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. Fiscal Provisions [14150 - 14164] *(Article 5 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

14150. Within 60 calendar days of the date that the annual Budget Act is chaptered, the department shall notify the chairpersons of the fiscal committees of each house of the Legislature, the Chairperson and the Vice Chairperson of the Joint Legislative Budget Committee, and appropriate county representatives if the department plans to withhold and not allocate any of the baseline allocation for county Medi-Cal eligibility activities that are appropriated for Medi-Cal administration.

(Added by Stats. 2002, Ch. 1161, Sec. 87. Effective September 30, 2002.)

14151. Bills for services rendered during the 1970–71 fiscal year to persons other than the beneficiaries under the California Medical Assistance Program submitted to the state by any county which has elected to come within the provisions of Section 14150.1 of the Welfare and Institutions Code are bills against the appropriation for the fiscal year during which the bills are submitted, and shall be submitted not later than 60 days following the start of the 1971–72 fiscal year. The director may, when he finds that delay in the submission of bills was caused by circumstances beyond the control of the county, extend the period of submissions of bills for a period not to extend beyond the end of the 1971–72 fiscal year. State general funds of $27,661,452 are made available from the 1971–72 appropriation to cover the state cost of such bills received. In the event such bills received are less than $27,661,452, the balance remaining may be used for the basic or supplemental schedules of benefits.

(Repealed and added by Stats. 1971, Ch. 577.)

14152. Bills for services rendered during the 1970–71 fiscal year to beneficiaries under the California Medical Assistance Program are bills against the appropriation for the fiscal year during which the bills are submitted, and shall be submitted not more than two months after the month in which the service is rendered, and shall be in the form prescribed by the director, except that in the event the patient does not identify himself to the provider as a Medi-Cal beneficiary, the provider shall be entitled to submit his statement at any time within 60 days after that date certified by the provider as the date said patient was first identified as a Medi-Cal beneficiary, provided, however, that such date certified by the provider as the date the patient was first so identified shall not be later than one year after the month in which the service was rendered. Further, the director may, where he finds that delay in the submission of bills was caused by circumstances beyond the control of the provider, extend the period for submission of bills for a period not to exceed one year. Funds in the amount of $106,269,000 are hereby made available from the 1971–72 appropriation to cover the cost of such 1970–71 services billed during the 1971–72 fiscal year. In the event such bills are less than $106,269,000 the balance remaining may be used for the basic or supplemental schedules of benefits.

(Added by Stats. 1971, Ch. 577.)

14153. Funds shall be advanced monthly to the respective counties for costs of administration of the Medi-Cal program in the manner prescribed in Chapter 9 (commencing with Section 15000).

Funds may be advanced monthly to the respective counties for the costs of care under the provisions of this chapter upon the order of the Director of Finance and the State Director of Health Services utilizing resources made available through the Health Care Deposit Fund.

County welfare departments shall submit administrative claims for the Medi-Cal program in accordance with procedures described in Section 10604.5.

(Amended by Stats. 1991, Ch. 611, Sec. 75. Effective October 7, 1991.)

14154. (a) (1) The department shall establish and maintain a plan whereby costs for county administration of the determination of eligibility for benefits under this chapter will be effectively controlled within the amounts annually appropriated for that administration. The plan, to be known as the County Administrative Cost Control Plan, shall establish standards and performance criteria, including workload, productivity, and support services standards, to which counties shall adhere. The plan shall include standards for controlling eligibility determination costs that are incurred by performing eligibility determinations at county hospitals, or that are incurred due to the outstationing of any other eligibility function. Except as provided in Section 14154.15, reimbursement to a county for outstationed eligibility functions shall be based solely on productivity standards applied to that county's welfare department office.

(2) (A) The plan shall delineate both of the following:

(i) The process for determining county administration base costs, which include salaries and benefits, support costs, and staff development.

(ii) The process for determining funding for caseload changes, cost-of-living adjustments, and program and other changes.

(B) The annual county budget survey document utilized under the plan shall be constructed to enable the counties to provide sufficient detail to the department to support their budget requests.

(3) The plan shall be part of a single state plan, jointly developed by the department and the State Department of Social Services, in conjunction with the counties, for administrative cost control for the California Work Opportunity and Responsibility to Kids (CalWORKs), CalFresh, and Medical Assistance (Medi-Cal) programs. Allocations shall be made to each county and shall be limited by and determined based upon the County Administrative Cost Control Plan. In administering the plan to control county administrative costs, the department shall not allocate state funds to cover county cost overruns that result from county failure to meet requirements of the plan. The department and the State Department of Social Services shall budget, administer, and allocate state funds for county administration in a uniform and consistent manner.

(4) The department and county welfare departments shall develop procedures to ensure the data clarity, consistency, and reliability of information contained in the county budget survey document submitted by counties to the department. These procedures shall include the format of the county budget survey document and process, data submittal and its documentation, and the use of the county budget survey documents for the development of determining county administration costs. Communication between the department and the county welfare departments shall be ongoing as needed regarding the content of the county budget surveys and any potential issues to ensure the information is complete and well understood by involved parties. Any changes developed pursuant to this section shall be incorporated within the state's annual budget process by no later than the 2011–12 fiscal year.

(5) The department shall provide a clear narrative description along with fiscal detail in the Medi-Cal estimate package, submitted to the Legislature in January and May of each year, of each component of the county administrative funding for the Medi-Cal program. This shall describe how the information obtained from the county budget survey documents was utilized and, if applicable, modified and the rationale for the changes.

(6) Notwithstanding any other law, the department shall develop and implement, in consultation with county program and fiscal representatives, a new budgeting methodology for Medi-Cal county administrative costs that reflects the impact of PPACA implementation on county administrative work. The new budgeting methodology shall be used to reimburse counties for eligibility processing and case maintenance for applicants and beneficiaries.

(A) The budgeting methodology may include, but is not limited to, identification of the costs of eligibility determinations for applicants, and the costs of eligibility redeterminations and case maintenance activities for recipients, for different groupings of cases, based on variations in time and resources needed to conduct eligibility determinations. The calculation of time and resources shall be based on the following factors: complexity of eligibility rules, ongoing eligibility requirements, and other factors as determined appropriate by the department. The development of the new budgeting methodology may include, but is not limited to, county survey of costs, time and motion studies, in-person observations by department staff, data reporting, and other factors deemed appropriate by the department.

(B) The new budgeting methodology shall be clearly described, state the necessary data elements to be collected from the counties, and establish the timeframes for counties to provide the data to the state.

(C) The new budgeting methodology developed pursuant to this paragraph shall be implemented no sooner than the 2015–16 fiscal year. The department may develop a process for counties to phase in the requirements of the new budgeting methodology.

(D) The department shall provide the new budgeting methodology to the legislative fiscal committees by March 1 of the fiscal year immediately preceding the first fiscal year of implementation of the new budgeting methodology.

(E) To the extent that the funding for the county budgets developed pursuant to the new budget methodology is not fully appropriated in any given fiscal year, the department, with input from the counties, shall identify and consider options to align funding and workload responsibilities.

(F) For purposes of this paragraph, “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(G) 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 paragraph by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the implementation of the new budgeting methodology pursuant to this paragraph, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(b) Nothing in this section, Section 15204.5, or Section 18906 shall be construed to limit the administrative or budgetary responsibilities of the department in a manner that would violate Section 14100.1, and thereby jeopardize federal financial participation under the Medi-Cal program.

(c) (1) The Legislature finds and declares that in order for counties to do the work that is expected of them, it is necessary that they receive adequate funding, including adjustments for reasonable annual cost-of-doing-business increases. The Legislature further finds and declares that linking appropriate funding for county Medi-Cal administrative operations, including annual cost-of-doing-business adjustments, with performance standards will give counties the incentive to meet the performance standards and enable them to continue to do the work they do on behalf of the state. It is therefore the Legislature’s intent, upon an appropriation by the Legislature for this purpose, to provide appropriate funding to the counties for the effective administration of the Medi-Cal program at the local level to ensure that counties can reasonably meet the purposes of the performance measures as contained in this section.

(2) It is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2008–09, 2009–10, 2010–11, 2011–12, 2012–13, 2014–15, 2015–16, 2016–17, and 2017–18 fiscal years and the 2024–25 to 2027–28, inclusive, fiscal years.

(d) The department is responsible for the Medi-Cal program in accordance with state and federal law. A county shall determine Medi-Cal eligibility in accordance with state and federal law. If in the course of its duties the department becomes aware of accuracy problems in any county, the department shall, within available resources, provide training and technical assistance as appropriate. This section shall not be interpreted to eliminate any remedy otherwise available to the department to enforce accurate county administration of the program. In administering the Medi-Cal eligibility process, each county shall meet the following performance standards each fiscal year:

(1) Complete eligibility determinations as follows:

(A) Ninety percent of the general applications without applicant errors and are complete shall be completed within 45 days.

(B) Ninety percent of the applications for Medi-Cal based on disability shall be completed within 90 days, excluding delays by the state.

(2) (A) The department shall establish best-practice guidelines for expedited enrollment of newborns into the Medi-Cal program, preferably with the goal of enrolling newborns within 10 days after the county is informed of the birth. The department, in consultation with counties and other stakeholders, shall work to develop a process for expediting enrollment for all newborns, including those born to mothers receiving CalWORKs assistance.

(B) Upon the development and implementation of the best-practice guidelines and expedited processes, the department and the counties may develop an expedited enrollment timeframe for newborns that is separate from the standards for all other applications, to the extent that the timeframe is consistent with these guidelines and processes.

(3) Perform timely annual redeterminations, as follows:

(A) Ninety percent of the annual redetermination forms shall be mailed to the recipient by the anniversary date.

(B) Ninety percent of the annual redeterminations shall be completed within 60 days of the recipient’s annual redetermination date for those redeterminations based on forms that are complete and have been returned to the county by the recipient in a

timely manner.

(C) Ninety percent of those annual redeterminations where the redetermination form has not been returned to the county by the recipient shall be completed by sending a notice of action to the recipient within 45 days after the date the form was due to the county.

(e) The department shall develop procedures in collaboration with the counties and stakeholder groups for determining county review cycles, sampling methodology and procedures, and data reporting.

(f) On January 1 of each year, each applicable county, as determined by the department, shall report to the department on the county's results in meeting the performance standards specified in this section. The report shall be subject to verification by the department. County reports shall be provided to the public upon written request.

(g) If the department finds that a county is not in compliance with one or more of the standards set forth in this section, the county shall, within 60 days, submit a corrective action plan to the department for approval. The corrective action plan shall, at a minimum, include steps that the county shall take to improve its performance on the standard or standards with which the county is out of compliance. The plan shall establish interim benchmarks for improvement that shall be expected to be met by the county in order to avoid a sanction.

(h) (1) If a county does not meet the performance standards for completing eligibility determinations and redeterminations as specified in this section, the department may, at its sole discretion, reduce the allocation of funds to that county in the following year by 2 percent. Any funds so reduced may be restored by the department if, in the determination of the department, sufficient improvement has been made by the county in meeting the performance standards during the year for which the funds were reduced. If the county continues not to meet the performance standards, the department may reduce the allocation by an additional 2 percent for each year thereafter in which sufficient improvement has not been made to meet the performance standards.

(2) No reduction of the allocation of funds to a county shall be imposed pursuant to this subdivision for failure to meet performance standards during any period of time in which the cost-of-doing-business increase is suspended.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and except as provided in subparagraph (G) of paragraph (6) of subdivision (a), the department shall, without taking any further regulatory action, implement, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters or similar instructions.

(Amended by Stats. 2024, Ch. 40, Sec. 65. (SB 159) Effective June 29, 2024.)

14154.1. Reimbursement for any Medi-Cal county administrative costs shall be made subject to the requirements specified in the County Administrative Cost Control Plan, established pursuant to Section 14154. However, notwithstanding any other provision of law, for applications taken on or after July 1, 1987, and thereafter, the department shall make allocations for Medi-Cal county administrative expenses taking into consideration all Medi-Cal applications. However, if the department determines that a county is inappropriately processing non-Medi-Cal applications through the Medi-Cal process, then the department shall not allocate state general funds for nonapproved Medi-Cal applications which exceed a specified level. That level shall be determined by multiplying the county's number of approved applications by the ratio of nonapproved applications to approved applications processed by the county during the base period used in the cost control plan which is in effect for the fiscal year the inappropriate processing of non-Medi-Cal applications occurred. Reimbursement to Los Angeles County hospitals shall be limited on the same basis.

(Amended by Stats. 1987, Ch. 1046, Sec. 1.)

14154.15. (a) Any county may petition the department for an augmentation of its County Administrative Cost Control Plan in order to implement a plan, as provided for in Section 1105 of the federal Social Security Act (42 U.S.C. Sec. 1305), for the outstationing of one or more eligibility workers at all types of outstation locations, as defined in Section 435.904(c)(3) of Title 42 of the Code of Federal Regulations in order to facilitate receipt and processing of applications for Medi-Cal eligibility for pregnant women, infants and children as specified by Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 and following). In order to participate pursuant to this section, a county welfare department shall petition under this section in accordance with guidelines established by the department. The petition shall include, but not be limited to, information about the need for outstation workers at alternative sites and the language skills needed by the outstation workers.

(b) In reviewing a petition from a county for an augmentation of its County Administrative Cost Control Plan for outstationing purposes, the department shall take into account the likely success rate of applications processed by the proposed outstationed eligibility workers, the amount of travel and training time required to implement and continue the outstationing plan, and other productivity factors associated with the outstationing plan.

(c) The department may approve those proposed augmentations which, based on its review of the outstationing plan, offer potential to increase eligibility determinations and access to Medi-Cal perinatal services by pregnant women and Medi-Cal services by infants and children specified by Title XIX of the Social Security Act (42 U.S.C., Sec. 1396 and following). The department shall review the

approved plan annually to determine if the plan shall be renewed, altered, discontinued, or incorporated into the county administrative funding base.

(d) In addition to any augmentations authorized by this section, the department may, at its discretion, advance administrative funding to a county welfare department for which it approves an augmentation of its County Administrative Cost Control Plan, to cover the initial incremental costs of outstationed eligibility workers under this section.

(e) The department shall conduct a one-time outreach plan to educate county welfare directors, county health officers, and county elected officials on the opportunities and advantages of outstationing Medi-Cal eligibility workers to facilitate access by pregnant women to Medi-Cal perinatal services and Medi-Cal eligibility for infants and children.

(Amended by Stats. 1997, Ch. 294, Sec. 75. Effective August 18, 1997.)

14154.2. (a) The Legislature finds that ambiguities have arisen regarding payment provisions relating to certain costs incurred in processing Medi-Cal eligibility applications for various fiscal years, and believes the ambiguities should be alleviated by means of legislation clarifying the Legislature's intent regarding such provisions.

(b) The Legislature recognizes that federal financial participation in the costs of administering the Medi-Cal program is an important element in funding such costs, and desires that federal financial participation be pursued and obtained whenever possible. With respect to Medi-Cal administration costs, for eligibility determinations, it is not and has not been the Legislature's intent to preclude federal financial participation which would otherwise be available from the Health Care Financing Administration.

(Added by Stats. 1987, Ch. 1227, Sec. 1. Effective September 27, 1987.)

14154.3. (a) A provision of a Budget Act or other statute shall not be interpreted or applied to limit the amount of federal financial participation, otherwise available under federal law, which may be reimbursable to counties in support of Medi-Cal administration costs for eligibility determinations. A provision of a Budget Act or another statute shall not be interpreted or applied to restrict the amount of federal financial participation for Medi-Cal administration costs, for eligibility determinations, otherwise available under federal law, which may be claimed by the department, and, upon receipt from the federal government, transferred by the department to a county.

(b) The Budget Acts referred to in subdivision (a) include, but are not limited to:

(1) Chapter 510 of the Statutes of 1980, including Item 288 of Section 2 thereof.

(2) Chapter 99 of the Statutes of 1981, including Items 426-101-001 and 426-101-890 of Section 2.00 thereof.

(3) Chapter 326 of the Statutes of 1982, including Items 4260-101-001 and 4260-101-890 of Section 2.00 thereof.

(4) Chapter 324 of the Statutes of 1983, including Items 4260-101-001 and 4260-101-890 of Section 2.00 thereof.

(5) Chapter 258 of the Statutes of 1984, including Items 4260-101-001 and 4260-101-890 of Section 2.00 thereof.

(6) Chapter 111 of the Statutes of 1985, including Items 4260-101-001 and 4260-101-890 of Section 2.00 thereof.

(7) Chapter 186 of the Statutes of 1986, including Items 4260-101-001 and 4260-101-890 of Section 2.00 thereof.

Provisions of the Budget Acts listed in paragraphs (1) to (7), inclusive, shall not be interpreted or applied as a prohibition regarding the amount of costs counties may incur for Medi-Cal eligibility administration activities. The provisions of those Budget Acts shall be interpreted and applied as a means of limiting the allocation of state general funds to be paid in support of Medi-Cal eligibility determination activities.

(c) To the extent necessary to effectuate the intent of subdivisions (a) and (b), the following Budget Act provisions shall be inoperative:

(1) Provision 17.5 of Item 426-101-890 of Section 2.00 of Chapter 99 of the Statutes of 1981.

(2) The incorporation by reference of Provision 16 of Item 4260-101-001 of Section 2.00 of Chapter 326 of the Statutes of 1982 into Provision 1 of Item 4260-101-890 of that chapter.

(3) The incorporation by reference of Provision 15 of Item 4260-101-001 of Section 2.00 of Chapter 324 of the Statutes of 1983 into Provision 1 of Item 4260-101-890 of Section 2.00 of that chapter.

(d) Sections 14154 and 14154.1 shall not be interpreted or applied to restrict the amount of federal financial participation, not deferred or disallowed by federal law or regulation which may be reimbursable to any county for Medi-Cal administration costs for

eligibility determinations. The County Administrative Cost Control Plan established pursuant to Section 14154 shall not be interpreted or applied as a prohibition regarding the amount of costs counties may incur for Medi-Cal county administration costs. That plan shall be interpreted and applied only as a means of limiting the allocation of state general funds to be paid in support of those county costs.

(e) Should federal financial participation be deferred or disallowed regarding funds transferred by the department to a county for costs incurred for Medi-Cal eligibility determinations, and that federal financial participation was matched by county expenditures, the county which received those federal funds shall repay the funds in question at such time as the federal deferral or disallowance has been issued. If the federal deferral or disallowance is noticed or issued prior to the transfer of the federal funds from the department to a county, the department shall not be responsible for transferring the federal funds to the county until the deferral or disallowance issue regarding these funds has been resolved.

(f) The department shall timely appeal from the federal deferrals or disallowances and the affected county may assist the department in preparing and presenting a pending appeal regarding a federal deferral or disallowance.

(g) Medi-Cal eligibility determination activities are undertaken by counties on behalf of the department. Reasonable and necessary costs incurred by counties relating to the eligibility determination activities shall be recognized as costs incurred by the state for purposes of inclusion in the nonfederal share of Medi-Cal eligibility determination expenditures for claiming federal financial participation.

(h) Subdivision (e) shall not apply to agreements between the department and a county executed prior to September 27, 1987.

(Amended by Stats. 2008, Ch. 179, Sec. 247. Effective January 1, 2009.)

14154.5. (a) Each county shall work, on a routine basis, any error alert from the department's Medi-Cal Eligibility Data System (MEDS). Any alert that affects eligibility or the spend down of excess income that is received by the 10th working day of the month shall be processed in time for the change to be effective the beginning of the following month. Any alert that affects eligibility or the spend down of excess income that is received after the 10th working day of the month shall be processed in time for the change to be effective the beginning of the month after the following month. The department shall consult with the County Welfare Directors Association to define those alerts that affect eligibility or the spend down of excess income.

(b) The county shall submit reconciliation files of its Medi-Cal eligible population to the department every three months, based upon a schedule determined by the department and in a format prescribed by the department, to identify any discrepancies between eligibility files in the county records and eligibility as reflected in MEDS. Counties shall be notified of any changes to the standard format for submitting reconciliation files sufficiently in advance to allow for budgeting, scheduling, development, testing, and implementation of any required change in county automated eligibility systems.

(c) For those records that are on the county's files, but not on MEDS, the county shall receive worker alerts from the department that identify these cases, and the county shall fix any data discrepancies. Any worker alert received by the 10th working day of the month shall be processed in time for the change to be effective the beginning of the following month. Any worker alert received after the 10th working day of the month shall be processed in time for the change to be effective the beginning of the month after the following month.

(d) In regard to any record that is on MEDS but not on the county's file, the county shall either correct the county record or MEDS, whichever is appropriate, within the same timeframes specified in subdivision (c).

(e) The department shall terminate a MEDS-eligible record if the person is not eligible on the county's file when there has been no eligibility update on the MEDS record for six months.

(f) (1) If the department finds that a county is not performing all of the following activities, the county shall, within 60 days, submit a corrective action plan to the department for approval:

(A) Conducting reconciliations as required in subdivision (b).

(B) Processing 95 percent of worker alerts referred to in subdivisions (c) and (d), within the timeframes specified.

(C) Processing 90 percent of the error alerts referred to in subdivision (a) that affect eligibility or the spend down of excess income, within the timeframes specified.

(2) The corrective action plan shall, at a minimum, include steps that the county shall take to improve its performance on the requirements with which the county is out of compliance. The plan shall establish interim benchmarks for improvement that shall be expected to be met by the county in order to avoid sanctions.

(g) (1) If the county does not meet the interim benchmarks for improvement standards, the department may, in its sole discretion, reduce the allocation of funds to that county in the following year by 2 percent. Any funds so reduced may be restored by the department if, in the determination of the department, sufficient improvement has been made by the county in meeting the performance standards during the year for which the funds were reduced.

(2) No reduction of the allocation of funds to a county shall be imposed pursuant to this subdivision for failure to meet performance standards during any period of time in which the cost-of-doing-business increase is suspended.

(h) The department, in consultation with the County Welfare Directors Association, shall investigate features that could be installed in MEDS to reduce the number of alerts and streamline the reconciliation process.

(i) 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, the department may implement, interpret, or make specific this section by means of all-county letters, provider bulletins, or similar instructions. Thereafter, the department may adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(Amended by Stats. 2023, Ch. 42, Sec. 154. (AB 118) Effective July 10, 2023.)

14157. There is hereby established a Health Care Deposit Fund from which expenditures of state, county and federal funds for health care and administration under this chapter and Chapter 8 (commencing with Section 14200) shall be made upon order of the Controller in accordance with certifications made by the director.

The Controller shall deposit in this fund all federal funds as received under the provisions of Title XIX of the Social Security Act and all county funds received under this chapter.

All money in the Health Care Deposit Fund is hereby appropriated, for expenditure for the purposes specified in this chapter and Chapter 8 (commencing with Section 14200).

(Amended by Stats. 1977, Ch. 1252.)

14157.6. Notwithstanding any other provision of law, any federal and county funds, excluding county funds used for the purposes of Section 4011.1 of the Penal Code, received under the provisions of Section 14157 during each fiscal year, as reimbursement for expenditures for health care services authorized under this chapter made from funds transferred to the Health Care Deposit Fund from the General Fund in prior years, shall be transferred from the Health Care Deposit Fund to the General Fund. When a projected deficiency exists in the Medical Assistance Program, these federal and county funds are hereby appropriated from the General Fund to the Health Care Deposit Fund and shall be expended as soon as practicable, but not sooner than 30 days after notification in writing of the necessity therefor, to the chairperson of the committee in each house which considers appropriations, and the Joint Legislative Budget Committee, for the state's share of payments for medical care and services, county administration, and fiscal intermediary services.

(Added by Stats. 1984, Ch. 268, Sec. 56.2. Effective June 30, 1984.)

14158. Funds for the medical assistance program shall be provided annually by appropriation in the Budget Act. The amount of state funds appropriated shall be transferred in such sums as are needed by the Controller from the General Fund to the Health Care Deposit Fund.

(Amended by Stats. 1969, Ch. 21.)

14158.1. Effective for expenditures incurred after enactment of any new demonstration project under Article 5.4 (commencing with Section 14180), any federal financial participation that is available under the federal Medicaid Program, or any related waiver or demonstration project, based on the certified public expenditures of designated public hospitals, as defined in subdivision (d) of Section 14166.1, or the governmental entities with which they are affiliated, shall be paid to designated public hospitals or the governmental entities with which they are affiliated.

(Added by Stats. 2010, Ch. 218, Sec. 1. (AB 1653) Effective September 8, 2010.)

14158.5. Funds appropriated for purposes of this chapter and Chapter 8 (commencing with Section 14200), shall fully cover and shall not exceed the state's share of payments under this chapter and Chapter 8 (commencing with Section 14200), for the costs of medical care and services, county administration, and fiscal intermediary services. The state's share of the costs of medical care and services, county administration, and fiscal intermediary services shall be determined pursuant to a plan approved by the Director of Finance and certified to by the director.

(Added by Stats. 1984, Ch. 268, Sec. 56.4. Effective June 30, 1984.)

14159. Commencing with the 2004–05 fiscal year, expenditures for Medi-Cal services and fiscal intermediary and county administration costs included in the department's budget shall be charged against the appropriation for the fiscal year in which the billing is paid. Commencing July 1, 2004, all 2002–03 fiscal year and prior accrued obligations of the Health Care Deposit Fund shall become obligations of the 2004–05 fiscal year and all moneys available from the 2002–03 fiscal year and prior appropriations shall be reappropriated to the 2004–05 fiscal year for that purpose.

(Added by Stats. 2003, Ch. 230, Sec. 72. Effective August 11, 2003.)

14159.1. The provisions of Chapter 577 of the Statutes of 1971 in no way eliminate fiscal obligation incurred prior to July 1, 1971, by any county or the state under Article 5 (commencing with Section 14150) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code. After June 30, 1971, all uncollected county share amounts under said Article 5 due the state for prior periods remain an obligation of the county to the state.

(Added by Stats. 1976, Ch. 504.)

14160. Whenever an amount is or was prior to the effective date of this section, erroneously deposited in the Health Care Deposit Fund, including, but not limited to, duplicate payments and payments in excess of the correct amount, the erroneous amount shall be refunded to the depositor. There is hereby appropriated out of the Health Care Deposit Fund amounts sufficient to pay such refunds.

(Added by Stats. 1969, Ch. 814.)

14161. Carriers and providers of Medi-Cal benefits shall be required to utilize uniform accounting and cost-reporting systems as shall be developed and adopted by the department. If any other provision of law provides for uniform accounting and cost-reporting systems for hospitals, the department shall adopt these systems.

Carriers and providers of Medi-Cal benefits shall provide cost information to the department as is necessary in order to conduct studies to determine payment for services provided under this chapter, including but not limited to copies of any Medicare cost reports and settlements, and any Medicare audit reports.

Failure to comply with the provisions of this section shall be cause for suspension from participation under this chapter.

The department shall conduct such studies as necessary to determine payments for services provided under this chapter.

(Amended by Stats. 2012, Ch. 728, Sec. 207. (SB 71) Effective January 1, 2013.)

14162. (a) Beginning in 1991, the State Department of Health Services shall include in the November estimate of Medi-Cal expenditures and the Governor's Budget an estimate of savings from the prior year which resulted from implementation of Senate Bill 2174 of the 1987–88 Regular Session of the Legislature.

(b) Beginning in 1992, the Department of Finance shall, by February 1, deposit an amount equal to the savings level identified in the November estimate of Medi-Cal expenditures into the Critical Needs Health Care Fund, which is hereby created. Funds deposited in the Critical Needs Health Care Fund shall be appropriated by the Legislature for high-priority health expenditures.

(Added by Stats. 1988, Ch. 1348, Sec. 15.)

14163. (a) For purposes of this section, the following definitions shall apply:

(1) "Public entity" means a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state.

(2) "Hospital" means a health facility that is licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code to provide acute inpatient hospital services, and includes all components of the facility.

(3) "Disproportionate share hospital" means a hospital providing acute inpatient services to Medi-Cal beneficiaries that meets the criteria for disproportionate share status relating to acute inpatient services set forth in Section 14105.98.

(4) "Disproportionate share list" means the annual list of disproportionate share hospitals for acute inpatient services issued by the department pursuant to Section 14105.98.

(5) "Fund" means the Medi-Cal Inpatient Payment Adjustment Fund.

(6) "Eligible hospital" means, for a particular state fiscal year, a hospital on the disproportionate share list that is eligible to receive payment adjustment amounts under Section 14105.98 with respect to that state fiscal year.

(7) "Transfer year" means the particular state fiscal year during which, or with respect to which, public entities are required by this section to make an intergovernmental transfer of funds to the Controller.

(8) "Transferor entity" means a public entity that, with respect to a particular transfer year, is required by this section to make an intergovernmental transfer of funds to the Controller.

(9) "Transfer amount" means an amount of intergovernmental transfer of funds that this section requires for a particular transferor entity with respect to a particular transfer year.

(10) “Intergovernmental transfer” means a transfer of funds from a public entity to the state that is local government financial participation in Medi-Cal pursuant to the terms of this section.

(11) “Licensee” means an entity that has been issued a license to operate a hospital by the department.

(12) “Annualized Medi-Cal inpatient paid days” means the total number of Medi-Cal acute inpatient hospital days, regardless of dates of service, for which payment was made by or on behalf of the department to a hospital, under present or previous ownership, during the most recent calendar year ending prior to the beginning of a particular transfer year, including all Medi-Cal acute inpatient covered days of care for hospitals that are paid on a different basis than per diem payments.

(13) “Medi-Cal acute inpatient hospital day” means any acute inpatient day of service attributable to patients who, for those days, were eligible for medical assistance under the California state plan, including any day of service that is reimbursed on a basis other than per diem payments.

(14) “OBRA 1993 payment limitation” means the hospital-specific limitation on the total annual amount of payment adjustments to each eligible hospital under the payment adjustment program that can be made with federal financial participation under Section 1396r-4(g) of Title 42 of the United States Code as implemented pursuant to the Medi-Cal State Plan.

(b) The Medi-Cal Inpatient Payment Adjustment Fund is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to, and under the administrative control of, the department for the purposes specified in subdivision (d). The fund shall consist of the following:

(1) Transfer amounts collected by the Controller under this section, whether submitted by transferor entities pursuant to applicable provisions of this section or obtained by offset pursuant to subdivision (j).

(2) Any other intergovernmental transfers deposited in the fund, as permitted by Section 14164 or Article 5.17 (commencing with Section 14165.55).

(3) Any interest that accrues with respect to amounts in the fund.

(c) Moneys in the fund, which shall not consist of any state general funds, shall be used as the source for the nonfederal share of payments to hospitals pursuant to Section 14105.98. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures, and used to make payments pursuant to Section 14105.98.

(d) Except as otherwise provided in Section 14105.98 or in any law appropriating a specified sum of money to the department for administering this section and Section 14105.98, moneys in the fund shall be used only for the following:

(1) Payments to hospitals pursuant to Section 14105.98.

(2) Transfers to the Health Care Deposit Fund as follows:

(A) In the amount of two hundred thirty-nine million seven hundred fifty-seven thousand six hundred ninety dollars ($239,757,690) for the 1994–95 and 1995–96 fiscal years.

(B) In the amount of two hundred twenty-nine million seven hundred fifty-seven thousand six hundred ninety dollars ($229,757,690) for the 1996–97 fiscal year.

(C) In the amount of one hundred fifty-four million seven hundred fifty-seven thousand six hundred ninety dollars ($154,757,690) for the 1997–98 fiscal year.

(D) In the amount of one hundred fourteen million seven hundred fifty-seven thousand six hundred ninety dollars ($114,757,690) for the 1998–99 fiscal year.

(E) (i) In the amount of eighty-four million seven hundred fifty-seven thousand six hundred ninety dollars ($84,757,690) for the 1999–2000 fiscal year.

(ii) It is the intent of the Legislature that the economic benefit of any reduction in the amount transferred, or to be transferred, to the Health Care Deposit Fund pursuant to this subdivision for the 1999–2000 fiscal year, as compared to the amount so transferred for the 1998–99 fiscal year, be allocated equally between public and nonpublic disproportionate share hospitals. To implement the reduction in clause (i) the department shall, by June 30, 2000, adjust the calculations in Section 14105.98 in order to allocate the funds in accordance with this clause.

(F) In the amount of twenty-nine million seven hundred fifty-seven thousand six hundred ninety dollars ($29,757,690) for the 2000–01 fiscal year and the 2001–02 fiscal year.

(G) In the amount of eighty-five million dollars ($85,000,000) for the 2002–03 fiscal year and each fiscal year thereafter.

(H) The transfers from the fund shall be made in six equal monthly installments to the Medi-Cal local assistance appropriation item (Item 4260-101-0001 of Section 2.00 of the annual Budget Act) in support of Medi-Cal expenditures. The first installment shall accrue in October of each transfer year, and all other installments shall accrue monthly thereafter from November through March.

(3) Transfers to the Health Care Deposit Fund for purposes set forth in Article 5.17 (commencing with Section 14165.55).

(e) For the 1991–92 state fiscal year, the department shall determine, no later than 70 days after the enactment of this section, the transferor entities for the 1991–92 transfer year. To make this determination, the department shall utilize the disproportionate share list for the 1991–92 fiscal year issued by the department pursuant to paragraph (1) of subdivision (f) of Section 14105.98. The department shall identify each eligible hospital on the list for which a public entity is the licensee as of July 1, 1991. The public entity that is the licensee of each identified eligible hospital shall be a transferor entity for the 1991–92 transfer year.

(f) The department shall determine, no later than 70 days after the enactment of this section, the transfer amounts for the 1991–92 transfer year.

The transfer amounts shall be determined as follows:

(1) The eligible hospitals for 1991–92 shall be identified. For each hospital, the applicable total per diem payment adjustment amount under Section 14105.98 for the 1991–92 transfer year shall be computed. This amount shall be multiplied by 80 percent of the eligible hospital's annualized Medi-Cal inpatient paid days as determined from all Medi-Cal paid claims records available through April 1, 1991. The products of these calculations for all eligible hospitals shall be added together to determine an aggregate sum for the 1991–92 transfer year.

(2) The eligible hospitals for 1991–92 involving transferor entities as licensees shall be identified. For each hospital, the applicable total per diem payment adjustment amount under Section 14105.98 for the 1991–92 transfer year shall be computed. This amount shall be multiplied by 80 percent of the eligible hospital's annualized Medi-Cal inpatient paid days as determined from all Medi-Cal paid claims records available through April 1, 1991. The products of these calculations for all eligible hospitals with transferor entities as licensees shall be added together to determine an aggregate sum for the 1991–92 transfer year.

(3) The aggregate sum determined under paragraph (1) shall be divided by the aggregate sum determined under paragraph (2), yielding a factor to be utilized in paragraph (4).

(4) The factor determined in paragraph (3) shall be multiplied by the amount determined for each hospital under paragraph (2). The product of this calculation for each hospital in paragraph (2) shall be divided by 1.771, yielding a transfer amount for the particular transferor entity for the transfer year.

(g) For the 1991–92 transfer year, the department shall notify each transferor entity in writing of its applicable transfer amount or amounts.

(h) For the 1992–93 transfer year and subsequent transfer years, transfer amounts shall be determined in the same procedural manner as set forth in subdivision (f), except:

(1) The department shall use all of the following:

(A) The disproportionate share list applicable to the particular transfer year to determine the eligible hospitals.

(B) The payment adjustment amounts calculated under Section 14105.98 for the particular transfer year. These amounts shall take into account any projected or actual increases or decreases in the size of the payment adjustment program as are required under Section 14105.98 for the particular year in question, including any decreases resulting from the application of the OBRA 1993 payment limitation. The department may issue interim, revised, and supplemental transfer requests as necessary and appropriate to address changes in payment adjustment levels that occur under Section 14105.98. All transfer requests, or adjustments thereto, issued to transferor entities by the department shall meet the requirements set forth in subdivision (i).

(C) Data regarding annualized Medi-Cal inpatient paid days for the most recent calendar year ending prior to the beginning of the particular transfer year, as determined from all Medi-Cal paid claims records available through April 1 preceding the particular transfer year.

(D) The status of public entities as licensees of eligible hospitals as of July 1 of the particular transfer year.

(E) For the 1993–94 transfer year and subsequent transfer years, the divisor to be used for purposes of the calculation referred to in paragraph (4) of subdivision (f) shall be determined by the department. The divisor shall be calculated to ensure that the appropriate amount of transfers from transferor entities are received into the fund to satisfy the requirements of Section 14105.98, exclusive of the amounts described in paragraph (2) of this subdivision, and to satisfy the requirements of paragraph (2) of subdivision (d), for the particular transfer year. For the 1993–94 transfer year, the divisor shall be 1.742.

(F) The following provisions shall apply for certain transfer amounts relating to nonsupplemental payments under Section 14105.98:

(i) For the 1998–99 transfer year, transfer amounts shall be determined as though the payment adjustment amounts arising pursuant to subdivision (ag) of Section 14105.98 were increased by the amounts paid or payable pursuant to subdivision (af) of Section 14105.98.

(ii) Any transfer amounts paid by a transferor entity pursuant to subparagraph (C) of paragraph (2) shall serve as credit for the particular transferor entity against an equal amount of its transfer obligation for the 1998–99 transfer year.

(iii) For the 1999–2000 transfer year, transfer amounts shall be determined as though the amount to be transferred to the Health Care Deposit Fund, as referred to in paragraph (2) of subdivision (d), were reduced by 28 percent.

(2) (A) Except as provided in subparagraphs (B), (C), and (D), for the 1993–94 transfer year and subsequent transfer years, transfer amounts shall be increased for the particular transfer year in the amounts necessary to fund the nonfederal share of the total supplemental payment adjustment amounts of all types that arise under Section 14105.98. These increases shall be paid only by those transferor entities that are licensees of hospitals that are projected to receive some or all of the particular supplemental payments, and the increases shall be paid by the transferor entities on a pro rata basis in connection with the particular supplemental payments. For purposes of this paragraph, supplemental payment adjustment amounts shall be deemed to arise for the particular transfer year as of the date specified in Section 14105.98. Transfer amounts to fund the nonfederal share of the payments shall be paid for the particular transfer year within 20 days after the department notifies the transferor entity in writing of the additional transfer amount to be paid.

(B) For the 1995–96 transfer year, the nonfederal share of the secondary supplemental payment adjustments described in paragraph (9) of subdivision (y) of Section 14105.98 shall be funded as follows:

(i) Ninety-nine percent of the nonfederal share shall be funded by a transfer from the University of California.

(ii) One percent of the nonfederal share shall be funded by transfers from those public entities that are the licensees of the hospitals included in the “other public hospitals” group referred to in clauses (ii) and (iii) of subparagraph (B) of paragraph (9) of subdivision (y) of Section 14105.98. The transfer responsibilities for this 1 percent shall be allocated to the particular public entities on a pro rata basis, based on a formula or formulae customarily used by the department for allocating transfer amounts under this section. The formula or formulae shall take into account, through reallocation of transfer amounts as appropriate, the situation of hospitals whose secondary supplemental payment adjustments are restricted due to the application of the limitation set forth in clause (v) of subparagraph (B) of paragraph (9) of subdivision (y) of Section 14105.98.

(iii) All transfer amounts under this subparagraph shall be paid by the particular transferor entities within 30 days after the department notifies the transferor entity in writing of the transfer amount to be paid.

(C) For the 1997–98 transfer year, transfer amounts to fund the nonfederal share of the supplemental payment adjustments described in subdivision (af) of Section 14105.98 shall be funded by a transfer from the County of Los Angeles.

(D) (i) For the 1998–99 transfer year, transfer amounts to fund the nonfederal share of the supplemental payment adjustment amounts arising under subdivision (ah) of Section 14105.98 shall be increased as set forth in clause (ii).

(ii) The transfer amounts otherwise calculated to fund the supplemental payment adjustments referred to in clause (i) shall be increased on a pro rata basis by an amount equal to 28 percent of the amount to be transferred to the Health Care Deposit Fund for the 1999–2000 fiscal year, as referred to in paragraph (2) of subdivision (d).

(3) The department shall prepare preliminary analyses and calculations regarding potential transfer amounts, and potential transferor entities shall be notified by the department of estimated transfer amounts as soon as reasonably feasible regarding any particular transfer year. Written notices of transfer amounts shall be issued by the department as soon as possible with respect to each transfer year. All state agencies shall take all necessary steps in order to supply applicable data to the department to accomplish these tasks. The Office of Statewide Health Planning and Development shall provide to the department quarterly access to the edited and unedited confidential patient discharge data files for all Medi-Cal eligible patients. The department shall maintain the confidentiality of that data to the same extent as is required of the Office of Statewide Health Planning and Development. In addition, the Office of Statewide Health Planning and Development shall provide to the department, not later than March 1 of each year, the data specified by the department, as the data existed on the statewide database file as of February 1 of each year, from all of the following:

(A) Hospital annual disclosure reports, filed with the Office of Statewide Health Planning and Development pursuant to former Section 443.31 of, or Section 128735 of, the Health and Safety Code, for hospital fiscal years that ended during the calendar

year ending 13 months prior to the applicable February 1.

(B) Annual reports of hospitals, filed with the Office of Statewide Health Planning and Development pursuant to former Section 439.2 of, or Section 127285 of, the Health and Safety Code, for the calendar year ending 13 months prior to the applicable February 1.

(C) Hospital patient discharge data reports, filed with the Office of Statewide Health Planning and Development pursuant to former subdivision (g) of Section 443.31 of, or Section 128735 of, the Health and Safety Code, for the calendar year ending 13 months prior to the applicable February 1.

(D) Any other materials on file with the Office of Statewide Health Planning and Development.

(4) Transfer amounts calculated by the department may be increased or decreased by a percentage amount consistent with the Medi-Cal state plan.

(5) For the 1993–94 fiscal year, the transfer amount that would otherwise be required from the University of California shall be increased by fifteen million dollars ($15,000,000).

(6) Notwithstanding any other law, except for subparagraph (D) of paragraph (2), the total amount of transfers required from the transferor entities for any particular transfer year shall not exceed the sum of the following:

(A) The amount needed to fund the nonfederal share of all payment adjustment amounts applicable to the particular payment adjustment year as calculated under Section 14105.98. Included in the calculations for this purpose shall be any decreases in the program as a whole, and for individual hospitals, that arise due to the provisions of Section 1396r-4(f) or (g) of Title 42 of the United States Code.

(B) The amount needed to fund the transfers to the Health Care Deposit Fund, as referred to in subdivision (d).

(7) (A) Except as provided in subparagraphs (B) and (C) and in paragraph (2) of subdivision (j), and except for a prudent reserve not to exceed two million dollars ($2,000,000) in the Medi-Cal Inpatient Payment Adjustment Fund, any amounts in the fund, including interest that accrues with respect to the amounts in the fund, that are not expended, or estimated to be required for expenditure, under Section 14105.98 with respect to a particular transfer year shall be returned on a pro rata basis to the transferor entities for the particular transfer year within 120 days after the department determines that the funds are not needed for an expenditure in connection with the particular transfer year.

(B) The department shall determine the interest amounts that have accrued in the fund from its inception through June 30, 1995, and, no later than January 1, 1996, shall distribute these interest amounts to transferor entities:

(C) With respect to those particular amounts in the fund resulting solely from the provisions of subparagraph (D) of paragraph (2), the department shall determine by September 30, 1999, whether these particular amounts exceed 28 percent of the amount to be transferred to the Health Care Deposit Fund for the 1999–2000 fiscal year, as referred to in paragraph (2) of subdivision (d). Any excess amount so determined shall be returned to the particular transferor entities on a pro rata basis no later than October 31, 1999.

(D) Regarding any funds returned to a transferor entity under subparagraph (A) or (C), or interest amounts distributed to a transferor entity under subparagraph (B), the department shall provide to the transferor entity a written statement that explains the basis for the particular return or distribution of funds and contains the general calculations used by the department in determining the amount of the particular return or distribution of funds.

(i) (1) For the 1991–92 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in eight equal installments.

(2) (A) Except as provided in subparagraphs (B) and (C), for the 1992–93 transfer year and subsequent transfer years, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in eight equal installments. However, for the 1997–98 and subsequent transfer years, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in the form of periodic installments according to a timetable established by the department. The timetable shall be structured to effectuate, on a reasonable basis, the prompt distribution of all nonsupplemental payment adjustments under Section 14105.98, and transfers to the Health Care Deposit Fund under subdivision (d).

(B) For the 1994–95 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in five equal installments.

(C) For the 1995–96 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in five equal installments.

(D) Except as otherwise specifically provided, subparagraphs (A) to (C), inclusive, shall not apply to increases in transfer amounts described in paragraph (2) of subdivision (h) or to additional transfer amounts described in subdivision (o).

(E) All requests for transfer payments, or adjustments thereto, issued by the department shall be in writing and shall include (i) an explanation of the basis for the particular transfer request or transfer activity, (ii) a summary description of program funding status for the particular transfer year, and (iii) the general calculations used by the department in connection with the particular transfer request or transfer activity.

(3) A transferor entity may use any of the following funds for purposes of meeting its transfer obligations under this section:

(A) General funds of the transferor entity.

(B) Any other funds permitted by law to be used for these purposes, except that a transferor entity shall not submit to the Controller any federal funds unless those federal funds are authorized by federal law to be used to match other federal funds. In addition, no private donated funds from any health care provider, or from any person or organization affiliated with the health care provider, shall be channeled through a transferor entity or any other public entity to the fund, unless the donated funds will qualify under federal rules as a valid component of the nonfederal share of the Medi-Cal program and will be matched by federal funds. The transferor entity shall be responsible for determining that funds transferred meet the requirements of this subparagraph.

(j) (1) If a transferor entity does not submit any transfer amount within the time period specified in this section, the Controller shall offset immediately the amount owed against any funds which otherwise would be payable by the state to the transferor entity. The Controller, however, shall not impose an offset against any particular funds payable to the transferor entity where the offset would violate state or federal law.

(2) Where a withhold or a recoupment occurs pursuant to the provisions of paragraph (2) of subdivision (r) of Section 14105.98, the nonfederal portion of the amount in question shall remain in the fund, or shall be redeposited in the fund by the department, as applicable. The department shall then proceed as follows:

(A) If the withhold or recoupment was imposed with respect to a hospital whose licensee was a transferor entity for the particular state fiscal year to which the withhold or recoupment related, the nonfederal portion of the amount withheld or recouped shall serve as a credit for the particular transferor entity against an equal amount of transfer obligations under this section, to be applied whenever the transfer obligations next arise. Should no such transfer obligation arise within 180 days, the department shall return the funds in question to the particular transferor entity within 30 days thereafter.

(B) For other situations, the withheld or recouped nonfederal portion shall be subject to paragraph (7) of subdivision (h).

(k) All transfer amounts received by the Controller or amounts offset by the Controller shall immediately be deposited in the fund.

(l) For purposes of this section, the disproportionate share list utilized by the department for a particular transfer year shall be identical to the disproportionate share list utilized by the department for the same state fiscal year for purposes of Section 14105.98. Nothing on a disproportionate share list, once issued by the department, shall be modified for any reason other than mathematical or typographical errors or omissions on the part of the department or the Office of Statewide Health Planning and Development in preparation of the list.

(m) Neither the intergovernmental transfers required by this section, nor any elective transfer made pursuant to Section 14164 or Article 5.17 (commencing with Section 14165.55), shall create, lead to, or expand the health care funding or service obligations for current or future years for any transferor entity, except as required of the state by this section or as may be required by federal law, in which case the state shall be held harmless by the transferor entities on a pro rata basis.

(n) Except as otherwise permitted by state and federal law, no transfer amount submitted to the Controller under this section, and no offset by the Controller pursuant to subdivision (j), shall be claimed or recognized as an allowable element of cost in Medi-Cal cost reports submitted to the department.

(o) Whenever additional transfer amounts are required to fund the nonfederal share of payment adjustment amounts under Section 14105.98 that are distributed after the close of the particular payment adjustment year to which the payment adjustment amounts apply, the additional transfer amounts shall be paid by the parties who were the transferor entities for the particular transfer year that was concurrent with the particular payment adjustment year. The additional transfer amounts shall be calculated under the formula that was in effect during the particular transfer year. For transfer years prior to the 1993–94 transfer year, the percentage of the additional transfer amounts available for transfer to the Health Care Deposit Fund under subdivision (d) shall be the percentage that was in effect during the particular transfer year. These additional transfer amounts shall be paid by transferor entities within 20 days after the department notifies the transferor entity in writing of the additional transfer amount to be paid.

(p) (1) Ten million dollars ($10,000,000) of the amount transferred from the Medi-Cal Inpatient Payment Adjustment Fund to the Health Care Deposit Fund due to amounts transferred attributable to years prior to the 1993–94 fiscal year is hereby appropriated

without regard to fiscal years to the State Department of Health Care Services to be used to support the development of managed care programs under the department's plan to expand Medi-Cal managed care.

(2) These funds shall be used by the department for both of the following purposes: (A) distributions to counties or other local entities that contract with the department to receive those funds to offset a portion of the costs of forming the local initiative entity and (B) distributions to local initiative entities that contract with the department to receive those funds to offset a portion of the costs of developing the local initiative health delivery system in accordance with the department's plan to expand Medi-Cal managed care.

(3) Entities contracting with the department for any portion of the ten million dollars ($10,000,000) shall meet the objectives of the department's plan to expand Medi-Cal managed care with regard to traditional and safety net providers.

(4) Entities contracting with the department for any portion of the ten million dollars ($10,000,000) may be authorized under those contracts to utilize their funds to provide for reimbursement of the costs of local organizations and entities incurred in participating in the development and operation of a local initiative.

(5) To the full extent permitted by state and federal law, these funds shall be distributed by the department for expenditure at the local level in a manner that qualifies for federal financial participation under the Medicaid Program.

(q) (1) Any local initiative entity that has performed unanticipated additional work for the purposes identified in subparagraph (B) of paragraph (2) of subdivision (p) resulting in additional costs attributable to the development of its local initiative health delivery system, may file a claim for reimbursement with the department for the additional costs incurred due to delays in start dates through the 1996–97 fiscal year. The claim shall be filed by the local initiative entity not later than 90 days after the effective date of the act adding this subdivision, and shall not seek extra compensation for any sum that is or could have been asserted pursuant to the contract disputes and appeals resolution provisions of the local initiative entity's respective two-plan model contract. All claims for unanticipated additional incurred costs shall be submitted with adequate supporting documentation including, but not limited to, all of the following:

(A) Invoices, receipts, job descriptions, payroll records, work plans, and other materials that identify the unanticipated additional claimed and incurred costs.

(B) Documents reflecting mitigation of costs.

(C) To the extent lost profits are included in the claim, documentation identifying those profits and the manner of calculation.

(D) Documents reflecting the anticipated start date, the actual start date, and reasons for the delay between the dates, if any.

(2) In determining any amount to be paid, the department shall do all of the following:

(A) Conduct a fiscal analysis of the local initiative entity's claimed costs.

(B) Determine the appropriate amount of payment, after taking into consideration the supporting documentation and the results of any audit.

(C) Provide funding for any such payment, as approved by the Department of Finance through the deficiency process.

(D) Complete the determination required in subparagraph (B) within six months after receipt of a local initiative entity's completed claim and supporting documentation. Prior to final determination, there shall be a review and comment period for that local initiative entity.

(E) Make reasonable efforts to obtain federal financial participation. In the event federal financial participation is not allowed for this payment, the state's payment shall be 50 percent of the total amount determined to be payable.

(r) Notwithstanding any other law, the Controller may use the moneys in the Medi-Cal Inpatient Payment Adjustment Fund for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. However, interest shall be paid on all moneys loaned to the General Fund from the Medi-Cal Inpatient Payment Adjustment Fund. Interest payable shall be computed at a rate determined by the Pooled Money Investment Board to be the current earning rate of the fund from which loaned. This subdivision does not authorize any transfer that will interfere with the carrying out of the object for which the Medi-Cal Inpatient Payment Adjustment Fund was created.

(Amended by Stats. 2011, Ch. 20, Sec. 1. (AB 113) Effective April 13, 2011.)

14164. (a) In addition to the required intergovernmental transfers set forth in Section 14163, any county, other political subdivision of the state, or governmental entity in the state may elect to transfer funds, subject to subdivision (m) of Section 14163, to the department in support of the Medi-Cal program. Those transfers may consist of cash or loans to the state. The department shall have the discretion to accept or not accept any elective transfer from a county, political subdivision, or other governmental entity, as

well as the discretion of whether to deposit the transfer in the Medi-Cal Inpatient Payment Adjustment Fund established pursuant to Section 14163. If the department accepts a transfer pursuant to this section, the department shall obtain federal matching funds to the full extent permitted by federal law.

(b) (1) The director may maximize available federal financial participation to provide access to services provided by hospitals that are not reimbursed by certified public expenditure pursuant to Article 5.2 (commencing with Section 14166) by authorizing the use of intergovernmental transfers to fund the nonfederal share of supplemental payments as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws. The transferring entity shall certify to the department that the funds are in compliance with all federal rules and regulations. Any payments funded by intergovernmental transfers shall remain with the hospital and shall not be transferred back to any county, other political subdivision of the state, or governmental entity in the state, except for federal disallowance or withhold recovery efforts by the department. Participation in intergovernmental transfers under this subdivision is voluntary on the part of the transferring entity for purposes of all applicable federal laws.

(2) This subdivision shall be implemented only to the extent federal financial participation is not jeopardized.

(Amended by Stats. 2013, Ch. 657, Sec. 1. (SB 239) Effective October 8, 2013.)