An act to amend Sections 17600.50, 17612.1, 17612.2, 17613.1, and 17613.2 of the Welfare and Institutions Code, relating to public social services.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 17600.50 of the Welfare and Institutions Code is amended to read:

17600.50. (a) ~~A~~ For the fiscal years before 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 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~~ 17606.20, as those sections read on August 1, 2017, and Section ~~17606.10~~ 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~~ 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, for 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, the following approach will be utilized to determine payments to the Family Support Subaccount:

(1) The amount of payments to the Family Support Subaccount shall be equal to 75 percent of the sum of the following:

(A) The 1991 health realignment funds that would have otherwise been allocated to the counties listed above 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, 2019, 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, 2019.

(2) The payment computed in paragraph (1) shall be achieved through the following:

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

(B) The County Medical Services Program shall pay the lesser of:

(i) 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 for the applicable state fiscal year.

(ii) The total amount of funds provided to the County Medical Services Program pursuant to the Welfare and Institutions Code for the applicable state fiscal year.

~~(b)~~

(c) 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~~ (i) For the fiscal years before the 2019–20 fiscal year, 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~~ 17603, as it read on January 1, 2012, Sections 17604 and ~~17606.20~~ 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.

(ii) For the 2019–20 fiscal year and each fiscal year thereafter, a calculation of 75 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, 2019, and Section 17606.10, as it read on July 1, 2013, and 75 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.

~~(c)~~

(d) 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~~ 17603, as it read on January 1, 2012, Sections 17604 and ~~17606.20~~ 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.

~~(d)~~

(e) (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. 2. 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, as those sections read on August 1, ~~2017,~~ 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, as those sections read on August 1, ~~2017,~~ 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,~~ processes and judicial ~~review~~ 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. 3. Section 17612.2 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

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

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

(1) Notwithstanding paragraphs (2) to (4), inclusive, at the public hospital health system county's ~~option~~ 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)~~ (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)~~ (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~~ 17603, as it read on January 1, 2012, Sections 17604 and 17606.20, as those sections read on August 1, ~~2017,~~ 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.~~ 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.~~ 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.~~ 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~~ 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~~ 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~~ revenues, as defined in subdivision (aj).

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

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

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

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

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

(iv) Multiply the product of subclause (I) of clause (iii) by the historical low-income shortfall percentage defined in subdivision (af) to determine the amount of special local health funds, as defined in subdivision (w) and not otherwise identified as restricted special local health funds under subparagraph (B), allocated to the historical low-income shortfall.

(v) Multiply the product of subclause (II) of clause (iii) by the historical low-income shortfall percentage defined in subdivision (af) to determine the amount of the imputed county low-income health amount defined in subdivision (*l*) allocated to the historical low-income shortfall.

(vi) Multiply the product of subclause (III) of clause (iii) by the historical low-income shortfall percentage defined in subdivision (af) to determine the amount of one-time and carry-forward revenues as defined in subdivision (aj) allocated to the historical low-income shortfall.

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

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

(ad) "New mandatory other entity intergovernmental transfer amounts" means other entity intergovernmental transfer amounts required by the state after July 1, 2013.

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

(af) "Historical low-income shortfall percentage" means, for each of the historical fiscal years described in subdivision (j), the historical low-income shortfall described in subdivision (ae) divided by the historical total shortfall described in subdivision (ah).

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

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

(ai) "Historical usage of funds percentage" means, for each of the historical fiscal years described in subdivision (j), the historical total shortfall described in subdivision (ah) divided by the sum of special local health funds as defined in subdivision (w) and

not otherwise identified as restricted special local health funds under subparagraph (B) of paragraph (2) of subdivision (ab), the imputed county low-income health amount defined in subdivision (*l*), and one-time and carry-forward ~~revenues~~ 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. 4. 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, as those sections read on August 1, ~~2017,~~ 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~~ health realignment funds under Section 17603, as it read on January 1, 2012, Sections 17604 and 17606.20, as those sections read on August 1, ~~2017,~~ 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. 5. 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.

(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.

(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) If a county's costs as determined in subparagraph (A) of paragraph (1) exceeds 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.

(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, as those sections read on August 1, ~~2017,~~ 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.~~ 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.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.
as introduced, _____.
General Subject: Public social services: 1991 health realignment funds: redirection.

Existing law provides for the allocation of funds appropriated from the continuously appropriated Local Revenue Fund for the distribution of sales tax and motor vehicle license fee moneys to local agencies for the administration of various health, mental health, and public social service programs (1991 realignment funds). Existing law generally requires specified counties with a County Medical Services Program to redirect to the Family Support Subaccount of the Local Revenue Fund 60% of certain 1991 realignment funds for health that would have otherwise been allocated to the counties and for a certain maintenance of effort requirement. Existing law requires specified counties with a public hospital system to redirect to the Family Support Subaccount 60% of similar 1991 realignment funds for health and maintenance of effort.

This bill would, commencing with the 2019–20 fiscal year, among other things, increase the percentage of 1991 health realignment funds that would have otherwise been allocated to the counties and maintenance of effort that are to be redirected to the Family Support Subaccount to 75%, and would make conforming changes.

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