AMENDED IN SENATE JUNE 20, 2019
CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL — No. 103

Introduced by — Assembly Member Ting Committee on Budget
(Assembly Members Ting (Chair), Arambula, Bloom, Chiu, Cooper,
Frazier, Cristina Garcia, Jones-Sawyer, Limón, McCarty, Medina,
Mullin, Muratsuchi, Nazarian, O’Donnell, Ramos, Reyes,
Luz Rivas, Blanca Rubio, Mark Stone, Weber, Wicks, and Wood)

December 3, 2018

An act relating to the Budget Act of 2019. An act to amend Sections 1001 and 1003 of, to amend the heading of Part 4 (commencing with Section 1000) of Division 1 of, and to repeal and add Section 1002 of, the Health and Safety Code, and to amend Sections 14005.18, 14005.40, 14007.8, 14301.1, 17600.50, 17612.1, 17612.2, 17613.1, and 17613.2 of the Welfare and Institutions Code, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

LEGISLATIVE COUNSEL’S DIGEST


(1) Until January 1, 2022, existing law establishes the Council on Health Care Delivery Systems to develop a plan that includes options for advancing progress toward achieving a health care delivery system in California that provides coverage and access through a unified financing system for all Californians. Existing law, on or before October 1, 2021, requires the council to submit to the Legislature and Governor a plan with options that include a timeline of the benchmarks and steps necessary to implement health care delivery system changes. Existing
law authorizes the California Health and Human Services Agency to provide staff support to implement these requirements.

Until January 1, 2022, this bill would instead establish the Healthy California for All Commission for purposes of developing a plan that includes options for advancing progress toward achieving a health care delivery system in California that provides coverage and access through a unified financing system, including, but not limited to, a single-payer financing system, for all Californians. The bill would require the commission, by July 1, 2020, to submit a report to the Legislature and the Governor with, among other things, an analysis of California’s existing health care delivery system and options to transition to a unified financing system, including a single-payer financing system. The bill would also require the commission, by February 1, 2021, to submit a report to the Legislature and the Governor that includes options for key design considerations for a unified financing system, including a single-payer financing system. The bill would require those reports to be posted on the California Health and Human Services Agency’s internet website.

(2) Under existing law, an individual is eligible for Medi-Cal benefits, to the extent required by federal law, as though the individual was pregnant, for all pregnancy-related and postpartum services for a 60-day period beginning on the last day of pregnancy.

This bill would, subject to an appropriation in the annual Budget Act, extend Medi-Cal eligibility for a pregnant individual who is receiving health care coverage under the Medi-Cal program, or another specified program, and who has been diagnosed with a maternal mental health condition, for a period of one year following the last day of the individual’s pregnancy if the individual complies with certain requirements. The bill would define “maternal mental health condition” for purposes of the bill. The bill would suspend implementation of these provisions on December 31, 2021, unless specified circumstances apply.

(3) The federal Medicaid program prohibits payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

Existing law requires that individuals under 19 years of age enrolled in restricted-scope Medi-Cal at the time the Director of Health Care Services makes a determination that systems have been programmed for implementation of these provisions be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible. Existing law requires the
department to maximize federal financial participation in implementing
the provisions.

This bill would extend eligibility for full-scope Medi-Cal benefits to
individuals 19 to 25 years of age, inclusive, and who are otherwise
eligible for those benefits but for their immigration status. This bill
would additionally require the department to claim federal financial
participation to the extent that the department determines it is available,
and to the extent that federal financial participation is not available,
would require the department to use state funds. Because counties are
required to make eligibility determinations and this bill would expand
Medicaid eligibility, the bill would impose a state-mandated local
program.

(4) Existing law also requires the State Department of Health Care
Services to exercise its option under federal law to implement a program
for aged and disabled persons, as described. Existing law requires an
individual under these provisions to satisfy certain financial eligibility
requirements, including, among other things, that the individual’s
countable income does not exceed an income standard equal to 100% of
the applicable federal poverty level, plus an income disregard of
$230 for an individual, or $310 in the case of a couple, except that the
income standard determined shall not be less than the SSI/SSP payment
level for a disabled individual or couple, as applicable. Existing law
requires the department to implement this program by means of
all-county letters or similar instructions without taking regulatory action
and thereafter requires the department to adopt regulations.

This bill would instead require, upon receipt of federal approval, all
countable income over 100% of the federal poverty level, up to 138%
of the federal poverty level, to be disregarded, after taking all other
disregards, deductions, and exclusions into account for those persons
eligible under the program for aged and disabled persons. The bill
would require that provision to be implemented after the Director of
Health Care Services determines, and communicates that determination
in writing to the Department of Finance, that systems have been
programmed for implementation of that provision, but no sooner than

The bill would require the department to implement, interpret, or
make specific the above-described program for aged and disabled
persons by means of all-county letters, plan or provider bulletins, or
similar instructions until regulations are adopted, and would require
the department to adopt regulations by July 1, 2023. The bill would
require the department to provide a status report on a semiannual basis to the Legislature until regulations are adopted. The bill would require the implementation of the program only if and to the extent that any necessary federal approvals have been obtained.

Because counties are required to make Medi-Cal eligibility determinations, and this bill would expand Medi-Cal eligibility by increasing the income disregard amounts and would increase the responsibility of counties in determining Medi-Cal eligibility, the bill would impose a state-mandated local program.

(5) Existing federal law establishes the Program of All-Inclusive Care for the Elderly (PACE), which provides specified services for older individuals, and authorizes states to implement the PACE program as a Medicaid state option. Existing law authorizes the State Department of Health Care Services to enter into contracts with public or private organizations for implementation of the PACE program and to enter into separate contracts with PACE organizations. Existing law requires the State Department of Health Care Services to develop and pay capitation rates to contracted PACE organizations using actuarial methods and in accordance with criteria specific to those organizations, based on, among other things, a standardized rate methodology across managed care plan models for comparable populations. Existing law requires the department to pay a capitation rate within the actuarially sound rate range during the first 2 years in which a new PACE organization enters a previously unserved area.

This bill would require the department’s rate methodology to be consistent with actuarial rate development principles and to provide for all reasonable, appropriate, and attainable costs for each PACE organization within a region. During the first 2 years in which a new PACE organization enters a previously unserved area, the bill would require the department to pay a capitation rate within the actuarially sound rate range to reflect the lower enrollment and higher operating costs associated with a new PACE organization.

(6) Existing law redirects specified 1991 health realignment funds to pay an increased county contribution toward the cost of CalWORKs grants, a county contribution toward the costs of the CalWORKs single allocation, or both. Existing law specifies the formula to be used in determining the amount of funds that are required to be redirected, which varies depending on the method a county uses to provide indigent health care services. Existing law requires, for counties that provide indigent health care services via the County Medical Services Program
(CMSP), 60% of 1991 health realignment funds be redirected to the Family Support Subaccount.

This bill would instead require, for counties that participate in CMSP, the amount identified on a specified schedule that would have otherwise been payable to the CMSP, and the amount that would have otherwise been allocated to the governing board of the CMSP, be redirected until the Department of Finance determines that the total reserves of the CMSP are projected to fall below an amount totaling 2 fiscal years of total expenditures, and, after the Department of Finance makes that determination, the bill would reinstate the existing formula for determining the amount of 1991 health realignment funds that are redirected to the Family Support Subaccount. By increasing county payments to the Family Support Subaccount of the continuously appropriated Local Revenue Fund, this bill would make an appropriation.

(7) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

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

This bill would express the intent of the Legislature to enact statutory changes relating to the Budget Act of 2019.


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

1 SECTION 1. The heading of Part 4 (commencing with Section 1000) of Division 1 of the Health and Safety Code is amended to read:

PART 4. COUNCIL ON HEALTH CARE DELIVERY SYSTEMS HEALTHY CALIFORNIA FOR ALL COMMISSION
SEC. 2. Section 1001 of the Health and Safety Code is amended to read:

1001. (a) Effective January 1, 2019, there is hereby established the Council on Health Care Delivery Systems, Healthy California for All Commission as an independent body to develop a plan that includes options for advancing progress toward achieving a health care delivery system in California that provides coverage and access through a unified financing system, including, but not limited to, a single-payer financing system, for all Californians.

(b) The council commission shall meet for the first time on or before July 1, 2019, and shall convene meetings at least quarterly at locations that are easily accessible to the public in accordance with the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

(c) (1) The council commission shall be comprised of five members as follows:

(A) The Secretary of California Health and Human Services, or the secretary’s designee, who shall serve as the chairperson.

(B) Eight members who shall be appointed by the Governor.

(C) Two members who shall be appointed by the Senate Committee on Rules.

(D) Two members who shall be appointed by the Speaker of the Assembly.

(2) There shall also be five ex officio, nonvoting members of the commission who shall be the Executive Director of the California Health Benefit Exchange, the Director of Health Care Services, the Chief Executive Officer of the Public Employees’ Retirement System, and the chairs of the health committees of the Senate and the Assembly, or their officially designated representatives.

(3) The appointees shall have appropriate knowledge and experience regarding health care coverage or financing, or other relevant expertise.

(3) The council shall elect a chairperson on an annual basis.
(4) The members of the council commission shall serve without compensation, but shall be reimbursed for necessary traveling and other expenses incurred in performing their duties and responsibilities.

(d) The council commission may establish advisory committees that include members of the public with knowledge and experience in health care that support stakeholder engagement and an analytical process by which key design options are developed. A member of an advisory committee need not be a member of the council commission.

(e) The council commission and each advisory committee shall keep official records of all of their proceedings.

SEC. 3. Section 1002 of the Health and Safety Code is repealed.

1002.—(a) On or before October 1, 2021, the council shall submit to the Legislature and Governor a plan with options that include a timeline of the benchmarks and steps necessary to implement health care delivery system changes, including steps necessary to achieve a unified financing system. The plan shall be submitted in compliance with Section 9795 of the Government Code. The plan shall also be posted on the California Health and Human Services Agency’s Internet Web site. The plan shall, at a minimum, consider all of the following:

(1) Key design options, including covered benefits, eligibility, service delivery, provider payments, and quality improvement.

(2) Requirements potentially necessary for the state, in consultation with the State Department of Health Care Services, to seek federal waivers and federal statutory changes, by which funds currently managed by the federal government, but used on behalf of Californians, may be consolidated with other funding sources;

(3) A summary of relevant requirements under current law and potential state constitutional and statutory amendments that may be evaluated to improve the health care system;

(4) Options for financing and an analysis of the need for voter approval of any financing;

(5) Potential considerations for building or restructuring information technology systems and financial management systems necessary for health care system changes;

(6) Opportunities for controlling health care costs, including mitigating rising health care costs and limiting administrative costs.
so that more money is spent on direct care to patients and less on
profits and overhead, in order to achieve a sustainable health care
system with more equitable access to quality health care.
(b) The council shall provide an update detailing its progress
in developing the plan required by subdivision (a) to the Governor
and the health committees of the Senate and the Assembly on or
before January 1, 2020, and shall update those committees every
six months thereafter.
SEC. 4. Section 1002 is added to the Health and Safety Code,
to read:
1002. (a) On or before July 1, 2020, the commission shall
submit a report to the Legislature and the Governor with options
that include all of the following:
(1) An analysis of California's existing health care delivery
system, including cost, quality, workforce, and provider
consolidation trends and how they impact the state's ability to
provide all Californians with timely access to high-quality,
affordable health care.
(2) Options for additional steps California can take to prepare
for transition to a unified financing system, including, but not
limited to, a single-payer financing system, including, but not
limited to, administrative changes, reorganization of state
programs, federal waivers, and statutory and constitutional
changes.
(3) Options for coverage expansions, including potential funding
sources. Options shall include expansion for full-scope Medi-Cal
to individuals over 64 years of age, regardless of immigration
status.
(b) On or before February 1, 2021, the commission shall submit
a report to the Legislature and the Governor that includes options
for key design considerations for a unified financing system,
including, but not limited to, a single-payer financing system,
including all of the following:
(1) Eligibility and enrollment.
(2) Covered benefits and services.
(3) Provider participation.
(4) Purchasing arrangements.
(5) Provider payments, including consideration of global
budgets.
(6) Cost containment.
(7) Quality improvement.
(8) Participant cost sharing.
(9) Quality monitoring and disparities reduction.
(10) Information technology systems and financial management systems.
(11) Data sharing and transparency.
(12) Governance and administration, including integration of federal funding sources.
(c) The reports required under this section shall be submitted in compliance with Section 9795 of the Government Code, and shall be posted on the California Health and Human Services Agency’s internet website.
(d) The commission shall provide an update detailing its progress in developing the reports required by subdivisions (a) and (b) to the Governor and the health committees of the Senate and the Assembly on or before January 1, 2020, and shall update those committees every six months thereafter.

SEC. 5. Section 1003 of the Health and Safety Code is amended to read:

1003. This part shall not be construed to authorize the council commission to implement any provision of the plan reports developed pursuant to Section 1002 until there is further action by the Legislature and the Governor.

SEC. 6. Section 14005.18 of the Welfare and Institutions Code is amended to read:

14005.18. A woman—(a) (1) An individual is eligible, to the extent required by federal law, as though she were the individual was pregnant, for all pregnancy-related and postpartum services for a 60-day period beginning on the last day of pregnancy.

For
(2) For purposes of this section, paragraph (1), “postpartum services” means those services provided after childbirth, child delivery, or miscarriage.

(b) (1) Notwithstanding subdivision (a), Section 15840, the income eligibility requirements specified in Section 15832, and the annual redetermination requirements described in Section 14005.37, a pregnant individual who is receiving health care coverage under a program identified in subdivision (d) and who is diagnosed with a maternal mental health condition shall remain eligible for the Medi-Cal program under their current eligibility
category for a period of one year following the last day of the
individual’s pregnancy if the individual complies with the
requirements specified in subdivision (c) and is otherwise eligible
for the Medi-Cal program.
(2) For purposes of this section, “maternal mental health
condition” means a mental health condition that occurs during
pregnancy or during the postpartum period and, includes, but is
not limited to, postpartum depression.
(c) (1) An individual, or a designee of the individual, who seeks
to extend Medi-Cal program coverage pursuant to this section
shall submit to a county eligibility worker a note from that
individual’s treating health care provider stating that the health
care provider has diagnosed the individual with a maternal mental
health condition within 60 days following the last day of the
individual’s pregnancy.
(2) Notwithstanding paragraph (1), an individual who has had
Medi-Cal coverage discontinued within the 60-day period
beginning on the last day of pregnancy, but who is diagnosed with
a maternal mental health condition more than 60 days following
the last day of pregnancy and within the time limited described in
subdivision (i) of Section 14005.37, may be reinstated to their
previous Medi-Cal eligibility pursuant to subdivision (i) of Section
14005.37 by submitting a note, as described in paragraph (1),
from the individual’s treating health care provider within the
timeframe described in that subdivision.
(d) For purposes of this section, “Medi-Cal program” refers
to any of the following programs:
(1) The Medi-Cal Access Program, as described in Chapter 2
(commencing with Section 15810) of Part 3.3.
(2) The Medi-Cal program, as described in this article.
(3) The Perinatal Services Program, as described in Article 4.7
(commencing with Section 14148).
(e) This section does not limit the ability of a qualified individual
to apply for and purchase a qualified health plan in Covered
California pursuant to Title 22 (commencing with Section 100500)
of the Government Code if the qualified individual is otherwise
eligible for coverage pursuant to that title.
(f) Notwithstanding Chapter 3.5 (commencing with Section
11340) of Part 1 of Division 3 of Title 2 of the Government Code,
the department may implement, interpret, or make specific this
section by means of all-county letters, provider bulletins, or similar
instructions, without taking regulatory action.
(g) Implementation of this section is subject to an appropriation
in the annual Budget Act for these purposes.
(h) Implementation of this section is suspended on December
31, 2021, except that if the estimates of General Fund revenues
and expenditures determined pursuant to Section 12.5 of Article
IV of the California Constitution that accompany the May Revision
required to be released by May 14, 2021, pursuant to Section
13308 of the Government Code, contain projected annual General
Fund revenues that exceed projected annual General Fund
expenditures in the 2021–22 fiscal year and the 2022–23 fiscal
year by the sum total of General Fund money appropriated for all
programs suspended pursuant to the Budget Act of 2019 and all
related trailer bill legislation implementing the provisions of the
Budget Act of 2019, then the suspension shall not take effect. It is
the intent of the Legislature to consider alternative solutions to
restore this program, should the suspension take effect.
SEC. 7. Section 14005.40 of the Welfare and Institutions Code
is amended to read:
14005.40. (a) To the extent federal financial participation is
available, the department shall exercise its option under Section
1902(a)(10)(A)(ii)(X) of the federal Social Security Act (42 U.S.C.
Sec. 1396a(a)(10)(A)(ii)(X)), to implement
a program for aged and disabled persons as described in Section
1902(m) of the federal Social Security Act (42 U.S.C. Sec.
1396a(m)(1)).
(b) To the extent federal financial participation is available, the
blind shall be included within the definition of disabled for the
purposes of the program established in this section.
(c) An individual shall satisfy the financial eligibility
requirement of this program if all of the following conditions are
met:
(1) Countable income, as determined in accordance with Section
1902(m) of the federal Social Security Act (42 U.S.C. Sec.
1396a(m)), does not exceed an income standard level equal to 100
percent of the applicable federal poverty level, plus two hundred
thirty dollars ($230) for an individual or, in the case of a couple,
three hundred ten dollars ($310), provided that the income standard
so determined shall not be less than the SSI/SSP payment level
for a disabled individual or, in the case of a couple, the SSI/SSP payment level for a disabled couple.

(2) (A) Until such time as the department obtains federal approval for the income disregard described in paragraph (3), countable income shall include an additional two hundred thirty dollars ($230) for an individual or, in the case of a couple, three hundred ten dollars ($310).

(B) Upon receipt of federal approval for, and implementation of, paragraph (3), this paragraph shall become inoperative. The director shall execute a declaration, which shall be retained by the director, stating that federal approval for paragraph (3) has been obtained and the date upon which paragraph (3) will be implemented. The director shall post the declaration on the department’s internet website.

(3) (A) Pursuant to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)), all countable income over 100 percent of the federal poverty level, up to 138 percent of the federal poverty level, shall be disregarded, after taking all other disregards, deductions, and exclusions into account for those persons eligible pursuant to this section.

(B) The department shall seek federal approval to implement this paragraph.

(4) (A) For the purposes of calculating countable income under this section, an income exemption shall be applied as necessary to adjust the SSI/SSP payment level as used in this section so that it is the same as the SSI/SSP payment level that was in place on May 1, 2009.

(B) This additional income exemption shall cease to be implemented when the SSI/SSP payment levels increase beyond those in effect on May 1, 2009.

(C) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, SSI/SSP payment level the department shall implement this paragraph by means of an all-county letter a couple, the SSI/SSP payment level the couple receives or similar instruction without taking regulatory action. would receive as a disabled or blind couple.
(3) Countable resources, as determined in accordance with Section 1902(m) of the federal Social Security Act (42 U.S.C. Sec. 1396a(m)), do not exceed the maximum levels established in that section.

(d) The financial eligibility requirements provided in subdivision (c) may be adjusted upwards to reflect the cost of living in California, contingent upon appropriation in the annual Budget Act.

(e)(1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, and without taking regulatory action. Thereafter, the department shall adopt instructions until regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code are adopted.

(2) The department shall adopt regulations by July 1, 2023, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations are adopted.

(f) For purposes of calculating income under this section during any calendar year, increases in social security benefit payments under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 et seq.) arising from cost-of-living adjustments shall be disregarded commencing in the month that these social security benefit payments are increased by the cost-of-living adjustment through the month before the month in which a change in the federal poverty level requires the department to modify the income standard level described in subdivision (c).

(g)(1) For purposes of this section the following definitions apply:

(A) “SSI” means the federal Supplemental Security Income program established under Title XVI of the federal Social Security Act.
(B) “Income--standard level” means the applicable income standard including the augmentations level specified in paragraph (1) of subdivision (c).

(C) The board and care “personal care services” or “PCS” deduction refers to an income disregard that is applied to a resident in a licensed community care facility in lieu of the board and care deduction (equal to the amount by which the basic board and care rate exceeds the income--standard level in subparagraph (B) of paragraph (1) of subdivision (g)) (B)) when the PCS deduction is greater than the board and care deduction.

(2) (A) For purposes of this section, the SSI recipient retention amount is the amount by which the SSI maximum payment amount to an individual residing in a licensed community care facility exceeds the maximum amount that the state allows community care facilities to charge a resident who is an SSI recipient.

(B) For the purposes of this section, the personal and incidental needs deduction for an individual residing in a licensed community care facility is either of the following:

(i) If the board and care deduction is applicable to the individual, the amount, not to exceed the amount by which the SSI recipient retention amount exceeds twenty dollars ($20), nor to be less than zero, by which the sum of the amount that the individual pays to his or her the individual’s licensed community care facility and the SSI recipient retention amount exceed the sum of the individual’s income--standard level, the individual’s board and care deduction, and twenty dollars ($20).

(ii) If the PCS deduction specified in paragraph (1) of subdivision (g) is applicable to the individual, an amount, not to exceed the amount by which the SSI recipient retention amount exceeds twenty dollars ($20), nor to be less than zero, by which the sum of the amount that the individual pays to his or her the individual’s community care facility and the SSI recipient retention amount exceed the sum of the individual’s income--standard level, the individual’s PCS deduction deduction, and twenty dollars ($20).

(3) In determining the countable income under this section of an individual residing in a licensed community care facility, the individual shall have deducted from his or her the individual’s income the amount specified in subparagraph (B) of paragraph (2).
(h) No later than one month after the effective date of subdivision (g), the department shall submit to the federal Medicaid administrator a state plan amendment seeking approval of the income deduction specified in paragraph (3) of subdivision (g), and of federal financial participation for the costs resulting from that income deduction.

(i) The deduction prescribed by paragraph (3) of subdivision (g) shall be applied no later than the first day of the fourth month after the month in which the department receives approval for the federal financial participation specified in subdivision (h). Until approval for federal financial participation is received, there shall be no deduction under paragraph (3) of subdivision (g).

(j) This section shall be implemented only if and to the extent that any necessary federal approvals have been obtained.

(k) Paragraph (3) of subdivision (c) shall be implemented after the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of paragraph (3) of subdivision (c), but no sooner than January 1, 2020.

SEC. 8. Section 14007.8 of the Welfare and Institutions Code is amended to read:

14007.8. (a) (1) After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of this section, but no sooner than May 1, 2016, an individual who is under 19 years of age and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status as required by Section 14011.2 shall be eligible for the full scope of Medi-Cal benefits, if he or she is otherwise eligible for benefits under this chapter.

(2) (A) An individual under 19 years of age enrolled in Medi-Cal pursuant to subdivision (d) of Section 14007.5 at the time the director makes the determination described in paragraph (1) shall be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, pursuant to an eligibility and enrollment plan. This plan shall include outreach strategies developed by the department in consultation with interested stakeholders, including, but not limited to, counties, health care service plans, consumer advocates, and the Legislature.

An individual subject
to this subparagraph shall not be required to file a new application
for Medi-Cal.

(B) The effective date of enrollment into Medi-Cal for
individuals an individual described in subparagraph (A) shall be
on the same day on which the systems are operational to begin
processing new applications pursuant to the director’s
determination described in paragraph (1).

(C) Beginning January 31, 2016, and until the director makes
the determination described in paragraph (1), the department shall
provide monthly updates to the appropriate policy and fiscal
committees of the Legislature on the status of the implementation
of this section.

(b) After the director determines, and communicates that
determination in writing to the Department of Finance, that systems
have been programmed for implementation of this subdivision, but
no sooner than July 1, 2019, an individual who is 19 to 25 years
of age, inclusive, and who does not have satisfactory immigration
status or is unable to establish satisfactory immigration status as
required by Section 14011.2 shall be eligible for the full scope of
Medi-Cal benefits, if they are otherwise eligible for benefits under
this chapter.

(c) To the extent permitted by state and federal law, an
individual eligible under this section shall be required to enroll in
a Medi-Cal managed care health plan. Enrollment in a Medi-Cal
managed care health plan shall not preclude a beneficiary from
being enrolled in any other children’s Medi-Cal specialty program
that he or she they would otherwise be eligible for.

(d) (1) The department shall seek any necessary maximize
federal approvals to obtain federal financial participation in
implementing this section. Benefits section to the extent allowable,
and, for services under purposes of implementing this section,
the department shall be provided with state only funds
only if claim federal financial participation is not available for
those services. to the extent that the department determines it is
available.

(2) To the extent that federal financial participation—is not available, the department shall implement
this section to the extent allowable. using state funds appropriated
for this purpose.
(e) This section shall be implemented only to the extent it is in
compliance with Section 1621(d) of Title 8 of the United States
Code.
(f) (1) Notwithstanding Chapter 3.5 (commencing with Section
11340) of Part 1 of Division 3 of Title 2 of the Government Code,
the department, without taking any further regulatory action, shall
implement, interpret, or make specific this section by means of
all-county letters, plan letters, plan or provider bulletins, or similar
instructions until the time any necessary regulations are adopted.
Thereafter, the department shall adopt regulations in accordance
with the requirements of Chapter 3.5 (commencing with Section
11340) of Part 1 of Division 3 of Title 2 of the Government Code.
(2) Commencing six months after the effective date of this
section, and notwithstanding Section 10231.5 of the Government
Code, the department shall provide a status report to the Legislature
on a semiannual basis, in compliance with Section 9795 of the
Government Code, until regulations have been adopted.
(g) In implementing this section, the department may contract,
as necessary, on a bid or nonbid basis. This subdivision establishes
an accelerated process for issuing contracts pursuant to this section.
Those contracts, and any other contracts entered into pursuant to
this subdivision, may be on a noncompetitive bid basis and shall
be exempt from the following:
(1) Part 2 (commencing with Section 10100) of Division 2 of
the Public Contract Code and any policies, procedures, or
regulations authorized by that part.
(2) Article 4 (commencing with Section 19130) of Chapter 5
of Part 2 of Division 5 of Title 2 of the Government Code.
(3) Review or approval of contracts by the Department of
General Services.
SEC. 9. Section 14301.1 of the Welfare and Institutions Code
is amended to read:
14301.1. (a) For rates established on or after August 1, 2007,
the department shall pay capitation rates to health plans
participating in the Medi-Cal managed care program using actuarial
methods and may establish health-plan- and county-specific rates.
Notwithstanding any other law, this section shall apply to any
managed care organization, licensed under the Knox-Keene Health
Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), that has contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7 to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS for rates established on or after July 1, 2012. The department shall utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:

1. Health-plan-specific encounter and claims data.
2. Supplemental utilization and cost data submitted by the health plans.
3. Fee-for-service data for the underlying county of operation or other appropriate counties as deemed necessary by the department.
4. Department of Managed Health Care financial statement data specific to Medi-Cal operations.
5. Other demographic factors, such as age, gender, or diagnostic-based risk adjustments, as the department deems appropriate.

(b) To the extent that the department is unable to obtain sufficient actual plan data, it may substitute plan model, similar plan, or county-specific fee-for-service data.

(c) The department shall develop rates that include administrative costs, and may apply different administrative costs with respect to separate aid code groups.

(d) The department shall develop rates that shall include, but are not limited to, assumptions for underwriting, return on investment, risk, contingencies, changes in policy, and a detailed review of health plan financial statements to validate and reconcile costs for use in developing rates.

(e) The department may develop rates that pay plans based on performance incentives, including quality indicators, access to care, and data submission.
(f) The department may develop and adopt condition-specific payment rates for health conditions, including, but not limited to, childbirth delivery.

(g) (1) Prior to finalizing Medi-Cal managed care capitation rates, the department shall provide health plans with information on how the rates were developed, including rate sheets for that specific health plan, and provide the plans with the opportunity to provide additional supplemental information.

(2) For contracts entered into between the department and any entity pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7, the department, by June 30 of each year, or, if the budget has not passed by that date, no later than five working days after the budget is signed, shall provide preliminary rates for the upcoming fiscal year.

(h) For the purposes of developing capitation rates through implementation of this ratesetting methodology, Medi-Cal managed care health plans shall provide the department with financial and utilization data in a form and substance as deemed necessary by the department to establish rates. This data shall be considered proprietary and shall be exempt from disclosure as official information pursuant to subdivision (k) of Section 6254 of the Government Code as contained in the California Public Records Act (Division 7 (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(i) Notwithstanding any other law, on and after the effective date of the act adding this subdivision, the department may apply this section to the capitation rates it pays under any managed care health plan contract.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may set and implement managed care capitation rates, and interpret or make specific this section and any applicable federal waivers and state plan amendments by means of plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

(k) The department shall report, upon request, to the fiscal and policy committees of the respective houses of the Legislature regarding implementation of this section.
Prior to October 1, 2011, the risk-adjusted countywide capitation rate shall comprise no more than 20 percent of the total capitation rate paid to each Medi-Cal managed care plan.

It is the intent of the Legislature to preserve the policy goal to support and strengthen traditional safety net providers who treat high volumes of uninsured and Medi-Cal patients when Medi-Cal enrollees are defaulted into Medi-Cal managed care plans.

As the department adds additional factors, such as managed care plan costs, to the Medi-Cal managed care plan default assignment algorithm, it shall consult with the Auto Assignment Performance Incentive Program stakeholder workgroup to develop cost factor disregards related to intergovernmental transfers and required wraparound payments that support safety net providers.

The department shall develop and pay capitation rates to entities contracted pursuant to Chapter 8.75 (commencing with Section 14591), using actuarial methods and in a manner consistent with this section, except as provided in this subdivision.

The department may develop capitation rates using a standardized rate methodology across managed care plan models for comparable populations. The specific rate methodology applied to PACE organizations shall address features of PACE that distinguishes it from other managed care plan models.

The rate methodology shall be consistent with actuarial rate development principles and shall provide for all reasonable, appropriate, and attainable costs for each PACE organization within a region.

The department may develop statewide rates and apply geographic adjustments, using available data sources deemed appropriate by the department. Consistent with actuarial methods, the primary source of data used to develop rates for each PACE organization shall be its Medi-Cal cost and utilization data or other data sources as deemed necessary by the department.

Rates developed pursuant to this subdivision shall reflect the level of care associated with the specific populations served under the contract.

The rate methodology developed pursuant to this subdivision shall contain a mechanism to account for the costs of high-cost drugs and treatments.
(6) Rates developed pursuant to this subdivision shall be actuarially certified prior to implementation.

(7) The department shall consult with those entities contracted pursuant to Chapter 8.75 (commencing with Section 14591) in developing a rate methodology according to this subdivision.

(8) Consistent with the requirements of federal law, the department shall calculate an upper payment limit for payments to PACE organizations. In calculating the upper payment limit, the department shall correct the applicable data as necessary and shall consider the risk of nursing home placement for the comparable population when estimating the level of care and risk of PACE participants.

(9) During the first three rate years in which the methodology developed pursuant to this subdivision is used by the department to set rates for entities contracted pursuant to Chapter 8.75 (commencing with Section 14591), the department shall pay the entity at a rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11), as necessary to mitigate the impact to the entity during the transition to the methodology developed pursuant to this subdivision.

(10) During the first two years in which a new PACE organization or existing PACE organization enters a previously unserved area, the department shall pay at a rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11), to reflect the lower enrollment and higher operating costs associated with a new PACE organization relative to a PACE organization with higher enrollment and more experience providing managed care interventions to its beneficiaries.

(11) This subdivision shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available.

(12) This subdivision shall apply for rates implemented no earlier than January 1, 2017.

SEC. 10. Section 17600.50 of the Welfare and Institutions Code is amended to read:

17600.50. (a) For fiscal years prior to the 2019–20 fiscal year, a county that participated in the County Medical Services
Program in the 2011–12 fiscal year, including the Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, and Yuba and the Governing Board of the County Medical Services Program, shall adopt resolutions by January 22, 2014, that confirm acceptance for the following approach to determining payments to the Family Support Subaccount:

1. The amount of payments to the Family Support Subaccount shall be equal to 60 percent of the sum of the following:
   
   (A) The 1991 health realignment funds that would have otherwise been allocated to the counties listed above in this subdivision pursuant to Section 17603 and the maintenance of effort in subdivision (a) of Section 17608.10 for these counties, as those sections read on January 1, 2012, Sections 17604 and 17606.20, as those sections read on August 1, 2017, and Section 17606.10, as it read on July 1, 2013.
   
   (B) The 1991 health realignment funds that would have otherwise been allocated to the County Medical Services Program pursuant to Sections 17603 and 17605.07, as those sections read on January 1, 2012, and Sections 17604 and 17606.20, as those sections read on August 1, 2017.

2. The payment computed in paragraph (1) shall be achieved through the following:
   
   (A) Each county listed in this subdivision (a) shall pay the amounts otherwise payable to the County Medical Services Program pursuant to subparagraph (B) of paragraph (2) of subdivision (j) of Section 16809 to the Family Support Subaccount.
   
   (B) The County Medical Services Program shall pay the difference between the total computed in paragraph (1) and the amount calculated in subparagraph (A) from funds provided pursuant to the Welfare and Institutions Code.

(b) For the 2019–20 fiscal year and each fiscal year thereafter, until the Department of Finance determines that the total reserves of the County Medical Services Program are projected to fall below an amount totaling two fiscal years of total expenditures pursuant to paragraph (1) of subdivision (c), payments to the
Family Support Subaccount shall be equal to the sum of the following:

1. (A) For the Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, and Yuba the amount otherwise payable to the County Medical Services Program pursuant to paragraph (2) of subdivision (j) of Section 16809.

2. (B) For the County of Yolo, the amount otherwise payable to the County Medical Services Program pursuant to subparagraph (A) of paragraph (3) of subdivision (j) of Section 16809.

3. (2) The 1991 health realignment funds that would have otherwise been allocated to the governing board of the County Medical Services Program pursuant to Sections 17603 and 17605.07, as those sections read on January 1, 2012, Section 17604, as it read on August 1, 2017, and Section 17606.20, as it read on August 1, 2019.

4. (c) (1) The payment computed in subdivision (b) shall become inoperative for the fiscal year immediately following the determination of the Department of Finance that the total reserves of the County Medical Services Program are projected to fall below an amount totaling two fiscal years of total expenditures.

5. (2) Beginning the fiscal year immediately following the Department of Finance’s determination pursuant to paragraph (1), and each fiscal year thereafter, for a county that participated in the County Medical Services Program in the 2019–20 fiscal year, including the Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba, and for the governing board of the County Medical Services Program, the following approach shall be utilized to determine payments to the Family Support Subaccount:

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

7. (i) The 1991 health realignment funds that would have otherwise been allocated to the counties listed in this subdivision pursuant
to Section 17603 and the maintenance of effort in subdivision (a) of Section 17608.10 for these counties, as those sections read on January 1, 2012, Sections 17604 and 17606.20, as those sections read on August 1, 2017, and Section 17606.10, as it read on July 1, 2013.

(ii) The 1991 health realignment funds that would have otherwise been allocated to the County Medical Services Program pursuant to Sections 17603 and 17605.07, as those sections read on January 1, 2012, and Sections 17604 and 17606.20, as those sections read on August 1, 2017.

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

(A) Each county listed in paragraph (2) shall pay the amounts otherwise payable to the County Medical Services Program pursuant to paragraphs (2) and (3) of subdivision (j) of Section 16809 to the Family Support Subaccount.

(B) The County Medical Services Program shall pay the difference between the total computed in paragraph (2) and the amount calculated in subparagraph (A) from funds provided pursuant to this code.

(b)

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

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

(2) (A) A calculation of 60 percent of the total of 1991 health realignment funds that would have otherwise been allocated to that county or city and county pursuant to Section 17603, as it read on January 1, 2012, Sections 17604 and 17606.20, as those sections read on August 1, 2017, and Section 17606.10, as it read on July 1, 2013, and 60 percent of the
maintenance of effort in subdivision (a) of Section 17608.10, as it read on January 1, 2012.

(B) If a county’s maintenance of effort in subdivision (a) of Section 17608.10 is greater than 14.6 percent of the total value of the county’s 2010–11 allocation pursuant to Sections 17603, 17604, 17606.10, and 17606.20 and subdivision (a) of Section 17608.10, the value of the maintenance of effort used in the calculation in subparagraph (A) shall be limited to 14.6 percent.

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

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

(2) (A) A calculation of 60 percent of the total of 1991 health realignment funds that would have otherwise been allocated to that county or city and county pursuant to Section 17603, as it read on January 1, 2012, Sections 17604 and 17606.20, as those sections read on August 1, 2017, and Section 17606.10, as it read on July 1, 2013, and 60 percent of the maintenance of effort in subdivision (a) of Section 17608.10, as it read on January 1, 2012.

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

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

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

SEC. 11. Section 17612.1 of the Welfare and Institutions Code
is amended to read:
17612.1. (a) For the 2013–14 fiscal year and each fiscal year
thereafter, for each public hospital health system county that
selected the option in paragraph (1) of subdivision (c) of Section
17600.50, the total amount that would be payable for the fiscal
year from 1991–Health Realignment health realignment funds
under Section 17603, as it read on January 1, 2012, Sections 17604
and 17606.20, Section 17604, as those sections it read on August
1, 2017, Section 17606.20, as it read on August 1, 2019, and
Section 17606.10, as it read on July 1, 2013, and deposited by the
Controller into the local health and welfare trust fund health
account of the county in the absence of this section shall be
determined.

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

(c) The resulting fraction determined in subdivision (b) shall
be the percentage of 1991–Health Realignment health realignment
funds under Section 17603, as it read on January 1, 2012, Sections
17604 and 17606.20, Section 17604, as those sections it read on
August 1, 2017, Section 17606.20, as it read on August 1, 2019,
and Section 17606.10, as it read on July 1, 2013, to be deposited each month into the Family Support Subaccount.

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

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

SEC. 12. Section 17612.2 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

(B) The public hospital health system county’s Medi-Cal costs, uninsured costs, and imputed other entity intergovernmental transfer amounts for the base year shall be added together and multiplied by the blended CPI trend factor. The base year costs used shall not reflect any adjustments under this subdivision.
(C) The fiscal year amount determined in subparagraph (A) shall be compared to the trended amount in subparagraph (B). If the amount in subparagraph (B) exceeds the amount in subparagraph (A), the public hospital health system county shall be deemed to have satisfied the cost containment limit. If the amount in subparagraph (A) exceeds the amount in subparagraph (B), the calculation in paragraph (3) shall be performed.

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

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

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

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

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

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

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

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

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

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

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

(h) “Health realignment amount” means the amount that, in the absence of this article, would be payable to a public hospital health system county under Section 17603, as it read on January 1, 2012, Sections 17604 and 17606.20, Section 17604, as it read on August 1, 2017, Section 17606.20, as it read on August 1, 2019, and Section 17606.10, as it read on July 1, 2013, for the fiscal year that is deposited by the Controller into the local health and welfare trust fund health account of the public hospital health system county.
(i) “Health realignment indigent care percentage” means the county-specific percentage determined in accordance with the following, and established in accordance with the procedures described in subdivision (c) of Section 17612.3.

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

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

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

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

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

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

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

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

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

(3) The annual amounts determined in paragraph (1) shall be averaged, and multiplied by the percentage trend factor, if applicable, determined in paragraph (2), for each fiscal year after the 2011–12 fiscal year through the applicable fiscal year. However, if the percentage trend factor determined in paragraph (2) is greater than the applicable percentage change for any year of the same period in the blended CPI trend factor, the percentage change in the blended CPI trend factor for that year shall be used. The resulting determination is the imputed county low-income health amount for purposes of Section 17612.3.

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

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

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

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

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

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

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

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

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

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

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

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

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

(s) “Newly eligible beneficiaries” means individuals who meet
the eligibility requirements in Section 1902(a)(10)(A)(I)(VIII) of
Title XIX of the federal Social Security Act (42 U.S.C. Sec.
1396a(a)(10)(A)(I)(VIII)), and who meet the conditions described
in Section 1905(y) of the federal Social Security Act (42 U.S.C.
Sec. 1396d(y)) such that expenditures for services provided to the
individual are eligible for the enhanced federal medical assistance
percentage described in that section.
(t) “Other entity intergovernmental transfer amount” means the amount of intergovernmental transfers by a county public hospital health system or affiliated governmental entities, and accepted by the department, that are for the nonfederal share of Medi-Cal payments or Medicaid demonstration payments for the fiscal year to any Medi-Cal provider other than the county public hospital health system, or to a Medi-Cal managed care plan for services rendered by those other providers, and any related fees imposed by the state on those transfers.

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

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

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

1. Assessments and fees restricted for health-related purposes. The amount of the assessment or fee for this purpose shall be the greater of subparagraph (A) or (B). If, because of restrictions and limitations applicable to the assessment or fee, the county public hospital health system cannot expend this amount, this amount shall be reduced to the amount actually expended.
   (A) The amount of the assessment or fee expended by the county public hospital health system for the provision of health services to Medi-Cal and uninsured beneficiaries during the fiscal year.
   (B) The amount of the assessment or fee multiplied by the average of the percentages of the amount of assessment or fees that were allocated to and expended by the county public hospital health system for health services to Medi-Cal and uninsured beneficiaries during the historical fiscal years. The percentages for the historical fiscal years shall be determined by dividing the amount allocated in each fiscal year as described in subparagraphs (B) and (C) of paragraph (2) of subdivision (ab) by the actual amount of assessment or fee expended in the fiscal year.

2. Funds available pursuant to the Master Settlement Agreement and related documents entered into on November 23, 1998, by the state and leading United States tobacco product manufacturers during a fiscal year. The amount of the tobacco settlement funds that may be used for this purpose shall be the greater of
subparagraph (A) or (B), less any bond payments and other costs
of securitization related to the funds described in this paragraph.
(A) The amount of the funds expended by the county public
hospital health system for the provision of health services to
Medi-Cal and uninsured beneficiaries during the fiscal year.
(B) The amount of the tobacco settlement funds multiplied by
the average of the percentages of the amount of tobacco settlement
funds that were allocated to and expended by the county public
hospital health system for health services to Medi-Cal and
uninsured beneficiaries during the historical fiscal years. The
percentages for the historical fiscal years shall be determined by
dividing the amount allocated in each fiscal year as described in
subparagraphs (B) and (C) of paragraph (2) of subdivision (ab) by
the actual amount of tobacco settlement funds expended in the
fiscal year.
(x) “Subsequent demonstration project” means the federally
approved Medicaid demonstration project implemented after the
termination of the federal Medicaid demonstration project
authorized under Section 1115 of the federal Social Security Act
entitled the “Bridge to Health Care Reform” (waiver number
11-W-00193/9), the extension of that demonstration project, or
the material amendment to that demonstration project.
(y) “Uninsured costs” means the costs incurred by the public
hospital health system county and its affiliated government entities
for purchasing, providing, or ensuring the availability of services
to uninsured patients during the fiscal year. Uninsured costs shall
be determined in a manner consistent with the cost claiming
protocols developed for the federal Medicaid demonstration project
authorized under Section 1115 of the federal Social Security Act
entitled the “Bridge to Health Care Reform” (waiver number
11-W-00193/9), including protocols pending federal approval, and
under Section 14166.8, and, in consultation with each county, shall
be based on any other cost reporting and statistical data necessary
for an accurate determination of actual costs incurred. For this
purpose, no reduction factor applicable to otherwise allowable
costs under the demonstration project or the subsequent
demonstration project shall apply. Uninsured costs shall exclude
costs for nursing facility, mental health, and substance use disorder
services.
(z) “Uninsured patients” means individuals who have no source of third-party coverage for the specific service furnished, as further defined in the reporting requirements established pursuant to Section 17612.4.

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

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

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

(2) The following shall be applied in sequential order against, but shall not exceed in the aggregate, the initial low-income shortfall determined in paragraph (1) for each of the historical fiscal years:
(A) First, the county indigent care health realignment amount shall be applied 100 percent against the initial low-income shortfall.

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

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

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

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

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

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

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

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

   (iv) Multiply the product of subclause (I) of clause (iii) by the historical low-income shortfall percentage defined in subdivision (af) to determine the amount of special local health funds, as defined in subdivision (w) and not otherwise identified as restricted
special local health funds under subparagraph (B), allocated to the
historical low-income shortfall.
(v) Multiply the product of subclause (II) of clause (iii) by the
historical low-income shortfall percentage defined in subdivision
(af) to determine the amount of the imputed county low-income
health amount defined in subdivision (l) allocated to the historical
low-income shortfall.
(vi) Multiply the product of subclause (III) of clause (iii) by the
historical low-income shortfall percentage defined in subdivision
(af) to determine the amount of one-time and carry-forward
revenues as defined in subdivision (aj) allocated to the historical
low-income shortfall.
(D) Finally, to the extent that the process above does not result
in completely allocating revenues up to the amount necessary to
address the initial low-income shortfall in the historical years,
gains from other payers shall be allocated to fund those costs only
to the extent that such other payer gains exist.
(ac) “Gains from other payers” means the county-specific
amount of revenues in excess of costs generated from all other
payers for health services. For purposes of this subdivision, patients
with other payer coverage are patients who are identified in all
other financial classes, including, but not limited to, commercial
coverage and dual eligible, other than allowable costs and
associated revenues for Medi-Cal and the uninsured.
(ad) “New mandatory other entity intergovernmental transfer
amounts” means other entity intergovernmental transfer amounts
required by the state after July 1, 2013.
(ea) “Historical low-income shortfall” means, for each of the
historical fiscal years described in subdivision (j), the initial
low-income shortfall for Medi-Cal and uninsured costs determined
in paragraph (1) of subdivision (ab), less amounts identified in
subparagraphs (A) and (B) of paragraph (2) of subdivision (ab).
(af) “Historical low-income shortfall percentage” means, for
each of the historical fiscal years described in subdivision (j), the
historical low-income shortfall described in subdivision (ae)
divided by the historical total shortfall described in subdivision
(ah).
(ag) “Historical other shortfall” means, for each of the historical
fiscal years described in subdivision (j), the shortfall for all other
types of costs incurred by the public hospital health system that
are not Medi-Cal or uninsured costs, and is determined as total costs less total revenues, excluding any costs and revenue amounts used in the calculation of the historical low-income shortfall, and also excluding those costs and revenues related to mental health and substance use disorder services. If the amount of historical other shortfall in a given historical fiscal year is less than zero, then the historical other shortfall for that historical fiscal year shall be deemed to be zero.

(ah) “Historical total shortfall” means, for each of the historical fiscal years described in subdivision (j), the sum of the historical low-income shortfall described in subdivision (ae) and the historical other shortfall described in subdivision (ag).

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

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

SEC. 13. Section 17613.1 of the Welfare and Institutions Code is amended to read:

17613.1. (a) For the 2013–14 fiscal year and each fiscal year thereafter, for each county, the total amount that would be payable for the fiscal year from 1991—Health Realignment health realignment funds under Section 17603, as it read on January 1, 2012, Sections 17604 and 17606.20, Section 17604, as those sections it read on August 1, 2017, Section 17606.20, as it read on August 1, 2019, and Section 17606.10, as it read on July 1, 2013, and deposited by the Controller into the local health and
welfare trust fund health account of the county in the absence of
this section, shall be determined.
(b) The redirected amount determined for the county pursuant
to Section 17613.3 shall be divided by the total determined in
subdivision (a).
(c) The resulting fraction determined in subdivision (b) shall
be the percentage of 1991 Health Realignment funds under Section 17603, as it read on January 1, 2012. Sections
17604 and 17606.20, Section 17604, as it read on August 1, 2017, Section 17606.20, as it read on August 1, 2019,
and Section 17606.10, as it read on July 1, 2013, to be deposited
each month into the Family Support Subaccount.
(d) The total amount deposited pursuant to subdivision (c) with
respect to a county for a fiscal year shall not exceed the redirected
amount determined pursuant to Section 17613.3, and shall be
subject to the appeal processes, and judicial review as described
in subdivision (d) of Section 17613.3.
(e) The Legislature finds and declares that this article is not
intended to change the local obligation pursuant to Section 17000.
SEC. 14. Section 17613.2 of the Welfare and Institutions Code
is amended to read:
17613.2. For purposes of this article, the following definitions
apply:
(a) “Base year” means the fiscal year ending three years prior
to the fiscal year for which the redirected amount is calculated.
(b) “Blended CPI trend factor” means the blended percent
change applicable for the fiscal year that is derived from the
nonseasonally adjusted Consumer Price Index for All Urban
Consumers (CPI-U), United States City Average, for Hospital and
Related Services, weighted at 75 percent, and for Medical Care
Services, weighted at 25 percent, all as published by the United
States Bureau of Labor Statistics, computed as follows:
(1) For each prior fiscal year within the period to be trended
through the state fiscal year, the annual average of the monthly
index amounts shall be determined separately for the Hospital and
Related Services Index and the Medical Care Services Index.
(2) The year-to-year percentage changes in the annual averages
determined in paragraph (1) for each of the Hospital and Related
Services Index and the Medical Care Services Index shall be
determined.
(3) A weighted average annual percentage change for each year-to-year period shall be calculated from the determinations made in paragraph (2), with the percentage changes in the Hospital and Related Services Index weighted at 75 percent, and the percentage changes in the Medical Care Services Index weighted at 25 percent. The resulting average annual percentage changes shall be expressed as a fraction, and increased by 1.00.

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

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

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

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

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

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

2. (2) If a county’s costs as determined in subparagraph (A) of paragraph (1)—exceeds exceed the amount determined in subparagraph (B) of paragraph (1), the following costs, as allocated to the county’s indigent care program, shall be added to the cost and reflected in any containment limit:
(A) Costs related to state or federally mandated activities, requirements, or benefit changes.

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

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

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

(e) “County” for purposes of this article means the following counties: Fresno, Merced, Orange, Placer, Sacramento, San Diego, San Luis Obispo, Santa Barbara, Santa Cruz, Stanislaus, Tulare, and Yolo. Beginning in the 2019–20 fiscal year and for each fiscal year thereafter, “county” does not include the County of Yolo.

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

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

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

(i) “Health realignment amount” means the amount that, in the absence of this article, would be payable to a county under Section 17603, as it read on January 1, 2012, Sections 17604 and 17606.20, Section 17604, as those sections it read on August 1, 2017, Section 17606.20, as it read on August 1, 2019, and Section 17606.10, as it read on July 1, 2013, for the fiscal year that is deposited by the Controller into the local health and welfare trust fund health account of the county.

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

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

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

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

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

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

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

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

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

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

(3) The annual amounts determined in paragraph (1) shall be averaged and multiplied by the percentage trend factor, if applicable, determined in paragraph (2), for each fiscal year after the 2011–12 fiscal year through the applicable fiscal year. Notwithstanding the foregoing, if the percentage trend factor determined in paragraph (2) is greater than the applicable
percentage change for any year of the same period in the blended
CPI trend factor, the percentage change in the blended CPI trend
factor for that year shall be used. The resulting determination is
the imputed county low-income health amount for purposes of
Section 17613.3.
(n) “Indigent program costs” means the costs incurred by the
county for purchasing, providing, or ensuring the availability of
services to indigent program individuals during the fiscal year.
The costs for mental health and substance use disorder services
shall not be included in these costs.
(o) “Indigent program individuals” means all individuals
enrolled in a county indigent health care program at any point
throughout the fiscal year. If a county does not enroll individuals
into an indigent health care program, indigent program individuals
shall mean all individuals who used services offered through the
county indigent health care program in the fiscal year.
(p) “Indigent program revenues” means self-pay payments made
by or on behalf of indigent program individuals to the county for
the services rendered in the fiscal year, but shall exclude revenues
received for mental health and substance use disorder services.
(q) “Redirected amount” means the amount to be redirected in
accordance with Section 17613.1, as calculated pursuant to
subdivision (a) of Section 17613.3.
(r) “Special local health funds” means the amount of the
following county funds received by the county for health services
to indigent program individuals during the fiscal year and shall
include funds available pursuant to the Master Settlement
Agreement and related documents entered into on November 23,
1998, by the state and leading United States tobacco product
manufacturers during a fiscal year. The amount of the tobacco
settlement funds to be used for this purpose shall be the greater of
paragraph (1) or (2), less any bond payments and other costs of
securitization related to the funds described in this subdivision.
(1) The amount of the funds expended by the county for the
provision of health services to indigent program individuals during
the fiscal year.
(2) The amount of the tobacco settlement funds multiplied by
the average of the percentages of the amount of tobacco settlement
funds that were allocated to and expended by the county for health
services to indigent program individuals during the historical fiscal years.

SEC. 15. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 16. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

SECTION 1. It is the intent of the Legislature to enact statutory changes relating to the Budget Act of 2019.