WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000 - 15771] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 7. Basic Health Care [14000 - 14199.87] *(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

ARTICLE 5.5. Medi-Cal 2020 Demonstration Project Act [14184 - 14184.90] *(Article 5.5 added by Stats. 2016, Ch. 111, Sec. 1.)*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Added by Stats. 2016, Ch. 111, Sec. 1. (SB 815) Effective July 25, 2016.)

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

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

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

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

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

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

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

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

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

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

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

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

(f) (1) “Designated public hospital” means any one of the following hospitals, and any successor, including any restructured, reorganized, or differently named hospital, which is operated by a county, a city and county, the University of California, or a special hospital authority described in Chapter 5 (commencing with Section 101850) or Chapter 5.5 (commencing with Section 101852) of Part 4 of Division 101 of the Health and Safety Code, or any additional public hospital to the extent identified as a “designated public hospital” in the Special Terms and Conditions or, effective July 1, 2021, the CalAIM Terms and Conditions as defined in Section 14184.101. Unless otherwise provided for in law, in the California Medicaid State Plan, or in the Special Terms and Conditions, all references in law to a designated public hospital as defined in subdivision (d) of Section 14166.1 shall be deemed to refer to a hospital described in this section effective as of January 1, 2016, except as provided in paragraph (2) or, for a hospital not otherwise listed in subparagraphs (A) through (T), inclusive, as of the date specified in the applicable Terms and Conditions or State Plan amendment:

(A) UC Davis Medical Center.

(B) UC Irvine Medical Center.

(C) UC San Diego Medical Center, including, effective no sooner than January 1, 2024, the East Campus Medical Center formerly known as Alvarado Hospital Medical Center.

(D) UC San Francisco Medical Center.

(E) UCLA Medical Center.

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

(G) LA County Health System Hospitals:

(i) LA County Harbor/UCLA Medical Center.

(ii) LA County Olive View UCLA Medical Center.

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

(iv) LA General Medical Center.

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

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

(ii) Alameda Hospital.

(iii) San Leandro Hospital.

(I) Arrowhead Regional Medical Center.

(J) Contra Costa Regional Medical Center.

(K) Kern Medical Center.

(L) Natividad Medical Center.

(M) Riverside University Health System-Medical Center.

(N) San Francisco General Hospital.

(O) San Joaquin General Hospital.

(P) San Mateo Medical Center.

(Q) Santa Clara Valley Medical Center.

(R) Ventura County Medical Center.

(S) The following hospitals, effective no sooner than April 1, 2024:

(i) UCLA West Valley Medical Center (formerly West Hills Hospital and Medical Center).

(ii) UCI Health – Fountain Valley.

(iii) UCI Health – Lakewood.

(iv) UCI Health – Placentia Linda.

(v) UCI Health – Los Alamitos.

(T) The following hospitals, effective no sooner than the later of July 1, 2024, or the first day of the quarter following the closing of the applicable affiliation transaction with the University of California, San Francisco:

(i) UCSF Health – St. Mary's (formerly St. Mary's Medical Center).

(ii) UCSF Health – Saint Francis (formerly Saint Francis Memorial Hospital).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Amended by Stats. 2024, Ch. 40, Sec. 67. (SB 159) Effective June 29, 2024.)

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

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

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

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

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

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

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

(d) 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 article or the Special Terms and Conditions, in whole or in part, by means of all-county letters, plan letters, provider bulletins, or other similar instructions, without taking regulatory action. The department shall provide notification to the Joint Legislative Budget Committee and to the Senate Committees on Appropriations, Budget and Fiscal Review, and Health, and the Assembly Committees on Appropriations, Budget, and Health within 10 business days after the above-described action is taken. The department shall make use of appropriate processes to ensure that affected stakeholders are timely informed of, and have access to, applicable guidance issued pursuant to this authority, and that this guidance remains publicly available until all payments related to the applicable demonstration project component are finalized.

(e) For purposes of implementing this article or the Special Terms and Conditions, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to

this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

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

(g) The director may modify any process or methodology specified in this article to the extent necessary to comply with federal law or the Special Terms and Conditions of the demonstration project, but only if the modification is consistent with the goals set forth in this article for the demonstration project, and its individual components, and does not significantly alter the relative level of support for participating entities. If the director, after consulting with those entities participating in the applicable demonstration project component and that would be affected by that modification, determines that the potential modification would not be consistent with the goals set forth in this article or would significantly alter the relative level of support for affected participating entities, the modification shall not be made and the director shall execute a declaration stating that this determination has been made. The director shall retain the declaration and provide a copy, within five working days of the execution of the declaration, to the fiscal and appropriate policy committees of the Legislature, and shall work with the affected participating entities and the Legislature to make the necessary statutory changes. The director shall post the declaration on the department's Internet Web site and the director shall send the declaration to the Secretary of State and the Legislative Counsel.

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

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

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

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

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

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

(Amended by Stats. 2016, Ch. 733, Sec. 9. (SB 1477) Effective January 1, 2017.)

14184.21. The department shall conduct, or arrange to have conducted, any study, report, assessment, including the access assessment described in Section 14184.80, evaluation, or other similar demonstration project activity required under the Special Terms and Conditions.

(Added by Stats. 2016, Ch. 42, Sec. 1. (AB 1568) Effective July 1, 2016. Operative July 25, 2016, pursuant to Stats. 2016, Ch. 42, Sec. 8, and enactment of SB 815 as Ch. 111.)

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

(a) (1) (A) For purposes of Section 14166.4, the references to "project year" and "successor demonstration year" shall include references to the demonstration term, as defined under this article, and to any extensions of the prior federal Medicaid

demonstration project entitled “California Bridge to Reform Demonstration (Waiver No. 11-W-00193/9).”

(B) For purposes of Section 14166.4, the references to “project year” and “successor demonstration year” shall include references to the CalAIM term, as defined in subdivision (b) of Section 14184.101, and to any extensions of the demonstration project pursuant to this article.

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

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

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

(b) During the 2015–16 state fiscal year, and subsequent state fiscal years that commence during the demonstration term or the CalAIM term, payment adjustments to disproportionate share hospitals shall not be made pursuant to Section 14105.98, except as otherwise provided in this article or Article 5.51 (commencing with Section 14184.100). Payment adjustments to disproportionate share hospitals shall be made solely in accordance with this article or Article 5.51 (commencing with Section 14184.100).

(1) Except as otherwise provided in this article or Article 5.51(commencing with Section 14184.100), the department shall continue to make all eligibility determinations and perform all payment adjustment amount computations under the disproportionate share hospital payment adjustment program pursuant to Section 14105.98 and pursuant to the disproportionate share hospital provisions of the Medi-Cal State Plan. For purposes of these determinations and computations, which include those made pursuant to Sections 14166.11 and 14166.16, all of the following shall apply:

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

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

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

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

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

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

(ii) As a funding component for payments under the Global Payment Program, as described in subparagraph (A) of paragraph (1) of subdivision (c) of Section 14184.40, or paragraph (1) of subdivision (c) of Section 14184.300, and the Special Terms and Conditions or the CalAIM Terms and Conditions.

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

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

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

(4) (A) During the state fiscal years for which the Global Payment Program under Section 14184.40, or Section 14184.300, is in effect, designated public hospitals that are participating GPP systems shall not be eligible to receive disproportionate share hospital payments pursuant to otherwise applicable disproportionate share hospital provisions of the Medi-Cal State Plan.

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

(C) Hospitals described in clause (i) of subparagraph (A) of paragraph (2) that are licensed to the University of California, except as provided in paragraph (4) of subdivision (b) of Section 14184.300, shall receive disproportionate share hospital payments as follows:

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

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

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

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

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

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

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

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

(VI) For the 2020–21 state fiscal year, and subsequent state fiscal years or portions thereof during the CalAIM Term, the amount determined in subclause (I) shall be multiplied by a percentage as determined by the department, in consultation with designated public hospitals and consistent with the applicable federal terms and conditions, that will be used to determine the maximum amount of the federal disproportionate share hospital allotment available as disproportionate share hospital payments for the state fiscal year to hospitals that are licensed to the University of California. The percentage shall be communicated in writing to all of the designated public hospitals.

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

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

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

(vi) Except as otherwise provided in this article or Article 5.51 (commencing with Section 14184.100), each hospital licensed to the University of California shall receive disproportionate share hospital payments subject to final audits of all applicable Medi-Cal, Medicare, and other cost, payment, discharge, and statistical data submitted by the hospital for the applicable state fiscal year.

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

(D) With respect to any state fiscal year commencing during the demonstration term or the CalAIM term for which the Global Payment Program pursuant to Section 14184.40 or 14184.300 is not in effect, designated public hospitals that are eligible hospitals as determined pursuant to Section 14105.98, and hospitals described in clause (i) of subparagraph (A) of paragraph (2) that are licensed to the University of California, shall claim disproportionate share hospital payments in accordance with the applicable disproportionate share hospital provisions of the Medi-Cal State Plan. The allocation of federal Medicaid funding from the applicable federal disproportionate share hospital allotment shall be made in accordance with the methodology set forth in Section 14166.61.

(5) For each applicable state fiscal year during the demonstration term or the CalAIM term, eligible hospitals, as determined pursuant to Section 14105.98, which are nonpublic hospitals, nonpublic-converted hospitals, and converted hospitals, as those terms are defined in paragraphs (26), (27), and (28), respectively, of subdivision (a) of Section 14105.98, shall continue to receive Medi-Cal disproportionate share hospital replacement payment adjustments pursuant to Section 14166.11 and other provisions of this article or Article 5.51 (commencing with Section 14184.100) and applicable provisions of the Medi-Cal State Plan. The payment adjustments so provided shall satisfy the state's payment obligations, if any, with respect to those hospitals under Section 1396r-4 of Title 42 of the United States Code. The provisions of subdivision (j) of Section 14166.11 shall continue to apply with respect to the 2015–16 state fiscal year and subsequent state fiscal years commencing during the demonstration term or the CalAIM term. Except as may otherwise be required by federal law, the federal share of these payments shall not be claimed from the federal disproportionate share hospital allotment.

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

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

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

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

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

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

(7) The Demonstration Disproportionate Share Hospital Fund established in the State Treasury pursuant to subdivision (d) of Section 14166.9 shall be retained during the demonstration term and the CalAIM term. All federal funds received by the department with respect to the certified public expenditures claimed pursuant to subparagraph (C), and, as applicable in subparagraph (D), of paragraph (4) shall be transferred to the fund and disbursed to the eligible designated public hospitals pursuant to those applicable provisions. Notwithstanding Section 13340 of the Government Code, moneys deposited in the fund shall be continuously appropriated, without regard to fiscal year, to the department solely for the purposes specified in this article and Article 5.51 (commencing with Section 14184.100).

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

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

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

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

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

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

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

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

(e) (1) Notwithstanding subdivision (h) of Section 14166.61 and subdivision (c) of Section 14166.71, the disproportionate share hospital allocation and safety net care pool payment determinations and payments for the 2013–14 and 2014–15 state fiscal years shall be deemed final as of the April 30 that is 22 months following the close of the respective state fiscal year, to the extent permitted under federal law and subject to recoupment pursuant to subdivision (f) if it is later determined that federal financial participation is unavailable for any portion of the applicable payments.

(2) The determinations and payments shall be finalized using the best available data, including unaudited data, and reasonable current estimates and projections submitted by the designated public hospitals. The department shall accept all appropriate

revisions to the data, estimates, and projections previously submitted, including revised cost reports, for purposes of this subdivision, to the extent these revisions are submitted in a timely manner as determined by the department.

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

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

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

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

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

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

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

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

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

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

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

(ii) Subject to subparagraph (E), any repayment amounts that were unallocated to hospitals due to the limitation in clause (iii) shall be allocated in a second stage among each of the remaining designated public hospitals that has not reached its applicable repayment limit, including the hospitals that were not subject to the allocations under clause (i), based pro rata

on the amounts determined and received by the hospital pursuant to subdivision (e), except that no repayment amount for a hospital shall exceed the limitation under clause (iii). The pro rata allocation process will be repeated in subsequent stages with respect to any repayment amounts that cannot be allocated in a prior stage to hospitals due to the limitation under clause (iii), until the entire federal repayment amount has been allocated among the hospitals.

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

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

(g) The provisions of Article 5.2 (commencing with Section 14166) shall remain in effect until all payments authorized pursuant to that article have been paid, finalized, and settled, and to the extent its provisions are retained for purposes of this article or Article 5.51 (commencing with Section 14184.100).

(h) For purposes of this article, commencing January 1, 2021, and thereafter, any references to "Designated Public Hospital," "CalAIM term," or "CalAIM Terms and Conditions" have the same meanings as set forth in Section 14184.101.

(Amended by Stats. 2021, Ch. 143, Sec. 400. (AB 133) Effective July 27, 2021.)

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

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

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

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

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

(1) "GPP system" means a public health care system that consists of a designated public hospital, as defined in subdivision (f) of Section 14184.10 but excluding the hospitals operated by the University of California, except as provided in paragraph (4) of subdivision (b) of Section 14184.300, and its affiliated and contracted providers. Multiple designated public hospitals operated by a single legal entity may belong to the same GPP system, to the extent set forth in the Special Terms and Conditions.

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

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

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

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

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

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

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

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

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

(6) If there is a change in the aggregate annual limit, the department shall adjust and recalculate each GPP system's annual threshold or the annual budget in proportion to changes in the aggregate annual limit calculated in paragraph (1) in accordance with the Special Terms and Conditions.

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

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

(2) The department shall develop a methodology to redistribute unearned Global Payment Program funds for a given GPP program year to those GPP systems that exceeded their respective threshold for that same year. To the extent sufficient funds are available for all qualifying GPP systems, the GPP system's redistributed amount shall equal the GPP system's annual budget multiplied by the percentage by which the GPP system exceeded its threshold, and any remaining amounts of unearned funds will remain undistributed. If sufficient funds are unavailable to make all these payments to qualifying GPP systems, the amounts of these additional payments will be reduced for all qualifying GPP systems by the same proportion, so that the full amount of unearned Global Payment Program funds are redistributed. Redistributed payment amounts calculated pursuant to this paragraph shall be added to the amounts payable to a GPP system calculated pursuant to paragraph (1).

(3) The department shall specify a reporting schedule for participating GPP systems to submit an interim yearend report and a final reconciliation report for each GPP program year. The interim yearend report and the final reconciliation report shall identify the services the GPP system provided to the uninsured during the GPP program year, the associated point calculation, and the

amount of payments earned by the GPP system before any redistribution. The method and format of the reporting shall be established by the department, consistent with the approved Special Terms and Conditions.

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

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

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

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

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

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

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

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

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

(f) The nonfederal share of any payments under the Global Payment Program shall consist of voluntary intergovernmental transfers of funds provided by designated public hospitals or affiliated governmental agencies or entities, in accordance with this section or Section 14184.300.

(1) The Global Payment Program Special Fund is hereby established in the State Treasury. Notwithstanding Section 13340 of the Government Code, moneys deposited in the Global Payment Program Special Fund shall be continuously appropriated, without regard to fiscal years, to the department for the purposes specified in this section or Section 14184.300. All funds derived pursuant to this section or Section 14184.300 shall be deposited in the State Treasury to the credit of the Global Payment Program Special Fund.

(2) The Global Payment Program Special Fund shall consist of moneys that a designated public hospital or affiliated governmental agency or entity elects to transfer to the department for deposit into the fund as a condition of participation in the Global Payment

Program, to the extent permitted under Section 433.51 of Title 42 of the Code of Federal Regulations, the Special Terms and Conditions, and any other applicable federal Medicaid laws. Except as otherwise provided in paragraph (3), moneys derived from these intergovernmental transfers in the Global Payment Program Special Fund shall be used as the source for the nonfederal share of Global Payment Program payments authorized under the demonstration project. Any intergovernmental transfer of funds provided for purposes of the Global Payment Program shall be made as specified in this section or Section 14184.300. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to applicable federal Medicaid laws and the Special Terms and Conditions, and in the form and manner as required by the department.

(3) The department shall claim federal financial participation for GPP payments using moneys derived from intergovernmental transfers made pursuant to this section or Section 14184.300, and deposited in the Global Payment Program Special Fund to the full extent permitted by law. The moneys disbursed from the fund, and all associated federal financial participation, shall be distributed only to GPP systems and the governmental agencies or entities to which they are affiliated, as applicable. If federal financial participation is unavailable with respect to a payment under this section or Section 14184.300 and either is not obtained, or results in a recoupment of payments already made, the department shall return any intergovernmental transfer fund amounts associated with the payment for which federal financial participation is unavailable to the applicable transferring entities within 14 days from the date of the associated recoupment or other determination, as applicable.

(4) As a condition of participation in the Global Payment Program, each designated public hospital or affiliated governmental agency or entity, agrees to provide intergovernmental transfer of funds necessary to meet the nonfederal share obligation as calculated under subdivision (g) for Global Payment Program payments made pursuant to this section or Section 14184.300 and the Special Terms and Conditions. Any intergovernmental transfer of funds made pursuant to this section or Section 14184.300 shall be considered voluntary for purposes of all federal laws. No state General Fund moneys shall be used to fund the nonfederal share of any Global Payment Program payment.

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

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

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

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

(A) Los Angeles County Health System: 1.100.

(B) Alameda Health System: 1.137.

(C) Arrowhead Regional Medical Center: 0.923.

(D) Contra Costa Regional Medical Center: 0.502.

(E) Kern Medical Center: 0.581.

(F) Natividad Medical Center: 1.183.

(G) Riverside University Health System-Medical Center: 0.720.

(H) San Francisco General Hospital: 0.507.

(I) San Joaquin General Hospital: 0.803.

(J) San Mateo Medical Center: 1.325.

(K) Santa Clara Valley Medical Center: 0.706.

(L) Ventura County Medical Center: 1.401.

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

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

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

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

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

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

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

(h) The department may initiate audits of GPP systems' data submissions and reports, and may request supporting documentation. Any audits conducted by the department shall be complete within 22 months of the end of the applicable GPP program year to allow for the appropriate finalization of payments to the participating GPP system, but subject to recoupment if it is later determined that federal financial participation is unavailable for any portion of the applicable payments.

(i) If the department determines, during the course of the demonstration term and in consultation with participating GPP systems, that the Global Payment Program should be terminated for subsequent years, the department shall terminate the Global Payment Program by notifying the federal Centers for Medicare and Medicaid Services in accordance with the timeframes specified in the Special Terms and Conditions. In the event of this type of termination, the department shall issue a declaration terminating the Global Payment Program and shall work with the federal Centers for Medicare and Medicaid Services to finalize all remaining payments under the Global Payment Program. Subsequent to the effective date for any termination accomplished pursuant to this subdivision, the designated public hospitals that participated in the Global Payment Program shall claim and receive disproportionate share hospital payments, if eligible, as described in subparagraph (D) of paragraph (4) of subdivision (b) of Section 14184.30, but only to the extent that any necessary federal approvals are obtained and federal financial participation is available and not otherwise jeopardized.

(j) Commencing January 1, 2021, the Global Payment Program shall be continued as modified pursuant to Section 14184.300.

(Amended by Stats. 2021, Ch. 143, Sec. 401. (AB 133) Effective July 27, 2021.)

14184.41. The department shall conduct, or arrange to have conducted, the two evaluations of the Global Payment Program methodology required under the Special Terms and Conditions.

(Added by Stats. 2016, Ch. 42, Sec. 2. (AB 1568) Effective July 1, 2016. Operative July 25, 2016, pursuant to Stats. 2016, Ch. 42, Sec. 8, and enactment of SB 815 as Ch. 111.)

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

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

(3) The department shall provide participating PRIME entities the opportunity to earn the maximum amount of funds authorized for the PRIME program under the demonstration project. Under the demonstration project, funding is available for the designated public hospital systems and the district and municipal public hospitals through two separate pools. Subject to the Special Terms and Conditions, up to one billion four hundred million dollars ($1,400,000,000) is authorized annually for the designated public hospital systems pool, and up to two hundred million dollars ($200,000,000) is authorized annually for the district and municipal public hospitals pool, during the first three years of the demonstration project, with reductions to these amounts in the fourth and fifth years. Except in those limited instances specifically authorized by the Special Terms and Conditions, the funding that is authorized for each respective pool shall only be available to participating PRIME entities within that pool.

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Participating PRIME entities or their affiliated governmental agencies or entities shall make the intergovernmental transfer to the department within seven days of receiving the department’s request. In the event federal approval for a payment is not

obtained, the department shall return the intergovernmental transfer funds to the transferring entity within 14 days.

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

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

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

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

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

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

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

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

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

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

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

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

(f) The nonfederal share of payments under the PRIME program shall consist of voluntary intergovernmental transfers of funds provided by designated public hospitals or affiliated governmental agencies or entities, or district and municipal public hospitals or

affiliated governmental agencies or entities, in accordance with this section.

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

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

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

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

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

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

(3) (A) Designated public hospital systems shall contract with at least one Medi-Cal managed care plan in the service area where they operate using an APM methodology by January 1, 2018. If a designated public hospital system is unable to meet this requirement and can demonstrate that it has made a good faith effort to contract with a Medi-Cal managed care plan in the service area that it operates in or a gap in contracting period occurs, the department has the discretion to waive this requirement.

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

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

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

(Amended by Stats. 2017, Ch. 561, Sec. 285. (AB 1516) Effective January 1, 2018.)

14184.51. The department shall conduct, or arrange to have conducted, the evaluation of the PRIME program required under the Special Terms and Conditions.

(Added by Stats. 2016, Ch. 42, Sec. 3. (AB 1568) Effective July 1, 2016. Operative July 25, 2016, pursuant to Stats. 2016, Ch. 42, Sec. 8, and enactment of SB 815 as Ch. 111.)

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

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

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

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

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

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

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

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

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

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

(4) “WPC participating entity” means those entities identified as participating in the WPC pilot, other than the WPC lead entity, including other local governmental entities, agencies within local governmental entities, Medi-Cal managed care plans, and WPC community partners.

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

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

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

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

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

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

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

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

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

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

(5) Notwithstanding any other law, including, but not limited to, Section 5328 of this code, and Sections 11812 and 11845.5 of the Health and Safety Code, the sharing of health information, records, and other data with and among WPC lead entities and WPC participating entities shall be permitted to the extent necessary for the activities and purposes set forth in this section. This provision shall also apply to the sharing of health information, records, and other data with and among prospective WPC lead entities and WPC participating entities in the process of identifying a proposed target population and preparing an application for a WPC pilot.

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

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

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

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

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

(2) Countywide housing pools.

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

(B) The housing pool may be funded through WPC pilot payments or direct contributions from community entities, or from state or local government. WPC pilot payments for the operation of a housing pool shall be subject to the restrictions in the Special Terms and Conditions and other applicable provisions of federal law. Housing pool funds that are not WPC pilot payments shall be maintained separately from WPC pilot payments and may be allocated to fund support for long-term housing, including rental housing subsidies. The housing pool may leverage local resources to increase access to subsidized housing units. The housing pool may also incorporate a financing component to reallocate or reinvest a portion of the savings from the reduced utilization of health care services into the housing pool. As applicable to an approved WPC pilot, WPC investments in housing units or housing subsidies, including any payment for room and board, shall not be eligible for federal financial participation, unless recognized as reimbursable under federal Centers for Medicare and Medicaid Services policy.

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

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

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

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

(5) WPC pilots are not intended as, and shall not be construed to constitute, health care coverage for individuals receiving services, and WPC pilots may determine the scope, type, and extent to which services are available, to the extent consistent with the Special Terms and Conditions. For purposes of the WPC pilots, WPC lead entities shall be exempt from Chapter 2.2

(commencing with Section 1340) of Division 2 of the Health and Safety Code, and shall not be considered Medi-Cal managed care health plans subject to the requirements applicable to the two-plan model and geographic managed care plans, as contained in Article 2.7 (commencing with Section 14087.3), Article 2.81 (commencing with Section 14087.96), and Article 2.91 (commencing with Section 14089), and the corresponding regulations, and shall not be considered prepaid health plans, as defined in Section 14251.

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

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

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

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

(2) The Whole Person Care Pilot Special Fund shall consist of moneys that a participating governmental agency or entity elects to transfer to the department into the fund as a condition of participation in the WPC pilot program, to the extent permitted under Section 433.51 of Title 42 of the Code of Federal Regulations, the Special Terms and Conditions, and any other applicable federal Medicaid laws. Except as provided in paragraph (3), moneys derived from these intergovernmental transfers in the Whole Person Care Pilot Special Fund shall be used as the nonfederal share of Whole Person Care pilot payments authorized under the demonstration project. Any intergovernmental transfer of funds provided for purposes of the WPC pilot program shall be made as specified in this section. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to applicable federal Medicaid laws and the Special Terms and Conditions, and in the form and manner as required by the department.

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

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

(Amended by Stats. 2017, Ch. 561, Sec. 286. (AB 1516) Effective January 1, 2018.)

14184.61. The department shall conduct, or arrange to have conducted, the evaluations of the WPC pilot program required under the Special Terms and Conditions.

(Added by Stats. 2016, Ch. 42, Sec. 5. (AB 1568) Effective July 1, 2016. Operative July 25, 2016, pursuant to Stats. 2016, Ch. 42, Sec. 8, and enactment of SB 815 as Ch. 111.)

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

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

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

(A) Preventive Services.

(B) Caries Risk Assessment.

(C) Continuity of Care.

(D) Local Dental Pilot Projects.

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

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

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

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

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

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

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

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

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

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

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

(B) The department shall disburse DTI incentive payments to eligible service office locations that did not previously participate in Medi-Cal before the demonstration and that render preventive dental services during the demonstration to the extent the service office location meets or exceeds the goals specified by the department in accordance with the Special Terms and Conditions.

(C) Safety net clinics are eligible for DTI incentive payments specified in the Special Terms and Conditions. Participating safety net clinics shall be responsible for submitting data in a manner specified by the department for receipt of DTI incentive

payments. Each safety net clinic office location shall be considered a dental service office location for purposes of specified domains outlined in the Special Terms and Conditions.

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

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

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

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

(2) Caries Risk Assessment and Disease Management Pilot:

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

(B) Medi-Cal dentists voluntarily participating in this pilot shall be eligible to receive DTI incentive payments for implementing preidentified treatment plans for children based upon that child beneficiary's risk level as determined by the service office location via a caries risk assessment, which shall include motivational interviewing and use of antimicrobials, as indicated. The department shall identify the criteria and preidentified treatment plans to correspond with the varying degrees of caries risk, low, moderate, and high, while the rendering provider shall develop and implement the appropriate treatment plan based on the needs of the beneficiary.

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

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

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

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

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

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

(Amended by Stats. 2017, Ch. 561, Sec. 287. (AB 1516) Effective January 1, 2018.)

14184.71. The department shall conduct, or arrange to have conducted, the evaluation of the DTI required under the Special Terms and Conditions.

(Added by Stats. 2016, Ch. 42, Sec. 7. (AB 1568) Effective July 1, 2016. Operative July 25, 2016, pursuant to Stats. 2016, Ch. 42, Sec. 8, and enactment of SB 815 as Ch. 111.)

14184.72. In connection with the evaluation of the DTI required by Section 14184.71, the department's report of data and quality measures submitted to the federal Centers for Medicare and Medicaid Services (CMS) and made publicly available pursuant to the

Special Terms and Conditions for the Increase Preventive Services Utilization for Children domain shall include, but not be limited to, all of the following:

(a) A detailed description of how the department has operationalized the domain, including information identifying which entities have responsibility for the components of the domain.

(b) The number of individual incentives paid and the total amount expended under the domain for the current program year.

(c) An awareness plan that describes all of the following:

(1) How the department has generated awareness of the availability of incentives for providing preventive dental services to children, including steps taken to increase awareness of the DTI among dental and primary care providers.

(2) How the department has generated awareness among beneficiaries of the availability of, the importance of, and how to access preventive dental services for children.

(3) The different approaches to raising awareness undertaken among specific groups, including age groups, rural and urban residents, and primary language groups. These approaches shall be developed in conjunction with interested dental and children's health stakeholders.

(d) An annual analysis of whether the awareness plan described in subdivision (c) has succeeded in generating the utilization necessary, by subgrouping, to meet the goals of the domain, and a description of changes to the awareness plan needed to address any identified deficiencies.

(e) Data describing both of the following:

(1) The use of, and expenditures on, preventive dental services.

(2) The use of, and expenditures on, other nonpreventive dental services.

(f) A discussion of the extent to which the metrics described for the domain are proving to be useful in understanding the effectiveness of the activities undertaken in the domain.

(g) An analysis of changes in cost per capita.

(h) A descriptive analysis of program integrity challenges generated by the domain and how those challenges have been, or will be, addressed.

(i) A descriptive analysis of the overall effectiveness of the activities in the domain in meeting the intended goals of the domain, any lessons learned, and any recommended adjustments.

(Added by Stats. 2016, Ch. 613, Sec. 3. (AB 2207) Effective January 1, 2017.)

14184.73. In connection with the evaluation of the DTI required by Section 14184.71, the department's report of data and quality measures submitted to the federal Centers for Medicare and Medicaid Services and made publicly available pursuant to the Special Terms and Conditions for the Caries Risk Assessment (CRA) and Disease Management Pilot domain shall include, but not be limited to, all of the following:

(a) A detailed description of how the department has operationalized the domain, including information identifying which entities have responsibility for the components of the domain.

(b) The number of individual incentives paid and the total amount expended, by county, under the domain in the current demonstration year.

(c) A descriptive assessment of the impact of the domain on targeted children in the age ranges of under one year of age, one through two years of age, three through four years of age, and five through six years of age, for all of the following:

(1) Provision of CRAs.

(2) Provision of dental exams.

(3) Use of, and expenditures on, preventive dental services.

(4) Use of, and expenditures on, dental treatment services.

(5) Use of, and expenditures on, dental-related general anesthesia, including facility costs.

(Added by Stats. 2016, Ch. 613, Sec. 4. (AB 2207) Effective January 1, 2017.)

14184.74. In connection with the evaluation of the DTI required by Section 14184.71, the department's report of data and quality measures submitted to the federal Centers for Medicare and Medicaid Services and made publicly available pursuant to the Special Terms and Conditions for the Increase Continuity of Care domain shall include, but not be limited to, all of the following:

(a) A detailed description of how the department has operationalized the domain, including information identifying which entities have responsibility for the components of the domain.

(b) The number of individual incentives paid and the total amount expended, by county, under the domain in the current demonstration year.

(c) A descriptive assessment of the impact of the domain, with respect to targeted children, of all of the following:

(1) Provision of dental exams.

(2) Use of, and expenditures on, preventive dental services.

(3) Use of, and expenditures on, other nonpreventive dental services.

(d) A discussion of the extent to which the metrics prescribed for the domain are proving to be useful in understanding the effectiveness of the activities undertaken in the domain.

(e) An analysis of change in cost per capita.

(f) A descriptive analysis of program integrity challenges generated by the domain and how those challenges have been, or will be, addressed.

(g) A descriptive analysis of the overall effectiveness of the activities in the domain in meeting the intended goals of the domain, any lessons learned, and any recommended adjustments.

(Added by Stats. 2016, Ch. 613, Sec. 5. (AB 2207) Effective January 1, 2017.)

14184.75. In connection with the evaluation of the DTI required by Section 14184.71, the department's report of data and quality measures submitted to the federal Centers for Medicare and Medicaid Services and made publicly available pursuant to the Special Terms and Conditions for the Local Dental Pilot Program domain shall include, but not be limited to, all of the following:

(a) A detailed description of how the department has operationalized this aspect of the demonstration project, including the solicitation and selection process.

(b) The number of pilot projects funded and the total amount expended, by project, under the domain in the current demonstration year.

(c) A description of the pilot projects selected for award that for each project shall include, but not be limited to, all of the following:

(1) Specific strategies for the project.

(2) Target populations.

(3) Payment methodologies.

(4) Annual budget for the project.

(5) Expected duration of the project.

(6) Performance metrics by which the project shall be measured.

(7) The intended goal of the project.

(d) An assessment of the pilot projects selected for award that includes for each project all of the following:

(1) Project performance and outcomes.

(2) Project replicability.

(3) Challenges encountered and actions undertaken to address those challenges.

(4) Information on payments made by the department to the project.

(e) A descriptive assessment of the impact of the Local Dental Pilot Program domain on achieving the goals of the Increase Preventive Services Utilization for Children, Caries Risk Assessment and Disease Management Pilot, and Increase Continuity of Care domains.

(f) A descriptive analysis of program integrity challenges generated by the domain and how those challenges have been, or will be, addressed.

(Added by Stats. 2016, Ch. 613, Sec. 6. (AB 2207) Effective January 1, 2017.)

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

(1) Evaluate primary, core specialty, and facility access to care for managed care beneficiaries based on the current health plan network adequacy requirements set forth in 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) and Medicaid managed care contracts, as applicable.

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

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

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

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

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

(1) Consumer advocacy organizations.

(2) Provider associations.

(3) Health plans and health plan associations.

(4) Legislative staff.

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

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

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

(3) Provide all of the following:

(A) Feedback on the access assessment structure.

(B) An initial draft access assessment report.

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

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

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

(1) Measure health plan compliance with network adequacy requirements as set forth in 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) and Medicaid managed care contracts, as applicable. The assessment shall consider State Fair Hearing and IMR decisions, and grievances and appeals or complaints data, and any other factors as selected with input from the advisory committee.

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

(3) Measure health plan compliance with timely access requirements, as set forth in 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) and Medicaid managed care contracts using a sample of provider-level data on the soonest appointment availability.

(4) Review compliance with network adequacy requirements for managed care plans, and other lines of business for primary and core specialty care areas and facility access, as set forth in 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) and Medicaid managed care contracts, as applicable, across the entire health plan network.

(5) Applicable network adequacy requirements of the proposed or final Notice of Proposed Rulemaking, as determined under the approved access assessment design, that are not already required 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) shall be reviewed and reported on against a metric range as identified by the department and approved by the federal Centers for Medicare and Medicaid Services in the access assessment design.

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

(7) Measure managed care plan compliance with network adequacy requirements within the department and managed care plan contract service areas using 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) and network adequacy standards within Medicaid managed care contracts, accounting for each of the following:

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

(B) Previously approved alternate network access standards, as provided for 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) and Medicaid managed care contracts.

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

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

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

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

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

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

(Amended by Stats. 2017, Ch. 561, Sec. 288. (AB 1516) Effective January 1, 2018.)

14184.90. (a) Subject to appropriation by the Legislature, beginning no sooner than July 1, 2019, and consistent with Section 14184.20, the department may authorize a dental integration pilot program in San Mateo County as a component of the Medi-Cal 2020 demonstration project established by this article, or any extension or amendment to the Medi-Cal 2020 demonstration project pursuant to subdivision (j) of Section 14184.20. The pilot program shall be designed to test the impact to oral care access, quality, and utilization, as well as medical cost impacts by the delivery of covered dental care services as a managed care benefit under the operation of the Health Plan of San Mateo.

(b) Before the start date of the approved pilot program, the department shall do all of the following:

(1) Seek input from affected stakeholders including, but not limited to, the Health Plan of San Mateo, currently enrolled Medi-Cal dental providers, other dental providers, and consumer advocates.

(2) Establish objectives for improving dental utilization through the pilot program.

(3) Establish objectives for improving access to oral health care through the pilot program.

(4) Determine that the Health Plan of San Mateo meets the department's readiness requirements, including, but not limited to, the demonstration of an adequate network of dental care providers.

(c) Under the approved pilot program, covered Medi-Cal dental care services currently provided under the Medi-Cal fee-for-service system to enrollees of the Health Plan of San Mateo shall be made the responsibility of the Health Plan of San Mateo, including covered dental care services provided through safety net clinics, such as federally qualified health centers. For the duration of the approved pilot program, enrollees of the Health Plan of San Mateo will no longer receive covered Medi-Cal dental care services through the Medi-Cal fee-for-service system.

(d) To minimize interruptions in ongoing dental care, enrollees impacted by the approved pilot program who have been in treatment with a specific Medi-Cal dental provider for more than 12 months shall be permitted to continue to receive covered dental services from that provider, if all of the following are met:

(1) The provider is willing to continue to treat the enrollee at existing Medi-Cal fee-for-service rates, or at another rate or rate methodology as agreed upon by the plan and provider.

(2) The provider remains an eligible provider of dental services in Medi-Cal.

(3) The Health Plan of San Mateo has not identified a significant quality issue with the provider.

(e) The pilot program described in this section shall be authorized for no more than a period of six years.

(f) Pursuant to subdivision (e) of Section 14184.20, and to the extent the department obtains federal approval for the pilot program described in this section, the department shall contract with an external entity to conduct an evaluation of the pilot program to be completed and published no later than December 31 of the sixth state fiscal year the pilot program is in operation. The evaluation shall include all of the following:

(1) Assessment of the pilot program's ability to meet the utilization objectives established in this section.

(2) Assessment of the pilot program's ability to meet the improved access objectives established in this section.

(3) Assessment of overall dental utilization and changes in utilization compared to utilization in the fee-for-service system that occurred prior to the pilot program.

(4) Assessment of the medical cost impacts of the pilot program, if any, such as reductions in emergency room visits.

(5) Assessment of the impacts to the available provider network for dental services in the pilot program compared to the provider network available in the fee-for-service system before the pilot program.

(g) The funding for the evaluation described in subdivision (f) shall be provided by the Health Plan of San Mateo to the department. The department shall seek federal matching funds if available.

(h) The department shall consult with the Health Plan of San Mateo no later than six months before the start date of the approved pilot program regarding any necessary adjustments to its capitation rates developed pursuant to Section 14301.1 and methods required to integrate dental care services for plan enrollees.

(i) (1) This section shall not be implemented until all necessary federal approvals have been obtained.

(2) This section shall be implemented only to the extent the department determines federal financial participation is available and is not otherwise jeopardized.

(Added by Stats. 2018, Ch. 47, Sec. 3. (SB 849) Effective June 27, 2018.)