

AMENDED IN ASSEMBLY JUNE 9, 2016

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 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:

1 Article 5.5. Medi-Cal 2020 Demonstration Project Act

2  
3 14184. (a) This article shall be known, and may be cited, as  
4 the Medi-Cal 2020 Demonstration Project Act.

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

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

13 (2) California’s “Medi-Cal 2020” Medicaid demonstration  
14 project, No. 11-W-00193/9, expands on these achievements by  
15 continuing to focus on expanded health care system capacity, better  
16 coordinated care, and aligned incentives within the Medi-Cal  
17 program in order to improve health outcomes for Medi-Cal  
18 beneficiaries, while simultaneously containing health care costs.

19 (3) Public safety net providers, including designated public  
20 hospitals, and nondesignated public hospitals, which are also  
21 known as district and municipal public hospitals, play an essential  
22 role in the Medi-Cal program, providing high-quality care to a  
23 disproportionate number of low-income Medi-Cal and uninsured  
24 populations in the state. Because Medi-Cal covers approximately  
25 one-third of the state’s population, the strength of these essential  
26 health care systems and hospitals is of critical importance to the  
27 health and welfare of the people of California.

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

35 (5) As a component of the “Medi-Cal 2020” demonstration  
36 project, the Public Hospital Redesign and Incentives in Medi-Cal  
37 (PRIME) program seeks to improve health outcomes for patients  
38 served by participating entities by building on the delivery system  
39 transformation work from the “Bridge to Reform” demonstration  
40 project. Using evidence-based quality improvement methods, the

1 PRIME program is intended to be ambitious in scope in order to  
2 accelerate transformation in care delivery and maximize value for  
3 patients, providers, and payers. The PRIME program also seeks  
4 to strengthen the ability of designated public hospitals to  
5 successfully perform under risk-based alternative payment models  
6 (APMs) in the long term.

7 (6) As a component of the “Medi-Cal 2020” demonstration  
8 project, the Whole Person Care pilot program creates an  
9 opportunity for counties, Medi-Cal managed care plans, and  
10 community providers to establish a new model for integrated care  
11 delivery that incorporates health care needs, behavioral health, and  
12 social support for the state’s most vulnerable, high-user  
13 populations. The Whole Person Care pilot program encourages  
14 coordination among local partners to address the root causes of  
15 poor health outcomes, including immediate health needs and other  
16 factors, such as housing and recidivism, that impact a beneficiary’s  
17 health status.

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

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

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

29 (2) Promoting value and improving health outcomes for  
30 low-income populations.

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

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

37 (5) Transitioning from a cost-based reimbursement system  
38 toward a reimbursement structure that incentivizes quality and  
39 value by financially rewarding alternative models of care that

1 support providers’ ability to deliver care in the most appropriate  
2 and cost-effective manner to patients.

3 14184.10. For purposes of this article, the following definitions  
4 shall apply:

5 (a) “Demonstration project” means the California Medi-Cal  
6 2020 Demonstration, Number 11-W-00193/9, as approved by the  
7 federal Centers for Medicare and Medicaid Services, effective for  
8 the period from December 30, 2015, to December 31, 2020,  
9 inclusive, and any applicable extension period.

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

14 (c) “Demonstration year” means the demonstration year as  
15 identified in the Special Terms and Conditions that corresponds  
16 to a specific period of time as set forth in paragraphs (1) to (6),  
17 inclusive. Individual programs under the demonstration project  
18 may be operated on program years that differ from the  
19 demonstration years identified in paragraphs (1) to (6), inclusive.

20 (1) Demonstration year 11 corresponds to the period of January  
21 1, 2016, to June 30, 2016, inclusive.

22 (2) Demonstration year 12 corresponds to the period of July 1,  
23 2016, to June 30, 2017, inclusive.

24 (3) Demonstration year 13 corresponds to the period of July 1,  
25 2017, to June 30, 2018, inclusive.

26 (4) Demonstration year 14 corresponds to the period of July 1,  
27 2018, to June 30, 2019, inclusive.

28 (5) Demonstration year 15 corresponds to the period of July 1,  
29 2019, to June 30, 2020, inclusive.

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

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

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

38 (f) (1) “Designated public hospital” means any one of the  
39 following hospitals, and any successor or differently named  
40 hospital, which is operated by a county, a city and county, the

1 University of California, or special hospital authority described in  
2 Chapter 5 (commencing with Section 101850) or Chapter 5.5  
3 (commencing with Section 101852) of Part 4 of Division 101 of  
4 the Health and Safety Code, or any additional public hospital, to  
5 the extent identified as a “designated public hospital” in the Special  
6 Terms and Conditions. Unless otherwise provided for in law, in  
7 the Medi-Cal State Plan, or in the Special Terms and Conditions,  
8 all references in law to a designated public hospital as defined in  
9 subdivision (d) of Section 14166.1 shall be deemed to refer to a  
10 hospital described in this section effective as of January 1, 2016,  
11 except as provided in paragraph (2):

12 (A) UC Davis Medical Center.

13 (B) UC Irvine Medical Center.

14 (C) UC San Diego Medical Center.

15 (D) UC San Francisco Medical Center.

16 (E) UCLA Medical Center.

17 (F) Santa Monica/UCLA Medical Center, also known as the  
18 Santa Monica-UCLA Medical Center and Orthopaedic Hospital.

19 (G) LA County Health System Hospitals:

20 (i) LA County Harbor/UCLA Medical Center.

21 (ii) LA County Olive View UCLA Medical Center.

22 (iii) LA County Rancho Los Amigos National Rehabilitation  
23 Center.

24 (iv) LA County University of Southern California Medical  
25 Center.

26 (H) Alameda Health System Hospitals, including the following:

27 (i) Highland Hospital, including the Fairmont and John George  
28 Psychiatric facilities.

29 (ii) Alameda Hospital.

30 (iii) San Leandro Hospital.

31 (I) Arrowhead Regional Medical Center.

32 (J) Contra Costa Regional Medical Center.

33 (K) Kern Medical Center.

34 (L) Natividad Medical Center.

35 (M) Riverside University Health System-Medical Center.

36 (N) San Francisco General Hospital.

37 (O) San Joaquin General Hospital.

38 (P) San Mateo Medical Center.

39 (Q) Santa Clara Valley Medical Center.

40 (R) Ventura County Medical Center.

1 (2) For purposes of the following reimbursement methodologies,  
2 the hospitals identified in clauses (ii) and (iii) of subparagraph (H)  
3 of paragraph (1) shall be deemed to be a designated public hospital  
4 as of the following effective dates:

5 (A) For purposes of the fee-for-service payment methodologies  
6 established and implemented under Section 14166.4, the effective  
7 date shall be the date described in paragraph (3) of subdivision (a)  
8 of Section 14184.30.

9 (B) For purposes of Article 5.230 (commencing with Section  
10 14169.50), the effective date shall be January 1, 2017.

11 (g) “Disproportionate share hospital provisions of the Medi-Cal  
12 State Plan” means those applicable provisions contained in  
13 Attachment 4.19-A of the California Medicaid state plan, approved  
14 by the federal Centers for Medicare and Medicaid Services, that  
15 implement the payment adjustment program for disproportionate  
16 share hospitals.

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

20 (i) “Federal medical assistance percentage” means the federal  
21 medical assistance percentage applicable for federal financial  
22 participation purposes for medical services under the Medi-Cal  
23 State Plan pursuant to Section 1396b(a)(1) of Title 42 of the United  
24 States Code.

25 (j) “Global Payment Program” or “GPP” means the payment  
26 program authorized under the demonstration project and described  
27 in Section 14184.40 that assists participating public health care  
28 systems that provide health care for the uninsured and that  
29 promotes the delivery of more cost-effective, higher-value health  
30 care services and activities.

31 (k) “Nondesignated public hospital” means a public hospital as  
32 that term is defined in paragraph (25) of subdivision (a) of Section  
33 14105.98, excluding designated public hospitals.

34 (l) “Nonfederal share percentage” means the difference between  
35 100 percent and the federal medical assistance percentage.

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

39 (n) “Total computable disproportionate share hospital allotment”  
40 means the federal disproportionate share hospital allotment for a

1 federal fiscal year, divided by the applicable federal medical  
2 assistance percentage with respect to that same federal fiscal year.

3 (o) “Special Terms and Conditions” means those terms and  
4 conditions issued by the federal Centers for Medicare and Medicaid  
5 Services, including all attachments to those terms and conditions  
6 and any subsequent amendments approved by the federal Centers  
7 for Medicare and Medicaid Services, that apply to the  
8 demonstration project.

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

13 (q) “Whole Person Care pilot program” means a local  
14 collaboration among local governmental agencies, Medi-Cal  
15 managed care plans, health care and behavioral health providers,  
16 or other community organizations, as applicable, that are approved  
17 by the department to implement strategies to serve one or more  
18 identified target populations, pursuant to Section 14184.60 and  
19 the Special Terms and Conditions.

20 14184.20. (a) Consistent with federal law, the Special Terms  
21 and Conditions, and this article, the department shall implement  
22 the Medi-Cal 2020 demonstration project, including, but not limited  
23 to, all of the following components:

24 (1) The Global Payment Program, as described in Section  
25 14184.40.

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

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

30 (4) The Dental Transformation Initiative, as described in Section  
31 14184.70.

32 (b) In the event of a conflict between any provision of this article  
33 and the Special Terms and Conditions, the Special Terms and  
34 Conditions shall control.

35 (c) The department, as appropriate, shall consult with the  
36 designated public hospitals, district and municipal public hospitals,  
37 and other local governmental agencies with regard to the  
38 implementation of the components of the demonstration project  
39 under subdivision (a) in which they will participate, including, but

1 not limited to, the issuance of guidance pursuant to subdivision  
2 (d).

3 (d) Notwithstanding Chapter 3.5 (commencing with Section  
4 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
5 the department may implement, interpret, or make specific this  
6 article or the Special Terms and Conditions, in whole or in part,  
7 by means of all-county letters, plan letters, provider bulletins, or  
8 other similar instructions, without taking regulatory action. The  
9 department shall provide notification to the Joint Legislative  
10 Budget Committee and to the Senate Committees on  
11 Appropriations, Budget and Fiscal Review, and Health, and the  
12 Assembly Committees on Appropriations, Budget, and Health  
13 within 10 business days after the above-described action is taken.  
14 The department shall make use of appropriate processes to ensure  
15 that affected stakeholders are timely informed of, and have access  
16 to, applicable guidance issued pursuant to this authority, and that  
17 this guidance remains publicly available until all payments related  
18 to the applicable demonstration component are finalized.

19 (e) For purposes of implementing this article or the Special  
20 Terms and Conditions, the department may enter into exclusive  
21 or nonexclusive contracts, or amend existing contracts, on a bid  
22 or negotiated basis. Contracts entered into or amended pursuant  
23 to this subdivision shall be exempt from Chapter 6 (commencing  
24 with Section 14825) of Part 5.5 of Division 3 of Title 2 of the  
25 Government Code and Part 2 (commencing with Section 10100)  
26 of Division 2 of the Public Contract Code, and shall be exempt  
27 from the review or approval of any division of the Department of  
28 General Services.

29 (f) During the course of the demonstration term, the department  
30 shall seek any federal approvals it deems necessary to implement  
31 the demonstration project and this article. This shall include, but  
32 is not limited to, approval of any amendment, addition, or technical  
33 correction to the Special Terms and Conditions, and any associated  
34 state plan amendment, as deemed necessary. This article shall be  
35 implemented only to the extent that any necessary federal approvals  
36 are obtained and federal financial participation is available and is  
37 not otherwise jeopardized.

38 (g) The director may modify any process or methodology  
39 specified in this article to the extent necessary to comply with  
40 federal law or the Special Terms and Conditions of the

1 demonstration project, but only if the modification is consistent  
2 with the goals set forth in this article for the demonstration project,  
3 and its individual components, and does not significantly alter the  
4 relative level of support for participating entities. If the director,  
5 after consulting with those entities participating in the applicable  
6 demonstration project component and that would be affected by  
7 that modification, determines that the potential modification would  
8 not be consistent with the goals set forth in this article or would  
9 significantly alter the relative level of support for affected  
10 participating entities, the modification shall not be made and the  
11 director shall execute a declaration stating that this determination  
12 has been made. The director shall retain the declaration and provide  
13 a copy, within five working days of the execution of the  
14 declaration, to the fiscal and appropriate policy committees of the  
15 Legislature, and shall work with the affected participating entities  
16 and the Legislature to make the necessary statutory changes. The  
17 director shall post the declaration on the department's Internet  
18 Web site and the director shall send the declaration to the Secretary  
19 of State and the Legislative Counsel.

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

32 (i) During the course of the demonstration term, the department  
33 may work to develop potential successor payment methodologies  
34 that could continue to support entities participating in the  
35 demonstration project following the expiration of the demonstration  
36 term and that further the goals set forth in this article and in the  
37 Special Terms and Conditions. The department shall consult with  
38 the entities participating in the payment methodologies under the  
39 demonstration project, affected stakeholders, and the Legislature

1 in the development of any potential successor payment  
2 methodologies pursuant to this subdivision.

3 (j) The department may seek to extend the payment  
4 methodologies described in this article through demonstration year  
5 16 or to subsequent time periods by way of amendment or  
6 extension of the demonstration project, amendment to the Medi-Cal  
7 State Plan, or any combination thereof, consistent with the  
8 applicable federal requirements. This subdivision shall only be  
9 implemented after consultation with the entities participating in,  
10 or affected by, those methodologies, and only to the extent that  
11 any necessary federal approvals are obtained and federal financial  
12 participation is available and is not otherwise jeopardized.

13 (k) (1) Notwithstanding any other law, and to the extent  
14 authorized by the Special Terms and Conditions, the department  
15 may claim federal financial participation for expenditures  
16 associated with the designated state health programs identified in  
17 the Special Terms and Conditions for use solely by the department  
18 as specified in this subdivision.

19 (2) Any federal financial participation claimed pursuant to  
20 paragraph (1) shall be used to offset applicable General Fund  
21 expenditures. These amounts are hereby appropriated to the  
22 department and shall be available for transfer to the General Fund  
23 for this purpose.

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

28 14184.30. The following payment methodologies and  
29 requirements implemented pursuant to Article 5.2 (commencing  
30 with Section 14166) shall be applicable as set forth in this section.

31 (a) (1) For purposes of Section 14166.4, the references to  
32 “project year” and “successor demonstration year” shall include  
33 references to the demonstration term, as defined under this article,  
34 and to any extensions of the prior federal Medicaid demonstration  
35 project entitled “California Bridge to Reform Demonstration  
36 (Waiver No. 11-W-00193/9).”

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

1 (3) For the hospitals identified in clauses (ii) and (iii) of  
2 subparagraph (H) of paragraph (1) of subdivision (f) of Section  
3 14184.10, the department shall seek any necessary federal  
4 approvals to apply the fee-for-service payment methodologies  
5 established and implemented under Section 14166.4 to these  
6 identified hospitals effective no earlier than the 2016–17 state  
7 fiscal year. This paragraph shall be implemented only to the extent  
8 that any necessary federal approvals are obtained and federal  
9 financial participation is available and not otherwise jeopardized.  
10 Prior to the effective date of any necessary federal approval  
11 obtained pursuant to this paragraph, these identified hospitals shall  
12 continue to be considered nondesignated public hospitals for  
13 purposes of the fee-for-service methodology authorized pursuant  
14 to Section 14105.28 and the applicable provisions of the Medi-Cal  
15 State Plan.

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

29 (b) During the 2015–16 state fiscal year, and subsequent state  
30 fiscal years that commence during the demonstration term, payment  
31 adjustments to disproportionate share hospitals shall not be made  
32 pursuant to Section 14105.98, except as otherwise provided in this  
33 article. Payment adjustments to disproportionate share hospitals  
34 shall be made solely in accordance with this article.

35 (1) Except as otherwise provided in this article, the department  
36 shall continue to make all eligibility determinations and perform  
37 all payment adjustment amount computations under the  
38 disproportionate share hospital payment adjustment program  
39 pursuant to Section 14105.98 and pursuant to the disproportionate  
40 share hospital provisions of the Medi-Cal State Plan. For purposes

1 of these determinations and computations, which include those  
2 made pursuant to Sections 14166.11 and 14166.16, all of the  
3 following shall apply:

4 (A) The federal Medicaid DSH reductions pursuant to Section  
5 1396r-4(f)(7) of Title 42 of the United States Code shall be  
6 reflected as appropriate, including, but not limited to, the  
7 calculations set forth in subparagraph (B) of paragraph (2) of  
8 subdivision (am) of Section 14105.98.

9 (B) Services that were rendered under the Low Income Health  
10 Program authorized pursuant to Part 3.6 (commencing with Section  
11 15909) shall be included.

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

19 (i) As disproportionate share hospital payments under the  
20 methodology set forth in applicable disproportionate share hospital  
21 provisions of the Medi-Cal State Plan, which, to the extent  
22 permitted under federal law and the Special Terms and Conditions,  
23 shall be limited to the following hospitals:

24 (I) Eligible hospitals, as determined pursuant to Section  
25 14105.98 for each state fiscal year in which the particular federal  
26 fiscal year commences, that meet the definition of a public hospital,  
27 as specified in paragraph (25) of subdivision (a) of Section  
28 14105.98, and that are not participating as GPP systems under the  
29 Global Payment Program.

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

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

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

1 (3) (A) During the 2015–16 state fiscal year and subsequent  
2 state fiscal years that commence during the demonstration term,  
3 a public entity shall not be obligated to make any intergovernmental  
4 transfer pursuant to Section 14163, and all transfer amount  
5 determinations for those state fiscal years shall be suspended.  
6 However, intergovernmental transfers shall be made with respect  
7 to the disproportionate share hospital payment adjustments made  
8 in accordance with clause (ii) of subparagraph (B) of paragraph  
9 (6), as applicable.

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

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

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

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

34 (i) Subject to clause (iii), each hospital licensed to the University  
35 of California may draw and receive federal Medicaid funding from  
36 the applicable federal disproportionate share hospital allotment on  
37 the amount of certified public expenditures for the hospital's  
38 expenditures that are eligible for federal financial participation as  
39 reported in accordance with Section 14166.8 and the applicable

1 disproportionate share hospital provisions of the Medi-Cal State  
2 Plan.

3 (ii) Subject to clause (iii) and to the extent the hospital meets  
4 the requirement in Section 1396r-4(b)(1)(A) of Title 42 of the  
5 United States Code regarding the Medicaid inpatient utilization  
6 rate or Section 1396r-4(b)(1)(B) of Title 42 of the United States  
7 Code regarding the low-income utilization rate, each hospital shall  
8 receive intergovernmental transfer-funded direct disproportionate  
9 share hospital payments as provided for under the applicable  
10 disproportionate share hospital provisions of the Medi-Cal State  
11 Plan. The total amount of these payments to the hospital, consisting  
12 of the federal and nonfederal components, shall in no case exceed  
13 that amount equal to 75 percent of the hospital's uncompensated  
14 Medi-Cal and uninsured costs of hospital services as reported in  
15 accordance with Section 14166.8.

16 (iii) Unless the provisions of subparagraph (D) apply, the  
17 aggregate amount of the federal disproportionate share hospital  
18 allotment with respect to payments for an applicable state fiscal  
19 year to hospitals licensed to the University of California shall be  
20 limited to an amount calculated as follows:

21 (I) The maximum amount of federal disproportionate share  
22 hospital allotment for the state fiscal year, less the amounts of  
23 federal disproportionate share hospital allotment associated with  
24 payments to nondesignated public hospitals under subparagraph  
25 (B) and other payments, if any, required to be made from the  
26 federal disproportionate share hospital allotment, shall be  
27 determined.

28 (II) For the 2015–16 state fiscal year, the amount determined  
29 in subclause (I) shall be multiplied by 26.296 percent, resulting in  
30 the maximum amount of the federal disproportionate share hospital  
31 allotment available as disproportionate share hospital payments  
32 for the state fiscal year to hospitals that are licensed to the  
33 University of California.

34 (III) For the 2016–17 state fiscal year, the amount determined  
35 in subclause (I) shall be multiplied by 24.053 percent, resulting in  
36 the maximum amount of the federal disproportionate share hospital  
37 allotment available as disproportionate share hospital payments  
38 for the state fiscal year to hospitals that are licensed to the  
39 University of California.

1 (IV) For the 2017–18 state fiscal year, the amount determined  
2 in subclause (I) shall be multiplied by 23.150 percent, resulting in  
3 the maximum amount of the federal disproportionate share hospital  
4 allotment available as disproportionate share hospital payments  
5 for the state fiscal year to hospitals that are licensed to the  
6 University of California.

7 (V) For each of the 2018–19 and 2019–20 state fiscal years, the  
8 amount determined in subclause (I) shall be multiplied by 21.896  
9 percent, resulting in the maximum amount of the federal  
10 disproportionate share hospital allotment available as  
11 disproportionate share hospital payments for the state fiscal year  
12 to hospitals that are licensed to the University of California.

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

16 (iv) Each hospital licensed to the University of California shall  
17 receive quarterly interim payments of its disproportionate share  
18 hospital allocation during the applicable state fiscal year. The  
19 determinations set forth in clauses (i) to (iii), inclusive, shall be  
20 made on an interim basis prior to the start of each state fiscal year,  
21 except that the determinations for the 2015–16 state fiscal year  
22 shall be made as soon as practicable. The department shall use the  
23 same cost and statistical data used in determining the interim  
24 payments for Medi-Cal inpatient hospital services under Section  
25 14166.4, and available payments and uncompensated and uninsured  
26 cost data, including data from the Medi-Cal paid claims file and  
27 the hospital's books and records, for the corresponding period, to  
28 the extent permitted under the Medi-Cal State Plan.

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

35 (vi) Except as otherwise provided in this article, each hospital  
36 licensed to the University of California shall receive  
37 disproportionate share hospital payments subject to final audits of  
38 all applicable Medi-Cal, Medicare, and other cost, payment,  
39 discharge, and statistical data submitted by the hospital for the  
40 applicable state fiscal year.

1 (vii) Prior to the interim and final distributions of payments  
2 pursuant to clauses (iv) ~~through~~ *to* (vi), inclusive, the department  
3 shall consult with the University of California, and implement any  
4 adjustments to the payment distributions for the hospitals as  
5 requested by the University of California, so long as the aggregate  
6 net effect of the requested adjustments for the affected hospitals  
7 is zero.

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

20 (5) For each applicable state fiscal year during the demonstration  
21 term, eligible hospitals, as determined pursuant to Section  
22 14105.98, which are nonpublic hospitals, nonpublic-converted  
23 hospitals, and converted hospitals, as those terms are defined in  
24 paragraphs (26), (27), and (28), respectively, of subdivision (a) of  
25 Section 14105.98, shall continue to receive Medi-Cal  
26 disproportionate share hospital replacement payment adjustments  
27 pursuant to Section 14166.11 and other provisions of this article  
28 and applicable provisions of the Medi-Cal State Plan. The payment  
29 adjustments so provided shall satisfy the state's payment  
30 obligations, if any, with respect to those hospitals under Section  
31 1396r-4 of Title 42 of the United States Code. The provisions of  
32 subdivision (j) of Section 14166.11 shall continue to apply with  
33 respect to the 2015–16 state fiscal year and subsequent state fiscal  
34 years commencing during the demonstration term. Except as may  
35 otherwise be required by federal law, the federal share of these  
36 payments shall not be claimed from the federal disproportionate  
37 share hospital allotment.

38 (6) The nonfederal share of disproportionate share hospital  
39 payments and disproportionate share hospital replacement payment

1 adjustments described in paragraphs (4) and (5) shall be derived  
2 from the following sources:

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

7 (B) With respect to the payments described in subparagraph (C)  
8 or (D), as applicable, of paragraph (4) that are made to designated  
9 public hospitals, the nonfederal share shall consist of both of the  
10 following:

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

14 (ii) Intergovernmental transfer amounts for direct  
15 disproportionate share hospital payments provided for under  
16 subparagraph (C) or (D) of paragraph (4) and the applicable  
17 disproportionate share hospital provisions of the Medi-Cal State  
18 Plan. A transfer amount shall be determined for each hospital that  
19 is eligible for these payments, equal to the nonfederal share of the  
20 payment amount established for the hospital. The transfer amount  
21 determined shall be paid by the hospital, or the public entity with  
22 which the hospital is affiliated, and deposited into the Medi-Cal  
23 Inpatient Payment Adjustment Fund established pursuant to  
24 subdivision (b) of Section 14163, as permitted under Section  
25 433.51 of Title 42 of the Code of Federal Regulations or any other  
26 applicable federal Medicaid laws.

27 (C) With respect to the payments described in paragraph (5),  
28 the nonfederal share shall consist of state General Fund  
29 appropriations.

30 (7) The Demonstration Disproportionate Share Hospital Fund  
31 established in the State Treasury pursuant to subdivision (d) of  
32 Section 14166.9 shall be retained during the demonstration term.  
33 All federal funds received by the department with respect to the  
34 certified public expenditures claimed pursuant to subparagraph  
35 (C), and, as applicable in subparagraph (D), of paragraph (4) shall  
36 be transferred to the fund and disbursed to the eligible designated  
37 public hospitals pursuant to those applicable provisions.  
38 Notwithstanding Section 13340 of the Government Code, moneys  
39 deposited in the fund shall be continuously appropriated, without

1 regard to fiscal year, to the department solely for the purposes  
2 specified in this article.

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

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

19 (3) The disproportionate share hospital payments described in  
20 paragraph (1) that were paid to designated public hospitals licensed  
21 to the University of California shall be reconciled to and offset  
22 against the disproportionate share hospital payments payable to  
23 the hospitals under subparagraph (C) of paragraph (4) of  
24 subdivision (b) for the 2015–16 state fiscal year.

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

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

36 (1) (A) The provisions of subdivision (c) of Section 14166.8  
37 shall not apply.

38 (B) Notwithstanding subparagraph (A), the department may  
39 require the reporting of any data the department deems necessary

1 to satisfy reporting requirements pursuant to the Special Terms  
2 and Conditions.

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

6 (e) (1) Notwithstanding subdivision (h) of Section 14166.61  
7 and subdivision (c) of Section 14166.71, the disproportionate share  
8 hospital allocation and safety net care pool payment determinations  
9 and payments for the 2013–14 and 2014–15 state fiscal years shall  
10 be deemed final as of the April 30 that is 22 months following the  
11 close of the respective state fiscal year, to the extent permitted  
12 under federal law and subject to recoupment pursuant to  
13 subdivision (f) if it is later determined that federal financial  
14 participation is not available for any portion of the applicable  
15 payments.

16 (2) The determinations and payments shall be finalized using  
17 the best available data, including unaudited data, and reasonable  
18 current estimates and projections submitted by the designated  
19 public hospitals. The department shall accept all appropriate  
20 revisions to the data, estimates, and projections previously  
21 submitted, including revised cost reports, for purposes of this  
22 subdivision, to the extent these revisions are submitted in a timely  
23 manner as determined by the department.

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

33 (1) To the extent there are additional certified public  
34 expenditures for the applicable state fiscal year for which federal  
35 funds have not been received, but for which federal funds could  
36 have been received had additional federal funds been available,  
37 including any subsequently allowable expenditures for designated  
38 state health programs, the department shall first respond to the  
39 deferral or disallowance by substituting the additional certified  
40 public expenditures or allowable expenditures for those deferred

1 or disallowed, consistent with the claiming optimization priorities  
2 set forth in Section 14166.9, in consultation with the designated  
3 public hospitals, but only to the extent that any necessary federal  
4 approvals are obtained or these actions are otherwise permitted by  
5 federal law.

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

9 (3) If the department elects to appeal pursuant to paragraph (3)  
10 of subdivision (d) of Section 14166.24, the department shall not  
11 implement any recoupment of payments from the affected  
12 designated public hospitals, until a final disposition has been made  
13 regarding the deferral or disallowance, including the conclusion  
14 of applicable administrative and judicial review, if any.

15 (4) (A) Upon final disposition of the federal deferral or  
16 disallowance, the department shall determine the resulting  
17 aggregate repayment amount of federal funds for each affected  
18 state fiscal year.

19 (B) The department shall determine the ratio of the aggregate  
20 repayment amount to the total amount of the federal share of  
21 payments finalized and distributed pursuant to Sections 14166.61  
22 and 14166.71 and subdivision (e) for each affected state fiscal  
23 year, expressed as a percentage.

24 (5) Notwithstanding paragraph (1) of subdivision (d) of Section  
25 14166.24, the responsibility for repayment of the federal portion  
26 of any deferral or disallowance for each affected year shall be  
27 determined as follows:

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

33 (B) Using the most recent data for the applicable fiscal year,  
34 and reflecting modifications to the applicable initial DSH claiming  
35 ability and initial SNCP claiming ability for individual hospitals  
36 resulting from the deferral or disallowance, the department shall  
37 perform the calculations and determinations for each designated  
38 public hospital as set forth in Sections 14166.61 and 14166.71.  
39 For this purpose, the calculations and determinations shall assume  
40 no reduction in the available federal disproportionate share hospital

1 allotment or in the amount of available safety net care pool  
2 payments as a result of the deferral or disallowance.

3 (C) For each designated public hospital, the revised  
4 determinations of disproportionate share hospital and safety net  
5 care pool payment amounts under subparagraph (B) shall be  
6 combined and compared to the combined disproportionate share  
7 hospital and safety net care pool payment amounts determined and  
8 received by the hospital pursuant to subdivision (e). For this  
9 purpose and purposes of subparagraph (D), the applicable data for  
10 designated public hospitals described in subparagraph (G) of  
11 paragraph (1) of subdivision (f) of Section 14184.10 shall be  
12 combined, and the applicable data for designated public hospitals  
13 described in subparagraphs (E) and (F) of paragraph (1) of  
14 subdivision (f) of Section 14184.10 shall be combined.

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

31 (ii) Subject to subparagraph (E), any repayment amounts that  
32 were unallocated to hospitals due to the limitation in clause (iii)  
33 shall be allocated in a second stage among each of the remaining  
34 designated public hospitals that has not reached its applicable  
35 repayment limit, including the hospitals that were not subject to  
36 the allocations under clause (i), based pro rata on the amounts  
37 determined and received by the hospital pursuant to subdivision  
38 (e), except that no repayment amount for a hospital shall exceed  
39 the limitation under clause (iii). The pro rata allocation process  
40 will be repeated in subsequent stages with respect to any repayment

1 amounts that cannot be allocated in a prior stage to hospitals due  
2 to the limitation under clause (iii), until the entire federal repayment  
3 amount has been allocated among the hospitals.

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

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

25 (g) The provisions of Article 5.2 (commencing with Section  
26 14166) shall remain in effect until all payments authorized pursuant  
27 to that article have been paid, finalized, and settled, and to the  
28 extent its provisions are retained for purposes of this article.

29 14184.40. (a) (1) The department shall implement the Global  
30 Payment Program authorized under the demonstration project to  
31 support participating public health care systems that provide health  
32 care services for the uninsured. Under the Global Payment  
33 Program, GPP systems receive global payments based on the health  
34 care they provide to the uninsured, in lieu of traditional  
35 disproportionate share hospital payments and safety net care pool  
36 payments previously made available pursuant to Article 5.2  
37 (commencing with Section 14166).

38 (2) The Global Payment Program is intended to streamline  
39 funding sources for care for California’s remaining uninsured  
40 population, creating a value-based mechanism to increase

1 incentives to provide primary and preventive care services and  
2 other high-value services. The Global Payment Program supports  
3 GPP systems for their key role providing and promoting effective,  
4 higher value services to California’s remaining uninsured.  
5 Promoting more cost-effective and higher value care means that  
6 the payment structure rewards the provision of care in more  
7 appropriate venues for patients, and will support structural changes  
8 to the care delivery system that will improve the options for treating  
9 both Medi-Cal and uninsured patients.

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

23 (4) The department shall implement and oversee the operation  
24 of the Global Payment Program in accordance with the Special  
25 Terms and Conditions and the requirements of this section, to  
26 maximize the amount of federal financial participation available  
27 to participating GPP systems.

28 (b) For purposes of this article, the following definitions shall  
29 apply:

30 (1) “GPP system” means a public health care system that  
31 consists of a designated public hospital, as defined in subdivision  
32 (f) of Section 14184.10 but excluding the hospitals operated by  
33 the University of California, and its affiliated and contracted  
34 providers. Multiple designated public hospitals operated by a single  
35 legal entity may belong to the same GPP system, to the extent set  
36 forth in the Special Terms and Conditions.

37 (2) “GPP program year” means a state fiscal year beginning on  
38 July 1 and ending on June 30 during which the Global Payment  
39 Program is authorized under the demonstration project, beginning  
40 with state fiscal year 2015–16, and, as applicable, each state fiscal

1 year thereafter through 2019–20, and any years or partial years  
2 during which the Global Payment Program is authorized under an  
3 extension or successor to the demonstration.

4 (c) (1) For each GPP program year, the department shall  
5 determine the Global Payment Program’s aggregate annual limit,  
6 which is the maximum amount of funding available under the  
7 demonstration project for the Global Payment Program and which  
8 is the sum of the components described in subparagraphs (A) and  
9 (B). To the extent feasible, the aggregate annual limit shall be  
10 determined and made available by the department prior to the  
11 implementation of a GPP program year, and shall be updated and  
12 adjusted as necessary to reflect changes or adjustments to the  
13 amount of funding available for the Global Payment Program.

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

27 (B) The aggregate annual limit shall also include the amount  
28 authorized under the demonstration project for the uncompensated  
29 care component of the Global Payment Program for the applicable  
30 GPP program year, as determined pursuant to the Special Terms  
31 and Conditions.

32 (2) The department shall develop a methodology for valuing  
33 health care services and activities provided to the uninsured that  
34 achieves the goals of the Global Payment Program, including those  
35 values set forth in subdivision (a) and as expressed in the Special  
36 Terms and Conditions. The points assigned to a particular service  
37 or activity shall be the same across all GPP systems. Points for  
38 specific services or activities may be increased or decreased over  
39 time as the Global Payment Program progresses, to incentivize  
40 appropriate changes in the mix of services provided to the

1 uninsured. To the extent necessary, the department shall obtain  
2 federal approval for the methodology and any applicable changes  
3 to the methodology.

4 (3) For each GPP system, the department shall perform a  
5 baseline analysis of the GPP system's historical volume, cost, and  
6 mix of services to the uninsured to establish an annual threshold  
7 for purposes of the Global Payment Program. The annual threshold  
8 shall be measured in points established through the methodology  
9 developed pursuant to paragraph (2) and as set forth in the Special  
10 Terms and Conditions.

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

15 (5) For each GPP system, the department shall determine an  
16 annual budget the GPP system will receive if it achieves its  
17 threshold. A GPP system's annual budget shall equal the allocation  
18 percentage determined in paragraph (4) for the GPP system,  
19 multiplied by the Global Payment Program's aggregate annual  
20 limit determined in paragraph (1).

21 (6) In the event of a change in the aggregate annual limit, the  
22 department shall adjust and recalculate each GPP system's annual  
23 threshold and annual budget in proportion to changes in the  
24 aggregate annual limit calculated in paragraph (1) in accordance  
25 with the Special Terms and Conditions.

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

29 (1) The full amount of a GPP system's annual budget shall be  
30 payable to the GPP system if the services it provided to the  
31 uninsured during the GPP program year, as measured and scored  
32 using the point methodology described under paragraph (2) of  
33 subdivision (c), meets or exceeds its threshold for a given year.  
34 For GPP systems that do not achieve their threshold, the amount  
35 payable to the GPP system shall equal its annual budget reduced  
36 by the proportion by which it fell short of its threshold.

37 (2) The department shall develop a methodology to redistribute  
38 unearned Global Payment Program funds for a given GPP program  
39 year to those GPP systems that exceeded their respective threshold  
40 for that same year. To the extent sufficient funds are available for

1 all qualifying GPP systems, the GPP system's redistributed amount  
2 shall equal the GPP system's annual budget multiplied by the  
3 percentage by which the GPP system exceeded its threshold, and  
4 any remaining amounts of unearned funds will remain  
5 undistributed. If sufficient funds are unavailable to make all these  
6 payments to qualifying GPP systems, the amounts of these  
7 additional payments will be reduced for all qualifying GPP systems  
8 by the same proportion, so that the full amount of unearned Global  
9 Payment Program funds are redistributed. Redistributed payment  
10 amounts calculated pursuant to this paragraph shall be added to  
11 the amounts payable to a GPP system calculated pursuant to  
12 paragraph (1).

13 (3) The department shall specify a reporting schedule for  
14 participating GPP systems to submit an interim yearend report and  
15 a final reconciliation report for each GPP program year. The interim  
16 yearend report and the final reconciliation report shall identify the  
17 services the GPP system provided to the uninsured during the GPP  
18 program year, the associated point calculation, and the amount of  
19 payments earned by the GPP system prior to any redistribution.  
20 The method and format of the reporting shall be established by  
21 the department, consistent with the approved Special Terms and  
22 Conditions.

23 (4) Payments shall be made in the manner and within the  
24 timeframes as follows, except if one or more GPP systems fail to  
25 provide the intergovernmental transfer amount determined pursuant  
26 to subdivision (g) by the date specified in this paragraph, the  
27 timeframe for the associated payments shall be extended to the  
28 extent necessary to allow the department to timely process the  
29 payments. In no event, however, shall payment be delayed beyond  
30 21 days after all the necessary intergovernmental transfers have  
31 been made.

32 (A) Except as provided in subparagraph (B), for each of the first  
33 three quarters of a GPP program year the department shall notify  
34 GPP systems of their payment amounts and intergovernmental  
35 transfer amounts and make a quarterly interim payment equal to  
36 25 percent of each GPP system's annual global budget to the GPP  
37 system.

38 (i) For quarters ending September 30, the payment amount and  
39 intergovernmental transfer amount notice shall be sent by

1 September 15, intergovernmental transfers shall be due by  
2 September 22, and payments shall be made by October 15.

3 (ii) For quarters ending December 31, the payment amount and  
4 intergovernmental transfer amount notice shall be sent by  
5 December 15, intergovernmental transfers shall be due by  
6 December 22, and payments shall be made by January 15.

7 (iii) For quarters ending March 31, the payment amount and  
8 intergovernmental transfer amount notice shall be sent by March  
9 15, intergovernmental transfers shall be due by March 22, and  
10 payments shall be made by April 15.

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

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

36 (D) By June 30 following the end of each GPP program year,  
37 the department shall review the final reconciliation reports and  
38 determine and notify each GPP system of the final amounts earned  
39 by the GPP system for the GPP program year pursuant to paragraph  
40 (1), as well as the redistribution amounts, if any, pursuant to

1 paragraph (2), the amount of the payment adjustments or  
2 recoupments necessary to reconcile interim payments to those  
3 amounts, and the transfer amount pursuant to subdivision (g).  
4 Intergovernmental transfer amounts shall be due by July 14  
5 following the notification, and final reconciliation payments for  
6 the GPP program year shall be made no later than August 15  
7 following this notification.

8 (e) The Global Payment Program provides a source of funding  
9 for GPP systems to support their ability to make health care  
10 activities and services available to the uninsured, and shall not be  
11 construed to constitute or offer health care coverage for individuals  
12 receiving services. Global Payment Program payments are not  
13 paid on behalf of specific individuals, and participating GPP  
14 systems may determine the scope, type, and extent to which  
15 services are available, to the extent consistent with the Special  
16 Terms and Conditions. The operation of the Global Payment  
17 Program shall not be construed to decrease, expand, or otherwise  
18 alter the scope of a county's obligations to the medically indigent  
19 pursuant to Part 5 (commencing with Section 17000) of Division  
20 9.

21 (f) The nonfederal share of any payments under the Global  
22 Payment Program shall consist of voluntary intergovernmental  
23 transfers of funds provided by designated public hospitals or  
24 affiliated governmental agencies or entities, in accordance with  
25 this section.

26 (1) The Global Payment Program Special Fund is hereby  
27 established in the State Treasury. Notwithstanding Section 13340  
28 of the Government Code, moneys deposited in the Global Payment  
29 Program Special Fund shall be continuously appropriated, without  
30 regard to fiscal years, to the department for the purposes specified  
31 in this section. All funds derived pursuant to this section shall be  
32 deposited in the State Treasury to the credit of the Global Payment  
33 Program Special Fund.

34 (2) The Global Payment Program Special Fund shall consist of  
35 moneys that a designated public hospital or affiliated governmental  
36 agency or entity elects to transfer to the department for deposit  
37 into the fund as a condition of participation in the Global Payment  
38 Program, to the extent permitted under Section 433.51 of Title 42  
39 of the Code of Federal Regulations, the Special Terms and  
40 Conditions, and any other applicable federal Medicaid laws. Except

1 as otherwise provided in paragraph (3), moneys derived from these  
2 intergovernmental transfers in the Global Payment Program Special  
3 Fund shall be used as the source for the nonfederal share of Global  
4 Payment Program payments authorized under the demonstration  
5 project. Any intergovernmental transfer of funds provided for  
6 purposes of the Global Payment Program shall be made as specified  
7 in this section. Upon providing any intergovernmental transfer of  
8 funds, each transferring entity shall certify that the transferred  
9 funds qualify for federal financial participation pursuant to  
10 applicable federal Medicaid laws and the Special Terms and  
11 Conditions, and in the form and manner as required by the  
12 department.

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

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

38 (g) For each scheduled quarterly interim payment, interim  
39 yearend payment, and final reconciliation payment pursuant to

1 subdivision (d), the department shall determine the  
2 intergovernmental transfer amount for each GPP system as follows:

3 (1) The department shall determine the amount of the quarterly  
4 interim payment, interim yearend payment, or final reconciliation  
5 payment, as applicable, that is payable to each GPP system  
6 pursuant to subdivision (d). For purposes of these determinations,  
7 the redistributed amounts described in paragraph (2) of subdivision  
8 (d) shall be disregarded.

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

14 (3) With respect to each quarterly interim payment, interim  
15 yearend payment, or final yearend reconciliation payment, as  
16 applicable, an initial transfer amount shall be determined for each  
17 GPP system, calculated as the amount for the GPP system  
18 determined in paragraph (1), multiplied by the nonfederal share  
19 percentage, as defined in Section 14184.10, and multiplied by the  
20 applicable GPP system-specific IGT factor as follows:

- 21 (A) Los Angeles County Health System: 1.100.
- 22 (B) Alameda Health System: 1.137.
- 23 (C) Arrowhead Regional Medical Center: 0.923.
- 24 (D) Contra Costa Regional Medical Center: 0.502.
- 25 (E) Kern Medical Center: 0.581.
- 26 (F) Natividad Medical Center: 1.183.
- 27 (G) Riverside University Health System-Medical Center: 0.720.
- 28 (H) San Francisco General Hospital: 0.507.
- 29 (I) San Joaquin General Hospital: 0.803.
- 30 (J) San Mateo Medical Center: 1.325.
- 31 (K) Santa Clara Valley Medical Center: 0.706.
- 32 (L) Ventura County Medical Center: 1.401.

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

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

1 (B) The sum of the initial transfer amounts in subparagraph (A)  
2 shall be subtracted from the aggregate amount of intergovernmental  
3 transfers necessary to fund the payments as determined in  
4 paragraph (2). The resulting positive or negative amount shall be  
5 the aggregate positive or negative intergovernmental transfer  
6 adjustment.

7 (C) Each GPP system-specific IGT factor, as specified in  
8 subparagraphs (A) to (L), inclusive, of paragraph (3) shall be  
9 subtracted from 2.000, yielding an IGT adjustment factor for each  
10 GPP system.

11 (D) The IGT adjustment factor calculated in subparagraph (C)  
12 for each GPP system shall be multiplied by the positive or negative  
13 amount in subparagraph (B), and multiplied by the allocation  
14 percentage determined for the GPP system in paragraph (4) of  
15 subdivision (c), yielding the amount to be added or subtracted from  
16 the initial transfer amount determined in paragraph (3) for the  
17 applicable GPP system.

18 (E) The transfer amount to be paid by each GPP system with  
19 respect to the applicable quarterly interim payment, interim yearend  
20 payment, or final reconciliation payment, shall equal the initial  
21 transfer amount determined in paragraph (3) as adjusted by the  
22 amount determined in subparagraph (D).

23 (5) Upon the determination of the redistributed amounts  
24 described in paragraph (2) of subdivision (d) for the final  
25 reconciliation payment, the department shall, with respect to each  
26 GPP system that exceeded its respective threshold, determine the  
27 associated intergovernmental transfer amount equal to the  
28 nonfederal share that is necessary to draw down the additional  
29 payment, and shall include this amount in the GPP system's  
30 transfer amount.

31 (h) The department may initiate audits of GPP systems' data  
32 submissions and reports, and may request supporting  
33 documentation. Any audits conducted by the department shall be  
34 complete within 22 months of the end of the applicable GPP  
35 program year to allow for the appropriate finalization of payments  
36 to the participating GPP system, but subject to recoupment if it is  
37 later determined that federal financial participation is not available  
38 for any portion of the applicable payments.

39 (i) If the department determines, during the course of the  
40 demonstration term and in consultation with participating GPP

1 systems, that the Global Payment Program should be terminated  
2 for subsequent years, the department shall terminate the Global  
3 Payment Program by notifying the federal Centers for Medicare  
4 and Medicaid Services in accordance with the timeframes specified  
5 in the Special Terms and Conditions. In the event of this type of  
6 termination, the department shall issue a declaration terminating  
7 the Global Payment Program and shall work with the federal  
8 Centers for Medicare and Medicaid Services to finalize all  
9 remaining payments under the Global Payment Program.  
10 Subsequent to the effective date for any termination accomplished  
11 pursuant to this subdivision, the designated public hospitals that  
12 participated in the Global Payment Program shall claim and receive  
13 disproportionate share hospital payments, if eligible, as described  
14 in subparagraph (D) of paragraph (4) of subdivision (b) of Section  
15 14184.30, but only to the extent that any necessary federal  
16 approvals are obtained and federal financial participation is  
17 available and not otherwise jeopardized.

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

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

37 (3) The department shall provide participating PRIME entities  
38 the opportunity to earn the maximum amount of funds authorized  
39 for the PRIME program under the demonstration project. Under  
40 the demonstration project, funding is available for the designated

1 public hospital systems and the district and municipal public  
2 hospitals through two separate pools. Subject to the Special Terms  
3 and Conditions, up to one billion four hundred million dollars  
4 (\$1,400,000,000) is authorized annually for the designated public  
5 hospital systems pool, and up to two hundred million dollars  
6 (\$200,000,000) is authorized annually for the district and municipal  
7 public hospitals pool, during the first three years of the  
8 demonstration project, with reductions to these amounts in the  
9 fourth and fifth years. Except in those limited instances specifically  
10 authorized by the Special Terms and Conditions, the funding that  
11 is authorized for each respective pool shall only be available to  
12 participating PRIME entities within that pool.

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

21 (b) For purposes of this article, the following definitions shall  
22 apply:

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

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

36 (3) “District and municipal public hospitals” means those  
37 nondesignated public hospitals, as listed in the Special Terms and  
38 Conditions, that have an approved project plan under the PRIME  
39 program.

1 (4) “Participating PRIME entity” means a designated public  
2 hospital system or district and municipal public hospital  
3 participating in the PRIME program.

4 (5) “PRIME program year” means the state fiscal year beginning  
5 on July 1 and ending on June 30 during which the PRIME program  
6 is authorized, except that the first PRIME program year shall  
7 commence on January 1, 2016, and, as applicable, means each  
8 state fiscal year thereafter through the 2019–20 state fiscal year,  
9 and any years or partial years during which the PRIME program  
10 is authorized under an extension or successor to the demonstration.

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

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

22 (d) (1) Each participating PRIME entity shall submit reports  
23 to the department twice a year demonstrating progress toward  
24 required metric targets. A standardized report form shall be  
25 developed jointly by the department and participating PRIME  
26 entities for this purpose. The mid-year report shall be due March  
27 31 of each PRIME program year, except that, for the 2015–16  
28 project year only, the submission of an acceptable five-year PRIME  
29 project plan in accordance with the Special Terms and Conditions  
30 shall constitute the submission of the mid-year report. The yearend  
31 report shall be due September 30 following each PRIME program  
32 year.

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

38 (3) Within 14 days following the submission of the mid-year  
39 and yearend reports, the department shall confirm the amounts  
40 payable to participating PRIME entities and shall issue requests

1 to each participating PRIME entity for the intergovernmental  
2 transfer amounts necessary to draw down the federal funding for  
3 the applicable PRIME incentive payment to that entity.

4 (A) Any intergovernmental transfers provided for purposes of  
5 this section shall be deposited in the Public Hospital Investment,  
6 Improvement, and Incentive Fund established pursuant to Section  
7 14182.4 and retained pursuant to paragraph (1) of subdivision (f).

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

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

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

37 (5) The department shall draw down the federal funding and  
38 pay both the nonfederal and federal shares of the incentive payment  
39 to the participating PRIME entity, to the extent federal financial  
40 participation is available.

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

3 (1) The department shall allocate the full amount of annual  
4 funding authorized under the PRIME project pools across all  
5 domains, projects, and metrics undertaken in the manner set forth  
6 in the Special Terms and Conditions. Separate allocations shall be  
7 determined for the designated public hospital system pool and the  
8 district and municipal hospital pool. The allocations shall determine  
9 the aggregate annual amount of funding that may be earned for  
10 each domain, project, and metric for all participating PRIME  
11 entities within the appropriate pool.

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

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

36 (2) Amounts payable to each participating PRIME entity shall  
37 be determined using the methodology described in the Special  
38 Terms and Conditions, based on the participating PRIME entity’s  
39 progress toward and achievement of the established metrics and

1 targets, as reflected in the mid-year and yearend reports submitted  
2 pursuant to paragraph (1) of subdivision (d).

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

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

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

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

24 (f) The nonfederal share of payments under the PRIME program  
25 shall consist of voluntary intergovernmental transfers of funds  
26 provided by designated public hospitals or affiliated governmental  
27 agencies or entities, or district and municipal public hospitals or  
28 affiliated governmental agencies or entities, in accordance with  
29 this section.

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

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

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

1 department shall return any intergovernmental transfer fund  
2 amounts associated with the payment for which federal financial  
3 participation is not available to the applicable transferring entities  
4 within 14 days from the date of the associated recoupment or other  
5 determination, as applicable.

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

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

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

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

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

6 *(B) Each designated public hospital system shall report to the*  
7 *department, in a format determined by the department in*  
8 *consultation with the designated public hospital systems and*  
9 *Medi-Cal managed care plans, a summary of the contracting*  
10 *arrangement the designated public hospital system has with*  
11 *Medi-Cal managed care plans and the scope of services covered*  
12 *under the contract.*

13 *(C) It is the intent of the Legislature to encourage contracting*  
14 *between designated public hospital systems and multiple Medi-Cal*  
15 *managed care plans so that Medi-Cal members have access to*  
16 *medically necessary and appropriate covered services.*

17 (4) Designated public hospital systems and Medi-Cal managed  
18 care plans shall seek to strengthen their data and information  
19 sharing for purposes of identifying and treating applicable  
20 beneficiaries, including the timely sharing and reporting of  
21 beneficiary data, assessment, and treatment information. Consistent  
22 with the Special Terms and Conditions and the goals of the  
23 demonstration project, and notwithstanding any other state law,  
24 the department shall provide guidelines, state-level infrastructure,  
25 and other mechanisms to support this data and information sharing.

26 14184.80. (a) Within 90 days of the effective date of the act  
27 that added this section, the department shall amend its contract  
28 with the external quality review organization (EQRO) currently  
29 under contract with the department and approved by the federal  
30 Centers for Medicare and Medicaid Services to complete an access  
31 assessment. This one-time assessment is intended to do all of the  
32 following:

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

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

4 (3) Report on the number of providers accepting new  
5 beneficiaries.

6 (b) The department shall submit to the federal Centers for  
7 Medicare and Medicaid Services for approval the access assessment  
8 design no later than 180 days after approval by the federal Centers  
9 for Medicare and Medicaid Services of the EQRO contract  
10 amendment.

11 (c) The department shall establish an advisory committee that  
12 will provide input into the structure of the access assessment. The  
13 EQRO shall work with the department to establish the advisory  
14 committee, which will provide input into the assessment structure,  
15 including network adequacy requirements and metrics, that should  
16 be considered.

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

- 21 (1) Consumer advocacy organizations.
- 22 (2) Provider associations.
- 23 (3) Health plans and health plan associations.
- 24 (4) Legislative staff.

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

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

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

32 (3) Provide all of the following:

- 33 (A) Feedback on the access assessment structure.
- 34 (B) An initial draft access assessment report.
- 35 (C) Recommendations that shall be made available on the  
36 department’s Internet Web site.

37 (f) The EQRO shall produce and publish an initial draft and a  
38 final access assessment report that includes a comparison of health  
39 plan network adequacy compliance across different lines of  
40 business. The report shall include recommendations in response

1 to any systemic network adequacy issues, if identified. The initial  
2 draft and final report shall describe the state’s current compliance  
3 with the access and network adequacy standards set forth in the  
4 Medicaid Managed Care proposed rule (80 FR 31097) or the  
5 finalized Part 438 of Title 42 of the Code of Federal Regulations,  
6 if published prior to submission of the assessment design to the  
7 federal Centers for Medicare and Medicaid Services.

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

9 (1) Measure health plan compliance with network adequacy  
10 requirements as set forth in the Knox-Keene Health Care Service  
11 Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340)  
12 of Division 2 of the Health and Safety Code) and Medicaid  
13 managed care contracts, as applicable. The assessment shall  
14 consider State Fair Hearing and IMR decisions, and grievances  
15 and appeals or complaints data, and any other factors as selected  
16 with input from the advisory committee.

17 (2) Review encounter data, including a review of data from  
18 subcapitated plans.

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

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

32 (5) Applicable network adequacy requirements of the proposed  
33 or final Notice of Proposed Rulemaking, as determined under the  
34 approved access assessment design, that are not already required  
35 under the Knox-Keene Health Care Service Plan Act of 1975  
36 (Chapter 2.2 (commencing with Section 1340) of Division 2 of  
37 the Health and Safety Code) shall be reviewed and reported on  
38 against a metric range as identified by the department and approved  
39 by the federal Centers for Medicare and Medicaid Services in the  
40 access assessment design.

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

7 (7) Measure managed care plan compliance with network  
8 adequacy requirements within the department and managed care  
9 plan contract service areas using the Knox-Keene Health Care  
10 Service Plan Act of 1975 (Chapter 2.2 (commencing with Section  
11 1340) of Division 2 of the Health and Safety Code) and network  
12 adequacy standards within Medicaid managed care contracts,  
13 accounting for each of the following:

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

16 (B) Previously approved alternate network access standards, as  
17 provided for under the Knox-Keene Health Care Service Plan Act  
18 of 1975 (Chapter 2.2 (commencing with Section 1340) of Division  
19 2 of the Health and Safety Code) and Medicaid managed care  
20 contracts.

21 (C) Access to in-network providers and out-of-network providers  
22 separately, presented and evaluated separately, when determining  
23 overall access to care.

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

26 (E) Other modalities used for accessing care, including  
27 telemedicine.

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

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

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

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

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

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

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