
27 ~~managed care plans, for Medi-Cal covered services.~~

28     ~~(5) WPC pilots are not intended as, and shall not be construed~~  
29 ~~to constitute, health care coverage for individuals receiving~~  
30 ~~services, and WPC pilots may determine the scope, type, and extent~~  
31 ~~to which services are available, to the extent consistent with the~~  
32 ~~Special Terms and Conditions. For purposes of the WPC pilots,~~  
33 ~~WPC lead entities shall be exempt from the provisions of Chapter~~  
34 ~~2.2 (commencing with Section 1340) of Division 2 of the Health~~  
35 ~~and Safety Code, and shall not be considered Medi-Cal managed~~  
36 ~~care health plans subject to the requirements applicable to the~~  
37 ~~two-plan model and geographic managed care plans, as contained~~  
38 ~~in Article 2.7 (commencing with Section 14087.3), Article 2.81~~  
39 ~~(commencing with Section 14087.96), and Article 2.91~~  
40 ~~(commencing with Section 14089) of Chapter 7 of Part 3 and the~~

1 corresponding regulations, and shall not be considered prepaid  
2 health plans, as defined in Section 14251.

3 (f) ~~WPC lead entities shall submit mid-year and annual reports~~  
4 ~~to the department, in accordance with the schedules and guidelines~~  
5 ~~established by the department and consistent with the Special~~  
6 ~~Terms and Conditions. No later than 60 days after submission, the~~  
7 ~~department shall determine the extent to which pilot requirements~~  
8 ~~were met and the associated interim or annual payment due to the~~  
9 ~~WPC pilot.~~

10 (g) ~~The department, in collaboration with WPC lead entities,~~  
11 ~~shall facilitate learning collaboratives to allow WPC pilots to share~~  
12 ~~information and lessons learned from the operation of the WPC~~  
13 ~~pilots, best practices with regard to specific beneficiary populations,~~  
14 ~~and strategies for improving coordination and data sharing among~~  
15 ~~WPC pilot entities.~~

16 (h) ~~The nonfederal share of any payments under the WPC pilot~~  
17 ~~program shall consist of voluntary intergovernmental transfers of~~  
18 ~~funds provided by participating governmental agencies or entities,~~  
19 ~~in accordance with this section and the terms of the pilot agreement.~~

20 (1) ~~The Whole Person Care Pilot Special Fund is hereby~~  
21 ~~established in the State Treasury. Notwithstanding Section 13340~~  
22 ~~of the Government Code, moneys deposited in the Whole Person~~  
23 ~~Care Pilot Special Fund pursuant to this section shall be~~  
24 ~~continuously appropriated, without regard to fiscal years, to the~~  
25 ~~department for the purposes specified in this section. All funds~~  
26 ~~derived pursuant to this section shall be deposited in the State~~  
27 ~~Treasury to the credit of the Whole Person Care Pilot Special Fund.~~

28 (2) ~~The Whole Person Care Pilot Special Fund shall consist of~~  
29 ~~moneys that a participating governmental agency or entity elects~~  
30 ~~to transfer to the department into the fund as a condition of~~  
31 ~~participation in the WPC pilot program, to the extent permitted~~  
32 ~~under Section 433.51 of Title 42 of the Code of Federal~~  
33 ~~Regulations, the Special Terms and Conditions, and any other~~  
34 ~~applicable federal Medicaid laws. Except as provided in paragraph~~  
35 ~~(3), moneys derived from these intergovernmental transfers in the~~  
36 ~~Whole Person Care Pilot Special Fund shall be used as the~~  
37 ~~nonfederal share of Whole Person Care pilot payments authorized~~  
38 ~~under the demonstration project. Any intergovernmental transfer~~  
39 ~~of funds provided for purposes of the WPC pilot program shall be~~  
40 ~~made as specified in this section. Upon providing any~~

1 intergovernmental transfer of funds, each transferring entity shall  
2 certify that the transferred funds qualify for federal financial  
3 participation pursuant to applicable federal Medicaid laws and the  
4 Special Terms and Conditions, and in the form and manner as  
5 required by the department.

6 ~~(3) The department shall claim federal financial participation~~  
7 ~~for WPC pilot payments using moneys derived from~~  
8 ~~intergovernmental transfers made pursuant to this section and~~  
9 ~~deposited in the Whole Person Care Pilot Special Fund to the full~~  
10 ~~extent permitted by law. The moneys disbursed from the fund, and~~  
11 ~~all associated federal financial participation, shall be distributed~~  
12 ~~to WPC lead entities in accordance with paragraph (1) of~~  
13 ~~subdivision (e). In the event federal financial participation is not~~  
14 ~~available with respect to a payment under this section and either~~  
15 ~~is not obtained, or results in a recoupment of funds from one or~~  
16 ~~more WPC lead entities, the department shall return any~~  
17 ~~intergovernmental transfer fund amounts associated with the~~  
18 ~~payment for which federal financial participation is not available~~  
19 ~~to the applicable transferring entities within 14 days from the date~~  
20 ~~of the associated recoupment or other determination, as applicable.~~

21 ~~(4) This section shall not be construed to require any local~~  
22 ~~governmental agency or entity, or any other provider, plan, or~~  
23 ~~similar entity, to participate in the WPC pilot program. As a~~  
24 ~~condition of participation in the WPC pilot program, participating~~  
25 ~~governmental agencies or entities agree to provide~~  
26 ~~intergovernmental transfers of funds necessary to meet the~~  
27 ~~nonfederal share obligation for any Whole Person Care pilot~~  
28 ~~program payment made pursuant to this section and the Special~~  
29 ~~Terms and Conditions. Any intergovernmental transfer of funds~~  
30 ~~made pursuant to this section shall be considered voluntary for~~  
31 ~~purposes of all federal law. No state General Fund moneys shall~~  
32 ~~be used to fund the nonfederal share of any WPC pilot program~~  
33 ~~payment.~~

34 ~~(i) The department shall conduct, or arrange to have conducted,~~  
35 ~~the evaluations of the WPC pilot program required by the Special~~  
36 ~~Terms and Conditions.~~

37 ~~14184.70. (a) (1) The department shall implement the Dental~~  
38 ~~Transformation Initiative, or DTI, in accordance with the Special~~  
39 ~~Terms and Conditions, with the goal of improving the oral health~~  
40 ~~care for Medi-Cal children 0 to 20, inclusive, years of age.~~

1 ~~(2) The DTI is intended to improve the oral health care for~~  
2 ~~Medi-Cal children with a particular focus on increasing the~~  
3 ~~statewide proportion of qualifying children enrolled in the~~  
4 ~~Medi-Cal Dental Program who receive a preventive dental service~~  
5 ~~by 10 percentage points over a five-year period.~~

6 ~~(3) The DTI includes the following four domains as outlined in~~  
7 ~~the Special Terms and Conditions:~~

8 ~~(A) Preventive Services.~~

9 ~~(B) Caries Risk Assessment.~~

10 ~~(C) Continuity of Care.~~

11 ~~(D) Local Dental Pilot Projects.~~

12 ~~(4) Under the DTI, incentive payments within each domain will~~  
13 ~~be available to qualified providers who meet the requirements of~~  
14 ~~the domain.~~

15 ~~(b) For purposes of this article, the following definitions shall~~  
16 ~~apply:~~

17 ~~(1) “DTI incentive payment” means a payment made to a eligible~~  
18 ~~contracted service office location pursuant to the DTI component~~  
19 ~~of the Special Terms and Conditions.~~

20 ~~(2) “DTI pool” means the funding available under the Special~~  
21 ~~Terms and Conditions for the purposes of the DTI program, as~~  
22 ~~described in paragraph (1) of subdivision (c).~~

23 ~~(3) “DTI program year” means a calendar year beginning on~~  
24 ~~January 1 and ending on December 31 during which the DTI~~  
25 ~~component is authorized under the Special Terms and Conditions,~~  
26 ~~beginning with the 2016 calendar year, and, as applicable, each~~  
27 ~~calendar year thereafter through 2020, and any years or partial~~  
28 ~~years during which the DTI is authorized under an extension or~~  
29 ~~successor to the demonstration project.~~

30 ~~(4) “Safety net clinics” means centers or clinics that provide~~  
31 ~~services defined under subdivision (a) or (b) of Section 14132.100~~  
32 ~~that are eligible for DTI incentive payments in accordance with~~  
33 ~~the Special Terms and Conditions. DTI incentive payments~~  
34 ~~received by safety net clinics shall be considered separate and apart~~  
35 ~~from either the Prospective Payment System reimbursement for~~  
36 ~~federally qualified health centers or rural health centers, or~~  
37 ~~Memorandum of Agreement reimbursement for Tribal Health~~  
38 ~~Centers. Each safety net clinic office location shall be considered~~  
39 ~~a dental service office location for purposes of the domains~~  
40 ~~authorized by the Special Terms and Conditions.~~

1     ~~(5) “Service office location” means the business, or pay-to~~  
2 ~~address, in which the provider, which may be an individual,~~  
3 ~~partnership, group, association, corporation, institution, or entity~~  
4 ~~that provides dental services, renders dental services. This may~~  
5 ~~include a provider that participates in either the dental~~  
6 ~~fee-for-service or dental managed care Medi-Cal delivery systems.~~

7     ~~(e) (1) The DTI shall be funded at a maximum of one hundred~~  
8 ~~forty-eight million dollars (\$148,000,000) annually, and for five~~  
9 ~~years totaling a maximum of seven hundred forty million dollars~~  
10 ~~(\$740,000,000), except as provided in the Special Terms and~~  
11 ~~Conditions. To the extent any of the funds associated with the DTI~~  
12 ~~are not fully expended in a given DTI program year, those~~  
13 ~~remaining prior DTI program year funds may be available for DTI~~  
14 ~~payments in subsequent years, notwithstanding the annual limits~~  
15 ~~stated in the Special Terms and Conditions. The department may~~  
16 ~~earn additional demonstration authority, up to a maximum of ten~~  
17 ~~million dollars (\$10,000,000), to be added to the DTI pool for use~~  
18 ~~in paying incentives to qualifying providers under DTI by~~  
19 ~~achieving higher performance improvement, as indicated in the~~  
20 ~~Special Terms and Conditions.~~

21     ~~(2) Providers in either the dental fee-for-service or dental~~  
22 ~~managed care Medi-Cal delivery systems are permitted to~~  
23 ~~participate in the DTI. The department shall make DTI incentive~~  
24 ~~payments directly to eligible contracted service office locations.~~  
25 ~~Incentive payments shall be issued to the service office location~~  
26 ~~based on the services rendered at the location and that service~~  
27 ~~office location’s compliance with the criteria enumerated in the~~  
28 ~~Special Terms and Conditions.~~

29     ~~(3) Incentive payments from the DTI pool are intended to~~  
30 ~~support and reward eligible service office locations for~~  
31 ~~achievements within one or more of the project domains. The~~  
32 ~~incentive payments shall not be considered as a direct~~  
33 ~~reimbursement for dental services under the Medi-Cal State Plan.~~

34     ~~(A) The department may provide DTI incentive payments to~~  
35 ~~eligible service office locations on a semiannual or annual basis,~~  
36 ~~or in a manner otherwise consistent with the Special Terms and~~  
37 ~~Conditions.~~

38     ~~(B) The department shall disburse DTI incentive payments to~~  
39 ~~eligible service office locations that did not previously participate~~  
40 ~~in Medi-Cal prior to the demonstration and that render preventive~~

1 dental services during the demonstration to the extent the service  
2 office location meets or exceeds the goals specified by the  
3 department in accordance with the Special Terms and Conditions.

4 (C) Safety net clinics are eligible for DTI incentive payments  
5 specified in the Special Terms and Conditions. Participating safety  
6 net clinics shall be responsible for submitting data in a manner  
7 specified by the department for receipt of DTI incentive payments.  
8 Each safety net clinic office location shall be considered a dental  
9 service office location for purposes of specified domains outlined  
10 in the Special Terms and Conditions.

11 (D) Dental managed care provider service office locations are  
12 eligible for DTI incentive payments, as specified in the Special  
13 Terms and Conditions, and these payments shall be considered  
14 separate from payment received from a dental managed care plan.

15 (E) Service office locations shall submit all data in a manner  
16 acceptable to the department within one year from the date of  
17 service or by January 31 for the preceding year that the service  
18 was rendered, whichever occurs sooner, to be eligible for DTI  
19 incentive payments associated with that timeframe.

20 (d) The domains of the DTI are as follows:

21 (1) Increase Preventive Services Utilization for Children: this  
22 domain aims to increase the statewide proportion of qualifying  
23 children enrolled in Medi-Cal who receive a preventive dental  
24 service in a given year. The statewide goal is to increase the  
25 utilization among children enrolled in the dental fee-for-service  
26 and dental managed care delivery systems by at least 10 percentage  
27 points by the end of the demonstration.

28 (2) Caries Risk Assessment and Disease Management Pilot:

29 (A) This domain will initially only be available to participating  
30 service office locations in select pilot counties, designated by the  
31 department, as specified in the Special Terms and Conditions.  
32 Participating service office locations shall elect to be approved by  
33 the department to participate in this domain of the DTI program.  
34 To the extent the department determines the pilots to be successful,  
35 the department may seek to implement this domain on a statewide  
36 basis and subject to the availability of funding under the DTI pool  
37 is available for this purpose.

38 (B) Medi-Cal dentists voluntarily participating in this pilot shall  
39 be eligible to receive DTI incentive payments for implementing  
40 preidentified treatment plans for children based upon that child

1 beneficiary’s risk level as determined by the service office location  
 2 via a caries risk assessment, which shall include motivational  
 3 interviewing and use of antimicrobials, as indicated. The  
 4 department shall identify the criteria and preidentified treatment  
 5 plans to correspond with the varying degrees of caries risk, low,  
 6 moderate, and high, while the rendering provider shall develop  
 7 and implement the appropriate treatment plan based on the needs  
 8 of the beneficiary.

9 (C) The department shall identify and select pilot counties  
 10 through an analysis of counties with a high percentage of  
 11 restorative services, a low percentage of preventive services, and  
 12 indication of likely participation by enrolled service office  
 13 locations.

14 (3) Increase continuity of care: A DTI incentive payment shall  
 15 be paid to eligible service office locations that have maintained  
 16 continuity of care through providing examinations for their enrolled  
 17 child beneficiaries under 21 years of age, as specified in the Special  
 18 Terms and Conditions. The department shall begin this effort in  
 19 select counties and shall seek to implement on a statewide basis  
 20 if the pilot is determined to be successful and subject to the  
 21 availability of funding under the DTI pool. If successful, the  
 22 department shall consider an expansion no sooner than nine months  
 23 following the end of the second DTI program year.

24 (4) Local dental pilot projects (LDPPs): LDPPs shall address  
 25 one or more of the three domains identified in paragraph (1), (2),  
 26 or (3) through alternative local dental pilot projects, as authorized  
 27 by the department pursuant to the Special Terms and Conditions.

28 (A) The department shall require local pilots to have broad-based  
 29 provider and community support and collaboration, including  
 30 engagement with tribes and Indian health programs, with DTI  
 31 incentive payments available to the pilot based on goals and metrics  
 32 that contribute to the overall goals of the domains described in  
 33 paragraphs (1), (2), and (3).

34 (B) The department shall solicit proposals at the beginning of  
 35 the demonstration and shall review, approve, and make DTI  
 36 incentive payments to approved LDPPs in accordance with the  
 37 Special Terms and Conditions.

38 (C) A maximum of 15 LDPPs shall be approved and no more  
 39 than 25 percent of the total funding in the DTI pool shall be used  
 40 for LDPPs.

1 ~~(e) The department shall conduct, or arrange to have conducted,~~  
2 ~~the evaluation of the DTI as required by the Special Terms and~~  
3 ~~Conditions.~~

4 14184.80. (a) Within 90 days of the effective date of the act  
5 that added this section, the department shall amend its contract  
6 with the external quality review organization (EQRO) currently  
7 under contract with the department and approved by the federal  
8 Centers for Medicare and Medicaid Services to complete an access  
9 assessment. This one-time assessment is intended to do all of the  
10 following:

11 (1) Evaluate primary, core specialty, and facility access to care  
12 for managed care beneficiaries based on the current health plan  
13 network adequacy requirements set forth in the Knox-Keene Health  
14 Care Service Plan Act of 1975 (Chapter 2.2 (commencing with  
15 Section 1340) of Division 2 of the Health and Safety Code) and  
16 Medicaid managed care contracts, as applicable.

17 (2) Consider State Fair Hearing and Independent Medical  
18 Review (IMR) decisions, and grievances and appeals or complaints  
19 data.

20 (3) Report on the number of providers accepting new  
21 beneficiaries.

22 (b) The department shall submit to the federal Centers for  
23 Medicare and Medicaid Services for approval the access assessment  
24 design no later than 180 days after approval by the federal Centers  
25 for Medicare and Medicaid Services of the EQRO contract  
26 amendment.

27 (c) The department shall establish an advisory committee that  
28 will provide input into the structure of the access assessment. The  
29 EQRO shall work with the department to establish the advisory  
30 committee, which will provide input into the assessment structure,  
31 including network adequacy requirements and metrics, that should  
32 be considered.

33 (d) The advisory committee shall include one or more  
34 representatives of each of the following stakeholders to ensure  
35 diverse and robust input into the assessment structure and feedback  
36 on the initial draft access assessment report:

- 37 (1) Consumer advocacy organizations.
- 38 (2) Provider associations.
- 39 (3) Health plans and health plan associations.
- 40 (4) Legislative staff.

1 (e) The advisory committee shall do all of the following:

2 (1) Begin to convene within 60 days of approval by the federal  
3 Centers for Medicare and Medicaid Services of the EQRO contract  
4 amendment.

5 (2) Participate in a minimum of two meetings, including an  
6 entrance and exit event, with all events and meetings open to the  
7 public.

8 (3) Provide all of the following:

9 (A) Feedback on the access assessment structure.

10 (B) An initial draft access assessment report.

11 (C) Recommendations that shall be made available on the  
12 department's Internet Web site.

13 (f) The EQRO shall produce and publish an initial draft and a  
14 final access assessment report that includes a comparison of health  
15 plan network adequacy compliance across different lines of  
16 business. The report shall include recommendations in response  
17 to any systemic network adequacy issues, if identified. The initial  
18 draft and final report shall describe the state's current compliance  
19 with the access and network adequacy standards set forth in the  
20 Medicaid Managed Care proposed rule (80 FR 31097) or the  
21 finalized Part 438 of Title 42 of the Code of Federal Regulations,  
22 if published prior to submission of the assessment design to the  
23 federal Centers for Medicare and Medicaid Services.

24 (g) The access assessment shall do all of the following:

25 (1) Measure health plan compliance with network adequacy  
26 requirements as set forth in the Knox-Keene Health Care Service  
27 Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340)  
28 of Division 2 of the Health and Safety Code) and Medicaid  
29 managed care contracts, as applicable. The assessment shall  
30 consider State Fair Hearing and IMR decisions, and grievances  
31 and appeals or complaints data, and any other factors as selected  
32 with input from the ~~Advisory Committee~~. *advisory committee*.

33 (2) Review encounter data, including a review of data from  
34 subcapitated plans.

35 (3) Measure health plan compliance with timely access  
36 requirements, as set forth in the Knox-Keene Health Care Service  
37 Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340)  
38 of Division 2 of the Health and Safety Code) and Medicaid  
39 managed care contracts using a sample of provider-level data on  
40 the soonest appointment availability.

1 (4) Review compliance with network adequacy requirements  
2 for managed care plans, and other lines of business for primary  
3 and core specialty care areas and facility access, as set forth in the  
4 Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2  
5 (commencing with Section 1340) of Division 2 of the Health and  
6 Safety Code) and Medicaid managed care contracts, as applicable,  
7 across the entire health plan network.

8 (5) Applicable network adequacy requirements of the proposed  
9 or final Notice of Proposed Rulemaking, as determined under the  
10 approved access assessment design, that are not already required  
11 under the Knox-Keene Health Care Service Plan Act of 1975  
12 (Chapter 2.2 (commencing with Section 1340) of Division 2 of  
13 the Health and Safety Code) shall be reviewed and reported on  
14 against a metric range as identified by the department and approved  
15 by the federal Centers for Medicare and Medicaid Services in the  
16 access assessment design.

17 (6) Determine health plan compliance with network adequacy  
18 through reviewing information or data from a one-year period  
19 using validated network data and utilize it for the time period  
20 following conclusion of the preassessment stakeholder process but  
21 no sooner than the second half of the 2016 calendar year in order  
22 to ensure use of the highest quality data source available.

23 (7) Measure managed care plan compliance with network  
24 adequacy requirements within the department and managed care  
25 plan contract service areas using the Knox-Keene Health Care  
26 Service Plan Act of 1975 (Chapter 2.2 (commencing with Section  
27 1340) of Division 2 of the Health and Safety Code) and network  
28 adequacy standards within Medicaid managed care contracts,  
29 accounting for each of the following:

30 (A) Geographic differences, including provider shortages at the  
31 local, state, and national levels, as applicable.

32 (B) Previously approved alternate network access standards, as  
33 provided for under the Knox-Keene Health Care Service Plan Act  
34 of 1975 (Chapter 2.2 (commencing with Section 1340) of Division  
35 2 of the Health and Safety Code) and Medicaid managed care  
36 contracts.

37 (C) Access to in-network providers and out-of-network providers  
38 separately, presented and evaluated separately, when determining  
39 overall access to care.

1 (D) The entire network of providers available to beneficiaries  
2 as the state contractor plan level.

3 (E) Other modalities used for accessing care, including  
4 telemedicine.

5 (h) The department shall post the initial draft report for a 30-day  
6 public comment period after it has incorporated the feedback from  
7 the advisory committee. The initial draft report shall be posted for  
8 public comment no later than 10 months after the federal Centers  
9 for Medicare and Medicaid Services approves the assessment  
10 design.

11 (i) The department shall also make publicly available the  
12 feedback from the advisory committee at the same time it posts  
13 the initial draft of the report.

14 (j) The department shall submit the final access assessment  
15 report to the federal Centers for Medicare and Medicaid Services  
16 no later than 90 days after the initial draft report is posted for public  
17 comment.

18 *SEC. 2. This act shall become operative only if Assembly Bill*  
19 *1568 of the 2015–16 Regular Session is enacted and takes effect*  
20 *on or before January 1, 2017.*

21 ~~SEC. 2.~~

22 *SEC. 3.* This act is an urgency statute necessary for the  
23 immediate preservation of the public peace, health, or safety within  
24 the meaning of Article IV of the Constitution and shall go into  
25 immediate effect. The facts constituting the necessity are:

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