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WELFARE AND INSTITUTIONS CODE - WIC

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

PART 5. COUNTY AID AND RELIEF TO INDIGENTS [17000 - 17613.4] (*Part 5 added by Stats. 1965, Ch. 1784.*)

CHAPTER 6. State and Local Fund Allocations [17600 - 17613.4] (*Chapter 6 added by Stats. 1991, Ch. 89, Sec. 201.5.*)

ARTICLE 12. Redirection of Realignment [17612.1 - 17612.8] (*Article 12 added by Stats. 2013, Ch. 24, Sec. 20.*)

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

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

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

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

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

(Amended by Stats. 2019, Ch. 67, Sec. 11. (SB 104) Effective July 9, 2019.)

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

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

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

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

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

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

(3) A weighted average annual percentage change for each year-to-year period shall be calculated from the determinations made in paragraph (2), with the percentage changes in the Hospital and Related Services Index weighted at 75 percent, and the

percentage changes in the Medical Care Services Index weighted at 25 percent. The resulting average annual percentage changes shall be expressed as a fraction, and increased by 1.00.

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

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

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

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

(B) The public hospital health system county's Medi-Cal costs, uninsured costs, and imputed other entity intergovernmental transfer amounts for the base year shall be added together and multiplied by the blended CPI trend factor. The base year costs used shall not reflect any adjustments under this subdivision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) "Health realignment indigent care percentage" means the county-specific percentage determined in accordance with the following, and established in accordance with the procedures described in subdivision (c) of Section 17612.3.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(s) "Newly eligible beneficiaries" means individuals who meet the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)) such that expenditures for services provided to the individual are eligible for the enhanced federal medical assistance percentage described in that section.

(t) "Other entity intergovernmental transfer amount" means the amount of intergovernmental transfers by a county public hospital health system or affiliated governmental entities, and accepted by the department, that are for the nonfederal share of Medi-Cal payments or Medicaid demonstration payments for the fiscal year to any Medi-Cal provider other than the county public hospital health system, or to a Medi-Cal managed care plan for services rendered by those other providers, and any related fees imposed by the state on those transfers.

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

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

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

(1) Assessments and fees restricted for health-related purposes. The amount of the assessment or fee for this purpose shall be the greater of subparagraph (A) or (B). If, because of restrictions and limitations applicable to the assessment or fee, the county public hospital health system cannot expend this amount, this amount shall be reduced to the amount actually expended.

(A) The amount of the assessment or fee expended by the county public hospital health system for the provision of health services to Medi-Cal and uninsured beneficiaries during the fiscal year.

(B) The amount of the assessment or fee multiplied by the average of the percentages of the amount of assessment or fees that were allocated to and expended by the county public hospital health system for health services to Medi-Cal and uninsured beneficiaries during the historical fiscal years. The percentages for the historical fiscal years shall be determined by dividing the amount allocated in each fiscal year as described in subparagraphs (B) and (C) of paragraph (2) of subdivision (ab) by the actual amount of assessment or fee expended in the fiscal year.

(2) Funds available pursuant to the Master Settlement Agreement and related documents entered into on November 23, 1998, by the state and leading United States tobacco product manufacturers during a fiscal year. The amount of the tobacco settlement funds that may be used for this purpose shall be the greater of subparagraph (A) or (B), less any bond payments and other costs of securitization related to the funds described in this paragraph.

(A) The amount of the funds expended by the county public hospital health system for the provision of health services to Medi-Cal and uninsured beneficiaries during the fiscal year.

(B) The amount of the tobacco settlement funds multiplied by the average of the percentages of the amount of tobacco settlement funds that were allocated to and expended by the county public hospital health system for health services to Medi-Cal and uninsured beneficiaries during the historical fiscal years. The percentages for the historical fiscal years shall be determined by dividing the amount allocated in each fiscal year as described in subparagraphs (B) and (C) of paragraph (2) of subdivision (ab) by the actual amount of tobacco settlement funds expended in the fiscal year.

(x) "Subsequent demonstration project" means the federally approved Medicaid demonstration project implemented after the termination of the federal Medicaid demonstration project authorized under Section 1115 of the federal Social Security Act entitled the "Bridge to Health Care Reform" (waiver number 11-W-00193/9), the extension of that demonstration project, or the material amendment to that demonstration project.

(y) "Uninsured costs" means the costs incurred by the public hospital health system county and its affiliated government entities for purchasing, providing, or ensuring the availability of services to uninsured patients during the fiscal year. Uninsured costs shall be determined in a manner consistent with the cost claiming protocols developed for the federal Medicaid demonstration project authorized under Section 1115 of the federal Social Security Act entitled the "Bridge to Health Care Reform" (waiver number 11-W-00193/9), including protocols pending federal approval, and under Section 14166.8, and, in consultation with each county, shall be based on any other cost reporting and statistical data necessary for an accurate determination of actual costs incurred. For this purpose, no reduction factor applicable to otherwise allowable costs under the demonstration project or the subsequent demonstration project shall apply. Uninsured costs shall exclude costs for nursing facility, mental health, and substance use disorder services.

(z) "Uninsured patients" means individuals who have no source of third-party coverage for the specific service furnished, as further defined in the reporting requirements established pursuant to Section 17612.4.

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

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

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

demonstration payments. The revenues shall be subtracted from the costs, yielding the initial low-income shortfall for each of the historical fiscal years.

(2) The following shall be applied in sequential order against, but shall not exceed in the aggregate, the initial low-income shortfall determined in paragraph (1) for each of the historical fiscal years:

(A) First, the county indigent care health realignment amount shall be applied 100 percent against the initial low-income shortfall.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Amended by Stats. 2019, Ch. 67, Sec. 12. (SB 104) Effective July 9, 2019.)

17612.3. (a) For each fiscal year, commencing with the 2013–14 fiscal year, the amount to be redirected in accordance with Section 17612.1 shall be determined for each public hospital health system county as follows:

(1) The public hospital health system county's revenues and other funds paid or payable for the state fiscal year shall be comprised of the total of the following:

(A) Medi-Cal revenues.

(B) Uninsured revenues.

(C) Medicaid demonstration revenues.

(D) Hospital fee direct grants.

(E) Special local health funds.

(F) The county indigent care health realignment amount.

(G) The imputed county low-income health amount.

(H) Imputed gains from other payers.

(I) The amount by which the public hospital health system county's costs exceeded the cost containment limit for the fiscal year, expressed as a negative number, multiplied by 0.50.

(2) The following, incurred by the public hospital health system county for the fiscal year, not to exceed in total the cost containment limit, shall be subtracted from the sum in paragraph (1):

(A) Medi-Cal costs.

(B) Uninsured costs.

(C) The lesser of the other entity intergovernmental transfer amount or the imputed other entity intergovernmental transfer amounts.

(D) New mandatory other entity intergovernmental transfer amounts.

(3) The resulting amount determined in paragraph (2) shall be multiplied by 0.80, except that for the 2013–14 fiscal year the resulting amount determined in paragraph (2) shall be multiplied by 0.70.

(4) If the amount in paragraph (3) is a positive number, that amount, subject to paragraph (5), shall be redirected in accordance with Section 17612.1, except that for the 2013–14 fiscal year the amount to be redirected shall not exceed the amount determined for the county for the 2013–14 fiscal year under subdivision (c) of Section 17603, as that amount may have been reduced by the application of Section 17610.5. If the amount determined in paragraph (3) is a negative number, the redirected amount shall be zero.

(5) Notwithstanding any other law, the amount to be redirected as determined in paragraph (4) for any fiscal year shall not exceed the county indigent care health realignment amount for that fiscal year.

(6) (A) The redirected amount shall be applied until the later of the following:

(i) June 30, 2023.

(ii) The beginning of the fiscal year following a period of two consecutive fiscal years in which both of the following occur:

(I) The total interim amount determined under subdivision (b) in May of the previous fiscal year is within 10 percent of the final, reconciled amount in subdivision (d).

(II) The final, reconciled amounts under subdivision (d) are within 5 percent of each other.

(B) After the redirected amount ceases as provided in subparagraph (A), a permanent redirected amount shall be established to be an amount determined by calculating the percentage that the redirected amount was in the last fiscal year of the operation of this article of the county's health realignment amount of that same fiscal year, multiplied by the county's health realignment amount of all subsequent years.

(b) Commencing with the 2014–15 fiscal year, the department shall calculate an interim redirected amount for each public hospital health system county under subdivision (a) by the January immediately prior to the starting fiscal year, using the most recent and accurate data available. For purposes of the interim determinations, the cost containment limit shall not be applied. The interim redirected amount shall be updated in the May before the start of the fiscal year in consultation with each public hospital health system county and based on any more recent and accurate data available at that time. During the fiscal year, the interim redirected amount will be applied pursuant to Section 17612.1.

(c) The predetermined amounts or historical percentages described in subdivisions (i), (l), (m), (n), and (w) of Section 17612.2 shall each be established in accordance with the following procedure:

(1) By October 31, 2013, each public hospital health system county shall determine the amount or percentage described in the applicable subdivision, and shall provide this calculation to the department, supported by verifiable data and a description of how the determination was made.

(2) If the department disagrees with the public hospital health system county's determination, the department shall confer with the public hospital health system county by December 15, 2013, and shall issue its determination by January 31, 2014.

(3) If no agreement between the parties has been reached by January 31, 2014, the department shall apply the county's determination when making the interim calculations pursuant to subdivision (b), until a decision is issued pursuant to paragraph (6).

(4) If no agreement between the parties has been reached by January 31, 2014, the public hospital health system county shall submit a petition by February 28, 2014, to the County Health Care Funding Resolution Committee, established pursuant to Section 17600.60, to seek a decision regarding the historical percentage or amount to be applied in calculations under this section.

(5) The County Health Care Funding Resolution Committee shall hear and make a determination as to whether the county's proposed percentage or amount complies with the requirements of this section taking into account the data and calculations of the county and any alternative data and calculations submitted by the department.

(6) The committee shall issue its final determination within 45 days of the petition. If the county chooses to contest the final determination, the final determination of the committee will be applied for purposes of any interim calculation under subdivision (b) until a final decision is issued pursuant to de novo administrative review pursuant to paragraph (2) of subdivision (d).

(d) (1) The data for the final calculations under subdivision (a) for the fiscal year shall be submitted by public hospital health system counties within 12 months after the conclusion of each fiscal year as required in Section 17612.4. The data shall be the most recent and accurate data from the public hospital health system county's books and records pertaining to the revenues paid or payable, and the costs incurred, for services provided in the subject fiscal year. After consulting with the county, the department shall make final calculations using the data submitted pursuant to this paragraph by December 15 of the following fiscal year, and shall provide its final determination to the county. The final determination will also reflect the application of the cost containment limit, if any. If the

county and the department agree, a revised recalculation and reconciliation may be completed by the department within six months thereafter.

(2) The director shall establish an expedited formal appeal process for a public hospital health system county to contest final determinations made under this article. No appeal shall be available for interim determinations made under subdivision (b). The appeals process shall include all of the following:

(A) The public hospital health system county shall have 30 calendar days, following the issuance of a final determination made under paragraph (6) of subdivision (c) or paragraph (1) of this subdivision, to file an appeal with the Director of Health Care Services. All appeals shall be governed by Section 100171 of the Health and Safety Code, except for those provisions of paragraph (1) of subdivision (d) of Section 100171 of the Health and Safety Code relating to accusations, statements of issues, statement to respondent, and notice of defense, and except as otherwise set forth in this section. All appeals shall be in writing and shall be filed with the State Department of Health Care Service's Office of Administrative Hearings and Appeals. An appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals.

(i) An appeal shall specifically set forth each issue in dispute, which may include any component of the determination, and include the public hospital health system county's contentions as to those issues. A formal hearing before an Office of Administrative Hearings and Appeals Administrative Law Judge shall commence within 60 days of the filing of the appeal requesting a formal hearing. A final decision under this paragraph shall be adopted no later than six months following the filing of the appeal.

(ii) If the public hospital health system county fails to file an appeal within 30 days of the issuance of a determination made under this section, the determination of the department shall be deemed final and not appealable either administratively or to a court of general jurisdiction, except that a county may elect to appeal a determination under subdivision (c) within 30 days of the issuance of the County Health Care Funding Resolution Committee's final determination under paragraph (6) of subdivision (c) or as a component of an appeal of the department's final determination under paragraph (1) of this subdivision for the 2013–14 fiscal year.

(B) If a final decision under this paragraph is not issued by the department within two years of the last day of the subject fiscal year, the public hospital health system county shall be deemed to have exhausted its administrative remedies and shall not be precluded from pursuing any available judicial review. However, the time period in this subdivision shall be extended by either of the following:

(i) Undue delay caused by the public hospital health system county.

(ii) An extension of time granted to a public hospital health system county at its sole request, or following the joint request of the public hospital health system county and the department.

(C) If the final decision issued by the department pursuant to this paragraph results in a different determination than that originally determined by the department, then the Department of Finance shall adjust the original determination by that amount, pursuant to a process developed by the Department of Finance and in consultation with the public hospital health system counties.

(e) For purposes of this article, all references to "health services" or "health care services," unless specified otherwise, shall exclude nursing facility, mental health, and substance use disorder services.

(Amended by Stats. 2014, Ch. 71, Sec. 204. (SB 1304) Effective January 1, 2015.)

17612.4. (a) Beginning with the 2013–14 state fiscal year, each county that has elected to participate in the County Savings Determination Process shall, within five months after the end of each fiscal year, submit initial reports including all of the following:

(1) All revenue data required for the operation of Section 17612.3, including all of the following:

(A) Medi-Cal revenues.

(B) Uninsured revenues.

(C) Medicaid demonstration revenues.

(D) Hospital fee direct grants.

(E) Special local health funds.

(2) All cost data required for the operation of Section 17612.3, including all of the following:

- (A) Medi-Cal costs.
- (B) Uninsured costs.
- (C) Other entity intergovernmental transfer amounts.
- (D) New mandatory other entity intergovernmental transfer amounts.

(b) Notwithstanding paragraph (2) of subdivision (a), a county that reports data to the department pursuant to Section 14166.8 is only required to report cost data under this section to the extent not already reported to the department pursuant to Section 14166.8 for a given fiscal year.

(c) Counties shall submit final reports of cost and revenue data identified in paragraphs (1) and (2) of subdivision (a) to the department for each fiscal year no later than June 30 of the fiscal year ending one year after the subject fiscal year.

(d) The department shall develop, in consultation with counties, the methodologies used to determine the costs and revenues required to be reported and the format of those submissions.

(e) Reports submitted under this section shall be accompanied by a certification by an appropriate local public official attesting to the accuracy of the reports.

(Added by Stats. 2013, Ch. 24, Sec. 20. (AB 85) Effective June 27, 2013.)

17612.5. (a) For the 2013–14 fiscal year and each year thereafter, the amount to be redirected in accordance with Section 17612.1 for the County of Los Angeles shall be determined in accordance with Section 17612.3, except that the formula in subdivision (a) of Section 17612.3 shall be replaced with the following formula:

(1) The total revenues as defined in paragraph (7) of subdivision (b) paid or payable to the County of Los Angeles, Department of Health Services, for the fiscal year, which shall include special local health funds and as adjusted in accordance with Section 17612.6, shall be added together.

(2) The sum of three hundred twenty-three million dollars (\$323,000,000), which represents the imputed county low-income health amount trended annually by 1 percent from the 2012–13 fiscal year through the applicable fiscal year, and the county indigent care health realignment amount, as determined in accordance with subdivision (e) of Section 17612.2 for the fiscal year.

(3) The amount by which the county's total costs exceeded the cost containment limit for the fiscal year, expressed as a negative number, multiplied by 0.50.

(4) (A) The total costs, as defined in paragraph (6) of subdivision (b), incurred by or on behalf of the County of Los Angeles, Department of Health Services, for the fiscal year shall be added together, but shall not exceed the cost containment limit determined in accordance with paragraph (3) of subdivision (b).

(B) The costs in paragraph (A) shall be subtracted from the sum of paragraphs (1) to (3), inclusive.

(5) The resulting amount determined in subparagraph (B) of paragraph (4) shall be multiplied by 0.80, except that for the 2013–14 fiscal year, the resulting amount determined in subparagraph (B) of paragraph (4) shall be multiplied by 0.70.

(6) If the amount in paragraph (5) is a positive number, that amount, subject to paragraph (7), shall be redirected in accordance with Section 17612.1 of this article, except that for the 2013–14 fiscal year the amount to be redirected shall not exceed the amount determined for the County of Los Angeles for the 2013–14 fiscal year under subdivision (c) of Section 17603, as that amount may have been reduced by the application of Section 17610.5. If the amount determined in paragraph (5) is a negative number, the redirected amount shall be zero.

(7) Notwithstanding any other law, the amount to be redirected as determined in paragraph (6) for any fiscal year shall not exceed the county indigent care health realignment amount for that fiscal year.

(8) (A) The redirected amount shall be applied until the later of:

(i) June 30, 2023.

(ii) The beginning of the fiscal year following a period of two consecutive fiscal years that both of the following occur:

(I) The total interim amount determined under subdivision (b) of Section 17612.3 in May of the previous fiscal year is within 10 percent of the final, reconciled amount in subdivision (d) of that section.

(II) The final, reconciled amounts under subdivision (d) of Section 17612.3 are within 5 percent of each other.

(B) After the redirected amount ceases as provided in subparagraph (A), a permanent redirected amount shall be established to be an amount determined by calculating the percentage that the redirected amount was in the last fiscal year of the operation of this article of the county's health realignment amount of that same fiscal year, multiplied by the county's health realignment amount of all subsequent years.

(b) Except as otherwise provided in this section, the definitions in Section 17612.2 apply. For purposes of this section, and for purposes of the calculations in Section 17612.3 that apply to the County of Los Angeles, the following definitions apply:

(1) "Adjusted patient day" means LA County DHS's total number of patient days multiplied by the following fraction: the numerator that is the sum of the county public hospital health system's total gross revenue for all services provided to all patients, including nonhospital services, and the denominator that is the sum of the county public hospital health system's gross inpatient revenue. The adjusted patient days shall pertain to those services that are provided by the LA County DHS, and shall exclude services that are provided by contract or out-of-network clinics or hospitals. For purposes of this paragraph, gross revenue shall be adjusted as necessary to reflect the relationship between inpatient costs and charges and outpatient costs and charges.

(2) "Blended CPI trend factor" means the blended percent change applicable for the state fiscal year that is derived from the nonseasonally adjusted Consumer Price Index for All Urban Consumers (CPI-U), United States City Average, for Hospital and Related Services, weighted at 90 percent, and for Medical Care Services, weighted at 10 percent, all as published by the United States Bureau of Labor Statistics, computed as follows:

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

(B) The year-to-year percentage changes in the annual averages determined in subparagraph (A) for each of the Hospital and Related Services Index and the Medical Care Services Index shall be determined.

(C) A weighted average annual percentage change for each year-to-year period shall be calculated from the determinations made in subparagraph (B), with the percentage changes in the Hospital and Related Services Index weighted at 90 percent, and the percentage changes in the Medical Care Services Index weighted at 10 percent. The resulting average annual percentage changes shall be expressed as a fraction, and increased by 1.00.

(D) The product of the successive year-to-year amounts determined in subparagraph (C) shall be the blended CPI trend factor.

(3) "Cost containment limit" means the LA County DHS's total costs determined for the 2014–15 fiscal year and each subsequent fiscal year adjusted as follows:

(A) The County of Los Angeles will be deemed to comply with the cost containment limit if the county demonstrates that its total costs for the fiscal year did not exceed its total costs in the base year, multiplied by the blended CPI trend factor for the fiscal year as reflected in the annual report of financial transactions required to be submitted to the Controller pursuant to Section 53891 of the Government Code. If the total costs for the fiscal year exceeded the total cost in the base year, multiplied by the blended CPI trend factor for the fiscal year, the calculation in subparagraph (B) shall be performed.

(B) (i) If the number of adjusted patient days of service provided by LA County DHS for the fiscal year exceeds its number of adjusted patient days of service rendered in the base year by at least 10 percent, the excess adjusted patient days above the base year for the fiscal year shall be multiplied by the cost per adjusted patient day of the public hospital health system for the base year. The result shall be added to the trended base year amount determined in subparagraph (A), yielding the applicable cost containment limit, subject to subparagraph (C). Costs per adjusted patient day shall be based upon only those LA County DHS costs incurred for patient care services.

(ii) If the number of adjusted patient days of service provided by LA County DHS for the fiscal year does not exceed its number of adjusted patient days of service rendered in the base year by at least 10 percent, the applicable limit is the trended base year amount determined in subparagraph (A) subject to subparagraph (C).

(C) If LA County DHS's total costs for the fiscal year, as determined in subparagraph (A), exceeds the trended cost as determined in subparagraph (A) as adjusted by subparagraph (B), the following cost increases shall be added to and reflected in any cost containment limit:

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

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

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

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

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

(vi) The total amount of any intergovernmental transfer for the nonfederal share of Medi-Cal payments to the hospital facility described in subdivision (f) of Section 14165.50.

(D) If LA County DHS's total costs for the fiscal year exceed the trended costs as adjusted by subparagraphs (B) and (C), the county may request that the department consider other costs as adjustments to the cost containment limit, including, but not limited to, transfer amounts in excess of the imputed other entity intergovernmental transfer amount trended by the blended CPI trend factor, costs related to case mix index increases, pension costs, expanded medical education programs, increased costs in response to delivery system changes in the local community, and system expansions, including capital expenditures necessary to ensure access to and the quality of health care. Costs approved by the department shall be added to and reflected in the cost containment limit.

(4) "Health realignment indigent care percentage" means 83 percent.

(5) "Special local health funds" means both of the following:

(A) The total amount of assessments and fees restricted for health-related purposes that are received by LA County DHS and expended for health services during the fiscal year.

(B) Ninety-one percent of the funds actually received by the County of Los Angeles during the fiscal year pursuant to the Master Settlement Agreement and related documents entered into on November 23, 1998, by the state and leading United States tobacco product manufacturers, less any bond payments and other costs of securitization related to the funds described in this paragraph.

(6) "Total costs" means the actual net expenditures, excluding encumbrances, for all operating budget units of the LA County DHS. Operating budget units consist of four Hospital Enterprise Funds plus the LA County DHS's budget units within the county general fund. Net expenditures, excluding encumbrances, are those recognized within LA County DHS, net of intrafund transfers, expenditure distributions, and all other billable services recorded from and to the LA County DHS enterprise funds and the LA County DHS general fund budget units, determined based on its central accounting system known as eCAPS, as of November 30 of the year following the fiscal year, and shall include the new mandatory other entity intergovernmental transfer amounts, as defined in subdivision (ad) of Section 17612.2, and the lesser of other entity intergovernmental transfer amounts or the imputed other entity intergovernmental transfer amounts.

(7) "Total revenues" means the sum of the revenue paid or payable for all operating budget units of the LA County DHS determined based on its central accounting system known as eCAPS, as of November 30 of the year following the fiscal year.

(8) "LA County DHS" means operating budget units consisting of four hospital enterprise funds plus the DHS budget units within the county's general fund.

(Amended by Stats. 2014, Ch. 71, Sec. 205. (SB 1304) Effective January 1, 2015.)

17612.6. (a) For purposes of this section, the following definitions shall apply:

(1) "Type A payers" means the following sources of revenue for amounts paid to the County of Los Angeles, Department of Health Services:

(A) Title XVIII of the federal Social Security Act, known as the Medicare program.

(B) Commercial health insurance.

(C) Health care coverage for providers of in-home supportive services, consistent with Article 7 (commencing with Section 12300) of Chapter 3 and Chapter 7 (commencing with Section 14000) of Part 3 of Division 9.

(2) "Type B payers" means the following sources of revenue for amounts paid to the County of Los Angeles, Department of Health Services:

(A) Patient care revenues received for services provided to other county departments.

(B) State payments for patient financial services workers.

(C) Other federal payers, not including federal grants, Medicare, Medicaid, and payments pursuant to Section 1011 of the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173).

(3) "Historical Base Type A revenues" means revenues from Type A payers in the historical fiscal years, calculated as follows:

(A) For each historical fiscal year, the actual revenue received from Type A payers.

(B) Calculate the average of the historical year's amounts in subparagraph (A). This average shall be considered the historical Base Type A revenues.

(4) "Historical Base Type B revenues" means revenues from Type B payers in the historical fiscal years, calculated as follows:

(A) For each historical fiscal year, the actual revenue received from Type B payers.

(B) Calculate the average of the historical years amounts in subparagraph (A). This average shall be considered the historical Base Type B revenues.

(5) "Type A payer revenue" means the amount of revenue that is the greater of the following:

(A) The amount of the revenue received from Type A payers for services rendered during the fiscal year.

(B) The historical Base Type A revenues, as adjusted by the Type A adjustment, defined in paragraph (8).

(6) "Type B payer revenue" means the amount of revenue that is the greater of the following:

(A) The amount of the revenue received from Type B payers for services rendered during the fiscal year.

(B) The historical Base Type B revenues.

(7) "Baseline Type A payer costs" means the average of the costs of services provided to Type A payer patients rendered in each of the four historical fiscal years to be determined as follows:

(A) For each historical year, the actual costs incurred in providing services to Type A payer patients.

(B) Calculate the average of the historical fiscal year amounts in subparagraph (A), this average shall be considered the baseline Type A payer costs.

(8) "Type A adjustment" means the value of the revenue adjustment to historical base Type A revenues as defined in paragraph (3).

(A) This adjustment will occur only if the Type A payer revenue for the fiscal year is less than historical base, otherwise the adjustment is considered to be zero.

(B) If the requirement in subparagraph (A) is met, then there will only be an adjustment if one or more of the specified Type A payers' data meets all of the following conditions:

(i) The Type A payer revenue for the fiscal year is less than the historical base.

(ii) The Type A payer costs for the fiscal year are less than the historical base trended by the blended CPI trend factor.

(iii) The Type A payer volume for the fiscal year is less than the historical base.

(C) For each Type A payer that meets all the conditions in subparagraph (B) the adjustment to the Type A payer revenue for that Type A payer will be as follows:

(i) Calculate the percentage decrease in cost from the baseline Type A payer cost as trended by the blended CPI trend factor as defined in paragraph (2) of subdivision (b) of Section 17612.5 and applied from the 2010–11 fiscal year to the subject fiscal year.

(ii) Calculate the percentage decrease in volume, based on the adjusted patient days, from the baseline Type A payer volume to the subject fiscal year.

(iii) Calculate the average of the percentages in clauses (i) and (ii).

(iv) The percentage reduction in clause (iii) shall be applied to the historical Base Type A payer revenue for the individual Type A payer.

(b) The Type A payer revenues included in the total revenues in subdivision (a) of Section 17612.5 shall be the greater of the adjusted historical Type A baseline or the actual revenues received from Type A payers for services rendered in the subject fiscal year.

(c) The Type B payer revenues included in the total revenues in subdivision (a) of Section 17612.5 shall be the greater of the historical Base Type B revenues or the actual revenues received from Type B payers for services rendered in the subject fiscal year.

(Amended by Stats. 2013, Ch. 358, Sec. 21. (SB 98) Effective September 26, 2013.)

17612.65. Notwithstanding the provisions of subdivision (d) of Section 17612.3 that require final reconciliation to occur within two years after the close of the fiscal year, if, subsequent to final reconciliation, payments to a county public hospital health system under the federal Medicaid demonstration project authorized by Section 1115 of the federal Social Security Act entitled the "Bridge to Health Care Reform" (waiver number 11-W-00193/9) or subsequent demonstration project are reduced or recouped based on the department's failure to meet the applicable budget neutrality limit on Medicaid funding or similar requirements contained in the applicable demonstration project Special Terms and Conditions, the redirected amount for the affected fiscal years shall be recalculated under subdivision (a) of Section 17612.3 to reflect the reduction in Medicaid demonstration revenues. The resulting reduction in the redirected amount for each affected year shall be refunded to the affected public hospital health system county in a manner to be agreed upon by the county and the Department of Finance.

(Added by Stats. 2013, Ch. 24, Sec. 20. (AB 85) Effective June 27, 2013.)

17612.7. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this article by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions.

(Added by Stats. 2013, Ch. 24, Sec. 20. (AB 85) Effective June 27, 2013.)

17612.8. The department shall submit an application to the federal Centers for Medicare and Medicaid Services for a subsequent demonstration project, as defined in subdivision (x) of Section 17612.2. The subsequent demonstration project shall seek to maximize federal Medicaid funding for county public hospital health systems and shall include components that maintain a comparable level of support for delivery system reform in the county public hospital health systems as was provided under the federal Medicaid demonstration project authorized under Section 1115 of the federal Social Security Act entitled the "Bridge to Health Care Reform" (waiver number 11-W-00193/9).

(Added by Stats. 2013, Ch. 24, Sec. 20. (AB 85) Effective June 27, 2013.)