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 5.2. Medi-Cal Hospital Care/Uninsured Hospital Care Demonstration Project Act [14166 - 14166.26] *(Article 5.2 added by Stats. 2005, Ch. 560, Sec. 1.)*

14166. (a) This article shall be known and may be cited as the “Medi-Cal Hospital/Uninsured Care Demonstration Project Act.”

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

(1) The preservation of the state’s disproportionate share hospitals and the University of California hospitals is of critical importance to the health and welfare of the people of the state.

(2) These hospitals, as well as many nondisproportionate district hospitals, are facing unprecedented financial challenges. Many are facing significant budget deficits impeding their ability to continue serving their essential role in the health care delivery system, including providing care to Medi-Cal beneficiaries and uninsured patients.

(3) The financial viability of these hospitals has been sustained through funding that has been available for California’s disproportionate share hospital program under Medi-Cal. Without these funds, many of these hospitals would be unable to keep their doors open and others would be forced to curtail services, thereby impacting service to Medi-Cal beneficiaries and other needy individuals.

(4) The federal Centers for Medicare and Medicaid Services has indicated in negotiations with the State Department of Health Services that it is changing its approach to federal funding of Medicaid in various respects. For instance, the methodology that many states, including California, have used to fund their disproportionate share hospital programs successfully for more than a decade has become the subject of negative attention by the federal Centers for Medicare and Medicaid Services, which is refusing to approve discretionary waivers and state plan amendments that rely on these funding methods. Accordingly, the State of California has proposed that the funding mechanism for inpatient hospital services under Medi-Cal be modified to secure federal approval and address continued and adequate funding to the University of California and disproportionate share hospitals. To this end, the state has negotiated a waiver from various federal Medicaid requirements that will allow it to implement a demonstration project using modified funding methodologies. The Medi-Cal Hospital/Uninsured Care Demonstration Project is intended to make up to $3.3 billion in additional federal funds available to California safety net hospitals over a five-year period.

(5) The methodologies used to fund the Medi-Cal program should maximize the use of federal funds consistent with federal Medicaid law in an effort to access all of the increased federal funding available under the Medi-Cal Hospital/Uninsured Care Demonstration Project.

(6) The amount of Medi-Cal funding to the University of California hospitals and disproportionate share hospitals as a whole should not be less than the amount of funding for the 2004-05 fiscal year. Similarly, the amount of Medi-Cal funding for the public disproportionate share hospitals as a group and for the private disproportionate share hospitals as a group should not be less than the amount of funding for the 2004-05 fiscal year.

(7) The distributions of Medi-Cal funds should provide a predictable and stable amount of funding for these hospitals in order to allow them to engage in short-term and long-term planning. The distribution methodologies should be fair and equitable, and take into account utilization changes among hospitals.

(8) The payments of Medi-Cal funds to these hospitals should be made regularly and periodically throughout the year in order to provide hospitals with necessary cashflow.

(Added by Stats. 2005, Ch. 560, Sec. 1. Effective October 5, 2005. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.1. For purposes of this article, the following definitions shall apply:

(a) “Allowable costs” means those costs recognized as allowable under Medicare reasonable cost principles and additional costs recognized under the demonstration project and successor demonstration project, including those expenditures identified in Appendix D to the Special Terms and Conditions for the demonstration project and successor demonstration project. Allowable costs under this subdivision shall be determined in accordance with the Special Terms and Conditions and implementation documents for the demonstration project and successor demonstration project approved by the federal Centers for Medicare and Medicaid Services.

(b) “Base year private DSH hospital” means a nonpublic hospital, nonpublic-converted hospital, or converted hospital, as those terms are defined in paragraphs (26), (27), and (28), respectively, of subdivision (a) of Section 14105.98, that was an eligible hospital under paragraph (3) of subdivision (a) of Section 14105.98 for the 2004–05 state fiscal year.

(c) “Demonstration project” means the Medi-Cal Hospital/Uninsured Care Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services, effective for the period of September 1, 2005, through October 31, 2010.

(d) “Designated public hospital” means any one of the following hospitals to the extent identified in Attachment C, “Government-operated Hospitals to be Reimbursed on a Certified Public Expenditure Basis,” to the Special Terms and Conditions for the demonstration project and successor demonstration project, as applicable, issued by the federal Centers for Medicare and Medicaid Services:

(1) UC Davis Medical Center.

(2) UC Irvine Medical Center.

(3) UC San Diego Medical Center.

(4) UC San Francisco Medical Center.

(5) UC Los Angeles Medical Center, including Santa Monica/UCLA Medical Center.

(6) LA County Harbor/UCLA Medical Center.

(7) LA County Martin Luther King Jr.-Harbor Hospital.

(8) LA County Olive View UCLA Medical Center.

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

(10) LA County University of Southern California Medical Center.

(11) Alameda Health System.

(12) Arrowhead Regional Medical Center.

(13) Contra Costa Regional Medical Center.

(14) Kern Medical Center.

(15) Natividad Medical Center.

(16) Riverside County Regional Medical Center.

(17) San Francisco General Hospital.

(18) San Joaquin General Hospital.

(19) San Mateo Medical Center.

(20) Santa Clara Valley Medical Center.

(21) Tuolumne General Hospital.

(22) Ventura County Medical Center.

(e) “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) of Title 42 of the United States Code.

(f) “Nondesignated public hospital” means a public hospital defined in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(g) “Project year” means the applicable state fiscal year of the Medi-Cal Hospital/Uninsured Care Demonstration Project through October 31, 2010.

(h) “Project year private DSH hospital” means a nonpublic hospital, nonpublic-converted hospital, or converted hospital, as those terms are defined in paragraphs (26), (27), and (28), respectively, of subdivision (a) of Section 14105.98, that was an eligible hospital under paragraph (3) of subdivision (a) of Section 14105.98, for the particular project year.

(i) “Prior supplemental funds” means the Emergency Services and Supplemental Payments Fund, the Medi-Cal Medical Education Supplemental Payment Fund, the Large Teaching Emphasis Hospital and Children’s Hospital Medi-Cal Medical Education Supplemental Payment Fund, and the Small and Rural Hospital Supplemental Payments Fund, established under Sections 14085.6, 14085.7, 14085.8, and 14085.9, respectively.

(j) “Private hospital” means a nonpublic hospital, nonpublic-converted hospital, or converted hospital, as those terms are defined in paragraphs (26) to (28), inclusive, respectively, of subdivision (a) of Section 14105.98.

(k) “Safety net care pool” means the federal funds available under the Medi-Cal Hospital/Uninsured Care Demonstration Project and the successor demonstration project to ensure continued government support for the provision of health care services to uninsured populations.

(l) “Uninsured” shall have the same meaning as that term has in the Special Terms and Conditions issued by the federal Centers for Medicare and Medicaid Services for the demonstration project and the successor demonstration project.

(m) “Successor demonstration project” means the Medicaid demonstration project entitled “California’s Bridge to Reform,” No. 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services, effective for the period of November 1, 2010, through October 31, 2015.

(n) “Successor demonstration year” means the demonstration year as identified in the Special Terms and Conditions for the successor demonstration project that corresponds to a specific period of time as follows:

(1) Successor demonstration year 6 corresponds to the period of November 1, 2010, through June 30, 2011.

(2) Successor demonstration year 7 corresponds to the period of July 1, 2011, through June 30, 2012.

(3) Successor demonstration year 8 corresponds to the period of July 1, 2012, through June 30, 2013.

(4) Successor demonstration year 9 corresponds to the period of July 1, 2013, through June 30, 2014.

(5) Successor demonstration year 10 corresponds to July 1, 2014, through October 31, 2015.

(o) “Low Income Health Program” means the county-based elective program to provide benefits for low-income individuals that is authorized by the successor demonstration project and implemented by Part 3.6 (commencing with Section 15909).

(p) “Delivery system reform incentive pool” means the separate federal funding pool created within the safety net care pool under the successor demonstration project that is available to support programs of activity to enhance the quality of care and health of patients served by designated public hospitals and nonhospital clinics and other provider types with which they are affiliated, and, under specified conditions and approval of the federal Centers for Medicare and Medicaid Services, to private disproportionate share hospitals and nondesignated public hospitals.

(Amended by Stats. 2014, Ch. 46, Sec. 5. (SB 1352) Effective January 1, 2015. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.2. (a) The demonstration project, and the successor demonstration project, as applicable, shall be implemented and administered pursuant to this article.

(b) (1) The director may modify any process or methodology specified in this article to the extent necessary to comply with federal law or the terms of the demonstration project or the successor demonstration project, as applicable, but only if the modification

results in the equitable distribution of funding, consistent with this article, among the hospitals affected by the modification. If the director, after consulting with affected hospitals, determines that an equitable distribution cannot be achieved, 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. This article shall become inoperative on the date that the director executes a declaration pursuant to this subdivision, and as of January 1 of the following year shall be repealed.

(2) In addition to the requirements specified in paragraph (1), 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.

(c) The director shall administer the demonstration project, the successor demonstration project, and related Medi-Cal payment programs in a manner that attempts to maximize available payment of federal financial participation, consistent with federal law, the applicable Special Terms and Conditions for the demonstration project and successor demonstration project issued by the federal Centers for Medicare and Medicaid Services, and this article.

(d) As permitted by the federal Centers for Medicare and Medicaid Services, this article shall be effective with regard to services rendered throughout the term of the demonstration project, and retroactively, with regard to services rendered on or after July 1, 2005, but prior to the implementation of the demonstration project, and with regard to services rendered throughout the term of the successor demonstration project.

(e) In the administration of this article, the state shall continue to make payments to 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 shall continue to make inpatient hospital payments not covered by the contract. These payments shall not duplicate any other payments made under this article.

(f) The department shall continue to operate the selective provider contracting program in accordance with Article 2.6 (commencing with Section 14081) in a manner consistent with this article. A designated public hospital participating in the certified public expenditure process shall maintain a selective provider contracting program contract. These contracts shall continue to be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(g) (1) In the event of a final judicial determination made by any state or federal court that is not appealed in any action by any party or a final determination by the administrator of the federal Centers for Medicare and Medicaid Services that federal financial participation is not available with respect to any payment made under any of the methodologies implemented pursuant to this article because the methodology is invalid, unlawful, or is contrary to any provision of federal law or regulation, the director may modify the process or methodology to comply with law, but only if the modification results in the equitable distribution of demonstration project funding, consistent with this article, among the hospitals affected by the modification. If the director, after consulting with affected hospitals, determines that an equitable distribution cannot be achieved, 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. This article shall become inoperative on the date that the director executes a declaration pursuant to this subdivision, and as of January 1 of the following year shall be repealed.

(2) In addition to the requirements specified in paragraph (1), 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) (1) The department may adopt regulations to implement this article. These regulations may initially be adopted as emergency regulations in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). For purposes of this article, the adoption of regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare. Any emergency regulations adopted pursuant to this section shall not remain in effect subsequent to 24 months after the effective date of this article.

(2) As an alternative, and notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, or any other provision of law, the department may implement and administer this article by means of provider bulletins, manuals, or other similar instructions, without taking regulatory action. The department shall notify the fiscal and appropriate policy committees of the Legislature of its intent to issue a provider bulletin, manual, or other similar instruction, at least five days prior to issuance. In addition, the department shall provide a copy of any provider bulletin, manual, or other similar instruction issued under this paragraph to the fiscal and appropriate policy committees of the Legislature. The department shall consult with interested parties and appropriate stakeholders, regarding the implementation and ongoing administration of this article.

(i) To the extent necessary to implement this article, the department shall submit, by September 30, 2005, to the federal Centers for Medicare and Medicaid Services proposed amendments to the Medi-Cal state plan, including, but not limited to, proposals to modify inpatient hospital payments to designated public hospitals, modify the disproportionate share hospital payment program, and provide for supplemental Medi-Cal reimbursement for certain physician and nonphysician professional services. The department shall,

subsequent to September 30, 2005, submit any additional proposed amendments to the Medi-Cal state plan that may be required by the federal Centers for Medicare and Medicaid Services, to the extent necessary to implement this article.

(j) Each designated public hospital shall implement a comprehensive process to offer individuals who receive services at the hospital the opportunity to apply for the Medi-Cal program, the Healthy Families Program, or any other public health coverage program for which the individual may be eligible, and shall refer the individual to those programs, as appropriate.

(k) In any judicial challenge of the provisions of this article, nothing shall create an obligation on the part of the state to fund any payment from state funds due to the absence or shortfall of federal funding.

(l) Any reference in this article to the "Medicare cost report" shall be deemed a reference to the Medi-Cal cost report to the extent that report is approved by the federal Centers for Medicare and Medicaid Services for any of the uses described in this article.

(Amended by Stats. 2011, Ch. 86, Sec. 2. (AB 1066) Effective July 15, 2011. Repealed on date prescribed in subd. (b) or (g) or in Section 14166.26. Note: Termination clauses affect Article 5.2, commencing with Section 14166.)

14166.3. (a) During the demonstration project and successor demonstration project terms, payment adjustments to disproportionate share hospitals shall not be made pursuant to Section 14105.98. Payment adjustments to disproportionate share hospitals shall be made solely in accordance with this article.

(b) Except as otherwise provided in this article, 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 Medicaid state plan in effect as of the 2004–05 state fiscal year. For purposes of these determinations and computations, services that are rendered under the Health Care Coverage Initiative authorized pursuant to Part 3.5 (commencing with Section 15900) or the Low Income Health Program authorized pursuant to Part 3.6 (commencing with Section 15909) shall be included.

(c) (1) 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 2006 to 2015, inclusive, and federal fiscal year 2016 with respect to the pro rata portion of the allotment that will apply during successor demonstration year 10 pursuant to paragraph (2), shall be distributed solely among the following hospitals:

(A) Eligible hospitals, as determined pursuant to Section 14105.98 for each project year and successor demonstration year in which the particular federal fiscal year commences, which meet the definition of a public hospital as specified in paragraph (25) of subdivision (a) of Section 14105.98.

(B) 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.

(2) The federal disproportionate share hospital allotment for each of the federal fiscal years 2006 to 2015, inclusive, shall be aligned with the project year or successor demonstration year in which the applicable federal fiscal year commences. The payment adjustment year, as used within the meaning of paragraph (6) of subdivision (a) of Section 14105.98, shall be the corresponding project year or successor demonstration year. With respect to successor demonstration year 10, the period of July 1, 2015, through October 31, 2015, shall be aligned with a pro rata portion of the federal disproportionate share hospital allotment for federal fiscal year 2016.

(3) Uncompensated Medi-Cal and uninsured costs as reported pursuant to Section 14166.8, shall be used by the department as the basis for determining the hospital-specific disproportionate share hospital payment limits required by Section 1396r-4(g) of Title 42 of the United States Code for the hospitals described in paragraph (1).

(4) The distribution of the federal disproportionate share hospital allotment to hospitals described in paragraph (1) 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.

(d) Eligible hospitals, as determined pursuant to Section 14105.98 for each project year and each successor demonstration year, 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 receive Medi-Cal disproportionate share hospital replacement payment adjustments pursuant to Section 14166.11 and other provisions of this chapter. 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 federal share of these payments shall not be claimed from the federal disproportionate share hospital allotment described in subdivision (c).

(e) The nonfederal share of payments described in subdivisions (c) and (d) shall be derived from the following sources:

(1) With respect to the payments described in paragraph (1) of subdivision (c) that are made to designated public hospitals, the nonfederal share shall consist of certified public expenditures described in subparagraphs (A) and (C) of paragraph (2) of

subdivision (a) of Section 14166.9, and intergovernmental transfer amounts described in paragraph (2) of subdivision (d) of Section 14166.6.

(2) With respect to the payments described in paragraph (1) of subdivision (c) that are made to nondesignated public hospitals, the nonfederal share shall consist solely of state General Fund appropriations.

(3) With respect to the payments described in subdivision (d), the nonfederal share shall consist of state General Fund appropriations.

(f) (1) During the terms of the demonstration project and successor demonstration project, for the 2005–06 state fiscal year and any subsequent state fiscal years, no public entity shall 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, during the demonstration project and successor demonstration project terms, intergovernmental transfers shall be made with respect to the disproportionate share hospital payment adjustments made in accordance with paragraph (2) of subdivision (d) of Section 14166.6, or paragraph (2) of subdivision (d) of Section 14166.61, as applicable.

(2) During the terms of the demonstration project and successor demonstration project, for the 2005–06 state fiscal year and any subsequent state fiscal years, transfer amounts from the Medi-Cal Inpatient Payment Adjustment Fund to the Health Care Deposit Fund, as provided for pursuant to paragraph (2) of subdivision (d) of Section 14163, are hereby reduced to zero. Unless otherwise specified in this article, this paragraph shall be disregarded for purposes of the calculations made under Section 14105.98 during the demonstration project and successor demonstration project.

(Amended by Stats. 2011, Ch. 86, Sec. 3. (AB 1066) Effective July 15, 2011. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.35. (a) For each project year through October 31, 2010, designated public hospitals shall be eligible to receive the following:

(1) Payments for Medi-Cal inpatient hospital services and supplemental payments for physician and nonphysician practitioner services, as specified in Section 14166.4.

(2) Disproportionate share hospital payment adjustments, as specified in Section 14166.6.

(3) Safety net care pool funding, as specified in Section 14166.7.

(4) Stabilization funding, as specified in Section 14166.75.

(5) Grants to distressed hospitals as negotiated by the California Medical Assistance Commission pursuant to Section 14166.23.

(b) For each successor demonstration year, designated public hospitals shall be eligible to receive the following:

(1) Payments for Medi-Cal inpatient hospital services and supplemental payments for physician and nonphysician practitioner services, as specified in Section 14166.4.

(2) Disproportionate share hospital payment adjustments, as specified in Section 14166.61.

(3) Safety net care pool funding, as specified in Section 14166.71.

(4) Delivery system reform incentive pool payments, as specified in Section 14166.77.

(5) Grants to distressed hospitals as negotiated by the California Medical Assistance Commission to the extent the funding is available pursuant to Section 14166.23 or any other provisions of this article.

(c) Payments under this section shall be in addition to other payments that may be made in accordance with law.

(Amended by Stats. 2011, Ch. 86, Sec. 4. (AB 1066) Effective July 15, 2011. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.4. (a) Notwithstanding Article 2.6 (commencing with Section 14081), and any other provision of law, fee-for-service payments to the designated public hospitals for inpatient services to Medi-Cal beneficiaries shall be governed by this section. Each of the designated public hospitals shall receive as payment for inpatient hospital services provided to Medi-Cal beneficiaries during any project year or successor demonstration year, the hospital's allowable costs incurred in providing those services, multiplied by the federal medical assistance percentage. These costs shall be determined, certified, and claimed in accordance with Sections 14166.8 and 14166.9. All Medicaid federal financial participation received by the state for the certified public expenditures of the hospital, or

the governmental entity with which the hospital is affiliated, for inpatient hospital services rendered to Medi-Cal beneficiaries shall be paid to the hospital.

(b) With respect to each project year and successor demonstration year, each of the designated public hospitals shall receive an interim payment for each day of inpatient hospital services rendered to Medi-Cal beneficiaries based upon claims filed by the hospital in accordance with the claiming process set forth in Division 3 (commencing with Section 50000) of Title 22 of the California Code of Regulations. The interim per diem payment amount shall be based on estimated costs, which shall be derived from statistical data from the following sources and which shall be multiplied by the federal medical assistance percentage:

(1) For allowable costs reflected in the Medicare cost report, the cost report most recently audited by the hospital's Medicare fiscal intermediary adjusted by a trend factor to reflect increased costs, as approved by the federal Centers for Medicare and Medicaid Services for the demonstration project.

(2) For allowable costs not reflected in the Medicare cost report, each hospital shall provide hospital-specific cost data requested by the department. The department shall adjust the data by a trend factor as necessary to reflect project year allowable costs.

(c) Until the department commences making payments pursuant to subdivision (b), the department may continue to make fee-for-service, per diem payments to the designated public hospitals, pursuant to the selective provider contracting program in accordance with Article 2.6 (commencing with Section 14081), for services rendered on and after July 1, 2005, for a period of 120 days following the award of this demonstration. Per diem payments shall be adjusted retroactively to the amounts determined under the payment methodology prescribed in this article.

(d) No later than April 1 following the end of the relevant reporting period for the project year or successor demonstration year, the department shall undertake an interim reconciliation of payments made pursuant to subdivisions (a) to (c), inclusive, based on Medicare and other cost and statistical data submitted by the hospital for the year and shall adjust payments to the hospital accordingly.

(e) (1) The designated public hospitals shall receive supplemental reimbursement for the costs incurred for physician and nonphysician practitioner services provided to Medi-Cal beneficiaries who are patients of the hospital, to the extent that those services are not claimed as inpatient hospital services by the hospital and the costs of those services are not otherwise recognized under subdivision (a).

(2) Expenditures made by the designated public hospital, or a governmental entity with which it is affiliated, for the services identified in paragraph (1) shall be reduced by any payments received pursuant to Article 7 (commencing with Section 51501) of Title 22 of the California Code of Regulations. The remainder shall be certified by the appropriate public official and claimed by the department in accordance with Sections 14166.8 and 14166.9. These expenditures may include any of the following:

(A) Compensation to physicians or nonphysician practitioners pursuant to contracts with the designated public hospital.

(B) Salaries and related costs for employed physicians and nonphysician practitioners.

(C) The costs of interns, residents, and related teaching physician and supervision costs.

(D) Administrative costs associated with the services described in subparagraphs (A) to (C), inclusive, including billing costs.

(3) Designated public hospitals shall receive federal funding based on the expenditures identified and certified in paragraph (2). All federal financial participation received by the department for the certified public expenditures identified in paragraph (2) shall be paid to the designated public hospital, or a governmental entity with which it is affiliated.

(4) To the extent that the supplemental reimbursement received under this subdivision relates to services provided to hospital inpatients, the reimbursement shall be applied in determining whether the designated public hospital has received full baseline payments for purposes of paragraph (1) of subdivision (b) of Section 14166.21.

(5) Supplemental reimbursement under this subdivision may be distributed as part of the interim payments under subdivision (b), on a per-visit basis, on a per-procedure basis, or on any other federally permissible basis.

(6) The department shall submit for federal approval, by September 30, 2005, a proposed amendment to the Medi-Cal state plan to implement this subdivision, retroactive to July 1, 2005, to the extent permitted by the federal Centers for Medicare and Medicaid Services. If necessary to obtain federal approval, the department may limit the application of this subdivision to costs determined allowable by the federal Centers for Medicare and Medicaid Services. If federal approval is not obtained, this subdivision shall not be implemented.

(Amended by Stats. 2011, Ch. 86, Sec. 5. (AB 1066) Effective July 15, 2011. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.5. (a) With respect to each project year through October 31, 2010, the director shall determine a baseline funding amount for each designated public hospital. A hospital's baseline funding amount shall be an amount equal to the total amount paid to the hospital for inpatient hospital services rendered to Medi-Cal beneficiaries during the 2004–05 fiscal year, including the following Medi-Cal payments, but excluding payments received under the Medi-Cal Specialty Mental Health Services Consolidation Program:

(1) Base payments under the selective provider contracting program as provided for under Article 2.6 (commencing with Section 14081).

(2) Emergency Services and Supplemental Payments Fund payments as provided for under Section 14085.6.

(3) Medi-Cal Medical Education Supplemental Payment Fund payments and Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund payments as provided for under Sections 14085.7 and 14085.8, respectively.

(4) Disproportionate share hospital payment adjustments as provided for under Section 14105.98.

(5) Administrative day payments as provided for under Section 51542 of Title 22 of the California Code of Regulations.

(b) The baseline funding amount for each designated public hospital shall reflect a reduction for the total amount of intergovernmental transfers made pursuant to Sections 14085.6, 14085.7, 14085.8, 14085.9, and 14163 for the 2004–05 state fiscal year by the designated public hospital, or the governmental entity with which it is affiliated.

(c) With respect to each project year beginning after the 2005–06 project year through October 31, 2010, the department shall determine an adjusted baseline funding amount for each designated public hospital to reflect any increase or decrease in volume. The adjustment for designated public hospitals shall be calculated as follows:

(1) Applying the cost-finding methodology approved under the demonstration project, and applying accounting and reporting practices consistent with those applied in paragraph (2), the department shall determine the total allowable costs incurred by the hospital, or the governmental entity with which it is affiliated, in rendering hospital services that would be recognized under the demonstration project to Medi-Cal beneficiaries and the uninsured during the 2004–05 state fiscal year.

(2) Applying the cost-finding methodology approved under the demonstration project, and applying accounting and reporting practices consistent with those applied in paragraph (1), the department shall determine the total allowable costs incurred by the hospital, or the governmental entity with which it is affiliated, in rendering hospital services under the demonstration project to Medi-Cal beneficiaries and the uninsured during the state fiscal year preceding the project year for which the volume adjustment is being calculated.

(3) The department shall:

(A) Calculate the difference between the amount determined under paragraph (1) and the amount determined under paragraph (2).

(B) Determine the percentage increase or decrease by dividing the difference in subparagraph (A) by the amount in paragraph (1).

(C) Apply the percentage determined in subparagraph (B) to that amount that results from the hospital's baseline funding amount determined under subdivision (a) as adjusted by subdivision (b), except for the reduction for the amount of intergovernmental transfers made pursuant to Section 14163, minus the amount of disproportionate share hospital payments in paragraph (4) of subdivision (a).

(4) The designated public hospital's adjusted baseline for the project year is the amount determined for the hospital in subdivision (a) as adjusted by subdivision (b), plus the amount in subparagraph (C) of paragraph (3).

(5) Notwithstanding paragraphs (3) and (4), when, as determined by the department, in consultation with the designated public hospital, there has been a material reduction in patient services at the designated public hospital during the project year, and the reduction has resulted in a diminution of access for Medi-Cal and uninsured patients and a related reduction in total costs at the designated public hospital of at least 20 percent, the department may utilize current or adjusted data that are reflective of the diminution of access, even if the data are not annual data, to determine the hospital's adjusted baseline amount.

(d) The aggregate designated public hospital baseline funding amount for each project year through October 31, 2010, shall be the sum of all baseline funding amounts determined under subdivisions (a) and (b), as adjusted in subdivision (c), as appropriate, for all

designated public hospitals.

(e) (1) If, with respect to any project year, the difference between the percentage adjustment in subparagraph (B) of paragraph (3) of subdivision (c) of this section, computed in the aggregate for designated public hospitals, excluding the percentage adjustment for any designated public hospital that was not in operation for the full project year, is greater than five percentage points more than the aggregate percentage adjustment for private DSH hospitals determined under subparagraph (B) of paragraph (3) of subdivision (c) of Section 14166.13, then the aggregate percentage adjustment for designated public hospitals shall be reduced in the amount necessary to reduce the difference to five percentage points. The reduction required by the previous sentence shall be allocated among designated public hospitals pro rata based on the relationship between each hospital's percentage determined under subparagraph (B) of paragraph (3) of subdivision (c) of this section and the aggregate percentage for designated public hospitals.

(2) Notwithstanding paragraph (1), the department may apply the adjustments set forth in paragraph (5) of subdivision (c).

(f) The provisions of this section shall apply only with respect to the demonstration project term, and shall not apply with respect to the successor demonstration project term. All references to baseline funding amounts and adjusted baseline funding amounts with respect to designated public hospitals shall be disregarded for purposes of successor demonstration year determinations.

(Amended by Stats. 2011, Ch. 86, Sec. 6. (AB 1066) Effective July 15, 2011. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.6. (a) For the 2005–06 project year and subsequent project years through October 31, 2010, each designated public hospital described in subdivision (c) of Section 14166.3 shall be eligible to receive an allocation of federal Medicaid funding from the applicable federal disproportionate share hospital allotment pursuant to this section. The department shall establish the allocations in a manner that maximizes federal Medicaid funding to the state during the term of the demonstration project, and shall consider, at a minimum, all of the following factors, taking into account all other payments to each hospital under this article:

(1) The optimal use of intergovernmental transfer-funded payments described in subdivision (d).

(2) Each hospital's pro rata share of the applicable aggregate designated public hospital baseline funding amount described in subdivision (d) of Section 14166.5.

(3) That the allocation under this section, in combination with the federal share of certified public expenditures for Medicaid inpatient hospital services for the project year determined under subdivision (a) of Section 14166.4, any supplemental reimbursement for professional services rendered to hospital inpatients determined for the project year under subdivision (e) of Section 14166.4, and the distribution of safety net care pool funds from the Health Care Support Fund determined under subdivision (a) of Section 14166.7, shall not exceed the baseline funding amount or adjusted baseline funding amount, as appropriate, for the hospital.

(4) Minimizing the need to redistribute federal funds that are based on the certified public expenditures of designated public hospitals as described in subdivision (c).

(b) Each designated public hospital shall receive its allocation of federal disproportionate share hospital payments in one or both of the following forms:

(1) Distributions from the Demonstration Disproportionate Share Hospital Fund established pursuant to subdivision (d) of Section 14166.9, consisting of federal funds claimed and received by the department, pursuant to subparagraphs (A) and (C) of paragraph (2) of subdivision (a) of Section 14166.9 based on designated public hospitals' certified public expenditures up to 100 percent of uncompensated Medi-Cal and uninsured costs.

(2) Intergovernmental transfer-funded payments, as described in subdivision (d). For purposes of determining whether the hospital has received its allocation of federal disproportionate share hospital payments established under this section, only the federal share of intergovernmental transfer-funded payments shall be considered.

(c) The distributions described in paragraph (1) of subdivision (b) may be made to a designated public hospital independent of the amount of uncompensated Medi-Cal and uninsured costs certified as public expenditures by that hospital pursuant to Section 14166.8, provided that, in accordance with the Special Terms and Conditions for the demonstration project, the recipient hospital does not return any portion of the funds received to any unit of government, excluding amounts recovered by the state or federal government.

(d) Designated public hospitals that meet the requirement of 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, may receive intergovernmental transfer-funded disproportionate share hospital payments as follows:

(1) The department shall establish the amount of the hospital's intergovernmental transfer-funded disproportionate share hospital payment. The total amount of that payment, 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, determined in accordance with the Special Terms and Conditions for the demonstration project.

(2) A transfer amount shall be determined for each hospital that is subject to this subdivision, equal to the nonfederal share of the payment amount established for the hospital pursuant to paragraph (1). The transfer amount so 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. The sources of funds utilized for the transfer amount shall not include impermissible provider taxes or donations as defined under Section 1396b(w) of Title 42 of the United States Code or other federal funds. For this purpose, federal funds do not include patient care revenue received as payment for services rendered under programs such as Medicare or Medicaid.

(3) The department shall pay the amounts established pursuant to paragraph (1) to each hospital using the transfer amounts deposited pursuant to paragraph (2) as the nonfederal share of those payments. The total intergovernmental transfer-funded payment amount, consisting of the federal and nonfederal share, paid to a hospital shall be retained by the hospital in accordance with the Special Terms and Conditions for the demonstration project.

(e) The total federal disproportionate share hospital funds allocated under this section to designated public hospitals with respect to each project year, in combination with the federal share of disproportionate share hospital payment adjustments made to nondesignated public hospitals pursuant to Section 14166.16 for the same project year, shall not exceed the applicable federal disproportionate share hospital allotment.

(f) (1) Each designated public hospital shall receive quarterly interim payments of its disproportionate share hospital allocation during the project year. The determinations set forth in subdivisions (a) to (e), inclusive, shall be made on an interim basis prior to the start of each project year, except that, with respect to the 2005–06 project year, the interim determinations shall be made prior to January 1, 2006. 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.

(2) Prior to the distribution of payments in accordance with paragraph (1) and with subdivision (g) to a designated public hospital that is part of a hospital system containing multiple designated public hospitals licensed to the same governmental entity, the department shall consult with the applicable governmental entity. The department shall implement any adjustments to the payment distributions for the hospitals in that hospital system as requested by the governmental entity if the net effect of the requested adjustments for those hospitals is zero. These payment redistributions shall recognize the level of care provided to Medi-Cal and uninsured patients and shall maintain the viability and effectiveness of the hospital system. The adjustments made pursuant to this paragraph with respect to an affected hospital shall be disregarded in the application of the limitations described in paragraph (3) of subdivision (a), and in paragraph (1) of subdivision (a) of Section 14166.7.

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

(h) Each designated public hospital shall receive its disproportionate share hospital allocation, as computed pursuant to subdivisions (a) to (e), inclusive, subject to final audits of all applicable Medicare and other cost, payment, and statistical data for the project year.

(i) The provisions of this section shall apply only with respect to the demonstration project term, and shall not apply with respect to the successor demonstration project term.

(Amended by Stats. 2011, Ch. 86, Sec. 7. (AB 1066) Effective July 15, 2011. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.61. (a) For successor demonstration year 6 and subsequent successor demonstration years, each designated public hospital described in subdivision (c) of Section 14166.3 shall be eligible to receive an allocation of federal Medicaid funding from the applicable federal disproportionate share hospital allotment pursuant to this section. The department shall establish the allocations and claim the federal funding in a manner that maximizes federal Medicaid funding to the state during the term of the successor demonstration project, and shall consider, at a minimum, all of the following factors:

(1) The optimal use of intergovernmental transfer-funded payments described in subdivision (d).

(2) Minimizing the need to redistribute federal funds that are based on the certified public expenditures of designated public hospitals as described in paragraph (1) of subdivision (c).

(b) Disproportionate share hospital allocations for designated public hospitals shall be determined for each successor demonstration year as set forth below. With respect to successor demonstration year 10, allocations shall be determined separately for each of the

periods of July 1, 2014, through June 30, 2015, and July 1, 2015, through October 31, 2015.

(1) The department shall determine the maximum federal disproportionate share hospital allotment that is available under this section for the successor demonstration year.

(2) An initial allocation shall be made to Kern Medical Center for the periods and in the amounts specified below:

(A) For successor demonstration year 6, the amount of eight million dollars ($8,000,000).

(B) For successor demonstration years 7 through 9, the amount of twelve million dollars ($12,000,000).

(C) For the period of July 1, 2014, through June 30, 2015, the amount of twelve million dollars ($12,000,000).

(D) For the period of July 1, 2015, through October 31, 2015, the amount of four million dollars ($4,000,000).

(3) Each designated public hospital shall be allocated an amount per hospital discharge as specified in this paragraph. The number of discharges per category occurring in the relevant period shall be derived from each hospital's data as reported pursuant to Section 14166.8. The reported discharges shall relate to the same hospital services for which costs are calculated for purposes of this section.

(A) One thousand one hundred dollars ($1,100) per hospital discharge with respect to an uninsured individual.

(B) Nine hundred dollars ($900) per hospital discharge with respect to an individual enrolled in the Low Income Health Program.

(C) Seven hundred fifty dollars ($750) per hospital discharge with respect to a Medi-Cal beneficiary, excluding discharges for which Medicare payments were received.

(4) The remaining available federal disproportionate share hospital allotment, after the allocations are made pursuant to paragraphs (2) and (3), shall be allocated to designated public hospitals as follows:

(A) The department shall calculate for each designated public hospital an initial DSH claiming ability amount. For the purposes of this article, the "initial DSH claiming ability amount" means the total sum of the hospital's uncompensated Medi-Cal, Low Income Health Program, and uninsured costs of hospital services that are reported as eligible certified public expenditures for disproportionate share hospital payments pursuant to Section 14166.8. For hospitals described in subdivision (d), the total sum shall be multiplied by 175 percent.

(B) The remaining available federal disproportionate share hospital allotment shall be allocated pro rata among the designated public hospitals based upon each hospital's initial DSH claiming ability amount as determined pursuant to subparagraph (A).

(c) Each designated public hospital shall receive its allocation of federal disproportionate share hospital payments in one or both of the following forms:

(1) Distributions from the Demonstration Disproportionate Share Hospital Fund established pursuant to subdivision (d) of Section 14166.9, consisting of federal funds claimed and received by the department, pursuant to clauses (ii) and (iii) of subparagraph (A) of paragraph (2) of subdivision (a) of Section 14166.9 based on designated public hospitals' certified public expenditures up to 100 percent of uncompensated Medi-Cal and uninsured costs. These distributions may be made to a designated public hospital independent of the amount of uncompensated Medi-Cal and uninsured costs certified as public expenditures by that hospital pursuant to Section 14166.8.

(2) Intergovernmental transfer-funded payments, as described in subdivision (d). For purposes of determining whether the hospital has received its allocation of federal disproportionate share hospital payments established under this section, only the federal share of intergovernmental transfer-funded payments shall be considered.

(d) Designated public hospitals that meet the requirements of 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, may receive intergovernmental transfer-funded disproportionate share hospital payments as follows:

(1) The department shall establish the amount of the hospital's intergovernmental transfer-funded disproportionate share hospital payment. The total amount of that payment, consisting of the federal and nonfederal components, shall in no case exceed an amount equal to 75 percent of the hospital's uncompensated Medi-Cal, Low Income Health Program, and uninsured costs of hospital services, determined in accordance with the Special Terms and Conditions for the successor demonstration project and the applicable provisions of the Medi-Cal State Plan.

(2) A transfer amount shall be determined for each hospital that is subject to this subdivision, equal to the nonfederal share of the payment amount established for the hospital pursuant to paragraph (1). 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. The sources of funds utilized for the transfer amount shall not include impermissible provider taxes or donations as defined under Section 1396b(w) of Title 42 of the United States Code or other federal funds. For this purpose, federal funds do not include delivery system reform incentive pool payments or patient care revenue received as payment for services rendered under programs such as designated state health programs, the Low Income Health Program, Medicare, or Medicaid.

(3) The department shall pay the amounts established pursuant to paragraph (1) to each hospital using the transfer amounts deposited pursuant to paragraph (2) as the nonfederal share of those payments.

(e) The total federal disproportionate share hospital funds allocated under this section to designated public hospitals with respect to each successor demonstration year, in combination with the federal share of disproportionate share hospital payment adjustments made to nondesignated public hospitals pursuant to Section 14166.16 and applicable provisions of the Medi-Cal State Plan for the same successor demonstration year, shall not exceed the applicable federal disproportionate share hospital allotment.

(f) (1) Each designated public hospital shall receive quarterly interim payments of its disproportionate share hospital allocation during the successor demonstration year, except that, with respect to the period of July 1, 2015, through October 31, 2015, the interim payment shall be made in October 2015. The determinations set forth in subdivisions (a) to (e), inclusive, shall be made on an interim basis prior to the start of each successor demonstration year. 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.

(2) Prior to the distribution of payments in accordance with paragraph (1) and subdivisions (g) and (h) to a designated public hospital that is part of a hospital system containing multiple designated public hospitals licensed to the same governmental entity, the department shall consult with the applicable governmental entity. The department shall implement any adjustments to the payment distributions for the hospitals in that hospital system as requested by the governmental entity if the net effect of the requested adjustments for those hospitals is zero. These payment redistributions shall recognize the level of care provided to Medi-Cal and uninsured patients and shall maintain the viability and effectiveness of the hospital system.

(3) If the determinations pursuant to subdivision (g) or (h) for a successor demonstration year result in total federal disproportionate share hospital funds claimable for distribution to designated public hospitals under this section that, in combination with the federal share of disproportionate share hospital payment adjustments made to nondesignated public hospitals for the same successor demonstration year as described in subdivision (e), are less than the applicable federal disproportionate share hospital allotment, the department shall follow the steps described in subparagraphs (A) to (C), inclusive. For purposes of this paragraph, the determinations for successor demonstration year 10 shall be made for the period of July 1, 2014, through June 30, 2015.

(A) The maximum available federal disproportionate share hospital funds for designated public hospitals for the successor demonstration year shall be determined by subtracting the federal share of disproportionate share hospital payment adjustments payable to nondesignated public hospitals pursuant to Section 14166.16 and applicable provisions of the Medi-Cal State Plan for the same successor demonstration year from the applicable federal disproportionate share hospital allotment.

(B) A reduction factor shall be calculated by dividing the total federal disproportionate share hospital funds that are claimable for distributions to designated public hospitals pursuant to subdivision (g) or (h), as applicable, by the maximum available federal disproportionate share hospital funds determined under subparagraph (A).

(C) The reduction factor calculated under subparagraph (B) shall be multiplied by the applicable allocation amount specified in paragraph (2) of subdivision (b), by the applicable amount per discharge specified in paragraph (3) of subdivision (b), and by the remaining available allotment otherwise allocable under paragraph (4) of subdivision (b). The total of these allocation amounts shall be incorporated as the payment distributions to be made pursuant to subdivision (g) or (h), as applicable.

(4) With respect to the period of July 1, 2014, through June 30, 2015, and notwithstanding subdivision (e) of Section 14184.30, if a final audit, reconciliation, or judicial or administrative determination is made or implemented subsequent to the applicable finalization date set forth in paragraph (1) of subdivision (e) of Section 14184.30 and results in federal disproportionate share hospital funds distributable to designated public hospitals in addition to the aggregate amount distributed pursuant to paragraph (3), the department shall proceed as follows:

(A) The department shall perform revised distribution calculations pursuant to subdivision (b) and, if applicable, paragraph (3).

(B) The amounts that would be allocated to each designated public hospital under the revised distribution calculations in subparagraph (A) shall be compared to the amounts previously distributed to the hospital for the same successor demonstration year.

(C) The additional federal disproportionate share hospital funds shall be distributed to those designated public hospitals to which additional amounts would be due under the revised distribution calculations.

(D) The timing of the adjustments under this paragraph shall be determined by the department in consultation with the affected designated public hospitals.

(E) Notwithstanding any other law, if the affiliated governmental entity for the designated public hospital is a county subject to 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 additional payment amount distributed to the designated public hospital pursuant to subparagraph (C) would otherwise have affected, if at all, the applicable county's redirection obligation for the 2014–15 fiscal year pursuant to paragraphs (4) and (5) of subdivision (a) of Section 17612.3 and shall determine which adjustments, if any, are necessary to either the repayment amount or the applicable county's redirection obligation. For purposes of this subparagraph, subdivision (f) of Section 17612.2 of this code and paragraph (7) of subdivision (e) of Section 101853 of the Health and Safety Code shall apply.

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

(h) Each designated public hospital shall receive its disproportionate share hospital allocation, as computed pursuant to subdivisions (a) to (e), inclusive, subject to final audits of all applicable Medicare and other cost, payment, discharge, and statistical data for the successor demonstration year.

(Amended by Stats. 2017, Ch. 52, Sec. 60. (SB 97) Effective July 10, 2017. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.7. (a) (1) With respect to each project year through October 31, 2010, designated public hospitals, or governmental entities with which they are affiliated, shall be eligible to receive safety net care pool payments from the Health Care Support Fund established pursuant to Section 14166.21. The total amount of these payments, in combination with the federal share of certified public expenditures for Medicaid inpatient hospital services determined for the project year under subdivision (a) of Section 14166.4, any supplemental reimbursement for physician and nonphysician practitioner services rendered to hospital inpatients determined for the project year under subdivision (e) of Section 14166.4, and the federal disproportionate share hospital allocation determined under Section 14166.6, shall not exceed the hospital's baseline funding amount or adjusted baseline funding amount, as appropriate.

(2) The department shall establish the amount of the safety net care pool payment described in paragraph (1) for each designated public hospital in a manner that maximizes federal Medicaid funding to the state during the term of the demonstration project.

(3) A safety net care pool payment amount may be paid to a designated public hospital, or governmental entity with which it is affiliated, pursuant to this section independent of the amount of uncompensated Medi-Cal and uninsured costs that is certified as public expenditures pursuant to Section 14166.8, provided that, in accordance with the Special Terms and Conditions for the demonstration project, the recipient hospital does not return any portion of the funds received to any unit of government, excluding amounts recovered by the state or federal government.

(4) In establishing the amount to be paid to each designated public hospital under this subdivision, the department shall minimize to the extent possible the redistribution of federal funds that are based on certified public expenditures as described in paragraph (3).

(b) (1) Each designated public hospital, or governmental entity with which it is affiliated, shall receive the amount established pursuant to subdivision (a) in quarterly interim payments during the project year. The determination of the interim payments shall be made on an interim basis prior to the start of each project year, except that, with respect to the 2005–06 project year, the determination of the interim payments shall be made prior to January 1, 2006. The department shall use the same cost and statistical data that is used in determining the interim payments for Medi-Cal inpatient hospital services under Section 14166.4 and for the disproportionate share hospital allocations under Section 14166.6, for the corresponding period.

(2) Prior to the distribution of payments in accordance with paragraph (1) and with subdivision (c) to a designated public hospital that is part of a hospital system containing multiple designated public hospitals licensed to the same governmental entity, the department shall consult with the applicable governmental entity. The department shall implement any adjustments to the payment distributions for the hospitals in that hospital system as requested by the governmental entity if the net effect of the requested adjustments for those hospitals is zero. These payment redistributions shall recognize the level of care provided to Medi-Cal and uninsured patients and shall maintain the viability and effectiveness of the hospital system. The adjustments made pursuant to this paragraph with respect to an affected hospital shall be disregarded in the application of the limitations described in paragraph (1) of subdivision (a), and in paragraph (3) of subdivision (a) of Section 14166.6.

(c) (1) No later than April 1 following the end of the project year, the department shall undertake an interim reconciliation of the payment amount established pursuant to subdivision (a) for each designated public hospital using Medicare and other cost, payment, and statistical data submitted by the hospital for the project year, and shall adjust payments to the hospital accordingly.

(2) The final payment to a designated public hospital for purposes of subdivision (b) and paragraph (1) of this subdivision, shall be subject to final audits of all applicable Medicare and other cost, payment, and statistical data for the project year, and the distribution priorities set forth in Section 14166.20.

(d) (1) Each designated public hospital, or governmental entity with which it is affiliated, shall be eligible to receive additional safety net care pool payments above the baseline funding amount or adjusted baseline funding amount, as appropriate, from the Health Care Support Fund, established pursuant to Section 14166.21, for the project year through October 31, 2010, in accordance with the stabilization funding determination for the hospital made pursuant to Section 14166.75.

(2) Payment of the additional safety net care pool amounts shall be subject to the distribution priorities set forth in Section 14166.21.

(3) The provisions of this section shall apply only with respect to the demonstration project term, and shall not apply with respect to the successor demonstration project term.

(Amended by Stats. 2011, Ch. 86, Sec. 9. (AB 1066) Effective July 15, 2011. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.71. (a) (1) With respect to each successor demonstration year, designated public hospitals, or governmental entities with which they are affiliated, shall be eligible to receive safety net care pool payments for uncompensated care from the Health Care Support Fund established pursuant to Section 14166.21. Safety net care pool payments for uncompensated care shall be allocated to designated public hospitals as follows:

(A) The department shall determine the maximum amount of safety net pool payments for uncompensated care that is available to designated public hospitals for the successor demonstration year.

(B) The department shall calculate for each designated public hospital an initial SNCP claiming ability amount. For the purposes of this article, “initial SNCP claiming ability amount” means the total sum of the uncompensated Medi-Cal, Low Income Health Program, and uninsured costs of services incurred by the designated public hospital, the governmental entity, nonhospital clinics, and other provider types with which it is affiliated, that are reported as eligible certified public expenditures for safety net care pool uncompensated care claiming pursuant to Section 14166.8.

(C) The available safety net pool payments shall be allocated pro rata among the designated public hospitals based upon each hospital’s initial SNCP claiming ability amount as determined pursuant to subparagraph (B).

(2) The department shall establish the amount of the safety net care pool payment described in paragraph (1) for each designated public hospital in a manner that maximizes federal Medicaid funding to the state during the term of the successor demonstration project.

(3) A safety net care pool payment amount may be paid to a designated public hospital, or governmental entity with which it is affiliated, pursuant to this section independent of the amount of uncompensated Medi-Cal and uninsured costs that is certified as public expenditures pursuant to Section 14166.8, provided that, in accordance with the Special Terms and Conditions for the successor demonstration project, the recipient hospital does not return any portion of the funds received to any unit of government, excluding amounts recovered by the state or federal government.

(4) In establishing the amount to be paid to each designated public hospital under this subdivision, the department shall minimize to the extent possible the redistribution of federal funds that are based on certified public expenditures as described in paragraph (3).

(b) (1) Each designated public hospital, or governmental entity with which it is affiliated, shall receive the amount established pursuant to subdivision (a) in quarterly interim payments during the successor demonstration year. The determination of the interim payments shall be made on an interim basis prior to the start of each successor demonstration year. The department shall use the same cost and statistical data that is used in determining the interim payments for Medi-Cal inpatient hospital services under Section 14166.4 and for the disproportionate share hospital allocations under Section 14166.61, for the corresponding period.

(2) Prior to the distribution of payments in accordance with paragraph (1) and subdivision (c) to a designated public hospital that is part of a hospital system containing multiple designated public hospitals licensed to the same governmental entity, the department shall consult with the applicable governmental entity. The department shall implement any adjustments to the payment distributions for the hospitals in that hospital system as requested by the governmental entity if the net effect of the requested

adjustments for those hospitals is zero. These payment redistributions shall recognize the level of care provided to Medi-Cal and uninsured patients and shall maintain the viability and effectiveness of the hospital system.

(c) (1) No later than April 1 following the end of the relevant reporting period for the successor demonstration year, the department shall undertake an interim reconciliation of the payment amount established pursuant to subdivision (a) for each designated public hospital using Medicare and other cost, payment, and statistical data submitted by the hospital for the successor demonstration year, and shall adjust payments to the hospital accordingly.

(2) The final payment to a designated public hospital for purposes of subdivision (b) and paragraph (1) of this subdivision, shall be subject to final audits of all applicable Medicare and other cost, payment, discharge, and statistical data for the successor demonstration year.

(Added by Stats. 2011, Ch. 86, Sec. 10. (AB 1066) Effective July 15, 2011. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.75. (a) For services provided during the 2005–06 and 2006–07 project years, the amount allocated to designated public hospitals pursuant to subparagraph (A) of paragraph (2) and subparagraph (A) of paragraph (5) of subdivision (b) of Section 14166.20 shall be allocated, in accordance with this section, among the designated public hospitals. For services provided during the 2007–08, 2008–09, and 2009–10 project years through October 31, 2010, amounts allocated to designated public hospitals as stabilization funding pursuant to any provision of this article, unless otherwise specified, shall be allocated among the designated public hospitals in accordance with this section. All amounts allocated to designated public hospitals in accordance with this section shall be paid as direct grants, which shall not constitute Medi-Cal payments.

(b) The baseline funding amount, as determined under Section 14166.5, for San Mateo Medical Center shall be increased by eight million dollars ($8,000,000) for purposes of this section.

(c) The following payments shall be made from the amount identified in subdivision (a), in addition to any other payments due to the University of California hospitals and health system and County of Los Angeles hospitals under this section:

(1) The lower of eleven million dollars ($11,000,000) or 3.67 percent of the amount identified in subdivision (a) to the University of California hospitals and health system.

(2) For each of the 2005–06 and 2006–07 project years, in the event that the one hundred eighty million dollars ($180,000,000) identified in paragraph 41 of the Special Terms and Conditions for the demonstration project is available in the safety net care pool for the project year, the lower of twenty-three million dollars ($23,000,000) or 7.67 percent of the amount identified in subdivision (a) to the County of Los Angeles, Department of Health Services, hospitals. If an amount less than the one hundred eighty million dollars ($180,000,000) is available during the project year, the amount determined under this paragraph shall be reduced proportionately.

(d) For the 2005–06 and 2006–07 project years, the amount identified in subdivision (a), as reduced by the amounts identified in subdivision (c), shall be distributed among the designated public hospitals pursuant to this subdivision.

(1) Designated public hospitals that are donor hospitals, and their associated donated certified public expenditures, shall be identified as follows:

(A) An initial pro rata allocation of the amount subject to this subdivision shall be made to each designated public hospital, based upon the hospital's baseline funding amount determined pursuant to Section 14166.5, and as further adjusted in subdivision (b). This initial allocation shall be used for purposes of the calculations under subparagraph (C) and paragraph (3).

(B) The federal financial participation amount arising from the certified public expenditures of each designated public hospital, including the expenditures of the governmental entity, nonhospital clinics, and other provider types with which it is affiliated, that were claimed by the department from the federal disproportionate share hospital allotment pursuant to subparagraphs (A) and (C) of paragraph (2) of subdivision (a) of Section 14166.9, and from the safety net care pool funds pursuant to paragraph (3) of subdivision (a) of Section 14166.9, shall be determined.

(C) The amount of federal financial participation received by each designated public hospital, and by the governmental entity, nonhospital clinics, and other provider types with which it is affiliated, based on certified public expenditures from the federal disproportionate share hospital allotment pursuant to paragraph (1) of subdivision (b) of Section 14166.6, and from the safety net care pool payments pursuant to subdivision (a) of Section 14166.7 shall be identified. With respect to this identification, if a payment adjustment for a hospital has been made pursuant to paragraph (2) of subdivision (f) of Section 14166.6, or paragraph (2) of subdivision (b) of Section 14166.7, the amount of federal financial participation received by the hospital based on certified public expenditures shall be determined as though no such payment adjustment had been made. The resulting

amount shall be increased by amounts distributed to the hospital pursuant to subdivision (c) of this section, paragraph (1) of subdivision (b) of Section 14166.20, and the initial allocation determined for the hospitals in subparagraph (A).

(D) If the amount in subparagraph (B) is greater than the amount determined in subparagraph (C), the hospital is a donor hospital, and the difference between the two amounts is deemed to be that donor hospital's associated donated certified public expenditures amount.

(2) Seventy percent of the total amount subject to this subdivision shall be allocated pro rata among the designated public hospitals based upon each hospital's baseline funding amount determined pursuant to Section 14166.5, and as further adjusted in subdivision (b).

(3) The lesser of the remaining 30 percent of the total amount subject to this subdivision or the total amounts of donated certified public expenditures for all donor hospitals, shall be distributed pro rata among the donor hospitals based upon the donated certified public expenditures amount determined for each donor hospital. Any amounts not distributed pursuant to this paragraph shall be distributed in the same manner as set forth in paragraph (2).

(e) For the 2007–08 and subsequent project years through October 31, 2010, the amount identified in subdivision (a), as reduced by the amounts identified in subdivision (c), shall be distributed among the designated public hospitals pursuant to this subdivision.

(1) Each designated public hospital that renders inpatient hospital services under the health care coverage initiative program authorized pursuant to Part 3.5 (commencing with Section 15900) shall be allocated an amount equal to the amount of the federal safety net pool funds claimed and received with respect to the services rendered by the hospital, including services rendered to enrollees of a managed care organization, to the extent the amount was included in the determination of total stabilization funding for the project year pursuant to Section 14166.20.

(2) Each designated public hospital for which, during the project year, the sum of the allowable costs incurred in rendering inpatient hospital services to Medi-Cal beneficiaries and the allowable costs incurred with respect to supplemental reimbursement for physician and nonphysician practitioner services rendered to Medi-Cal hospital inpatients, as specified in Section 14166.4, exceeds the allowable costs incurred for those services rendered in the prior year, shall be allocated an amount equal to 60 percent of the difference in the allowable costs, multiplied by the applicable federal medical assistance percentage. The allocations under this paragraph, however, shall be reduced pro rata as necessary to ensure that the total of those allocations does not exceed 80 percent of the amount subject to this subdivision after the allocations in paragraph (1). For purposes of this paragraph, the most recent cost data that are available at the time of the department's determinations for the project year pursuant to Section 14166.20 shall be used.

(3) The remaining amount subject to this subdivision that is not otherwise allocated pursuant to paragraphs (1) and (2) shall be allocated as set forth below:

(A) Designated public hospitals that are donor hospitals, and their associated donated certified public expenditures, shall be identified as follows:

(i) An initial pro rata allocation of the amount subject to this paragraph shall be made to each designated public hospital, based upon the total allowable costs incurred by each hospital, or governmental entity with which it is affiliated, in rendering hospital services to the uninsured during the project year as reported pursuant to Section 14166.8. This initial allocation shall be used for purposes of the calculations under clause (iii) and subparagraph (C).

(ii) The federal financial participation amount arising from the certified public expenditures of each designated public hospital, including the expenditures of the governmental entity, nonhospital clinics, and other provider types with which it is affiliated, that were claimed by the department from the federal disproportionate share hospital allotment pursuant to subparagraphs (A) and (C) of paragraph (2) of subdivision (a) of Section 14166.9, and from the safety net care pool funds pursuant to paragraph (3) of subdivision (a) of Section 14166.9, shall be determined.

(iii) The amount of federal financial participation received by each designated public hospital, and by the governmental entity, nonhospital clinics, and other provider types with which it is affiliated, based on certified public expenditures from the federal disproportionate share hospital allotment pursuant to paragraph (1) of subdivision (b) of Section 14166.6, and from the safety net care pool payments pursuant to subdivision (a) of Section 14166.7 shall be identified. With respect to this identification, if a payment adjustment for a hospital has been made pursuant to paragraph (2) of subdivision (f) of Section 14166.6, or paragraph (2) of subdivision (b) of Section 14166.7, the amount of federal financial participation received by the hospital based on certified public expenditures shall be determined as though no payment adjustment had been made. The resulting amount shall be increased by amounts distributed to the hospital pursuant to subdivision (c), paragraphs (1) and (2) of this subdivision, paragraph (1) of subdivision (b) of Section 14166.20, and the initial allocation determined for the hospitals in clause (i).

(iv) If the amount in clause (ii) is greater than the amount determined in clause (iii), the hospital is a donor hospital, and the difference between the two amounts is deemed to be that donor hospital's associated donated certified public expenditures amount.

(B) Fifty percent of the total amount subject to this paragraph shall be allocated pro rata among the designated public hospitals in the same manner described in clause (i) of subparagraph (A).

(C) The lesser of the remaining 50 percent of the total amount subject to this paragraph, the total amounts of donated certified public expenditures for all donor hospitals or that amount that is 30 percent of the amount subject to this subdivision after the allocations in paragraph (1), shall be distributed pro rata among the donor hospitals based upon the donated certified public expenditures amount determined for each donor hospital. Any amounts not distributed pursuant to this subparagraph shall be distributed in the same manner as set forth in subparagraph (B).

(D) The federal financial participation amount arising from the certified public expenditures that has been paid to designated public hospitals, or the governmental entities with which they are affiliated, pursuant to subdivision (g) of Section 14166.221 shall be disregarded for purposes of this paragraph.

(f) The department shall consult with designated public hospital representatives regarding the appropriate distribution of stabilization funding before stabilization funds are allocated and paid to hospitals. No later than 30 days after this consultation, the department shall issue a final allocation of stabilization funding under this section that shall not be modified for any reason other than mathematical errors or mathematical omissions on the part of the department.

(g) The provisions of this section shall apply only with respect to the demonstration project term, and shall not apply with respect to the successor demonstration project term.

(Amended by Stats. 2011, Ch. 86, Sec. 11. (AB 1066) Effective July 15, 2011. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.77. (a) (1) The amount of delivery system reform incentive pool funding, consisting of both the federal and nonfederal share of payments, that is made available to each designated public hospital system in the aggregate for the term of the successor demonstration project shall be based initially on the delivery system reform proposals that are submitted by the designated public hospitals to the department for review and submission to the federal Centers for Medicare and Medicaid Services for final approval. The initial percentages of delivery system reform incentive pool funding among the designated public hospital systems for each successor demonstration year shall be determined based on the annual components as contained in the approved proposals.

(2) The actual receipt of funds shall be conditioned on the designated public hospital system's progress toward, and achievement of, the specified milestones and other metrics established in its approved delivery system reform incentive pool proposal. A designated public hospital system may carry forward available incentive pool funding associated with milestones and metrics from one year to a subsequent period as authorized by the Special Terms and Conditions and the final delivery system reform incentive pool protocol.

(3) The department may reallocate incentive pool funding under conditions specified, and as authorized by, the Special Terms and Conditions and the final delivery system reform incentive pool protocol.

(b) Each designated public hospital system shall be individually responsible for progress toward, and achievement of, milestones and other metrics in its proposal, as well as other applicable requirements specified in the Special Terms and Conditions and the final delivery system reform incentive pool protocol, in order to receive its specified allocation of incentive pool funding under this section.

(1) The designated public hospital system shall submit semiannual reports and requests for payment to the department by March 31 and the September 30 following the end of the second and fourth quarters of the successor demonstration year, or comply with such other process as approved by the federal Centers for Medicare and Medicaid Services. A standardized report form shall be developed jointly by the department and designated public hospital systems for this purpose.

(2) Within 14 days after the semiannual report due date, the designated public hospital system or its affiliated governmental entity shall make an intergovernmental transfer of funds equal to the nonfederal share that is necessary to draw down the federal funding for the pool payment related to the achievement or progress metric that is certified. The intergovernmental transfers shall be deposited into the Public Hospital Investment, Improvement, and Incentive Fund, established pursuant to Section 14182.4.

(3) The department shall draw down the federal funding and pay both the nonfederal and federal shares of the incentive payment to the designated public hospital system or other affiliated governmental provider as applicable. If the intergovernmental transfer is made within the appropriate 14-day timeframe, the incentive payment shall be disbursed within seven days with the expedited

payment process as approved by the federal Centers for Medicare and Medicaid Services, otherwise the payment shall be disbursed within 20 days of when the transfer is made.

(4) Notwithstanding any other provision of this subdivision, payment requests for successor demonstration year 6 shall be submitted, processed, and paid in accordance with the expedited payment process as approved by the federal Centers for Medicare and Medicaid Services.

(5) The designated public hospital system or other affiliated governmental provider is responsible for any fee or cost required to implement the expedited payment process in accordance with Section 8422.1 of the State Administrative Manual.

(c) In the event of a conflict between any provision of this section and the Special Terms and Conditions for the successor demonstration project and the final delivery system reform incentive pool protocol, the Special Terms and Conditions and the final delivery system reform incentive pool protocol shall control.

(Added by Stats. 2011, Ch. 86, Sec. 12. (AB 1066) Effective July 15, 2011. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.8. (a) Within five months after the end of each project year or successor demonstration year, each of the designated public hospitals shall submit to the department all of the following reports:

(1) The hospital's Medicare cost report for the project year or successor demonstration year.

(2) Other cost reporting and statistical data necessary for the determination of amounts due the hospital under the demonstration project or successor demonstration project, as requested by the department.

(b) For each project year or successor demonstration year, the reports shall identify all of the following:

(1) The costs incurred in providing inpatient hospital services to Medi-Cal beneficiaries on a fee-for-service basis and physician and nonphysician practitioner services costs, as identified in subdivision (e) of Section 14166.4.

(2) The amount of uncompensated costs incurred in providing hospital services to Medi-Cal beneficiaries, including managed care enrollees.

(3) The costs incurred in providing hospital services to uninsured individuals.

(4) (A) Discharge data, commencing with successor demonstration year 6, and retrospectively for prior periods as necessary to establish interim payment determinations, for the following patient categories:

(i) Uninsured patients.

(ii) Low Income Health Program patients.

(iii) Medi-Cal patients, excluding discharges for which Medicare payments were received.

(B) The department shall consult with the designated public hospitals regarding a methodology for adjusting prior period discharge data to reflect the projected number of discharges relating to Low Income Health Program patients for the period at issue.

(c) (1) Each designated public hospital, or governmental entity with which it is affiliated, that operates nonhospital clinics or provides physician, nonphysician practitioner, or other health care services that are not identified as hospital services under the Special Terms and Conditions for the demonstration project and successor demonstration project, may report and certify all, or a portion, of the uncompensated Medi-Cal and uninsured costs of the services furnished.

(2) Notwithstanding paragraph (1), beginning with the 2012–13 fiscal year, and for each successor demonstration year thereafter, each designated public hospital, or governmental entity with which it is affiliated, that operates nonhospital clinics or provides physician, nonphysician practitioner, or other health care services that are not identified as hospital services under the Special Terms and Conditions for the successor demonstration project, shall report and certify all of the uncompensated uninsured costs of the services furnished that meet the requirements of subdivisions (d) and (e).

(3) The amount of these uncompensated costs to be claimed by the department shall be determined by the department in consultation with the governmental entity so as to optimize the level of claimable federal Medicaid funding.

(d) Reports submitted under this section shall include all allowable costs.

(e) The appropriate public official shall certify to all of the following:

(1) The accuracy of the reports required under this section.

(2) That the expenditures to meet the reported costs comply with Section 433.51 of Title 42 of the Code of Federal Regulations.

(3) That the sources of funds used to make the expenditures certified under this section do not include impermissible provider taxes or donations as defined under Section 1396b(w) of Title 42 of the United States Code or other federal funds. For this purpose, federal funds do not include delivery system reform incentive pool payments, patient care revenue received as payment for services rendered under programs such as designated state health programs, the Low Income Health Program, Medicare, or Medicaid.

(f) The certification of public expenditures made pursuant to this section shall be based on a schedule established by the department. The director may require the designated public hospitals to submit quarterly estimates of anticipated expenditures, if these estimates are necessary to obtain interim payments of federal Medicaid funds. All reported expenditures shall be subject to reconciliation to allowable costs, as determined in accordance with applicable implementing documents for the demonstration project and successor demonstration project.

(g) Subject to the determination made under paragraph (3) of subdivision (c), the director shall seek Medicaid federal financial participation for all certified public expenditures reported by the designated public hospitals and recognized under the demonstration project and successor demonstration project, to the extent consistent with Section 14166.9.

(h) Governmental or public entities other than those that operate a designated public hospital may, at the request of a governmental or public entity, certify uncompensated Medi-Cal and uninsured costs in accordance with this section, subject to the department's discretion and prior approval of the federal Centers for Medicare and Medicaid Services.

(i) The timeframes for data submission and reporting periods may be adjusted as necessary with respect to the 2010–11 project year through October 31, 2010, and successor demonstration years 6 and 10.

(Amended by Stats. 2012, Ch. 23, Sec. 89. (AB 1467) Effective June 27, 2012. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.9. (a) The department, in consultation with the designated public hospitals, shall determine the mix of sources of federal funds for payments to the designated public hospitals in a manner that provides baseline funding to hospitals as applicable during the demonstration project term and maximizes federal Medicaid funding to the state during the terms of the demonstration project and successor demonstration project.

(1) During the demonstration project term through October 31, 2010, federal funds shall be claimed according to the following priorities:

(A) The certified public expenditures of the designated public hospitals for inpatient hospital services and physician and nonphysician practitioner services, as identified in subdivision (e) of Section 14166.4, rendered to Medi-Cal beneficiaries.

(B) Federal disproportionate share hospital allotment, subject to the federal hospital-specific limit, in the following order:

(i) Those hospital expenditures that are eligible for federal financial participation only from the federal disproportionate share hospital allotment.

(ii) Payments funded with intergovernmental transfers, consistent with the requirements of the demonstration project, up to the hospital's baseline funding amount or adjusted baseline funding amount, as appropriate, for the project year.

(iii) Any other certified public expenditures for hospital services that are eligible for federal financial participation from the federal disproportionate share hospital allotment.

(C) Safety net care pool funds, using the optimal combination of hospital-certified public expenditures and certified public expenditures of a hospital, or governmental entity with which the hospital is affiliated, that operates nonhospital clinics or provides physician, nonphysician practitioner, or other health care services that are not identified as hospital services under the Special Terms and Conditions for the demonstration project, except that certified public expenditures reported by the County of Los Angeles or its designated public hospitals shall be the exclusive source of certified public expenditures for claiming those federal funds deposited in the South Los Angeles Medical Services Preservation Fund under Section 14166.25.

(D) Health care expenditures of the state that represent alternate state funding mechanisms approved by the federal Centers for Medicare and Medicaid Services under the demonstration project as set forth in Section 14166.22.

(2) During each successor demonstration year, federal funds for payments to the designated public hospitals pursuant to Sections 14166.61 and 14166.71 shall be claimed according to the following priorities:

(A) With respect to the applicable federal disproportionate share hospital allotment, subject to the federal hospital-specific limit, in the following order:

(i) Payments funded with intergovernmental transfers, as determined pursuant to subdivision (d) of Section 14166.61.

(ii) Those hospital expenditures that are eligible for federal financial participation only from the federal disproportionate share hospital allotment.

(iii) Any other certified public expenditures for hospital services that are eligible for federal financial participation from the federal disproportionate share hospital allotment.

(B) With respect to safety net care pool payments for uncompensated care, in the following order:

(i) The certified public expenditures of the designated public hospitals, or the governmental entities with which they are affiliated that operate nonhospital clinics or provide physician, nonphysician practitioner, or other health care services, that are not identified as hospital services under the Special Terms and Conditions for the successor demonstration project and eligible for federal financial participation from the safety net care pool for uncompensated care.

(ii) The available certified public expenditures of designated public hospitals for hospital services that are eligible for federal financial participation from either the federal disproportionate share hospital allotment or safety net care pool for uncompensated care, that were not otherwise claimed for purposes of subparagraph (A).

(b) The department shall implement these priorities, to the extent possible, in a manner that minimizes the redistribution of federal funds that are based on the certified public expenditures of the designated public hospitals.

(c) The department may adjust the claiming priorities to the extent that these adjustments result in additional federal medicaid funding during the term of the demonstration project and successor demonstration project, or facilitate the objectives of subdivision (b).

(d) There is hereby established in the State Treasury the “Demonstration Disproportionate Share Hospital Fund.” All federal funds received by the department with respect to the certified public expenditures claimed pursuant to subparagraphs (A) and (C) of paragraph (2) of subdivision (a) shall be transferred to the fund. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department solely for the purposes specified in Sections 14166.6 and 14166.61.

(e) (1) Except as provided in Section 14166.25, all federal safety net care pool funds claimed and received by the department based on health care expenditures incurred by the designated public hospitals, or other governmental entities, shall be transferred to the Health Care Support Fund, established pursuant to Section 14166.21.

(2) The department shall separately identify and account for federal safety net care pool funds claimed and received by the department under the health care coverage initiative program authorized under Part 3.5 (commencing with Section 15900) and under paragraphs 43 and 44 of the Special Terms and Conditions for the demonstration project.

(3) With respect to those funds identified under paragraph (2), the department shall separately identify and account for federal safety net care pool funds claimed and received for inpatient hospital services rendered under the health care coverage initiative, including services rendered to enrollees of a managed care organization, by designated public hospitals, nondesignated public hospitals, and project year private DSH hospitals.

(Amended by Stats. 2011, Ch. 86, Sec. 14. (AB 1066) Effective July 15, 2011. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.10. (a) Payments to private hospitals under the demonstration project shall include, as applicable, all of the following:

(1) Payments under selective provider contracts with the department negotiated by the California Medical Assistance Commission in accordance with Article 2.6 (commencing with Section 14081).

(2) Disproportionate share hospital replacement payments under Section 14166.11.

(3) Supplemental payments under Section 14166.12.

(4) Payments to distressed hospitals as negotiated by the California Medical Assistance Commission pursuant to Section 14166.23.

(5) Payments of amounts described in Section 14166.14.

(b) Payments under subdivision (a) shall be in addition to other payments that may be made in accordance with law.

(Amended by Stats. 2006, Ch. 327, Sec. 6. Effective January 1, 2007. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.11. (a) The department shall pay to each project year private DSH hospital the amounts that would have been paid under the disproportionate share hospital program using the formulas and methodology in effect for the 2004–05 fiscal year as more specifically set forth in this section.

(b) For each project year, the department shall develop and issue a tentative and final disproportionate share list in accordance with Section 14105.98.

(c) For each project year, the department shall perform the computations set forth in paragraphs (1) to (4), inclusive, and (6) to (8), inclusive, of subdivision (am) and paragraphs (1) to (3), inclusive, of subdivision (an) of Section 14105.98, subject to the following:

(1) For purposes of these computations, the maximum state disproportionate share hospital allotment for California for each project year shall be the allotment effective during the federal fiscal year beginning during the project year.

(2) All references to October 1 shall be deemed to be references to July 1.

(3) Notwithstanding any other provision of law, the transfer amounts for the Medi-Cal Inpatient Payment Adjustment Fund to the Health Care Deposit Fund, as provided for pursuant to paragraph (2) of subdivision (d) of Section 14163 shall be deemed to be eighty-five million dollars ($85,000,000) for purposes of the computations under this subdivision.

(4) Notwithstanding any other provision of law, the payments made under this section shall be treated as payment adjustments made under Section 14105.98 for purposes of computing the OBRA 1993 payment limitation, as defined in paragraph (24) of subdivision (a) of Section 14105.98, the low-income utilization rate, and all related computations.

(5) Subdivision (m) of Section 14105.98 shall apply to payments made under this section.

(d) Interim payments shall be made for the first five months of each project year as follows:

(1) Interim payments shall be made to each private hospital identified on a tentative disproportionate share list for the project year that was also on the final disproportionate share list for the prior fiscal year. The interim payment amount per month for each of these hospitals shall equal one-twelfth of the total payments, excluding stabilization funds, made to the hospital for the prior fiscal year under this section or under Section 14105.98. The interim payment amount may be adjusted to reflect any changes in the total payment amounts, excluding stabilization funds, projected to be made under this section for the project year.

(2) The computation of interim payments described in this subdivision shall be made promptly after the department issues the tentative disproportionate share hospital list for the project year.

(3) The first interim payment for a project year shall be made to each hospital no later than 60 days after the issuance of the tentative disproportionate share hospital list for that project year and shall include the interim payment amounts for all prior months in the project year. Subsequent interim payments for a project year shall be made on the last checkwrite of each month made by the Controller until interim payments for the first five months of the project year have been made.

(4) The department may recover any interim payments for a project year made under this subdivision to a hospital that is not on the final disproportionate share hospital list for that project year. These interim payments shall be considered an overpayment. The department shall issue a demand for repayment to a hospital at least 30 days prior to taking action to recover the overpayment. After the 30-day period, the department may recover the overpayment using any of the methods set forth in Section 14115.5 or subdivision (c) of Section 14172.5. Any offset shall be subject to Section 14115.5 or subdivision (d) of Section 14172.5. No other provision of Section 14172.5 shall be applicable with respect to the recovery of overpayments under this subdivision. A hospital may appeal the department's determination of an overpayment under this subdivision pursuant to the appeal procedures set forth in Sections 51016 to 51047, inclusive, of Title 22 of the California Code of Regulations, and seek judicial review of the final administrative decision pursuant to Section 14171, provided that the only issues that may be raised in this appeal are whether the hospital, but for inadvertent error by the department, was on the final disproportionate share list for the project year and whether the department's computation of the overpayment amount is correct. If the hospital is reinstated on the final disproportionate share list pursuant to Section 14105.98, the department shall promptly refund any amount recovered under this paragraph.

(e) Tentative adjusted monthly payments shall be made for the months of December through March of each project year to each private hospital identified on the final disproportionate share hospital list for the project year, computed and paid as follows:

(1) An adjusted payment amount shall be computed for each hospital equal to the sum of the total payment adjustment amount for the hospital computed pursuant to subdivision (am) of Section 14105.98, plus the supplemental lump-sum payment adjustment amount computed pursuant to subdivision (an) of Section 14105.98, each as most recently computed by the department, plus any applicable interim estimated stabilization funding pursuant to subdivision (b) of Section 14166.14.

(2) A tentative adjusted monthly payment amount shall be computed for each hospital equal to the adjusted payment amount for the hospital, minus the aggregate interim payments made to the hospital for the project year, divided by seven.

(3) The computation of tentative adjusted monthly payments described in this subdivision shall be made promptly after the department issues the final disproportionate share hospital list for the project year.

(4) The first tentative adjusted monthly payment for a project year shall be made to each hospital by January 15 or within 60 days after the issuance of the final disproportionate share hospital list for the project year, whichever is later, and shall include the tentative adjusted monthly payment amounts for all prior months in the project year for which those payments are due. Subsequent tentative adjusted monthly payments for a project year shall be made on the last checkwrite of each month made by the Controller until tentative adjusted monthly payments for December through March of the project year have been made.

(f) Three data corrected payments shall be made on the last checkwrite of the month made by the Controller for the months of April through June of each project year to each private hospital identified on the final disproportionate share hospital list for the project year, computed and paid as follows:

(1) An annual data corrected payment amount shall be computed for each hospital equal to the sum of the total payment adjustment amount for the hospital computed pursuant to subdivision (am) of Section 14105.98, plus the supplemental lump-sum payment adjustment amount computed pursuant to subdivision (an) of Section 14105.98, each as most recently computed by the department, plus any interim estimated stabilization funding. The annual data corrected payment amounts shall reflect data corrections, hospital closures, and other revisions made by the department to the adjusted payment amounts computed under paragraph (1) of subdivision (e).

(2) A monthly data corrected payment amount shall be computed for each hospital equal to the annual data corrected payment amount for the hospital, minus both the aggregate interim payments made to the hospital for the project year and the aggregate tentative adjusted monthly payments made to the hospital, divided by three.

(g) Payment under subdivisions (d), (e), and (f) for a month shall be made only to private hospitals open for patient care through the 15th day of the month.

(h) The department shall compute a final adjusted payment amount for each private hospital on the final disproportionate share list for a project year after the completion of the project year and the determination of the amount of stabilization funding available to be paid under this section as follows:

(1) An amount shall be computed for each hospital equal to the sum of the total payment adjustment amount for the hospital computed pursuant to subdivision (am) of Section 14105.98, plus the supplemental lump-sum payment adjustment amount computed pursuant to subdivision (an) of Section 14105.98, each as most recently computed by the department. These amounts shall reflect data corrections, hospital closures, and other revisions made by the department to the annual data corrected payment amounts computed under paragraph (1) of subdivision (f) in a manner that ensures that any payments not payable or recouped are redistributed among hospitals eligible for a final adjusted payment amount in accordance with the calculations made pursuant to Section 14105.98.

(2) The department shall add to the amount computed for each hospital under paragraph (1) a pro rata share of any stabilization funding to be allocated and paid under this section, allocated based on the amounts computed under paragraph (1).

(3) The department shall for each hospital for each project year reconcile the total amount paid to the hospital for that project year under subdivisions (d), (e), and (f) with the amount determined under paragraph (2). The department shall issue a report to each hospital setting forth the result of the reconciliation that shall include the department’s computation, data, and identification of data sources. The department shall pay to the hospital any underpayment determined as a result of this reconciliation and collect from the hospital any overpayment determined as a result of this reconciliation pursuant to paragraph (4) of subdivision (d).

(4) A hospital may seek to correct the department’s data and computations under this section in accordance with the processes undertaken by the department to implement Section 14105.98 in effect during the 2004–05 state fiscal year.

(i) In accordance with the demonstration project, the following shall apply:

(1) Payments under this section shall satisfy the state’s obligation to have a payment adjustment program for disproportionate share hospitals under Section 1923 of the Social Security Act (42 U.S.C. Sec. 1396r-4).

(2) Payments under this section and federal financial participation shall not be counted against the state's allotment of federal funding for Medicaid disproportionate share payment adjustments.

(j) (1) For purposes of this subdivision, "federal disproportionate share allotment" means the federal Medicaid disproportionate share hospital allotment specified for California under Section 1396r-4(f) of Title 42 of the United States Code.

(2) In the event any hospital, or any party on behalf of a hospital, shall initiate a case or proceeding in any state or federal court in which the hospital seeks any relief of any sort whatsoever, including, but not limited to, monetary relief, injunctive relief, declaratory relief, or a writ, based in whole or in part on a contention that the hospital is entitled to, or should receive any portion of, the federal disproportionate share hospital allotment for any or all of federal fiscal years 2006 to 2010, inclusive, all of the following shall apply:

(A) No payments shall be made to the hospital pursuant to this section until the case or proceeding is finally resolved, including the final disposition of all appeals.

(B) Any amount computed to be payable to the hospital pursuant to this section for a project year shall be withheld by the department and shall be paid to the hospital only after the case or proceeding is finally resolved, including the final disposition of all appeals, and only if the case or proceeding does not result in any amount being paid or payable to the hospital from the federal disproportionate share hospital allotment for any portion of the project year.

(C) The hospital shall become ineligible to receive any amount pursuant to this section for any project year for which it is determined that the hospital is entitled to be paid any portion of the federal disproportionate share hospital allotment.

(D) Any amount that would have been payable to the hospital pursuant to this section, but is not paid to the hospital because the hospital has become ineligible to receive payments pursuant to this section shall be returned to the state General Fund.

(E) In the event any portion of the federal disproportionate share hospital allotment is applied to payments to any private hospital, the department shall make any additional payments that may be necessary from state funds so that the amount of the disproportionate share hospital payments that are made to designated public hospitals or nondesignated public hospitals is not less than the amount that would have been made if the allotment had not been applied to payments to any private hospital.

(F) A hospital's total project year payment amount determined under this section may be subject to reduction by offset pursuant to Section 14115.5 or 14172.5.

(Amended by Stats. 2006, Ch. 327, Sec. 7. Effective January 1, 2007. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.115. (a) Due to the state budget deficit and in order to implement changes in the level of funding for health care services, the department shall reduce disproportionate share hospital replacement payments to private hospitals made pursuant to Section 14166.11 as specified in this section.

(b) (1) Disproportionate share hospital replacement payments to private hospitals pursuant to Section 14166.11 shall be reduced by 10 percent. The reductions shall be applied to all disproportionate share hospital replacement payments to private hospitals made for the 2009–10 fiscal year, including, but not limited to, interim payments, tentative adjusted monthly payments, data corrected payments, and the final adjusted payment.

(2) Disproportionate share hospital replacement payments to private hospitals pursuant to Section 14166.11 shall be reduced in the 2010–11 fiscal year by thirty million dollars ($30,000,000) in General Fund moneys and by the corresponding federal financial participation. To the extent permitted by federal law, the additional room created by this paragraph under the federal upper payment limit shall be used to increase supplemental payments under Article 5.226 (commencing with Section 14168.1) and Article 5.227 (commencing with Section 14168.31).

(3) Disproportionate share hospital replacement payments to private hospitals pursuant to Section 14166.11 shall be reduced in the 2011–12 fiscal year by seventy-five million dollars ($75,000,000) in General Fund moneys and by the corresponding federal financial participation. To the extent permitted by federal law, the additional room created by this paragraph under the federal upper payment limit shall be used to increase supplemental payments under legislation extending or creating a new supplemental hospital payment program supported by a fee.

(4) Disproportionate share hospital replacement payments to private hospitals pursuant to Section 14166.11 shall be reduced in the 2012–13 fiscal year by ten million five hundred thousand dollars ($10,500,000) in General Fund moneys and by the corresponding federal financial participation.

(5) Disproportionate share hospital replacement payments to private hospitals pursuant to Section 14166.11 shall be reduced in the 2013–14 fiscal year by five million two hundred fifty thousand dollars ($5,250,000) in General Fund moneys and by the

corresponding federal financial participation.

(c) 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 and administer this section by means of provider bulletins, or similar instructions, without taking further regulatory action.

(d) The reductions described in this section shall apply only to payments for services when the General Fund share of the payment is paid with funds appropriated to the department in the annual Budget Act.

(e) The department shall promptly seek any necessary federal approvals for the implementation of this section.

(Amended by Stats. 2011, Ch. 286, Sec. 3. (SB 335) Effective September 16, 2011. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.12. (a) The California Medical Assistance Commission shall negotiate payment amounts, in accordance with the selective provider contracting program established pursuant to Article 2.6 (commencing with Section 14081), from the Private Hospital Supplemental Fund established pursuant to subdivision (b) for distribution to private hospitals that satisfy the criteria of subdivision (s). Pursuant to Section 14165, on and after July 1, 2012, the Director of Health Care Services shall exercise the discretion granted to the California Medical Assistance Commission.

(b) The Private Hospital Supplemental Fund is hereby established in the State Treasury. For purposes of this section, “fund” means the Private Hospital Supplemental Fund.

(c) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department for the purposes specified in this section.

(d) Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) One hundred eighteen million four hundred thousand dollars ($118,400,000), which shall be transferred annually from General Fund amounts appropriated in the annual Budget Act for the Medi-Cal program, except as follows:

(A) For the 2008–09 fiscal year, this amount shall be reduced by thirteen million six hundred thousand dollars ($13,600,000) and by an amount equal to one-half of the difference between eighteen million three hundred thousand dollars ($18,300,000) and the amount of any reduction in the additional payments for distressed hospitals calculated pursuant to subparagraph (B) of paragraph (3) of subdivision (b) of Section 14166.20.

(B) For the 2012–13 fiscal year, this amount shall be reduced by seventeen million five hundred thousand dollars ($17,500,000).

(C) For the 2013–14 fiscal year, this amount shall be reduced by eight million seven hundred fifty thousand dollars ($8,750,000).

(2) Any additional moneys appropriated to the fund.

(3) All stabilization funding transferred to the fund pursuant to paragraph (2) of subdivision (a) of Section 14166.14.

(4) Any moneys that any county, other political subdivision of the state, or other governmental entity in the state may elect to transfer to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.

(5) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal Medicaid laws.

(6) Any interest that accrues on amounts in the fund.

(e) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(f) The department may accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal financial participation to the full extent permitted by law. With respect to funds transferred or donated from private individuals or entities, the department shall accept only those funds that are certified by the transferring or donating entity that qualify for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable. The department may return any funds transferred or donated in error.

(g) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section.

(h) Any funds remaining in the fund at the end of a fiscal year shall be carried forward for use in the following fiscal year.

(i) Moneys shall be allocated from the fund by the department and shall be applied to obtain federal financial participation in accordance with customary Medi-Cal accounting procedures for purposes of payments under this section. Distributions from the fund shall be supplemental to any other Medi-Cal reimbursement received by the hospitals, including amounts that hospitals receive under the selective provider contracting program (Article 2.6 (commencing with Section 14081)), and shall not affect provider rates paid under the selective provider contracting program.

(j) Each private hospital that was a private hospital during the 2002–03 fiscal year, received payments for the 2002–03 fiscal year from any of the prior supplemental funds, and, during the project year, satisfies the criteria in subdivision (s) to be eligible to negotiate for distributions under any of those sections, shall receive no less from the Private Hospital Supplemental Fund for the project year than 100 percent of the amount the hospital received from the prior supplemental funds for the 2002–03 fiscal year. Each private hospital described in this subdivision shall be eligible for additional payments from the fund pursuant to subdivision (k).

(k) All amounts that are in the fund for a project year in excess of the amount necessary to make the payments under subdivision (j) shall be available for negotiation by the California Medical Assistance Commission, along with corresponding federal financial participation, for supplemental payments to private hospitals, which for the project year satisfy the criteria under subdivision (s) to be eligible to negotiate for distributions under any of those sections, and paid for services rendered during the project year pursuant to the selective provider contracting program established under Article 2.6 (commencing with Section 14081).

(l) The amount of any stabilization funding transferred to the fund, or the amount of intergovernmental transfers deposited to the fund pursuant to subdivision (o), together with the associated federal reimbursement, with respect to a particular project year, may, in the discretion of the California Medical Assistance Commission, until its dissolution on June 30, 2012, be paid for services furnished in the same project year regardless of when the stabilization funds or intergovernmental transfer funds, and the associated federal reimbursement, become available, provided the payment is consistent with other applicable federal or state law requirements and does not result in a hospital exceeding any applicable reimbursement limitations. On and after July 1, 2012, the Director of Health Care Services shall exercise the discretion granted to the California Medical Assistance Commission by this subdivision.

(m) The department shall pay amounts due to a private hospital from the fund for a project year, with the exception of stabilization funding, in up to four installment payments, unless otherwise provided in the hospital's contract negotiated with the California Medical Assistance Commission, except that hospitals that are not described in subdivision (j) shall not receive the first installment payment. The first payment shall be made as soon as practicable after the issuance of the tentative disproportionate share hospital list for the project year, and in no event later than January 1 of the project year. The second and subsequent payments shall be made after the issuance of the final disproportionate hospital list for the project year, and shall be made only to hospitals that are on the final disproportionate share hospital list for the project year. The second payment shall be made by February 1 of the project year or as soon as practicable after the issuance of the final disproportionate share hospital list for the project year. The third payment, if scheduled, shall be made by April 1 of the project year. The fourth payment, if scheduled, shall be made by June 30 of the project year. This subdivision does not apply to hospitals that are scheduled to receive payments from the fund because they meet the criteria under paragraph (2) of subdivision (s) and do not meet the criteria under paragraph (1), (3), or (4) of subdivision (s), which shall be paid in accordance with the applicable contract or contract amendment negotiated by the California Medical Assistance Commission.

(n) The department shall pay stabilization funding transferred to the fund in amounts negotiated by the California Medical Assistance Commission and shall pay the scheduled payments in accordance with the applicable contract or contract amendment.

(o) Payments to private hospitals that are eligible to receive payments pursuant to subdivision (s) may be made using funds transferred from governmental entities to the state, at the option of the governmental entity. Any payments funded by intergovernmental transfers shall remain with the private hospital and shall not be transferred back to any unit of government. An amount equal to 25 percent of the amount of any intergovernmental transfer made in the project year that results in a supplemental payment made for the same project year to a project year private DSH hospital designated by the governmental entity that made the intergovernmental transfer shall be deposited in the fund for distribution as determined by the California Medical Assistance Commission. An amount equal to 75 percent shall be deposited in the fund and distributed to the private hospitals designated by the governmental entity.

(p) A private hospital that receives payment pursuant to this section for a particular project year shall not submit a notice for the termination of its participation in the selective provider contracting program established pursuant to Article 2.6 (commencing with Section 14081) until the later of the following dates:

(1) On or after December 31 of the next project year.

(2) The date specified in the hospital's contract, if applicable.

(q) (1) For the 2007–08, 2008–09, and 2009–10 project years, the County of Los Angeles shall make intergovernmental transfers to the state to fund the nonfederal share of increased Medi-Cal payments to those private hospitals that serve the South Los Angeles

population formerly served by Los Angeles County Martin Luther King, Jr.-Harbor Hospital. The intergovernmental transfers required under this subdivision shall be funded by county tax revenues and shall total five million dollars ($5,000,000) per project year, except that, in the event that the director determines that any amount is due to the County of Los Angeles under the demonstration project for services rendered during the portion of a project year during which Los Angeles County Martin Luther King, Jr.-Harbor Hospital was operational, the amount of intergovernmental transfers required under this subdivision shall be reduced by a percentage determined by reducing 100 percent by the percentage reduction in Los Angeles County Martin Luther King, Jr.-Harbor Hospital's baseline, as determined under subdivision (c) of Section 14166.5 for that project year.

(2) Notwithstanding subdivision (o), an amount equal to 100 percent of the county's intergovernmental transfers under this subdivision shall be deposited in the fund and, within 30 days after receipt of the intergovernmental transfer, shall be distributed, together with related federal financial participation, to the private hospitals designated by the county in the amounts designated by the county. The director shall disregard amounts received pursuant to this subdivision in calculating the OBRA 1993 payment limitation, as defined in paragraph (24) of subdivision (a) of Section 14105.98, for purposes of determining the amount of disproportionate share hospital replacement payments due a private hospital under Section 14166.11.

(r) (1) The reductions in supplemental payments under this section that result from the reductions in the amounts transferred from the General Fund to the Private Hospital Supplemental Fund for the 2012–13 and 2013–14 fiscal years under subparagraphs (B) and (C) of paragraph (1) of subdivision (d) shall be allocated equally in the aggregate between children's hospitals eligible for supplemental payments under this section and other hospitals eligible for supplemental payments under this section. When negotiating payment amounts to a hospital under this section for the 2012–13 and 2013–14 fiscal years, the California Medical Assistance Commission, or its successor agency, shall identify both a payment amount that would have been made absent the funding reductions in subparagraphs (B) and (C) of paragraph (1) of subdivision (d) and the payment amount that will be made taking into account the funding reductions under subparagraphs (B) and (C) of paragraph (1) of subdivision (d). For purposes of this subdivision, "children's hospital" shall have the meaning set forth in paragraph (13) of subdivision (a) of Section 14105.98.

(2) This subdivision shall not preclude the department from including some or all of the reductions under this section within the payments made under a new diagnosis-related group payment methodology for the 2012–13 fiscal year or the 2013–14 fiscal year. In the event the department includes some or all of the amounts, including reductions, within the payments made under a new diagnosis-related group payment methodology for the 2012–13 fiscal year or the 2013–14 fiscal year, the department, in implementing the reductions in paragraph (1) of subdivision (d), shall, to the extent feasible, utilize the allocation specified in paragraph (1).

(s) In order for a hospital to receive distributions pursuant to Article 2.6 (commencing with Section 14081), the hospital shall satisfy the eligibility criteria in paragraph (1), (2), (3), or (4) of this subdivision.

(1) The hospital meets all of the following criteria:

(A) The hospital is contracting under Article 2.6 (commencing with Section 14081).

(B) The hospital meets the criteria contained in the Medicaid State Plan for disproportionate share hospital status.

(C) The hospital is one of the following:

(i) A licensed provider of basic emergency services as described in Section 70411 of Title 22 of the California Code of Regulations.

(ii) A licensed provider of comprehensive emergency medical services as defined in Section 70451 of Title 22 of the California Code of Regulations.

(iii) A children's hospital, as defined in Section 14087.21, that satisfies clause (i) or (ii), or that jointly provides basic or comprehensive emergency services in conjunction with another licensed hospital.

(iv) A hospital owned and operated by a public agency that operates two or more hospitals that qualify under subparagraph (A) or (B) with respect to the particular state fiscal year.

(v) A hospital designated by the National Cancer Institute as a comprehensive or clinical cancer research center that primarily treats acutely ill cancer patients and that is exempt from the federal Medicare prospective payment system pursuant to Section 1886(d)(1)(B)(v) of the federal Social Security Act (42 U.S.C. Sec. 1395ww(d)(1)(B)(v)).

(D) The hospital is able to demonstrate a purpose for additional funding under the selective provider contracting program including proposals relating to emergency services and other health care services, including infrequent yet high-cost services, such as anti-AB human antitoxin treatment for infant botulism (human botulinum immune globulin (HBIG), commonly referred to as "Baby-BIG"), that are made available, or will be made available, to Medi-Cal beneficiaries.

(2) The hospital is contracting under Article 2.6 (commencing with Section 14081) and meets the definition of a university teaching hospital or major, nonuniversity, teaching hospital as set forth on page 51 and as listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping." Payments from the fund shall be used solely for the purposes identified in the contract between the hospital and the state.

(3) The hospital is contracting under Article 2.6 (commencing with Section 14081), and meets the definition of any of the following:

(A) A large teaching emphasis hospital, as set forth on page 51 and listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," and also meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(B) A children's hospital pursuant to Section 10727, and also meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(C) Notwithstanding the requirement in subparagraph (A) that a hospital must be listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," any hospital whose license pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code was consolidated during the 1999 calendar year with a large teaching emphasis hospital that is listed on page 57 of the above-described report shall be eligible. All other requirements of paragraph (3) shall continue to apply.

(4) The hospital meets all of the following criteria:

(A) The hospital is contracting under Article 2.6 (commencing with Section 14081).

(B) The hospital satisfies the Medicaid State Plan criteria for disproportionate share hospital status.

(C) The hospital is a small and rural hospital as defined in Section 124840 of the Health and Safety Code.

(D) The hospital is a licensed provider of standby emergency services as described in Section 70649 of Title 22 of the California Code of Regulations.

(E) The hospital is able to demonstrate a purpose for additional funding under the selective provider contracting program with proposals relating to health care services that are made available, or will be made available, to Medi-Cal beneficiaries.

(F) The hospital is determined by the California Medical Assistance Commission to be a hospital that provides an important community service that otherwise would not be provided in the community.

(Amended by Stats. 2012, Ch. 438, Sec. 21. (AB 1468) Effective September 22, 2012. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.125. (a) Effective the first fiscal year in which reimbursement to private hospitals is provided under the diagnosis-related group methodology established pursuant to Section 14105.28, the director shall allocate the Private Hospital Supplemental Fund among eligible private hospitals pursuant to a methodology developed in consultation with the statewide associations representing children's hospitals and private DSH hospitals.

(b) Subject to subdivision (a), for the 2013–14 fiscal year only as a transition, this methodology shall, to the extent possible, ensure that each eligible hospital is allocated funding at a proportionate level of payments it received for the 2011–12 fiscal year, taking into consideration applicable eligibility criteria and the amount of funding available in the Private Hospital Supplemental Fund established in Section 14166.12.

(Added by Stats. 2012, Ch. 452, Sec. 1. (SB 920) Effective September 22, 2012. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.13. (a) With respect to each project year, the director shall determine a baseline funding amount for each base year private DSH hospital that is also a project year private DSH hospital. A private hospital's baseline funding amount shall be an amount equal to the total amount paid to the hospital for inpatient hospital services rendered to Medi-Cal beneficiaries during the 2004–05 state fiscal year, including the following Medi-Cal payments, but excluding payments received under the Medi-Cal Specialty Mental Health Services Consolidation Program:

(1) Base payments under the selective provider contracting program as provided for under Article 2.6 (commencing with Section 14081), or under the Medi-Cal state plan cost reimbursement system for inpatient hospital services for noncontracting hospitals.

(2) Emergency Services and Supplemental Payments Fund payments as provided for under Section 14085.6.

(3) Medi-Cal Medical Education Supplemental Payment Fund payments and Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund payments as provided for under Sections 14085.7 and 14085.8, respectively.

(4) Small and Rural Hospital Supplemental Payments Fund payments as provided for under Section 14085.9.

(5) Disproportionate share hospital payment adjustments as provided for under Section 14105.98.

(6) Administrative day payments as provided for under Section 51542 of Title 22 of the California Code of Regulations.

(b) The aggregate project year private DSH hospital baseline funding amount shall be the sum of all baseline funding amounts determined under subdivision (a).

(c) With respect to each project year beginning after the 2005–06 project year, an aggregate project year private DSH hospital adjusted baseline funding amount shall be determined as follows:

(1) The department shall determine the aggregate total Medi-Cal revenue, using amounts determined under subdivision (a), for inpatient hospital services rendered during the 2004–05 fiscal year for project year private DSH hospitals, less the total amount of disproportionate share hospital payments identified in paragraph (5) of subdivision (a) for those hospitals.

(2) The department shall determine the aggregate total Medi-Cal revenue paid or payable for inpatient hospital services rendered during the fiscal year immediately preceding the project year for which the private hospital adjusted baseline funding amount is being calculated for project year private DSH hospitals. The aggregate total revenue for services rendered in the relevant preceding fiscal year shall include the payments described in paragraphs (1) and (6) of subdivision (a), and all other payments made to project year private DSH hospitals under this article, excluding disproportionate share hospital replacement payments made under Section 14166.11, stabilization funding under Section 14166.14, and distressed hospital funding under Section 14166.23 and paragraph (3) of subdivision (b) of Section 14166.20.

(3) The department shall:

(A) Calculate the difference between the amount determined under paragraph (1) and the amount determined under paragraph (2).

(B) Determine the percentage increase or decrease by dividing the difference in subparagraph (A) by the amount in paragraph (1).

(C) Apply the percentage in subparagraph (B) to the amount determined under paragraph (1).

(4) The aggregate private DSH hospital adjusted baseline funding amount is the amount determined in paragraph (1), plus the amount determined in subparagraph (C), plus the amount in paragraph (5) of subdivision (a).

(d) If, with respect to any project year, the difference between the percentage adjustment in subparagraph (B) of paragraph (3) of subdivision (c) of this section is greater than five percentage points more than the aggregate percentage adjustment for designated public hospitals, excluding the percentage adjustment for any designated public hospital that was not in operation for the full project year, determined under subparagraph (B) of paragraph (3) of subdivision (c) of Section 14166.5, then the aggregate percentage adjustment for private DSH hospitals shall be reduced in the amount necessary to reduce the difference to five percentage points.

(Amended by Stats. 2007, Ch. 518, Sec. 5. Effective January 1, 2008. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.14. The amount of any stabilization funding payable to the project year private DSH hospitals under Section 14166.20 for a project year, which amount shall not include the amount of stabilization funding paid or payable to hospitals prior to the computation of the stabilization funding under Section 14166.20, plus any amount payable to project year private DSH hospitals under paragraph (1) of subdivision (b) of Section 14166.21, shall be allocated as follows:

(a) (1) To fund any shortfall due under Section 14166.11.

(2) An amount shall be transferred to the Private Hospital Supplemental Fund established pursuant to Section 14166.12, as may be necessary so that the amount for the Private Hospital Supplemental Fund for the project year, including all funds previously transferred to, or deposited in, the Private Hospital Supplemental Fund for the project year, is not less than the Private Hospital Supplemental Fund base amount determined pursuant to subdivision (j) of Section 14166.12.

(3) The amounts paid or transferred under paragraphs (1) and (2) shall be reduced pro rata if there is not sufficient funding described under paragraphs (1) and (2).

(b) Of the stabilization funding remaining, after allocations pursuant to subdivision (a), that are payable to project year private DSH hospitals, 66.4 percent shall be allocated and distributed among those hospitals pro rata based on the amounts determined in accordance with Section 14166.11, and 33.6 percent shall be transferred to the Private Hospital Supplemental Fund.

(c) (1) Notwithstanding any other law, the stabilization funding payable to project year private DSH hospitals under Section 14166.20 for a project year as determined under this section that has not been paid, or specifically committed for payment, to hospitals prior to January 1, 2012, may be utilized by the director to make payments to hospitals that received underpayments pursuant to Section 14166.11 due to improper peer group classifications for the 2005–06 and 2006–07 payment adjustment years.

(2) The balance after payments made pursuant to paragraph (1), if any, of the stabilization funding payable to project year private DSH hospitals under Section 14166.20 shall not be paid to the project year private DSH hospitals pursuant to Section 14166.20. The funds that would otherwise be paid from the Private Hospital Supplemental Fund shall be transferred to the General Fund, and funds that would otherwise be drawn from the General Fund for payments to the private DSH hospitals pursuant to Section 14166.20 shall be retained in the General Fund.

(Amended by Stats. 2012, Ch. 23, Sec. 91. (AB 1467) Effective June 27, 2012. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.15. (a) Payments to nondesignated public hospitals under the demonstration project shall include, as applicable, the following:

(1) Payments under selective provider contracts with the department negotiated by the California Medical Assistance Commission in accordance with Article 2.6 (commencing with Section 14081).

(2) Disproportionate share hospital payments under Section 14166.16.

(3) Supplemental payments under Section 14166.17.

(4) Payments to distressed hospitals as negotiated by the California Medical Assistance Commission pursuant to Section 14166.23.

(5) Payment of amounts described in Section 14166.19.

(b) Payments under subdivision (a) shall be in addition to other payments that may be made in accordance with law.

(Added by Stats. 2005, Ch. 560, Sec. 1. Effective October 5, 2005. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.151. (a) It is the intent of the Legislature to allow for a voluntary process for nondesignated public hospitals to claim reimbursement from the safety net care pool in the successor demonstration project based on their public structure, to the extent that there is funding available for nondesignated public hospitals in that pool, as allowed by the federal government, which shall be allocated equally between the state and the nondesignated public hospital, so that for every dollar of certified public expenditure used by the nondesignated public hospital, the nondesignated public hospital shall voluntarily allow the state to use a corresponding certified public expenditure amount for claiming purposes.

(b) (1) Beginning with services provided on or after July 1, 2013, nondesignated public hospitals shall be eligible to receive safety net care pool payments for uncompensated care costs to the extent that additional federal funding is made available pursuant to the Special Terms and Conditions for the safety net care pool uncompensated care limit of the successor demonstration project and if they comply with the requirements set forth in this section.

(2) The amount of funds that may be claimed pursuant to paragraph (1) shall not exceed the additional federal funding made available under the safety net care pool for nondesignated public hospital uncompensated care costs, and shall not reduce the amounts of federal funding for safety net care pool uncompensated care costs that would otherwise be made available to designated public hospitals in the absence of this paragraph, including the amounts available under the Special Terms and Conditions in effect as of July 1, 2013, and amounts available pursuant to Section 15916.

(3) (A) Notwithstanding paragraph (2), if the designated public hospitals do not have sufficient certified public expenditures to claim the full amount of federal funding made available to the designated public hospitals as referenced in paragraph (2), including consideration of the potential for the designated public hospitals to have sufficient certified public expenditures in a subsequent year, the department may authorize the funding to be claimed by the nondesignated public hospitals.

(B) The department may determine whether designated public hospitals do not have sufficient certified public expenditures to claim the full amount of federal funding pursuant to subparagraph (B) no sooner than after the submission of the cost reporting information required pursuant to Section 14166.8 for the applicable successor demonstration year.

(C) If the department makes the determination identified in subparagraph (B) based on as-filed cost reporting information submitted prior to a final audit, the department shall make the determination in consultation with the designated public hospitals and shall apply an audit cushion of at least 5 percent to the as-filed cost information. If the department makes the determination identified in subparagraph (B) based on audited cost reporting information, no audit cushion shall be applied.

(c) Beginning in the 2013–14 fiscal year, within five months after the end of a successor demonstration year, nondesignated public hospitals shall submit to the department all of the following reports:

(1) The hospital's Medicare or Medicaid cost report for the successor demonstration year.

(2) Other cost reporting and statistical data necessary for the determination of amounts due to the hospital under the successor demonstration project, as requested by the department.

(d) For each successor demonstration year, the reports shall identify all of the costs incurred in providing hospital services to uninsured individuals.

(e) A nondesignated public hospital, or the governmental entity with which it is affiliated, that operates nonhospital clinics or provides physician, nonphysician practitioner, or other health care services that are not identified as hospital services under the Special Terms and Conditions for the successor demonstration project, shall report and certify all of the uncompensated uninsured costs of the services furnished.

(f) Reports submitted under this section shall include all allowable costs.

(g) The appropriate public official shall certify to all of the following:

(1) The accuracy of the reports required under this section.

(2) That the expenditures to meet the reported costs comply with Section 433.51 of Title 42 of the Code of Federal Regulations.

(3) That the sources of funds used to make the expenditures certified under this section do not include impermissible provider taxes or donations, as defined under Section 1396b(w) of Title 42 of the United States Code, or other federal funds. For this purpose, federal funds do not include delivery system reform incentive pool payments or patient care revenue received as payment for services rendered under programs such as nondesignated state health programs, the Low Income Health Program, Medicare, or Medicaid.

(h) The certification of public expenditures made pursuant to this section shall be based on a schedule established by the department in accordance with federal requirements.

(1) The director may require nondesignated public hospitals to submit quarterly estimates of anticipated expenditures, if these estimates are necessary to obtain interim payments of federal Medicaid funds.

(2) All reported expenditures shall be subject to reconciliation to allowable costs, as determined in accordance with applicable implementing documents for the successor demonstration project.

(i) The timeframes for data submission and reporting periods may be adjusted as necessary in accordance with federal requirements.

(j) (1) Beginning in the 2013–14 fiscal year, safety net care pool payments for uncompensated care shall be allocated to nondesignated public hospitals as follows:

(A) The department shall determine the maximum amount of safety net care pool payments for uncompensated care that is available to nondesignated public hospitals for the successor demonstration year pursuant to this section. This determination shall be made solely with respect to allowable uncompensated care costs incurred by nondesignated public hospitals and reported pursuant to subdivisions (c) to (i), inclusive.

(B) The department shall establish, in consultation with the nondesignated public hospitals, an allocation methodology to determine the amount of safety net care pool payments to be made to the nondesignated public hospitals. The allocation methodology shall be implemented when the director issues a declaration stating that the methodology complies with all applicable federal requirements for federal financial participation.

(2) A safety net care pool payment amount may be paid to a nondesignated public hospital, or governmental entity with which it is affiliated, pursuant to this section independent of the amount of uncompensated uninsured costs that is certified as public expenditures pursuant to subdivisions (c) to (i), inclusive, provided that, in accordance with the Special Terms and Conditions for the successor demonstration project, the recipient hospital shall not return any portion of the funds received to any unit of government, excluding amounts recovered by the state or federal government.

(3) Nondesignated public hospitals, or governmental entities with which they are affiliated, shall receive the amount established pursuant to this subdivision, less the 50 percent retained by the state pursuant to subdivision (l), in quarterly interim payments

during the successor demonstration year. The determination of the interim payments shall be made on an interim basis prior to the start of each successor demonstration year. The department shall use the cost and statistical data that is in subdivisions (c) to (i), inclusive.

(k) (1) No later than April 1 following the end of the relevant reporting period for the successor demonstration year, the department shall undertake an interim reconciliation of the payment amount established pursuant to subdivision (j) for nondesignated public hospitals using Medicare and other cost, payment, and statistical data submitted by the hospitals for the successor demonstration year, and shall adjust payments to the hospitals accordingly.

(2) All payments to nondesignated public hospitals are subject to a final reconciliation that is subject to final audits of all applicable Medicare and other cost, payment, discharge, and statistical data for the successor demonstration year.

(l) The process for supplemental payments made in subdivisions (j) and (k) is a voluntary process the implementation of which is limited by this subdivision. The department may submit for federal approval a proposed amendment to the successor demonstration project to implement this section.

(1) If a nondesignated public hospital voluntarily agrees to participate in a process that, up to the amount of safety net care pool funds available, allows the certified public expenditures for uncompensated care under this section to be allocated equally between the state and the nondesignated public hospital, so that for every dollar of certified public expenditure used by the nondesignated public hospital, the nondesignated public hospital shall voluntarily allow the state to use a corresponding certified public expenditure amount for claiming purposes. Participation in the safety net care pool under this section is voluntary on the part of the nondesignated public hospital for the purposes of all applicable federal laws. If a nondesignated public hospital does not voluntarily agree to participate in this process, it shall not be eligible to receive safety net care pool funds.

(2) If the budget neutrality requirements established under Section XI of the Special Terms and Conditions of the successor demonstration project are exceeded, payments made under this section shall be reduced or refunded to achieve budget neutrality before any other payments under the successor demonstration project are made. The state's share of the federal financial participation shall be reduced after the provider's share has been exhausted.

(3) Notwithstanding any other provision of law, upon the receipt of a notice of disallowance or deferral from the federal government related to any certified public expenditures for uncompensated care incurred by the nondesignated public hospital that are used for federal claiming under the safety net care pool pursuant to the successor demonstration project after this section is implemented, and subject to the processes set forth in this section, the department and the nondesignated public hospitals shall each be responsible for one-half of the repayment of the federal portion of any federal disallowance or deferral for the applicable successor demonstration year, up to the amount claimed and allocated pursuant to this section for that particular year beginning with the 2013–14 fiscal year.

(4) This section shall be implemented only to the extent other federal financial participation is not jeopardized.

(m) Eligible providers, as a condition of receiving supplemental reimbursement pursuant to this section, shall enter into, and maintain, an agreement with the department for the purposes of implementing this section and reimbursing the department for the costs of administering this section, including, but not limited to, the state personnel costs. No General Fund moneys shall be expended for the implementation and administration of this section.

(Amended by Stats. 2013, Ch. 672, Sec. 2. (AB 498) Effective January 1, 2014. Section initially operative January 1, 2014, pursuant to this amendment's removal of the condition formerly in subd. (f). Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.16. (a) The department shall pay to each nondesignated public hospital that is an eligible hospital for the project year, as determined under Section 14105.98, disproportionate share hospital payment adjustments as more specifically set forth in this section.

(b) For each project year, the department shall develop and issue a tentative and final disproportionate share list in accordance with Section 14105.98.

(c) (1) The department shall compute, for each nondesignated public hospital that is an eligible disproportionate share hospital for the project year, the payment adjustment amounts as determined under paragraphs (1) to (4), inclusive, and (6) to (8), inclusive, of subdivision (am) of Section 14105.98, and the supplemental payment adjustment amounts as determined under paragraphs (1) to (3), inclusive, of subdivision (an) of Section 14105.98.

(2) The department shall perform the computations set forth in Section 14163 to determine the hospital's transfer amount as though that section were still in effect.

(3) The disproportionate share hospital payment amount for each nondesignated public hospital for each project year shall be the sum of the amounts computed under paragraph (1) less the amount determined for the hospital under paragraph (2).

(4) For purposes of the computations under this subdivision, the federal disproportionate share hospital allotment for California for each project year shall be the allotment effective during the federal fiscal year beginning during the project year.

(5) Notwithstanding any other provision of law, the transfer amounts from the Medi-Cal Inpatient Payment Adjustment Fund to the Health Care Deposit Fund, as provided for pursuant to paragraph (2) of subdivision (d) of Section 14163, shall be deemed to be eighty-five million dollars ($85,000,000) for purposes of the computations under this subdivision.

(6) Subdivision (m) of Section 14105.98 shall apply to payments made under this section.

(7) The federal share of the payment amounts determined under this subdivision and paid pursuant to this section, excluding the stabilization funding amounts allocated and paid pursuant to paragraph (2) of subdivision (i), shall be drawn from the allotment of federal funds for Medicaid disproportionate share hospital payment adjustments for California specified under Section 1396r-4(f) of Title 42 of the United States Code.

(d) To the extent necessary to compute and determine compliance with the hospital-specific disproportionate share hospital payment limitations described in paragraph (3) of subdivision (c) of Section 14166.3, nondesignated public hospitals shall comply with subdivisions (a), (b), and (d) of Section 14166.8.

(e) Two interim payments shall be made for the first portion of the project year, on October 1 and December 1 of each project year, as follows:

(1) The interim payments shall be made to each nondesignated public hospital identified on a tentative disproportionate share list for the project year that was also on the final disproportionate share list for the prior fiscal year. The interim payment amount for each hospital shall be paid in two equal amounts on October 1 and December 1 of each project year, which combined shall equal five-twelfths of the total payments, excluding stabilization funds, made to the hospital for the prior fiscal year under this section, except that for the 2005–06 project year, the combined amount shall equal the amount that was payable to the hospital for the 2004–05 fiscal year under Section 14105.98, less the transfer amount assessed with respect to the hospital under Section 14163 for the same fiscal year, multiplied by five-twelfths. The interim payment amount may be adjusted to reflect any changes in the total payment amounts, excluding stabilization funds, projected to be made under this section for the project year.

(2) The computation of interim payments described in this subdivision shall be made promptly after the department issues the tentative disproportionate share hospital list for the project year.

(3) The first interim payment to each hospital for a project year shall be made no later than 60 days after the issuance of the tentative disproportionate share hospital list for the project year and shall include the interim payment amounts for all prior months in the project year. Subsequent interim payments for a project year shall be made on the last checkwrite of each month made by the Controller until interim payments for the first five months of the project year have been made.

(4) The department may recover any interim payments made under this subdivision for a project year to a hospital that is not on the final disproportionate share hospital list for the project year. These interim payments shall be considered an overpayment. The department shall issue a demand for repayment to a hospital at least 30 days prior to taking action to recover the overpayment. After the 30-day period, the department may recover the overpayment using any of the methods set forth in Section 14115.5 or subdivision (c) of Section 14172.5. Any offset shall be subject to Section 14115.5 or subdivision (d) of Section 14172.5. No other provision of Section 14172.5 shall be applicable with respect to the recovery of overpayments under this subdivision. A hospital may appeal the department's determination of an overpayment under this subdivision pursuant to the appeal procedures set forth in Sections 51016 to 51047, inclusive, of Title 22 of the California Code of Regulations, and seek judicial review of the final administrative decision pursuant to Section 14171, provided that the only issues that may be raised in the appeal are whether the hospital, but for inadvertent error by the department, was on the final disproportionate share list for the project year and whether the department's computation of the overpayment amount is correct. If the hospital is reinstated on the final disproportionate share list pursuant to Section 14105.98, the department shall promptly refund any amount recovered under this paragraph.

(f) Tentative adjusted monthly payments shall be made for December through March of each project year to each nondesignated public hospital identified on the final disproportionate share hospital list for the project year, computed and paid as follows:

(1) An adjusted payment amount shall be computed for each hospital equal to the sum of the total payment adjustment amount for the hospital computed pursuant to subdivision (am) of Section 14105.98, plus the supplemental lump-sum payment adjustment amount computed pursuant to subdivision (an) of Section 14105.98, less the amount computed pursuant to Section 14163, each as most recently computed by the department as described in subdivision (c).

(2) A tentative adjusted monthly payment amount shall be computed for each hospital equal to the adjusted payment amount for the hospital, minus the aggregate interim payments made to the hospital for the project year, divided by seven.

(3) The computation of tentative adjusted monthly payments described in this subdivision shall be made promptly after the department issues the final disproportionate share hospital list for the project year.

(4) The first tentative adjusted monthly payment to each hospital for a project year shall be made by January 15 or within 60 days after the issuance of the final disproportionate share hospital list for the project year, whichever is later, and shall include the tentative adjusted monthly payment amounts for all prior months in the project year for which those payments are due. Subsequent tentative adjusted monthly payments for a project year shall be made on the last checkwrite of each month made by the Controller until tentative adjusted monthly payments for December through March of the project year have been made.

(g) Three data corrected payments shall be made on the last checkwrite of the month made by the Controller for the months of April through June of each project year to each nondesignated public hospital identified on the final disproportionate share hospital list for the project year, computed and paid as follows:

(1) An annual data corrected payment amount shall be computed for each hospital equal to the sum of the total payment adjustment amount for the hospital computed pursuant to subdivision (am) of Section 14105.98, plus the supplemental lump-sum payment adjustment amount computed pursuant to subdivision (an) of Section 14105.98, less the amount computed pursuant to Section 14163, each as most recently computed by the department as described in subdivision (c). The annual data corrected payment amounts shall reflect data corrections, hospital closures, and other revisions made by the department to the adjusted payment amounts computed under paragraph (1) of subdivision (d).

(2) A monthly data corrected payment amount shall be computed for each hospital equal to the annual data corrected payment amount for the hospital, minus both the aggregate interim payments made to the hospital for the project year and the aggregate tentative adjusted monthly payments made to the hospital, divided by three.

(h) Payment under subdivisions (e), (f), and (g) for a month shall be made only to hospitals open for patient care through the 15th day of the month.

(i) The department shall compute a final adjusted payment amount for each nondesignated public hospital on the final disproportionate share list for a project year after the completion of the project year and the determination of the amount of stabilization funding available to be paid under this section as follows:

(1) An amount shall be computed for each hospital equal to the sum of the total payment adjustment amount for the hospital computed pursuant to subdivision (am) of Section 14105.98, plus the supplemental lump-sum payment adjustment amount computed pursuant to subdivision (an) of Section 14105.98, less the amount computed pursuant to Section 14163, each as most recently computed by the department as described in subdivision (c). These amounts shall reflect data corrections, hospital closures, and other revisions made by the department to the annual data corrected payment amounts computed under paragraph (1) of subdivision (e) in a manner that ensures that any payments not payable or recouped are redistributed among hospitals eligible for a final adjusted payment amount in accordance with the calculations made pursuant to Section 14105.98.

(2) The department shall add to the amount computed for each hospital under paragraph (1) a pro rata share of any stabilization funding to be allocated and paid under this section allocated based on the amounts computed under paragraph (1). The federal share of any stabilization funding allocated and paid under this section shall not be drawn from the allotment of federal funding for Medicaid disproportionate share hospital payment adjustments for California specified under Section 1396r-4(f) of Title 42 of the United States Code.

(3) The department shall for each hospital for each project year reconcile the total amount computed for the hospital for the project year under subdivisions (c), (d), and (e) with the amount determined under paragraph (2). The department shall issue a report to each hospital setting forth the result of the reconciliation that shall include the department's computation, data, and identification of data sources. The department shall pay to the hospital any underpayment determined as a result of this reconciliation and collect from the hospital any overpayment determined as a result of this reconciliation.

(4) A hospital may seek to correct the department's data and computations under this section in accordance with the processes undertaken by the department to implement Section 14105.98 in effect during the 2004–05 fiscal year.

(Amended by Stats. 2006, Ch. 327, Sec. 11. Effective January 1, 2007. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.17. (a) The California Medical Assistance Commission shall negotiate payment amounts in accordance with the selective provider contracting program established pursuant to Article 2.6 (commencing with Section 14081) from the Nondesignated Public Hospital Supplemental Fund established pursuant to subdivision (b) for distribution to nondesignated public hospitals that satisfy the criteria of subdivision (o). Pursuant to Section 14165, on and after July 1, 2012, the Director of Health Care Services shall exercise the discretion granted to the California Medical Assistance Commission.

(b) (1) The Nondesignated Public Hospital Supplemental Fund is hereby established in the State Treasury. For purposes of this section, "fund" means the Nondesignated Public Hospital Supplemental Fund.

(2) Effective December 31, 2028, the Nondesignated Public Hospital Supplemental Fund in the State Treasury, created pursuant to this section, is hereby abolished. All moneys remaining in the fund or moneys designated to be deposited to the fund shall be

transferred to the General Fund.

(c) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department for the purposes specified in this section.

(d) Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) One million nine hundred thousand dollars ($1,900,000), which shall be transferred annually from General Fund amounts appropriated in the annual Budget Act for the fund.

(2) Any additional moneys appropriated to the fund.

(3) All stabilization funding transferred to the fund.

(4) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal Medicaid laws.

(5) Any interest that accrues on amounts in the fund.

(e) The department may accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal financial participation to the full extent permitted by law. With respect to funds transferred or donated from private individuals or entities, the department shall accept only those funds that are certified by the transferring or donating entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable. The department may return any funds transferred or donated in error.

(f) Moneys in the funds shall be used as the source for the nonfederal share of payments to hospitals under this section.

(g) Any funds remaining in the fund at the end of a fiscal year shall be carried forward for use in the following fiscal year.

(h) Moneys shall be allocated from the fund by the department and shall be applied to obtain federal financial participation in accordance with customary Medi-Cal accounting procedures for purposes of payments under this section. Distributions from the fund shall be supplemental to any other Medi-Cal reimbursement received by the hospitals, including amounts that hospitals receive under the selective provider contracts negotiated under Article 2.6 (commencing with Section 14081), and shall not affect provider rates paid under the selective provider contracting program.

(i) Each nondesignated public hospital that was a nondesignated public hospital during the 2002–03 fiscal year, received payments for the 2002–03 fiscal year from any of the prior supplemental funds, and, during the project year satisfies the criteria in subdivision (o) to be eligible to negotiate for distributions under any of those sections shall receive no less from the Nondesignated Public Hospital Supplemental Fund for the project year than 100 percent of the amount the hospital received from the prior supplemental funds for the 2002–03 fiscal year, minus the total amount of intergovernmental transfers made by or on behalf of the hospital pursuant to subdivision (o) for the same fiscal year. Each hospital described in this subdivision shall be eligible for additional payments from the fund pursuant to subdivision (j).

(j) (1) For each fiscal year up to and including the 2024–25 fiscal year, all amounts that are in the fund for a project year in excess of the amount necessary to make the payments under subdivision (i) shall be available for negotiation by the California Medical Assistance Commission, along with corresponding federal financial participation, for supplemental payments to nondesignated public hospitals that for the project year satisfy the criteria under subdivision (o) to be eligible to negotiate for distributions under any of those sections, and paid for services rendered during the project year pursuant to the selective provider contracting program under Article 2.6 (commencing with Section 14081).

(2) For the 2025–26 fiscal year, all amounts that are in the fund for a project year in excess of the amount necessary to make the payments under subdivision (i) shall be available for supplemental payments to nondesignated public hospitals, as follows:

(A) Additional supplemental payments shall be made to nondesignated public hospitals that meet the criteria for supplemental payments pursuant to paragraph (1) such that the payments under this subparagraph together with the payments under subdivision (i) to those hospitals are equal to the amounts transferred to the fund pursuant to paragraph (1) of subdivision (d) plus the applicable amount of federal financial participation that is available for the nonfederal share of payments described in paragraph (1) of subdivision (d).

(B) All remaining amounts in the fund, including any funds that have been carried forward pursuant to subdivision (g), shall be used for supplemental payments to nondesignated public hospitals pursuant to a methodology developed by the department that is based on all Medi-Cal inpatient days, as described in Section 1396r-4(b)(2) of Title 42 of the United States Code, in the numerator of the Medi-Cal inpatient utilization rate for each hospital, as determined in the most recent final calculation of the Medi-Cal inpatient utilization rate pursuant to paragraph (4) of subdivision (f) of Section 14105.98 as of July 1, 2025.

(k) The amount of any stabilization funding transferred to the fund with respect to a project year may in the discretion of the California Medical Assistance Commission, until its dissolution on June 30, 2012, to be paid for services furnished in the same project year regardless of when the stabilization funds become available, provided the payment is consistent with other applicable federal or state legal requirements and does not result in a hospital exceeding any applicable reimbursement limitations. On and after July 1, 2012, the Director of Health Care Services shall exercise the discretion granted to the California Medical Assistance Commission by this subdivision.

(l) The department shall pay amounts due to a nondesignated hospital from the fund for a project year, with the exception of stabilization funding, in up to four installment payments, unless otherwise provided in the hospital's contract negotiated with the California Medical Assistance Commission, except that hospitals that are not described in subdivision (i) shall not receive the first installment payment. The first payment shall be made as soon as practicable after the issuance of the tentative disproportionate share hospital list for the project year, and in no event later than January 1 of the project year. The second and subsequent payments shall be made after the issuance of the final disproportionate hospital list for the project year, and shall be made only to hospitals that are on the final disproportionate share hospital list for the project year. The second payment shall be made by February 1 of the project year or as soon as practicable after the issuance of the final disproportionate share hospital list for the project year. The third payment, if scheduled, shall be made by April 1 of the project year. The fourth payment, if scheduled, shall be made by June 30 of the project year. This subdivision does not apply to hospitals that are scheduled to receive payments from the fund because they meet the criteria under paragraph (2) of subdivision (o) but do not meet the criteria under paragraph (1), (3), or (4) of subdivision (o).

(m) The department shall pay stabilization funding transferred to the fund in amounts negotiated by the California Medical Assistance Commission and paid in accordance with the applicable contract or contract amendment.

(n) A nondesignated public hospital that receives payment pursuant to this section for a particular project year shall not submit a notice for the termination of its participation in the selective provider contracting program established pursuant to Article 2.6 (commencing with Section 14081) until the later of the following dates:

(1) On or after December 31 of the next project year.

(2) The date specified in the hospital's contract, if applicable.

(o) In order for a hospital to receive distributions pursuant to Article 2.6 (commencing with Section 14081), the hospital shall satisfy the eligibility criteria in paragraph (1), (2), (3), or (4) of this subdivision.

(1) The hospital meets all of the following criteria:

(A) The hospital is contracting under Article 2.6 (commencing with Section 14081).

(B) The hospital meets the criteria contained in the Medicaid State Plan for disproportionate share hospital status.

(C) The hospital is one of the following:

(i) A licensed provider of basic emergency services as described in Section 70411 of Title 22 of the California Code of Regulations.

(ii) A licensed provider of comprehensive emergency medical services as defined in Section 70451 of Title 22 of the California Code of Regulations.

(iii) A children's hospital, as defined in Section 14087.21, that satisfies clause (i) or (ii), or that jointly provides basic or comprehensive emergency services in conjunction with another licensed hospital.

(iv) A hospital owned and operated by a public agency that operates two or more hospitals that qualify under subparagraph (A) or (B) with respect to the particular state fiscal year.

(v) A hospital designated by the National Cancer Institute as a comprehensive or clinical cancer research center that primarily treats acutely ill cancer patients and that is exempt from the federal Medicare prospective payment system pursuant to Section 1886(d)(1)(B)(v) of the federal Social Security Act (42 U.S.C. Sec. 1395ww(d)(1)(B)(v)).

(D) (1) The hospital is able to demonstrate a purpose for additional funding under the selective provider contracting program including proposals relating to emergency services and other health care services, including infrequent yet high-cost services, such as anti-AB human antitoxin treatment for infant botulism (human botulinum immune globulin (HBIG), commonly referred to as "Baby-BIG"), that are made available, or will be made available, to Medi-Cal beneficiaries.

(2) The hospital is contracting under Article 2.6 (commencing with Section 14081) and meets the definition of a university teaching hospital or major, nonuniversity, teaching hospital as set forth on page 51 and as listed on page 57 of the department's report

dated May 1991, entitled “Hospital Peer Grouping.” Payments from the fund shall be used solely for the purposes identified in the contract between the hospital and the state.

(3) The hospital is contracting under Article 2.6 (commencing with Section 14081) and meets the definition of any of the following:

(A) A large teaching emphasis hospital, as set forth on page 51 and listed on page 57 of the department’s report dated May 1991, entitled “Hospital Peer Grouping,” and also meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(B) A children’s hospital pursuant to Section 10727, and also meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(C) Notwithstanding the requirement in subparagraph (A) of paragraph (3) that a hospital must be listed on page 57 of the department’s report dated May 1991, entitled “Hospital Peer Grouping,” any hospital whose license pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code was consolidated during the 1999 calendar year with a large teaching emphasis hospital that is listed on page 57 of the above-described report shall be eligible. All other requirements of paragraph (3) shall continue to apply.

(4) The hospital meets all of the following criteria:

(A) The hospital is contracting under Article 2.6 (commencing with Section 14081).

(B) The hospital satisfies the Medicaid State Plan criteria for disproportionate share hospital status.

(C) The hospital is a small and rural hospital as defined in Section 124840 of the Health and Safety Code.

(D) The hospital is a licensed provider of standby emergency services as described in Section 70649 of Title 22 of the California Code of Regulations.

(E) The hospital is able to demonstrate a purpose for additional funding under the selective provider contracting program with proposals relating to health care services that are made available, or will be made available, to Medi-Cal beneficiaries.

(F) The hospital is determined by the California Medical Assistance Commission to be a hospital that provides an important community service that otherwise would not be provided in the community.

(p) This section shall become inoperative on June 30, 2026, and, as of July 1, 2030, is repealed. The department may conduct any necessary and remaining duties related to this section even after the section becomes inoperative.

(Amended by Stats. 2025, Ch. 21, Sec. 111. (AB 116) Effective June 30, 2025. Inoperative June 30, 2026, by its own provisions. Repealed as of July 1, 2030, by its own provisions.)

14166.18. (a) With respect to each project year, the director shall determine a baseline funding amount for each nondesignated public hospital that was an eligible hospital under paragraph (3) of subdivision (a) of Section 14105.98 for both the 2004–05 fiscal year and the project year. A hospital’s baseline funding amount shall be an amount equal to the total amount paid to the hospital for inpatient hospital services rendered to Medi-Cal beneficiaries during the 2004–05 fiscal year, including the following Medi-Cal payments, but excluding payments received under the Medi-Cal Specialty Mental Health Services Consolidation Program:

(1) Base payments under the selective provider contracting program as provided for under Article 2.6 (commencing with Section 14081) or the Medi-Cal state plan cost reimbursement system for inpatient hospital services for noncontracting hospitals.

(2) Emergency Services and Supplemental Payments Fund payments as provided for under Section 14085.6.

(3) Medi-Cal Medical Education Supplemental Payment Fund payments and Large Teaching Emphasis Hospital and Children’s Hospital Medi-Cal Medical Education Supplemental Payment Fund payments as provided for under Sections 14085.7 and 14085.8, respectively.

(4) Small and Rural Hospital Supplemental Payments Fund payments as provided for under Section 14085.9.

(5) Disproportionate share hospital payment adjustments as provided for under Section 14105.98.

(6) Administrative day payments as provided for under Section 51542 of Title 22 of the California Code of Regulations.

(b) The baseline funding amount for each nondesignated public hospital shall reflect a reduction for the total amount of intergovernmental transfers made pursuant to Sections 14085.6, 14085.7, 14085.8, 14085.9, and 14163 for the 2004–05 state fiscal year by the nondesignated public hospital, or on its behalf by the governmental entity with which it is affiliated.

(c) The aggregate nondesignated public hospital baseline funding amount shall be the sum of all baseline funding amounts determined under subdivision (a), as adjusted by subdivision (b).

(d) With respect to each project year beginning after the 2005–06 project year, an aggregate nondesignated public hospital adjusted baseline funding amount shall be determined as follows:

(1) The department shall determine the aggregate total Medi-Cal revenue, using amounts determined under subdivision (a), as adjusted by subdivision (b), but excluding the reductions for the amount of intergovernmental transfers made pursuant to Section 14163, with respect to inpatient hospital services rendered during the 2004–05 fiscal year, for nondesignated public hospitals that were eligible hospitals under paragraph (3) of subdivision (a) of Section 14105.98 for the project year, less the total amount of disproportionate share hospital payments identified in paragraph (5) of subdivision (a) for those hospitals.

(2) The department shall determine the aggregate total Medi-Cal revenue paid or payable for inpatient hospital services rendered during the fiscal year preceding the project year for which the nondesignated public hospital adjusted baseline funding amount is being calculated for the nondesignated public hospitals described in paragraph (1). The aggregate total revenue for services rendered in the particular preceding fiscal year shall include the payments that are described under paragraphs (1) and (6) of subdivision (a), and all other payments made to nondesignated public hospitals under this article, excluding disproportionate share hospital payments pursuant to Section 14166.16, stabilization funding pursuant to Section 14166.19, and distressed hospital funding pursuant to Section 14166.23 and paragraph (3) of subdivision (b) of Section 14166.20.

(3) The department shall:

(A) Calculate the difference between the amount determined under paragraph (1) and the amount determined under paragraph (2).

(B) Determine the percentage increase or decrease by dividing the difference in subparagraph (A) by the amount in paragraph (1).

(C) Apply the percentage determined in subparagraph (B) to the amount that results from both of the following:

(i) Aggregating the nondesignated public hospital baseline funding amounts determined under subdivision (a), as adjusted by subdivision (b), but excluding the reductions for the amount of intergovernmental transfers made pursuant to Section 14163.

(ii) Subtracting from the amount in clause (i) the total amount of disproportionate share hospital payments in paragraph (5) of subdivision (a) for those hospitals.

(D) The aggregate nondesignated public hospital adjusted baseline funding amount is the amount determined in subdivision (c), plus the resulting product determined in subparagraph (C).

(Amended by Stats. 2007, Ch. 130, Sec. 250. Effective January 1, 2008. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.19. The amount of any stabilization funding payable to the nondesignated public hospitals under paragraph (4) of subdivision (b) of Section 14166.20 for a project year, which amount shall not include the amount of stabilization funding paid or payable to hospitals prior to the computation of the stabilization funding under Section 14166.20, shall be allocated in the following priority:

(a) An amount shall be transferred to the Nondesignated Public Hospital Supplemental Fund, as may be necessary so that the amount for the Nondesignated Public Hospital Supplemental Fund for the project year, including all funds previously transferred to, or deposited in, the Nondesignated Public Hospital Supplemental Fund for the project year, is not less than one million nine hundred thousand dollars ($1,900,000).

(b) Of the remaining stabilization funding payable to nondesignated public hospitals, 75 percent shall be allocated, distributed, and paid in accordance with Section 14166.16, and 25 percent shall be transferred to the Nondesignated Public Hospital Supplemental Fund.

(c) Notwithstanding any other law, the amount of any stabilization funding payable to nondesignated public hospitals under Section 14166.20 for a project year as determined under this section that has not been paid, or specifically committed for payment, to nondesignated public hospitals before January 1, 2012, shall not be paid pursuant to Section 14166.20. The funds that would otherwise be paid from the Nondesignated Public Hospital Supplemental Fund shall be transferred to the General Fund, and funds that would otherwise be drawn from the General Fund for payments to the nondesignated public hospitals pursuant to Section 14166.20 shall be retained in the General Fund.

(Amended by Stats. 2012, Ch. 23, Sec. 98. (AB 1467) Effective June 27, 2012. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.20. (a) With respect to each project year through October 31, 2010, the total amount of stabilization funding shall be the sum of the following:

(1) (A) Federal Medicaid funds available in the Health Care Support Fund, established pursuant to Section 14166.21, reduced by the amount necessary to meet the baseline funding amount, or the adjusted baseline funding amount, as appropriate, for project years after the 2005–06 project year for each designated public hospital, project year private DSH hospitals in the aggregate, and nondesignated public hospitals in the aggregate as determined in Sections 14166.5, 14166.13, and 14166.18, respectively, taking into account all other payments to each hospital under this article. This amount shall be not less than zero.

(B) For purposes of subparagraph (A), federal Medicaid funds available in the Health Care Support Fund shall not include health care coverage initiative amounts identified under paragraph (2) of subdivision (e) of Section 14166.9.

(C) The federal financial participation amount arising from the certified public expenditures that has been paid to designated public hospitals, or the governmental entities with which they are affiliated, pursuant to subdivision (g) of Section 14166.221, shall be disregarded for purposes of this section.

(2) The state general funds that were made available due to the receipt of federal funding for previously state-funded programs through the safety net care pool and any federal Medicaid hospital reimbursements resulting from these expenditures, unless otherwise recognized under paragraph (1), to the extent those funds are in excess of the amount necessary to meet the baseline funding amount, or the adjusted baseline funding amount, as appropriate, for project years after the 2005–06 project year for each designated public hospital, for project year private DSH hospitals in the aggregate, and for nondesignated public hospitals in the aggregate, as determined in Sections 14166.5, 14166.13, and 14166.18, respectively.

(3) To the extent not included in paragraph (1) or (2), the amount of the increase in state General Fund expenditures for Medi-Cal inpatient hospital services for the project year for project year private DSH hospitals and nondesignated public hospitals, including amounts expended in accordance with paragraph (1) of subdivision (c) of Section 14166.23, that exceeds the expenditure amount for the same purpose and the same hospitals necessary to provide the aggregate baseline funding amounts applicable to the project determined pursuant to Sections 14166.13 and 14166.18, and any direct grants to designated public hospitals for services under the demonstration project.

(4) To the extent not included in paragraph (2), federal Medicaid funds received by the state as a result of the General Fund expenditures described in paragraph (3).

(5) The federal Medicaid funds received by the state as a result of federal financial participation with respect to Medi-Cal payments for inpatient hospital services made to project year private DSH hospitals and to nondesignated public hospitals for services rendered during the project year, the state share of which was derived from intergovernmental transfers or certified public expenditures of any public entity that does not own or operate a public hospital.

(6) Federal safety net care pool funds claimed and received for inpatient hospital services rendered under the health care coverage initiative identified under paragraph (3) of subdivision (e) of Section 14166.9.

(b) With respect to the 2005–06, 2006–07, and subsequent project years through October 31, 2010, the stabilization funding determined under subdivision (a) shall be allocated as follows:

(1) Eight million dollars ($8,000,000) shall be paid to San Mateo Medical Center. All or a portion of this amount may be paid as disproportionate share hospital payments in addition to the hospital's allocation that would otherwise be determined under Section 14166.6. The amount provided for in this paragraph shall be disregarded in the application of the limitations described in paragraph (3) of subdivision (a) of Section 14166.6, and in paragraph (1) of subdivision (a) of Section 14166.7.

(2) (A) Ninety-six million two hundred twenty-eight thousand dollars ($96,228,000) shall be allocated to designated public hospitals to be paid in accordance with Section 14166.75.

(B) Forty-two million two hundred twenty-eight thousand dollars ($42,228,000) shall be allocated to private DSH hospitals to be paid in accordance with Section 14166.14.

(C) Five hundred forty-four thousand dollars ($544,000) shall be allocated to nondesignated public hospitals to be paid in accordance with Section 14166.17.

(D) In the event that stabilization funding is less than one hundred forty-seven million dollars ($147,000,000), the amounts allocated to designated public hospitals, private DSH hospitals, and nondesignated public hospitals under this paragraph shall

be reduced proportionately.

(3) (A) An amount equal to the lesser of 10 percent of the total amount determined under subdivision (a) or twenty-three million five hundred thousand dollars ($23,500,000), but at least fifteen million three hundred thousand dollars ($15,300,000), shall be made available for additional payments to distressed hospitals that participate in the selective provider contracting program under Article 2.6 (commencing with Section 14081), including designated public hospitals, in amounts to be determined by the California Medical Assistance Commission. The additional payments to designated public hospitals shall be negotiated by the California Medical Assistance Commission, but shall be paid by the department in the form of a direct grant rather than as Medi-Cal payments.

(B) Notwithstanding subparagraph (A) and solely for the 2006–07 fiscal year, if the amount that otherwise would be made available for additional payments to distressed hospitals under subparagraph (A) is equal to or greater than eighteen million three hundred thousand dollars ($18,300,000), that amount shall be reduced by eighteen million three hundred thousand dollars ($18,300,000) and the state's obligation to make these payments shall be reduced by this amount. In the event the amount that otherwise would be made available under subparagraph (A) is less than eighteen million three hundred thousand dollars ($18,300,000), but greater than or equal to the minimum amount of fifteen million three hundred thousand dollars ($15,300,000), then the amount available under this paragraph shall be zero and the state's obligation to make these payments shall be zero.

(C) Notwithstanding subparagraph (A) and solely for the 2008–09 and 2009–10 fiscal years, the amount to be made available shall be reduced by fifteen million three hundred thousand dollars ($15,300,000) in each of the two years. The funds generated from this reduction shall be retained in the General Fund.

(4) An amount equal to 0.64 percent of the total amount determined under subdivision (a), to nondesignated public hospitals to be paid in accordance with Section 14166.19.

(5) The amount remaining after subtracting the amount determined in paragraphs (1) and (2), subparagraph (A) of paragraph (3), and paragraph (4), without taking into account subparagraphs (B) and (C) of paragraph (3), shall be allocated as follows:

(A) Sixty percent to designated public hospitals to be paid in accordance with Section 14166.75.

(B) Forty percent to project year private DSH hospitals to be paid in accordance with Section 14166.14.

(c) By April 1 of the year following the project year for which the payment is made, and after taking into account final amounts otherwise paid or payable to hospitals under this article, the director shall calculate in accordance with subdivision (a), allocate in accordance with subdivision (b), and pay to hospitals in accordance with Sections 14166.75, 14166.14, and 14166.19, as applicable, the stabilization funding.

(d) For purposes of determining amounts paid or payable to hospitals under subdivision (c), the department shall apply the following:

(1) In determining amounts paid or payable to designated public hospitals that are based on allowable costs incurred by the hospital, or the governmental entity with which it is affiliated, the following shall apply:

(A) If the final payment amount is based on the hospital's Medicare cost report, the department shall rely on the cost report filed with the Medicare fiscal intermediary for the project year for which the calculation is made, reduced by a percentage that represents the average percentage change from total reported costs to final costs for the three most recent cost reporting periods for which final determinations have been made, taking into account all administrative and judicial appeals. Protested amounts shall not be considered in determining the average percentage change unless the same or similar costs are included in the project year cost report.

(B) If the final payment amount is based on costs not included in subparagraph (A), the reported costs as of the date the determination is made under subdivision (c), shall be reduced by 10 percent.

(C) In addition to adjustments required in subparagraphs (A) and (B), the department shall adjust amounts paid or payable to designated public hospitals by any applicable deferrals or disallowances identified by the federal Centers for Medicare and Medicaid Services as of the date the determination is made under subdivision (c) not otherwise reflected in subparagraphs (A) and (B).

(2) Amounts paid or payable to project year private DSH hospitals and nondesignated public hospitals shall be determined by the most recently available Medi-Cal paid claims data increased by a percentage to reflect an estimate of amounts remaining unpaid.

(e) The department shall consult with hospital representatives regarding the appropriate calculation of stabilization funding before stabilization funds are paid to hospitals. The calculation may be comprised of multiple steps involving interim computations and assumptions as may be necessary to determine the total amount of stabilization funding under subdivision (a) and the allocations under subdivision (b). No later than 30 days after this consultation, the department shall establish a final determination of

stabilization funding that shall not be modified for any reason other than mathematical errors or mathematical omissions on the part of the department.

(f) The department shall distribute 75 percent of the estimated stabilization funding on an interim basis throughout the project year.

(g) The allocation and payment of stabilization funding shall not reduce the amount otherwise paid or payable to a hospital under this article or any other provision of law, unless the reduction is required by the demonstration project's Special Terms and Conditions or by federal law.

(h) It is the intent of the Legislature that the amendments made to Section 14166.12 and to this section by the act that added this subdivision in the 2007–08 Regular Session shall not be construed to amend or otherwise alter the ongoing structure of the department's Medicaid Demonstration Project and Waiver approved by the federal Centers for Medicare and Medicaid Services to begin on September 1, 2005.

(i) The provisions of this section shall only apply with respect to the demonstration project term, and shall not apply with respect to the successor demonstration project term.

(Amended by Stats. 2012, Ch. 162, Sec. 220. (SB 1171) Effective January 1, 2013. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.21. (a) The Health Care Support Fund is hereby established in the State Treasury. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department for the purposes specified in this article. The fund shall include any interest that accrues on amounts in the fund.

(b) During the term of the demonstration project, amounts in the Health Care Support Fund shall be paid in the following order of priority:

(1) To hospitals for services rendered to Medi-Cal beneficiaries and the uninsured in an amount necessary to meet the aggregate baseline funding amount, or the adjusted aggregate baseline funding amount for project years after the 2005-06 project year, as specified in subdivision (d) of Section 14166.5, subdivision (b) of Section 14166.13, and Section 14166.18, taking into account all other payments to each hospital under this article, except payments made from the Distressed Hospital Fund pursuant to Section 14166.23 and payments made to distressed hospitals pursuant to paragraph (3) of subdivision (b) of Section 14166.20. If the amount in the Health Care Support Fund is inadequate to provide full aggregate baseline funding, or adjusted aggregate baseline funding, to all designated public hospitals, project year private DSH hospitals, and nondesignated public hospitals, each group's payments shall be reduced pro rata.

(2) To the extent necessary to maximize federal funding under the demonstration project and consistent with Section 14166.22, the department may claim safety net care pool funds based on health care expenditures incurred by the department for uncompensated medical care costs of medical services provided to uninsured individuals, as approved by the federal Centers for Medicare and Medicaid Services.

(3) Stabilization funding, allocated and paid in accordance with Sections 14166.75, 14166.14, and 14166.19, and paragraph (3) of subdivision (b) of Section 14166.20.

(4) Any amounts remaining after final reconciliation of all amounts due at the end of a project year shall remain available for payments in accordance with this section in the next project year.

(c) Subdivision (b) shall not apply to federal safety net care pool funds claimed and received for services rendered under the health care coverage initiative identified under paragraph (2) of subdivision (e) of Section 14166.9, which shall be paid in accordance with Part 3.5 (commencing with Section 15900) and under paragraphs 43 and 44 of the Special Terms and Conditions for the demonstration project.

(d) During the term of the successor demonstration project, amounts in the Health Care Support Fund shall be paid as follows:

(1) To the department consistent with Section 14166.22, with respect to amounts claimed by the department based on health care expenditures incurred by the state for uncompensated medical care costs of medical services provided to uninsured individuals, or expenditures incurred by the state for uncompensated costs of state-funded workforce development programs, as approved by the federal Centers for Medicare and Medicaid Services.

(2) To designated public hospitals and the governmental entities with which they are affiliated pursuant to Section 14166.71, with respect to amounts claimed based on certified public expenditures as reported pursuant to Section 14166.8.

(3) Any amounts remaining after final reconciliation of all amounts due at the end of a successor demonstration year shall remain available for payments in accordance with this section in the next successor demonstration year, as authorized by the Special Terms and Conditions for the successor demonstration project.

(Amended by Stats. 2011, Ch. 86, Sec. 16. (AB 1066) Effective July 15, 2011. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.22. (a) To the extent required to maximize available federal funds under the demonstration project and to the extent authorized by the Special Terms and Conditions for the demonstration project, the department may claim federal reimbursement for expenditures, consistent with the equitable distribution established under this article, in the following priority order:

(1) The medically indigent adults long-term care program.

(2) The Genetically Handicapped Persons Program established pursuant to Article 1 (commencing with Section 125125) of Chapter 2 of Part 5 of Division 106 of the Health and Safety Code.

(3) The Breast and Cervical Cancer Treatment Program established pursuant to Article 1.5 (commencing with Section 104160) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code.

(4) The California Children's Services Program established pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code.

(b) Notwithstanding any other law, the federal reimbursement received as a result of a claim made pursuant to subdivision (a) shall be used to create General Fund savings solely for the department for use in support of safety net hospitals under the demonstration project.

(c) The federal reimbursement received as a result of a claim made pursuant to subdivision (a) is hereby appropriated to the department for the program in which the claimed expenditures were made.

(d) An amount of General Fund moneys appropriated to the department for programs specified in subdivision (a) equal to the amount of federal reimbursement identified pursuant to subdivision (c) is hereby reappropriated to the Health Care Deposit Fund to be used for the purposes set forth in this article.

(Amended by Stats. 2015, Ch. 303, Sec. 621. (AB 731) Effective January 1, 2016. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.221. (a) It is the intent of the Legislature for the department to maximize the receipt of federal funds for California's Medi-Cal program, including this demonstration project, by identifying state resources which will enable the state to obtain additional federal reimbursement during this unprecedented fiscal crisis. It is further the intent of the Legislature that any program identified by the department for the purposes specified in this section shall not be modified or altered in any manner unless subsequent statutory authority is expressly provided by the Legislature.

(b) Notwithstanding Section 14166.22, in order to maximize federal claiming under the demonstration project, the department shall have broad discretion to claim federal reimbursement consistent with all applicable federal claiming rules for the following expenditures in an order of priority determined by the department:

(1) Expenditures in programs funded in whole or in part by realignment funds under Chapter 6 (commencing with Section 17600) of Part 5, including, but not limited to, the County Medical Services Program.

(2) Expenditures in programs funded in whole or in part by the County Mental Health Services Act.

(3) Other public expenditures, to the extent the department determines the expenditures to be appropriate for claiming under the demonstration project.

(4) Expenditures in any programs referenced in subdivision (a) of Section 14166.22 or other state-only funded programs as the department, in its discretion, determines should be used for the purposes of this section. These programs may include programs administered by other state agencies or departments.

(c) The department shall have discretion to claim under this section for any and all additional demonstration project funding made available pursuant to any amendments to the demonstration project made on or after October 1, 2008, or pursuant to any federal laws that increase the amount of available funding, including, but not limited to, the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5). This additional funding shall include federal funds made available due to an increase in the federal medical assistance percentage in addition to any other increase in the amount of federal funding.

(d) Any amounts received in the 2008–09, 2009–10, and 2010–11 fiscal years from the federal government pursuant to additional demonstration project funding as specified in this section shall be deposited in the Federal Trust Fund. Notwithstanding Section 28.00 of the Budget Act of 2009, the Department of Finance may authorize expenditure of these funds in a manner consistent with federal law and that offsets General Fund expenditures otherwise authorized in the Budget Act of 2009 for the Medi-Cal program,

and as appropriated in Item 4260-101-0001, or for the Health Care Support Fund. For any adjustments made under the authority provided for by this section, the Department of Finance shall provide notification in writing to the Chairperson of the Joint Legislative Budget Committee not less than 30 days prior to the effective date of the adjustment, or not sooner than whatever lesser time the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may in each instance determine. The notification to the chairperson of the joint committee shall include, at a minimum, the amounts of the proposed appropriation adjustments, a description of any assumptions used in making the adjustments, the relevant federal authority, and any other clarifying description as relevant.

(e) If the federal Centers for Medicare and Medicaid Services or any federal or state court issues a ruling that any or all federal dollars obtained by claiming for expenditures from any particular program referenced in subdivision (b) cannot be used to increase state revenues, the department may discontinue use of those expenditures for claiming under this section and substitute other expenditures from other programs referenced in subdivision (b) at its discretion.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of a provider bulletin, or other similar instruction, without taking regulatory action. The department shall also provide notification to the Joint Legislative Budget Committee within five working days if that action is taken in order to inform the Legislature that the action is being implemented.

(g) (1) A portion of the additional federal funding described in subdivision (c) shall be allocated to the designated public hospitals and shall be identical in amount to the fee proceeds retained by the state under Section 14167.5.

(2) Funding under this subdivision shall be made available to the designated public hospitals in increments that reflect the quarters of the subject federal fiscal year for which payments are made to private hospitals from the Hospital Quality Assurance Revenue Fund established pursuant to Section 14167.35.

(3) The department shall claim the federal funds made available to the designated public hospitals under this subdivision upon receipt of the necessary expenditure reports and certifications from the designated public hospitals, or the governmental entities with which they are affiliated, and distribute those funds pursuant to Section 14167.5 so that receipt of the federal funds by the designated public hospitals is aligned with the payment schedule set forth in subdivision (c) of Section 14167.9.

(h) The department shall implement subdivision (g) of this section and subdivision (e) of Section 14167.5 only if and to the extent that all of the following are satisfied:

(1) The state has determined, after consultation with the designated public hospitals, that the designated public hospitals, or the governmental entities with which they are affiliated, have incurred sufficient expenditures during the 2009 and 2010 project years, or that portion of the 2011 project year to the extent federal funds are available under Section 15900 or under an extension of the demonstration project, so that each designated public hospital receives the total amount, taking into account grant funds under Section 14167.5 and payments under this section, that it would have received for each installment under subdivision (c) of Section 14167.9 had subdivision (e) of Section 14167.5 not been implemented.

(2) The implementation of subdivision (g) of this section and subdivision (e) of Section 14167.5 does not result in the receipt by any designated public hospital, or the governmental entity with which it is affiliated, of less than what would otherwise be paid to that hospital or entity pursuant to Part 3.5 (commencing with Section 15900), the sections referred to in Section 14166.35, or Article 5.21 (commencing with Section 14167.1).

(3) In determining the amount retained by the state under subdivision (e) of Section 14167.5 and made available to the designated public hospitals in subdivision (g), the department makes adjustments to the reported expenditures for possible audit disallowances, consistent with the type of adjustments applied in prior project years to reduce the likelihood of a federal recoupment.

(4) The department is satisfied that the expenditures claimed under paragraph (3) of subdivision (g) represent valid expenditures for the purposes of federal financial participation under the Special Terms and Conditions for the demonstration project based on federal law and guidance provided by the federal Centers for Medicare and Medicaid Services.

(5) Notwithstanding subdivision (b), the department has claimed federal reimbursement for the state-only expenditures in the programs referenced in subdivision (a) of Section 14166.22 and in the programs authorized by paragraph (4) of subdivision (b) of Section 14166.221, to the maximum extent authorized under the Special Terms and Conditions for the demonstration project.

(6) Federal financial participation is available and implementation of these provisions does not jeopardize the federal financial participation for other programs.

(Amended by Stats. 2010, Ch. 218, Sec. 3. (AB 1653) Effective September 8, 2010. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.225. (a) In order to implement changes in the level of funding for health care services, the director shall reduce safety net care pool payments as specified in this section.

(b) Notwithstanding the provisions of this article, safety net care pool payments made to the designated public hospitals and the South Los Angeles Medical Services Preservation Fund, for services rendered on or after July 1, 2009, through and including June 30, 2010, shall be reduced by 10 percent, but in no event shall the total amount of the reduction exceed fifty-four million two-hundred thousand dollars ($54,200,000).

(c) (1) Notwithstanding Section 14166.22 and any other provision of this article, the department shall increase federal claiming from the safety net care pool for the state-funded programs listed in subdivision (a) of Section 14166.22 above the amount necessary to maintain stabilization funding to private hospitals, nondesignated public hospitals, and distressed hospitals pursuant to Section 14166.20, by an amount equivalent to the reduction made pursuant to subdivision (b), but only to the extent that the state-only funded programs have sufficient costs available for the claiming of federal funds from the safety net care pool.

(2) If necessary to reach the full amount of the reduction set forth in subdivision (b), the department may increase federal claiming from the safety net care pool for the state-funded programs listed in subdivision (a) of Section 14166.22 for fiscal years prior to the 2009–10 fiscal year, but only to the extent that the state-only funded programs have sufficient costs available in fiscal years prior to the 2009–10 fiscal year that were not previously the basis for claiming federal funds.

(d) The General Fund savings generated pursuant to subdivision (c) shall be made available to the General Fund and shall not be subject to the provisions of subdivisions (b) and (d) of Section 14166.22.

(e) 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 this section by means of a provider bulletin, or other similar instruction, without taking regulatory action.

(Amended by Stats. 2009, 4th Ex. Sess., Ch. 5, Sec. 48. Effective July 28, 2009. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.23. (a) For purposes of this section, “distressed hospitals” are hospitals that participate in selective providers contracting under Article 2.6 (commencing with Section 14081) and that meet all of the following requirements, as determined by the California Medical Assistance Commission in its discretion:

(1) The hospital serves a substantial volume of Medi-Cal patients measured either as a percentage of the hospital’s overall volume or by the total volume of Medi-Cal services furnished by the hospital.

(2) The hospital is a critical component of the Medi-Cal program’s health care delivery system, such that the Medi-Cal health care delivery system would be significantly disrupted if the hospital reduced its Medi-Cal services or no longer participated in the Medi-Cal program.

(3) The hospital is facing a significant financial hardship that may impair its ability to continue its range of services for the Medi-Cal program.

(b) The Distressed Hospital Fund is hereby created in the State Treasury.

(c) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department for the purposes specified in this section.

(d) Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) The amounts transferred to the fund pursuant to subdivision (e).

(2) Any additional amounts appropriated to the fund by the Legislature.

(3) Any interest that accrues on amounts in the fund.

(e) The following amounts shall be transferred to the fund from the prior supplemental funds at the beginning of each project year.

(1) Twenty percent of the amount in the prior supplemental funds on the effective date of this article, less any and all payments for services rendered prior to July 1, 2005, but paid after July 1, 2005.

(2) Interest that accrued on the prior supplemental funds during the prior project year.

(3) Notwithstanding paragraph (1), solely for the 2009–10 fiscal year, the amount of funds transferred shall be reduced by six million one hundred and ninety-one thousand dollars ($6,191,000). The funds generated from this reduction shall be transferred to the General Fund.

(f) No distributions, payments, transfers, or disbursements shall be made from the prior supplemental funds except as set forth in this section.

(g) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section.

(h) Except as otherwise provided in subdivision (j), moneys shall be applied to obtain federal financial participation to the extent available in accordance with customary Medi-Cal accounting procedures for purposes of payments under this section. Distributions from the fund shall be supplemental to any other Medi-Cal reimbursement received by the hospitals, including amounts that hospitals receive under the selective provider contracting program, and shall not affect provider rates paid under the selective provider contracting program.

(i) Subject to subdivision (j), all amounts that are in the fund shall be available for negotiation by the California Medical Assistance Commission, along with corresponding federal financial participation, for additional payments to distressed hospitals. These amounts shall be paid under contracts entered into by the department and negotiated by the California Medical Assistance Commission pursuant to Article 2.6 (commencing with Section 14081), provided that any amounts payable to a designated public hospital shall be paid in the form of a direct grant of state general funds pursuant to a contract negotiated by the California Medical Assistance Commission. The commission shall not consider the lack of federal financial participation in direct grants to designated public hospitals in determining which hospital may receive funding under this section.

(j) After April 1, 2007, and each April 1 thereafter, in the event that funding under this article is insufficient to meet the adjusted aggregate baseline funding amounts for a particular project year, as determined in subdivision (d) of Section 14166.5, and in Sections 14166.13 and 14166.18, funds under this section shall first be available for use under contracts negotiated by the California Medical Assistance Commission for hospitals contracting under the selective provider contracting program under Article 2.6 (commencing with Section 14081) in an effort to address the insufficiency, to the extent funds under this section are available on or after April 1 for the particular project year.

(k) Any funds remaining in the fund at the end of a fiscal year shall be carried forward for use in the following fiscal year.

(Amended by Stats. 2009, 4th Ex. Sess., Ch. 5, Sec. 49. Effective July 28, 2009. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.24. (a) Any determination of the amount due a designated public hospital that is based in whole or in part on costs reported to or audited by a Medicare fiscal intermediary shall not be deemed final for purposes of this article unless the hospital has received a final determination of Medicare payment for the cost reporting for Medicare purposes. Designated public hospitals shall be entitled to pursue all administrative and judicial review available under the Medicare Program and any final determination shall be incorporated into the department's final determination of payment due the hospital under this article.

(b) If as a result of an audit performed by the department or any state or federal agency, the department determines that any hospital has been overpaid under the demonstration project or the successor demonstration project, the department shall recoup the overpayment in accordance with Section 14172.5 or 14115.5. The hospital may appeal the overpayment determinations and any related audit determination in accordance with the appeal procedures set forth in Sections 51016 to 51047, inclusive, of Title 22 of the California Code of Regulations. The hospital may seek judicial review of the final administrative decision as set forth in Section 14171.

(c) The department shall promptly consult with the affected governmental entity regarding a dispute between a designated public hospital and the department regarding the validity of the hospital's certified public expenditures. If the department determines that the hospital's certification is valid, the department shall submit the claim to obtain federal reimbursement for the certified expenditure in question.

(d) (1) Upon receipt of a notice of disallowance or deferral from the federal government related to the certified public expenditures or intergovernmental transfers of any governmental entity participating in the demonstration project, the department shall promptly notify the affected governmental entity. The governmental entity that certified the public expenditure shall be the entity responsible for the federal portion of that expenditure.

(2) The department and the affected governmental entity shall promptly consult regarding the proposed disallowance or deferral.

(3) After consulting with the governmental entity, the department shall determine whether the disallowance or response to a deferral should be filed with the federal government. If the department determines the appeal or response has merit, the department shall timely appeal. If necessary, the department may request an extension of the deadline to file an appeal or response to a deferral. The affected governmental entity may provide the department with the legal and factual basis for the appeal or response.

(e) Notwithstanding any other provision of law, if the department has exercised the authority set forth in subdivision (g) of Section 14166.221 and subdivision (e) of Section 14167.5, then all of the following shall occur:

(1) (A) The state shall be solely responsible for the repayment of the federal portion of any federal disallowance associated with any certified public expenditures for the 2009, 2010, and 2011 project years through October 31, 2010, and paragraph (1) of

subdivision (d) of Section 14166.24 shall be disregarded, up to the total amount of the grant funds retained by the state under subdivision (e) of Section 14167.5.

(B) If the hospitals have additional certified public expenditures for which federal funds have not been received but for which federal funds could have been received under the demonstration project had additional federal funds been available, including federal funds made available under an extension of the demonstration project, the state shall first be allowed to respond to a deferral or disallowance based on the certified public expenditures of designated public hospitals, or the governmental entities with which they are affiliated, by substituting the additional certified public expenditures for those deferred or disallowed.

(2) The department shall not recoup any overpayment from a designated public hospital, or a governmental entity with which it is affiliated, with respect to payments under this article for the 2009, 2010, and 2011 project years through October 31, 2010, until the state has repaid all federal funds due up to the amount of the grant funds retained by the state under subdivision (e) of Section 14167.5.

(Amended by Stats. 2011, Ch. 86, Sec. 17. (AB 1066) Effective July 15, 2011. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.25. (a) The Legislature finds and declares all of the following:

(1) In light of the closure of Los Angeles County Martin Luther King, Jr.-Harbor Hospital, there is a need to ensure adequate funding for continued health care services to the uninsured population of South Los Angeles, including, but not limited to, the Cities of Compton, Lynwood, South Gate, and Huntington Park, the southern and central portions of the Cities of Los Angeles, Inglewood, Gardena, and surrounding unincorporated communities.

(2) The state, the County of Los Angeles, and all health care providers in the South Los Angeles community must work together to meet the health care needs of the community until the critical hospital services previously provided by Los Angeles County Martin Luther King, Jr.-Harbor Hospital can be restored at this location.

(3) The Medi-Cal Hospital/Uninsured Care Demonstration Project provides a critical source of funding for services to low-income communities throughout the state that are provided by California's safety net hospital systems.

(4) The special funding provided in this section is predicated on the express intent of the County of Los Angeles to restore hospital services on the hospital campus, to be operated by either a private or public entity. The county has undertaken a specific plan to do so as quickly as possible.

(5) The Legislature anticipates that demonstration project funds will be available to help fund the reopened hospital. The nature and amount of that funding cannot be determined until the new structure and operation of the hospital is known.

(6) As an interim response to the specific circumstances caused by the closure of this hospital, and until hospital services can be restored at this location, a special fund will be created to receive demonstration project funding to be available to the County of Los Angeles for expenditures to preserve health care services for the uninsured population of South Los Angeles, as defined above.

(b) The South Los Angeles Medical Services Preservation Fund is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department for the purposes specified in this section.

(c) Subject to the conditions in this section, a maximum amount of one hundred million dollars ($100,000,000) of the safety net care pool funds claimed and received by the state that are based on the certified public expenditures of the County of Los Angeles or its designated public hospitals shall be transferred to the South Los Angeles Medical Services Preservation Fund for each of the three project years, 2007–08, 2008–09, and 2009–10.

(1) In the event that the director determines that any amount is due to the County of Los Angeles under the demonstration project for services rendered during the portion of a project year during which Los Angeles County Martin Luther King, Jr.-Harbor Hospital was operational, the amount deposited in the fund under this subdivision shall be reduced by a percentage determined by reducing 100 percent by the percentage reduction in the hospital's baseline as determined under subdivision (c) of Section 14166.5 for that project year.

(2) If, in the aggregate, the federal medical assistance percentage of the certified public expenditures reported by the County of Los Angeles and its designated public hospitals under Section 14166.8, excluding those certified public expenditures reported under paragraph (1) of subdivision (b) of Section 14166.8, in any project year do not exceed the amounts paid or payable to the county and its designated public hospitals in the aggregate under Section 14166.6, excluding disproportionate share payments

funded with intergovernmental transfers, Section 14166.7, and subdivision (d) for the same project year, then the amount deposited in the fund under subdivision (c) shall be reduced by the amount of excess payments over the federal medical assistance percentage of certified public expenditures.

(d) Moneys in the South Los Angeles Medical Services Preservation Fund shall be distributed to the County of Los Angeles in amounts equal to the costs incurred by the county, including indirect costs associated with adequately maintaining the hospital building so that it can be reopened, in providing, or compensating other providers for, health services rendered to the uninsured population of South Los Angeles, including all of the following:

(1) Services provided in the multiservice ambulatory care center operating on the former Los Angeles County Martin Luther King, Jr.-Harbor Hospital campus.

(2) Services rendered to patients in beds at other designated public hospitals operated by the County of Los Angeles that have been opened specifically for the purpose of serving patients that would have been served by the former Los Angeles County Martin Luther King, Jr.-Harbor Hospital.

(3) Services rendered in the county-operated health center and the comprehensive health center formerly operated under Los Angeles County Martin Luther King, Jr.-Harbor Hospital.

(4) Services rendered to the uninsured by other public or private health care providers for which the County of Los Angeles has agreed to pay under a contract with the provider as a result of the downsizing or closure of Los Angeles County Martin Luther King, Jr.-Harbor Hospital.

(e) As a condition for receiving distributions from the South Los Angeles Medical Services Preservation Fund in any project year, the County of Los Angeles shall assure the director that it will not reduce the county's ongoing, systemwide financial contribution to the county department of health services during that project year for health care services to the uninsured.

(f) No funds shall be available from the South Los Angeles Medical Services Preservation Fund for services rendered when a hospital on the former Los Angeles County Martin Luther King, Jr.-Harbor Hospital campus is certified for Medi-Cal participation.

(g) If the full amount of the South Los Angeles Medical Services Preservation Fund for any project year is not distributed to the County of Los Angeles, based on the cost of services identified in subdivision (d) that were rendered during that project year, any remaining amounts shall revert to the Health Care Support Fund established pursuant to Section 14166.21.

(h) To the extent that the County of Los Angeles receives distributions from the South Los Angeles Medical Services Preservation Fund based on the cost of services rendered by county-operated providers, or based on payments made to private providers for services rendered to the uninsured population of South Los Angeles, the costs of the services rendered shall not be considered for purposes of any of the following determinations with respect to either the county or the private provider:

(1) Medi-Cal payments under the selective provider contracting program under Article 2.6 (commencing with Section 14081), including payments to distressed hospitals under Section 14166.23.

(2) Baseline amounts, or adjustments thereto, under Section 14166.5, 14166.13, or 14166.18.

(3) Any other payment under Medi-Cal or other health care program.

(i) This section shall be implemented only to the extent that the director determines that it will not result in the loss of federal funds under the demonstration project.

(Amended by Stats. 2009, Ch. 140, Sec. 213. (AB 1164) Effective January 1, 2010. Conditionally inoperative as provided in Section 14166.26 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.252. (a) In the event of a partial year extension of a demonstration project pursuant to this article, the director shall have discretion to determine allocations for the extension period on either an annual or partial year basis, consistent with any requirements in the letter from the federal Centers for Medicare and Medicaid Services granting the extension.

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

(Added by Stats. 2010, Ch. 714, Sec. 4. (SB 208) Effective October 19, 2010. Conditionally inoperative as provided in Section 14166.25 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.253. (a) If the department has not received adequate assurances from the federal Centers for Medicare and Medicaid Services (CMS) before November 1, 2015, that the department's application for a subsequent demonstration project, as defined in subdivision (x) of Section 17612.2 and as submitted pursuant to Section 17612.8, is likely to be approved with an effective date of November 1, 2015, the director may request one or more temporary extensions, as necessary to continue the operation of, and the authorities provided under, the federal Medicaid demonstration project titled "California Bridge to Reform Demonstration" (waiver number 11-W-00193/9), until the approved effective date of the subsequent demonstration project.

(b) To the extent permitted under the terms of any approved temporary extension obtained by the department pursuant to subdivision (a), an approved subsequent demonstration project, or as otherwise permitted under federal Medicaid law, the department shall, after consulting with the affected designated public hospitals, extend and apply the payment methodologies and allocations described in this article and in effect during the successor demonstration project, on a state fiscal year, annual, partial year, or other basis, consistent with any applicable implementing provisions of the Medi-Cal state plan and requirements imposed by the CMS. The department may make payments on an interim basis and subject to reconciliation to amounts payable under the payment and allocation methodologies applicable to any approved temporary extension obtained by the department pursuant to subdivision (a) or approved subsequent demonstration project.

(c) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not jeopardized.

(d) Until July 1, 2016, in the event of a conflict between the terms of any federally approved extension obtained by the department pursuant to subdivision (a) and this article, the terms of the federally approved temporary extension shall control, and the department shall provide notice of the conflict to the appropriate policy and fiscal committees of the Legislature.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions without taking regulatory action until July 1, 2016.

(Added by Stats. 2015, Ch. 759, Sec. 1. (SB 36) Effective October 10, 2015. Conditionally inoperative as provided in Section 14166.25 or in subd. (b) or (g) of Section 14166.2. Repealed on date prescribed in Section 14166.26 or in subd. (b) or (g) of Section 14166.2.)

14166.26. (a) Unless this article is repealed pursuant to subdivision (b) or (g) of Section 14166.2, this article shall become inoperative on the date that the director executes a declaration, which shall be retained by the director and provided to the fiscal and appropriate policy committees of the Legislature, stating that the federal demonstration project or the successor demonstration project provided for in this article has been terminated by the federal Centers for Medicare and Medicaid Services, and shall, six months after the date the declaration is executed, be repealed.

(b) In addition to the requirements specified in subdivision (a), 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.

(Amended by Stats. 2011, Ch. 86, Sec. 18. (AB 1066) Effective July 15, 2011. Repealed on date prescribed by this section's own provisions or by subd. (b) or (g) of Section 14166.2. Note: Termination clause affects Article 5.2, commencing with Section 14166.)