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CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 1383

Introduced by Assembly Member Jones
(Principal coauthor: Senator Alquist)
(Coauthor: Assembly Member De Leon)

February 27, 2009

An act to add and repeal Articles 5.21 (commencing with Section 14167.1) and 5.22 (commencing with Section 14167.31) of, Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to Medi-Cal, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 1383, as amended, Jones. Medi-Cal: hospitals: supplemental payments: coverage dividend fee.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. Under existing law, the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, specified hospital reimbursement methodologies are applied in order to maximize the use of federal funds consistent with federal

Medicaid law and stabilize the distribution of funding for hospitals that provide care to Medi-Cal beneficiaries and uninsured patients.

This bill would require the department to pay specified hospitals *and Medi-Cal managed health care plans* supplemental amounts for certain hospital services provided on or before December 31, 2010. ~~This bill would require the supplemental payments to be made to hospitals at certain specified dates depending upon the federal fiscal year for which the payments are being made.~~

~~This bill would prohibit the payment rates for specified hospitals for certain services furnished before October 1, 2011, exclusive of amounts payable pursuant to this bill, from being reduced below the rates in effect on June 30, 2008. The bill would also prohibit the payment rates for hospital inpatient services furnished before October 1, 2011, under contracts negotiated pursuant to specified provisions of existing law, from being reduced below the contract rates in effect on June 1, 2009.~~

This bill would require the Director of Health Care Services to promptly seek the federal approvals, waivers, waiver modifications, and any other federal action that may be necessary to implement the ~~bill~~ *above-described supplemental payment provisions*. The bill would, on or before June 30, 2009, require *that* the director ~~to submit~~ *have submitted* any Medicaid state plan amendment necessary to implement the *supplemental payment* provisions of this bill for some or all of the federal fiscal year ending September 30, 2009. The bill would separately require the director to submit a Medicaid state plan amendment request on or before September 30, 2009, to implement the *supplemental payment* provisions of this bill for some or all of the period beginning October 1, 2009, and ending December 31, 2010. ~~The~~

The bill would ~~also~~ require the director to request from the federal government certain written assurances from the Secretary of the United States Department of Health and Human Services. ~~The bill provides that the supplemental payment provisions shall not be implemented unless and until the written assurances are obtained from the federal government.~~

~~The bill would repeal the provisions regarding the supplemental payments on the earlier of January 1, 2013, or the date the director executes a declaration stating that a final judicial or administrative determination has been made, as specified, that any of the above provisions cannot be implemented.~~

This bill would ~~require the department to calculate and~~ impose a coverage dividend fee on certain hospitals starting on the date that the

bill becomes effective and continue through and, including December 31, 2010, as specified. This bill would require the director to seek federal approval of the fee ~~and provides that if approval is denied, the provisions regarding the fee shall become inoperative~~. The bill would provide that no hospital shall be required to pay the coverage dividend fee to the department ~~unless and~~ until the state receives and maintains federal approval of the fee *and the above-described supplemental payments* from the federal Centers for Medicare and Medicaid Services.

~~This bill would provide that for calendar quarters prior to federal approval of the fee and for the calendar quarter when the department receives notice of federal approval, a hospital shall certify to the best of its knowledge, on a form provided by the department, that it is prepared to pay an amount equal to the coverage dividend fee for that hospital, as specified. The bill would require hospitals, within a specified period of time depending upon when the fee was assessed, to pay the principal amount of the coverage dividend fee it certified that it was prepared to pay to the department, as specified.~~

~~This bill would require the department, within 10 days of receiving federal approval, to send notice to providers, and publish on its Internet Web site, certain information regarding the coverage dividend fee. This bill would require, upon federal approval, that within 45 days following the beginning of each calendar quarter, commencing with the quarter in which the department receives federal approval and ending with, and including, the calendar quarter ending December 31, 2010, each hospital pay the department the coverage dividend fee, as specified. This bill would authorize the department, if a hospital fails to pay all or part of the coverage dividend fee within 60 days of the date that payment is due, to deduct the unpaid assessment and interest owed from any Medi-Cal payments to the hospital until the full amount is recovered.~~

~~This bill would create the Coverage Dividend Revenue Fund in the State Treasury and require the money collected from the coverage dividend fee to be deposited into the fund. The money in the fund would be continuously appropriated without regard to fiscal year to the department for the purpose of making the above-described supplemental reimbursement or expanding health care coverage for children, with the supplemental reimbursement taking priority over the expansion of health care coverage for children.~~

~~This bill would authorize the department, in consultation with the hospital community, to modify any methodology regarding the supplemental payments or the coverage dividend fee to the extent~~

~~necessary to meet the requirements of federal law or regulations or to obtain federal approval, provided modifications do not violate the intent of the provisions of this bill and are not inconsistent with specified conditions of implementation.~~

~~The bill would repeal the provisions regarding the coverage dividend fee on the earlier of January 1, 2013, or the date the director executes a declaration stating either that any of specified conditions have not been met, the date that a final judicial or administrative determination has been made, as specified, that the coverage dividend fee cannot be implemented, or that federal approval for the fee has been denied.~~

This bill would provide that the funds collected from the coverage dividend fee, and any matching federal funds, shall only be used for certain purposes, including providing the above-described supplemental payments and health care coverage for children.

This bill would provide that its provisions shall become inoperative during specified periods if the federal Centers for Medicare and Medicaid Services deny approval for, or do not approve before January 1, 2012, the implementation of the supplemental payment or the coverage dividend fee during those periods and the above-described provisions cannot be modified by the department in order to meet the requirements of federal law or to obtain federal approval.

This bill provides that it is the intent of the Legislature to enact additional legislation that will specify more precisely the calculation of the supplemental payment to individual hospitals and the amount of the coverage dividend fee due from individual hospitals. The bill provides that no supplemental payment shall be paid or coverage dividend fee made due or payable until the ~~above-described~~ *additional* legislation has been enacted. *If the additional legislation is not enacted, and becomes effective, by October 1, 2009, the bill would provide that its provisions shall be repealed on October 1, 2009, but if the additional legislation is enacted, and becomes effective, by October 1, 2009, the bill would provide that its provisions shall be repealed on October 1, 2009.*

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ⅔. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Article 5.21 (commencing with Section 14167.1) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.21. Medi-Cal Hospital Provider Rate Stabilization Act

14167.1. (a) "Current Section 1115 Waiver" means California's Medi-Cal Hospital/Uninsured Care Section 1115 Waiver Demonstration in effect on the effective date of this article.

(b) "Designated public hospital" shall have the meaning set forth in subdivision (d) of Section 14166.1.

(c) "Federal upper payment limit" means the upper payment limit on the applicable category of hospitals pursuant to federal law that will be allowed for purposes of federal financial participation. The federal upper payment limit for hospital outpatient services is as set forth in Section 447.321 of Title 42 of the Code of Federal Regulations. The federal upper payment limit for hospital inpatient services is as set forth in Section 447.272 of Title 42 of the Code of Federal Regulations.

(d) "Nondesignated public hospital" means a public hospital that is licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's annual financial disclosure report for the hospital's latest fiscal year ending in 2008, and is defined in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(e) "Phase 1" means the implementation of this article for some or all of the federal fiscal year ending September 30, 2009.

(f) "Phase 2" means the implementation of this article for some or all of the period beginning October 1, 2009, and ending December 31, 2010.

(g) "Private hospital" means a hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's annual financial disclosure report for the hospital's latest fiscal year ending in 2008, and is a nonpublic hospital, nonpublic-converted hospital, or converted hospital as those terms are defined in

paragraphs (26) to (28), inclusive, respectively, of subdivision (a) of Section 14105.98.

14167.2. (a) Medi-Cal payments plus supplemental payments made pursuant to this article for hospital outpatient services furnished by private hospitals and hospital inpatient services furnished by private hospitals and nondesignated public hospitals shall equal the federal upper payment limit for that portion of phase 1 and phase 2 for which federal approval of the supplemental payments described in this article is obtained. Hospitals shall receive supplemental payments funded by the coverage dividend fee set forth in Article 5.22 (commencing with Section 14167.31) and available matching federal funds to comply with this subdivision.

(b) Designated public hospitals shall be paid direct grants in support of expenditures incurred under the Medi-Cal program, the Current Section 1115 Waiver, or any new or replacement waiver. The aggregate amount of the grants shall be the total amount of payments that would be made to designated public hospitals if the nonfederal component of payments up to the applicable federal upper payment limit and the additional managed care payments received by designated public hospitals as a consequence of subdivision (c) was funded by the coverage dividend fee set forth in Article 5.22 (commencing with Section 14167.31), less the amount of those fees that would have been paid by the designated public hospitals if the hospitals were required to pay the fee.

(c) Medi-Cal managed health care plans shall receive supplemental payments to the extent available from the funds generated by the coverage dividend fee, including matching federal funds. The Medi-Cal managed care health plans shall pay all of the supplemental payments to hospitals in the form of increased payments for hospital services. The supplemental payments to hospitals shall not affect the Medi-Cal managed care payment rates to hospitals apart from the supplemental payments.

14167.3. (a) The director shall submit any Medicaid state plan amendment that may be necessary to implement this article for phase 1 on or before June 30, 2009, shall seek approval for the use of the entire federal upper payment limit for the 2008–09 federal fiscal year, and shall seek all federal approvals, waivers, waiver modifications, and any other federal action as may be

necessary to implement phase 1 and obtain federal financial participation to the maximum extent possible for the payments made with respect to phase 1. The director shall request from the federal government, in connection with obtaining federal approval for phase 1, the following written assurances from the Secretary of the United States Department of Health and Human Services:

(1) The approval of phase 1 will not result in funding reductions to hospitals under the Current Section 1115 Waiver, and that the maximum federal funds available annually for the safety net care pool will be no less than the amount that would be available pursuant to the Current Section 1115 Waiver Special Terms and Conditions, as amended October 5, 2007.

(2) The federal Centers for Medicare and Medicaid Services will explore, with the state, the need for growth in the safety net care pool established pursuant to the Current Section 1115 Waiver.

(b) Phase 1 shall not be implemented unless both of the following have occurred:

(1) Written assurances substantially as described in subdivision (a) are obtained from the federal government.

(2) The director executes a declaration, which shall be submitted to the legislature, stating that, taking into account all relevant information available from the federal government, there is no reasonable basis on which to conclude that the implementation of phase 1 will adversely impact funding that otherwise would be available for Medi-Cal and uninsured services pursuant to the state plan or a waiver under Section 1115 of the federal Social Security Act (42 U.S.C. Sec. 1315) for a demonstration that will replace the Current Section 1115 Waiver.

(c) (1) The director shall submit a Medicaid state plan amendment for phase 2 to the federal government on or before September 30, 2009, and shall seek all federal approvals, waivers, waiver modifications, and any other federal action as may be necessary to implement phase 2 and obtain federal financial participation to the maximum extent possible for the payments made with respect to phase 2.

(2) The director shall negotiate the federal approvals required to implement phase 2 concurrently with the negotiation of a federal waiver under Section 1115 of the federal Social Security Act for a demonstration that will replace the Current Section 1115 Waiver.

(3) Phase 2 shall not be implemented unless and until the federal government approves a federal waiver under Section 1115 of the federal Social Security Act (42 U.S.C. Sec. 1315) for a demonstration that will replace the Current Section 1115 Waiver and that is not adversely impacted by the provisions of this article and Article 5.22 (commencing with Section 14167.31).

(4) In negotiating the terms of the replacement federal waiver under Section 1115 of the Social Security Act (42 U.S.C. Sec. 1315), the department shall explore opportunities for reform of the Medi-Cal program. Subject to subsequent legislative approval, the department shall explore program reforms, which may include, but need not be limited to, strategies to accomplish the following goals:

(A) Payment system reforms for hospital inpatient and outpatient care, including incentive-based payments, patient safety protocols, and quality measurement.

(B) Improvements in the coordination of care for children, seniors, and adults with multiple chronic and complex medical conditions, to reduce the high-cost use of emergency and inpatient hospital services, including reimbursement for medical homes, enhanced access to primary and preventive care services, disease management, and case management programs.

(C) Improvements in managed care delivery systems, including the measurement of health plan performance and pay-for-performance payment methodologies.

(d) (1) This article shall become inoperative during phase 1 if both of the following conditions exist:

(A) The federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before January 1, 2012, the implementation of Article 5.22 (commencing with Section 14167.31) or this article for phase 1.

(B) Neither article can be modified by the department pursuant to subdivision (g) of Section 14167.32 in order to meet the requirements of federal law or to obtain federal approval.

(2) This article shall become inoperative during phase 2 if both of the following conditions exist:

(A) The federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before January 1, 2012, the implementation of Article 5.22 (commencing with Section 14167.31) or this article for phase 2.

(B) Neither article can be modified by the department pursuant to subdivision (g) of Section 14167.32 in order to meet the requirements of federal law or to obtain federal approval.

14167.4. (a) It is the intent of the Legislature to enact additional legislation that will specify more precisely the calculation of the supplemental payments to hospitals and to Medi-Cal managed health care plans under this article.

(b) No supplemental payments shall be made pursuant to this article until the legislation described in subdivision (a) has been enacted.

14167.5. (a) If the legislation described in subdivision (a) of Section 14167.4 is not enacted, and becomes effective, by October 1, 2009, this article shall remain in effect only until October 1, 2009, and as of that date is repealed.

(b) If the legislation described in subdivision (a) of Section 14167.4 is enacted, and becomes effective, by October 1, 2009, this article shall remain in effect only until January 1, 2013, and as of that date is repealed.

SEC. 2. Article 5.22 (commencing with Section 14167.31) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.22. Hospital Coverage Dividend Fee Act

14167.31. For purposes of this article, the following definitions shall apply:

(a) "Phase 1" means the implementation of this article for some or all of the federal fiscal year ending September 30, 2009.

(b) "Phase 2" means the implementation of this article for some or all of the period beginning October 1, 2009, and ending December 31, 2010.

14167.32. (a) There shall be imposed a coverage dividend fee that is consistent with the principle of shared benefit and shared responsibility.

(b) The coverage dividend fee shall be assessed on hospitals licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code, except for public hospitals, as defined in paragraph (25) of subdivision (a) of Section 14105.98, and hospitals that are designated as specialty hospitals in the hospital's annual financial disclosure reports for the hospital's latest fiscal

year ending in 2008, commencing on the effective date of this article and shall continue through and, including December 31, 2010.

(c) In no case shall the aggregate fees collected in a subject federal fiscal year pursuant to this section exceed the maximum percentage of the annual aggregate net patient revenue for hospitals subject to the fee that is prescribed pursuant to federal law and regulations as necessary to preclude a finding that an indirect guarantee has been created.

(d) The director shall seek, in a timely manner, any and all federal approvals that may be necessary for the implementation of each element of this article. The department may separately seek approval for phase 1 and for phase 2.

(e) (1) This article shall become inoperative during phase 1 if both of the following conditions exist:

(A) The federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before January 1, 2012, the implementation of Article 5.21 (commencing with Section 14167.1) or this article for phase 1.

(B) Neither article can be modified by the department pursuant to subdivision (g) in order to meet the requirements of federal law or to obtain federal approval.

(2) This article shall become inoperative during phase 2 if both of the following conditions exist:

(A) The federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before January 1, 2012, the implementation of Article 5.21 (commencing with Section 14167.1) or this article for phase 2.

(B) Neither article can be modified by the department pursuant to subdivision (g) in order to meet the requirements of federal law or to obtain federal approval.

(f) No hospital shall be required to pay the coverage dividend fee to the department until the state receives and maintains federal approval of the coverage dividend fee and Article 5.21 (commencing with Section 14167.1) from the federal Centers for Medicare and Medicaid Services for the period for which the coverage dividend fee is assessed.

(g) Any methodology specified in Article 5.21 (commencing with Section 14167.1) and this article may be modified by the department, in consultation with the hospital community, to the

extent necessary to meet the requirements of federal law or regulations or to obtain federal approval, provided the modifications do not violate the intent of Article 5.21 (commencing with Section 14167.1) or this article.

14167.35. (a) The funds collected from the fees assessed pursuant to this article, and any matching federal funds, shall be available only for the following purposes:

(1) To provide supplemental payments and grants to hospitals under subdivisions (a) and (b) of section 14167.2.

(2) To provide supplemental payments to Medi-Cal managed care health plans under subdivision (c) of Section 14167.2.

(3) To pay for health care coverage for children.

(4) To pay for the department's staffing costs directly attributable to implementing Article 5.21 (commencing with Section 14167.1) or this article.

(b) The amount of the coverage dividend fee that shall be used for health care coverage for children shall be eighty million dollars ($80,000,000) for each quarter during the 2008–09 federal fiscal year that begins after the actual date on which all federal approvals are obtained that are necessary to implement Article 5.21 (commencing with Section 14167.1) and this article for phase 1, and each quarter that begins after the actual date on which all federal approvals are obtained that are necessary to implement Article 5.21 (commencing with Section 14167.1) and this article for phase 2 and ends on or before December 31, 2010.

14167.38. (a) It is the intent of the Legislature to enact additional legislation that will specify more precisely the calculation of the amount of the coverage dividend fee due from individual hospitals under this article.

(b) No coverage dividend fee shall be made due or payable pursuant to this article until the legislation described in subdivision (a) has been enacted.

14167.39. (a) If the legislation described in subdivision (a) of Section 14167.38 is not enacted, and becomes effective, by October 1, 2009, this article shall remain in effect only until October 1, 2009, and as of that date is repealed.

(b) If the legislation described in subdivision (a) of Section 14167.38 is enacted, and becomes effective, by October 1, 2009, this article shall remain in effect only until January 1, 2013, and as of that date is repealed.

~~SECTION 1. Article 5.21 (commencing with Section 14167.1) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:~~

~~Article 5.21. Medi-Cal Hospital Provider Rate Stabilization Act~~

~~14167.1. (a) "Aggregate designated public hospital amount" means, for a subject federal fiscal year, the aggregate amount of payments that would be made to designated public hospitals if the nonfederal component of payments up to the applicable federal upper payment limit defined in subdivision (f) and the managed care supplement described in Sections 14167.6 and 14167.13 was funded by the Hospital Coverage Dividend Fee set forth in Article 5.22 (commencing with Section 14167.31), less the amount of those fees that would have been paid by the designated public hospitals if the hospitals were required to pay the fee.~~

~~(b) "Aggregate managed care payment enhancement" means, for a subject federal fiscal year, the aggregate amount of the coverage dividend fee paid by hospitals for the subject federal fiscal year under Article 5.22 (commencing with Section 14167.31) less the nonmanaged care fee payments for the subject federal fiscal year.~~

~~(c) "Coverage enhancement amount" means the amount for a subject federal fiscal year used to pay for health care coverage for children, as described in paragraph (2) of subdivision (c) of Section 14167.35.~~

~~(d) "Current Section 1115 Waiver" means California's Medi-Cal Hospital/Uninsured Care Section 1115 Waiver Demonstration in effect on the effective date of this article.~~

~~(e) "Designated public hospital" means any one of the following hospitals:~~

~~(1) UC Davis Medical Center.~~

~~(2) UC Irvine Medical Center.~~

~~(3) UC San Diego Medical Center.~~

~~(4) UC San Francisco Medical Center.~~

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

~~(6) LA County Harbor-UCLA Medical Center.~~

~~(7) LA County Olive View-UCLA Medical Center.~~

~~(8) LA County Rancho Los Amigos National Rehabilitation Center.~~

~~(9) LA County University of Southern California Medical Center.~~

~~(10) Alameda County Medical Center.~~

~~(11) Arrowhead Regional Medical Center.~~

~~(12) Contra Costa Regional Medical Center.~~

~~(13) Kern Medical Center.~~

~~(14) Natividad Medical Center.~~

~~(15) Riverside County Regional Medical Center.~~

~~(16) San Francisco General Hospital.~~

~~(17) San Joaquin General Hospital.~~

~~(18) San Mateo Medical Center.~~

~~(19) Santa Clara Valley Medical Center.~~

~~(20) Ventura County Medical Center.~~

~~(f) "Federal upper payment limit" means the upper payment limit on the applicable category of hospitals pursuant to federal law that will be allowed for purposes of federal financial participation. The federal upper payment limit for hospital outpatient services is as set forth in Section 447.321 of Title 42 of the Code of Federal Regulations. The federal upper payment limit for hospital inpatient services is as set forth in Section 447.272 of Title 42 of the Code of Federal Regulations.~~

~~(g) "Federal upper payment limit room" means, for a subject federal fiscal year, the amount by which the federal upper payment limit exceeds the Medi-Cal payments for the services subject to the federal upper payment limit exclusive of payments made under this article.~~

~~(h) "Hospital inpatient services" means all services covered under the Medi-Cal program and furnished by hospitals to patients who are admitted as hospital inpatients and reimbursed on a fee-for-service basis by the department directly or through its fiscal intermediary. Hospital inpatient services include outpatient services furnished by a hospital to a patient who is admitted to that hospital within 24 hours of the provision of the outpatient services that are related to the condition for which the patient is admitted. Hospital inpatient services include physician services only if the service is furnished to a hospital inpatient, the physician is compensated by the hospital for the service, and the service is billed to the Medi-Cal program by the hospital under a provider number assigned to the~~

~~hospital. Hospital inpatient services do not include services for which a managed health care plan is financially responsible.~~

~~(i) "Hospital litigant means" a hospital that initiates, or on whose behalf is initiated, a case or proceeding in any state or federal court in which the hospital seeks any relief of any sort whatsoever, including, but not limited to, monetary relief, injunctive relief, declaratory relief, or a writ, based in whole or in part on a contention that any or all of this article or Article 5.22 (commencing with Section 14167.31) is unlawful and may not be lawfully implemented. A hospital on whose behalf a case or proceeding described in this subdivision is brought shall not be a hospital litigant if the hospital successfully opts out or is dismissed from the case or proceeding so that the hospital will not be in a position to receive a benefit as a result of the case or proceeding.~~

~~(j) "Hospital outpatient services" means all services covered under the Medi-Cal program furnished by hospitals to patients who are registered as hospital outpatients and reimbursed by the department on a fee-for-service basis directly or through its fiscal intermediary. Hospital outpatient services include physician services only if the service is furnished to a hospital outpatient, the physician is compensated by the hospital for the service, and the service is billed to the Medi-Cal program by the hospital under a provider number assigned to the hospital. Hospital outpatient services do not include services for which a managed health care plan is financially responsible or services rendered by a hospital-based federally qualified health center that receives reimbursement pursuant to Section 14132.100.~~

~~(k) "Inpatient share percentage" means the percentage of total Medi-Cal acute care inpatient hospital days covered by all managed health care plans that the department estimates will be covered by a particular managed health care plan for the portion of a subject federal fiscal year that begins on or after the phase 1 implementation date and ends on or before December 31, 2010.~~

~~(*l*) "Managed care inpatient day" means an acute inpatient day of service covered under the Medi-Cal program for which a managed health care plan is financially responsible.~~

~~(m) "Managed health care plan" means a health care delivery system that manages the provision of health care and receives prepaid capitated payments from the state in return for providing services to Medi-Cal beneficiaries. Managed health care plans~~

include, but are not limited to, county organized health systems, prepaid health plans and entities contracting with the department to provide services pursuant to two-plan models, and geographic managed care. Entities providing these services contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), or Article 2.91 (commencing with Section 14089) of Chapter 7, or Article 1 (commencing with Section 14200) or Article 7 (commencing with Section 14490) of Chapter 8.

(n) "Nondesignated public hospital" means a public hospital that is licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's annual financial disclosure report for the hospital's latest fiscal year ending in 2008, and is defined in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(o) "Nonmanaged care fee payments" means, for a subject federal fiscal year, the aggregate amount paid for services furnished during the subject federal fiscal year under Sections 14167.2, 14167.3, 14167.4, 14167.5, 14167.9, 14167.10, 14167.11, and 14167.12, plus the coverage enhancement amount for the subject federal fiscal year.

(p) "Outpatient base rates" means the Medi-Cal payment rates for hospital outpatient services in effect on the date immediately preceding the implementation date.

(q) "Phase 1" means the implementation of this article for some or all of the federal fiscal year ending September 30, 2009.

(r) "Phase 1 approval" means the federal approvals or waivers necessary for implementation of this article for some or all of the federal fiscal year ending September 30, 2009.

(s) "Phase 1 implementation date" means the effective date of all federal approvals or waivers necessary for implementation of this article for some or all of the federal fiscal year ending September 30, 2009.

(t) "Phase 2" means the implementation of this article for some or all of the period beginning October 1, 2009, and ending December 31, 2010.

(u) "Phase 2 approval" means the federal approvals or waivers necessary for implementation of this article for the period beginning October 1, 2009, and ending December 31, 2010.

~~(v) "Phase 2 implementation date" means the effective date of all federal approvals or waivers necessary for implementation of this article for the period beginning October 1, 2009, and ending December 31, 2010.~~

~~(w) "Private hospital" means a hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's annual financial disclosure report for the hospital's latest fiscal year ending in 2008, and is a nonpublic hospital, nonpublic-converted hospital, or converted hospital as those terms are defined in paragraphs (26) to (28), inclusive, respectively, of subdivision (a) of Section 14105.98.~~

~~(x) "Subject federal fiscal year" means a federal fiscal year that ends after the phase 1 implementation date and begins before the termination date.~~

~~(y) "Termination date" means December 31, 2010.~~

~~14167.2. (a) Private hospitals shall be paid supplemental amounts for hospital outpatient services provided on or after the phase 1 implementation date and on or before September 30, 2009, that shall be in addition to any other amounts payable to hospitals with respect to hospital outpatient services. These supplemental payments shall not affect any other payments to hospitals.~~

~~(b) Medi-Cal rates for hospital outpatient services provided on or after the phase 1 implementation date and on or before September 30, 2009, shall result in aggregate payments equal to the federal upper payment limit for the federal fiscal year ending September 30, 2009, or the portion of the federal fiscal year that is approved by the federal government if the federal government approves the utilization of the federal upper payment limit room for less than the entire federal fiscal year.~~

~~14167.3. (a) Private hospitals shall be paid supplemental amounts for hospital inpatient services provided on or after the phase 1 implementation date and on or before September 30, 2009, that shall be in addition to any other amounts payable to private hospitals with respect to hospital inpatient services. These supplemental payments shall not affect any other payments to private hospitals.~~

~~(b) Medi-Cal rates for hospital inpatient services provided by private hospitals on or after the phase 1 implementation date and on or before September 30, 2009, shall result in aggregate payments~~

~~equal to the federal upper payment limit for the federal fiscal year ending September 30, 2009, or the portion of the federal fiscal year that is approved by the federal government if the federal government approves the utilization of the federal upper payment limit room for less than the entire federal fiscal year.~~

~~14167.4. (a) Nondesignated public hospitals shall be paid supplemental amounts for hospital inpatient services provided on or after the phase 1 implementation date and on or before September 30, 2009, that shall be in addition to any other amounts payable to nondesignated public hospitals with respect to hospital inpatient services. These supplemental payments shall not affect any other payments to nondesignated public hospitals.~~

~~(b) Medi-Cal rates for hospital inpatient services provided by nondesignated public hospitals on or after the phase 1 implementation date and on or before September 30, 2009, shall result in aggregate payments equal to the portion of the federal upper payment limit allocable to nondesignated public hospitals for the subject federal fiscal year ending September 30, 2009, or the portion of the federal fiscal year that is approved by the federal government if the federal government approves the utilization of the federal upper payment limit room for less than the entire federal fiscal year.~~

~~14167.5. Designated public hospitals shall be paid supplemental amounts for services they provide on or after the phase 1 implementation date and on or before September 30, 2009. The amount paid under this section shall, in the aggregate, be the aggregate designated public hospital amount for the subject federal fiscal year ending September 30, 2009, less the amount paid to designated public hospitals under Section 14167.6 for services rendered during the federal fiscal year ending September 30, 2009. All amounts shall be paid as direct grants in support of expenditures incurred under the Medi-Cal program or Section 1115 Waiver, and these payments shall not constitute Medi-Cal payments.~~

~~14167.6. (a) The department shall increase payments in the aggregate to Medi-Cal managed health care plans for the provision of Medi-Cal services on or after the phase 1 implementation date and on or before September 30, 2009, in the amount of the aggregate managed care hospital payment enhancement.~~

~~(b) The department shall increase payments for the subject federal fiscal year ending September 30, 2009, to each Medi-Cal~~

~~managed health care plan that furnishes or is responsible for furnishing hospital inpatient services by a percentage of the aggregate managed care hospital payment enhancement equal to the department's estimate of the managed health care plan's inpatient share percentage for the period beginning on the phase 1 implementation date and ending September 30, 2009.~~

~~(c) The department shall estimate before the phase 1 implementation date each managed health care plan's inpatient percentage using the methods and data that the department determines is appropriate.~~

~~(d) The department may adjust managed health care plans' inpatient percentages during the subject federal fiscal year ending September 30, 2009, to reflect changes in Medi-Cal enrollment among managed health care plans during the fiscal year, provided that the sum of the inpatient percentages for all managed health care plans shall always total 100 percent of managed care inpatient days.~~

~~(e) Each Medi-Cal managed health care plan shall equitably expend, in the form of additional payments to hospitals for managed care inpatient days, 100 percent of any rate increase it receives under this section. The amount of the additional payments shall be determined on a per diem basis so that each hospital receives the same additional amount per managed care inpatient day furnished during a calendar quarter. Any delegation or attempted delegation by a Medi-Cal managed health care plan of its obligation to make payments under this section shall not relieve the managed health care plan from its obligation to make the payments. Medi-Cal managed health care plans shall submit the documentation the department may require to demonstrate compliance with the provisions of this subdivision. The documentation shall be available to hospitals for inspection and copying under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), and no exemption from disclosure under the California Public Records Act shall apply as to hospitals.~~

~~14167.8. The payments made pursuant to Sections 14167.2, 14167.3, 14167.4, 14167.5, and 14167.6 to hospitals and managed health care plans for the 2008–09 federal fiscal year shall be made on or before the later of August 31, 2009, or the 30th day following the date on which phase 1 approval is granted.~~

~~14167.9. (a) Private hospitals shall be paid supplemental amounts for hospital outpatient services provided on or after the phase 2 implementation date and on or before December 31, 2010, that shall be in addition to any other amounts payable to hospitals with respect to hospital outpatient services. These supplemental payments shall not affect any other payments to hospitals.~~

~~(b) Medi-Cal rates for hospital outpatient services provided on or after the phase 2 implementation date and on or before December 31, 2010, shall result in aggregate payments equal to the federal upper payment limit for the subject federal fiscal year during which the services are rendered or the portion of the subject federal fiscal year that is approved by the federal government if the federal government approves the utilization of the federal upper payment limit room for less than the entire subject federal fiscal year.~~

~~14167.10. (a) Private hospitals shall be paid supplemental amounts for hospital inpatient services provided on or after the phase 2 implementation date and on or before December 31, 2010, that shall be in addition to any other amounts payable to private hospitals with respect to hospital inpatient services. These supplemental payments shall not affect any other payments to private hospitals.~~

~~(b) Medi-Cal rates for hospital inpatient services provided by private hospitals on or after the phase 2 implementation date and on or before December 31, 2010, shall result in aggregate payments equal to the federal upper payment limit for the subject federal fiscal year during which the services are rendered or the portion of the subject federal fiscal year that is approved by the federal government if the federal government approves the utilization of the federal upper payment limit room for less than the entire subject federal fiscal year.~~

~~14167.11. (a) Nondesignated public hospitals shall be paid supplemental amounts for hospital inpatient services provided on or after the phase 2 implementation date and on or before December 31, 2010, that shall be in addition to any other amounts payable to nondesignated public hospitals with respect to hospital inpatient services. These supplemental payments shall not affect any other payments to nondesignated public hospitals.~~

~~(b) Medi-Cal rates for hospital inpatient services provided by nondesignated public hospitals on or after the phase 2 implementation date and on or before December 31, 2010, shall~~

~~result in aggregate payments equal to the portion of the federal upper payment limit allocable to nondesignated public hospitals for the subject federal fiscal year during which the services are rendered or the portion of the subject federal fiscal year that is approved by the federal government if the federal government approves the utilization of the federal upper payment limit room for less than the entire subject federal fiscal year.~~

~~14167.12. Designated public hospitals shall be paid supplemental amounts for services for each subject federal fiscal year that begins on or after the phase 2 implementation date and ends on or before September 30, 2011. The amount paid under this section for a subject federal fiscal year shall, in the aggregate, be the aggregate designated public hospital amount for the subject federal fiscal year less the amount paid to designated public hospitals under Section 14167.13 for services rendered during the subject federal fiscal year. All amounts shall be paid as direct grants in support of expenditures incurred under the Medi-Cal program or Section 1115 Waiver, and these payments shall not constitute Medi-Cal payments.~~

~~14167.13. (a) The department shall increase payments in the aggregate to Medi-Cal managed health care plans for the provision of Medi-Cal services for each subject federal fiscal year which begins on or after the phase 2 implementation date and ends on or before September 30, 2011, in the amount of the aggregate managed care hospital payment enhancement.~~

~~(b) The department shall increase payments for each subject federal fiscal year to each Medi-Cal managed health care plan that furnishes or is responsible for furnishing hospital inpatient services a percentage of the aggregate managed health care hospital payment enhancement equal to the department's estimate of the managed health care plan's inpatient share percentage for the subject federal fiscal year.~~

~~(c) The department shall estimate before the implementation date and the beginning of each subject federal fiscal year beginning on or after the implementation date each managed health care plan's inpatient percentage using methods and data that the department determines is appropriate.~~

~~(d) The department may adjust managed health care plans' inpatient percentages during a subject federal fiscal year to reflect changes in Medi-Cal enrollment among plans during the fiscal~~

~~year, provided that the sum of the inpatient share percentages for all managed health care plans shall always total 100 percent of managed care inpatient days.~~

~~(e) Each Medi-Cal managed health care plan shall equitably expend, in the form of additional payments to hospitals for managed care inpatient days, 100 percent of any rate increase it receives under this section. The amount of the additional payments shall be determined on a per diem basis so that each hospital receives the same additional amount per managed care inpatient day furnished during a calendar quarter. Any delegation or attempted delegation by a Medi-Cal managed health care plan of its obligation to make payments under this section shall not relieve the managed health care plan from its obligation to make the payments. Medi-Cal managed health care plans shall submit the documentation that the department may require to demonstrate compliance with the provisions of this subdivision. The documentation shall be available to the public under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), and no exemption from disclosure under the California Public Records Act shall apply.~~

~~14167.14. The amount of any payments made pursuant to this article to private hospitals, made either directly or by managed health care plans pursuant to sections 14167.6 and 14167.13, shall not be included in the calculation of the numerator or denominator of the low-income percent of the OBRA limit for purposes of disproportionate share hospital replacement fund payments to private hospitals made pursuant to Section 14166.11.~~

~~14167.15. (a) The payments made pursuant to Sections 14167.9, 14167.10, 14167.11, 14167.12, and 14167.13 to hospitals and managed health care plans for the 2009–10 federal fiscal year shall be made on a quarterly basis. The amounts payable to the hospital for each quarter shall be one-fourth of the amount payable to the hospital for the entire federal fiscal year. Payments to hospitals for each quarter during the 2009–10 federal fiscal year shall be made on the later of the last day of the second month of the quarter or the 30th day following the day on which phase 2 federal approval is granted.~~

~~(b) The payments made pursuant to Sections 14167.9, 14167.10, 14167.11, 14167.12, and 14167.13 to hospitals and managed health~~

~~care plans for the 2010–11 federal fiscal year shall be made on or before the later of November 30, 2010, or the 30th day following the day on which phase 2 federal approval is granted.~~

~~14167.16. (a) Payment rates for hospital outpatient services furnished by private hospitals, nondesignated public hospitals, and designated public hospitals, before October 1, 2011, exclusive of amounts payable under this article, shall not be reduced below the rates in effect on June 30, 2008.~~

~~(b) Rates payable to hospitals for hospital inpatient services furnished before October 1, 2011, under contracts negotiated pursuant to the Selective Provider Contracting Program shall not be reduced below the contract rates in effect on June 1, 2009. This subdivision shall not prohibit changes to the supplemental payments paid to individual hospitals pursuant to Sections 14166.12 and 14166.17 that are not otherwise derived from intergovernmental transfers described in paragraph (4) of subdivision (d) of Section 14166.12, or from private donations described in paragraph (4) of subdivision (d) of Section 14166.17, or the funding made available under Section 14166.20 and Section 14166.23. The aggregate supplemental payments made pursuant to Sections 14166.12, 14166.17, and 14166.23 for a state fiscal year that ends after the implementation date and begins before the termination date shall not be less than the aggregate payments made pursuant to Sections 14166.12 and 14166.17 that are not otherwise derived from intergovernmental transfers described in paragraph (4) of subdivision (d) of Section 14166.12, or from private donations described in paragraph (4) of subdivision (d) of Section 14166.17, or the funding made available under Section 14166.20 and Section 14166.23 during the 2007–08 state fiscal year.~~

~~(c) Payments to private hospitals and nondesignated public hospitals for hospital inpatient services furnished before October 1, 2011, that are not reimbursed pursuant to a contract negotiated pursuant to the Selective Provider Contracting Program (Article 2.6 (commencing with Section 14081)), exclusive of amounts payable under this article, shall not be less than the amount of payments that would have been made pursuant to the payment methodology in effect on June 30, 2008.~~

~~(d) Payments to hospitals pursuant to Sections 14166.6, 14166.11, and 14166.16 for a state fiscal year that ends after the~~

~~implementation date and begins before the termination date shall not be less than the payments due under the methodology set forth in those sections in effect for the 2007–08 state fiscal year.~~

~~(e) Reimbursement to designated public hospitals for services furnished before October 1, 2011, pursuant to Sections 14166.4 and 14166.7 shall not be reduced below the level of reimbursement provided for in the applicable methodologies in effect on June 1, 2009.~~

~~(f) Managed health care plans shall not take into account payments made pursuant to this article in negotiating the amount of payments to hospitals that are not made pursuant to this article.~~

~~14167.17. (a) The director shall promptly seek the federal approvals, waivers, waiver modifications, and any other federal action as may be necessary to implement phase 1 and obtain federal financial participation to the maximum extent possible for the payments made with respect to phase 1. The director shall submit any Medicaid state plan amendment that may be necessary to implement phase 1 on or before June 30, 2009.~~

~~(b) The director shall request from the federal government, in connection with obtaining federal approval for phase 1, the following written assurances from the Secretary of the United States Department of Health and Human Services:~~

~~(1) The approval of phase 1 will not result in funding reductions to hospitals under the current Section 1115 Waiver, and that the maximum federal funds available annually for the Safety Net Care Pool will be no less than that amount that would be available pursuant to the current Section 1115 Waiver Special Terms and Conditions, as amended October 5, 2007.~~

~~(2) The federal Centers for Medicare and Medicaid Services will explore, with the state, the need for growth in the safety net care pool established pursuant to the current Section 1115 Waiver.~~

~~(3) The additional federal funding provided for the 2008–09 federal fiscal year as a result of the implementation of phase 1 will not adversely impact funding that otherwise would be available for Medi-Cal and uninsured services pursuant to the state plan or a waiver under Section 1115 of the federal Social Security Act for a demonstration that will replace the current Section 1115 Waiver except as it may increase the amount available under budget neutrality.~~

~~(c) Phase 1 shall not be implemented unless and until written assurances substantially as described in subdivision (b) are obtained from the federal government.~~

~~14167.18. (a) The director shall submit a Medicaid state plan amendment for phase 2 to the federal government on or before September 30, 2009, and shall seek all federal approvals, waivers, waiver modifications, and any other federal action as may be necessary to implement phase 2 and obtain federal financial participation to the maximum extent possible for the payments made with respect to phase 2.~~

~~(b) The director shall negotiate the federal approvals required to implement phase 2 concurrently with the negotiation of a federal waiver under Section 1115 of the federal Social Security Act for a demonstration that will replace the current Section 1115 Waiver.~~

~~(c) Phase 2 shall not be implemented unless and until the federal government approves a federal waiver under Section 1115 of the federal Social Security Act for a demonstration that will replace the current Section 1115 Waiver and that is not adversely impacted by the provisions of this article and Article 5.22 (commencing with Section 14167.31).~~

~~(d) In negotiating the terms of the replacement federal waiver under Section 1115 of the Social Security Act, the department shall explore opportunities for reform of the Medi-Cal program. Subject to subsequent legislative approval, the department shall explore program reforms, which may include, but need not be limited to, strategies to accomplish the following goals:~~

~~(1) Payment system reforms for hospital inpatient and outpatient care, including incentive-based payments, patient safety protocols, and quality measurement.~~

~~(2) Improvements in the coordination of care for children, seniors, and adults with multiple chronic and complex medical conditions, to reduce the high-cost use of emergency and inpatient hospital services, including reimbursing for medical homes, enhanced access to primary and preventive care services, disease management and case management programs.~~

~~(3) Improvements in managed care delivery systems, including the measurement of health plan performance and pay-for-performance payment methodologies.~~

~~14167.19. (a) In implementing this article, the department may utilize the services of the Medi-Cal fiscal intermediary through a~~

~~change order to the fiscal intermediary contract to administer this program, consistent with the requirements of Sections 14104.6, 14104.7, 14104.8, and 14104.9. Contracts entered into with any Medi-Cal fiscal intermediary shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.~~

~~(b) This article shall become inoperative in the event, and on the effective date, of a final judicial determination by any court of appellate jurisdiction or a final determination by the federal Department of Health and Human Services or the federal Centers for Medicare and Medicaid Services that any element of this article cannot be implemented.~~

~~(c) In the event any hospital, or any party on behalf of a hospital, shall initiate a case or proceeding in any state or federal court in which the hospital seeks any relief of any sort whatsoever, including, but not limited to, monetary relief, injunctive relief, declaratory relief, or a writ, based in whole or in part on a contention that any or all of this article is unlawful and may not be lawfully implemented, all of the following shall apply:~~

~~(1) No payments shall be made to a hospital litigant pursuant to this article until the case or proceeding is finally resolved, including the final disposition of all appeals.~~

~~(2) Any amount computed to be payable to a hospital litigant pursuant to this article for a subject federal fiscal year shall be withheld by the department and shall be paid to the hospital litigant only after the case or proceeding is finally resolved, including the final disposition of all appeals.~~

~~14167.20. (a) It is the intent of the Legislature to enact additional legislation that will specify more precisely the calculation of the supplemental payment to individual hospitals under this article.~~

~~(b) No supplemental payments shall be made pursuant to this article until the legislation described in subdivision (a) has been enacted.~~

~~14167.21. This article shall remain in effect only until the earlier of the following dates and as of that date is repealed:~~

~~(a) January 1, 2013.~~

~~(b) The date the director executes a declaration, which shall be submitted to the Secretary of State, the Assembly and Senate Committees on Health, the Assembly and Senate Committees on~~

~~Appropriations, the Assembly Committee on Budget, and the Senate Committee on Budget and Fiscal Review, stating that a final judicial or administrative determination described in subdivision (b) of Section 14167.19 has been made.~~

~~SEC. 2. Article 5.22 (commencing with Section 14167.31) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:~~

~~Article 5.22. Hospital Coverage Dividend Fee Act~~

~~14167.31. For purposes of this article, the following definitions shall apply:~~

~~(a) "Phase 1" means the implementation of this article for some or all of the subject federal fiscal year ending September 30, 2009.~~

~~(b) "Phase 1 approval" means the federal approvals or waivers necessary for implementation of this article for some or all of the subject federal fiscal year ending September 30, 2009.~~

~~(c) "Phase 2" means the implementation of this article for some or all of the period beginning October 1, 2009, and ending December 31, 2010.~~

~~(d) "Phase 2 approval" means the federal approvals or waivers necessary for implementation of this article for the period beginning October 1, 2009, and ending December 31, 2010.~~

~~(e) "Subject federal fiscal year" means a federal fiscal year ending on or after the effective date of federal approval of Article 5.21 (commencing with Section 14167.1) and beginning on or before December 31, 2010.~~

~~14167.32. (a) There shall be imposed a coverage dividend fee that is consistent with the principle of shared benefit and shared responsibility.~~

~~(b) The coverage dividend fee shall be assessed on hospitals licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code, except for public hospitals, as defined in paragraph (25) of subdivision (a) of Section 14105.98, and hospitals that are designated as specialty hospitals in the hospital's annual financial disclosure reports for the hospital's latest fiscal year ending in 2008, commencing on the effective date of this article and shall continue through and including December 31, 2010.~~

~~(c) The department shall calculate the amount of the coverage dividend fee for each hospital within 10 days after the date when this article becomes effective. Within two days of calculating the coverage dividend fee, the department shall send notice of the amount of the coverage dividend fee to each hospital.~~

~~(d) For calendar quarters, and partial quarters thereof, in phase 1, the following provisions shall apply:~~

~~(1) Within 30 days after the effective date of this article, each hospital shall certify to the best of its knowledge, on a form provided by the department, that the hospital is prepared to pay the coverage dividend fee for that hospital for the subject federal fiscal year by the later of 30 days after phase 1 approval or August 15, 2009.~~

~~(2) Upon phase 1 approval, all of the following shall become operative:~~

~~(A) Within 10 days following the notice of phase 1 approval, the department shall send notice to providers, and publish on its Internet Web site, the following information:~~

~~(i) The date that the state received notice of phase 1 approval.~~

~~(ii) The amount of the fee that shall be assessed and collected sufficient to support the purposes of this article and Article 5.21 (commencing with Section 14167.1).~~

~~(B) The notice to each hospital subject to the coverage dividend fee shall also state all of the following:~~

~~(i) That the hospital shall pay the coverage dividend fee for the subject federal fiscal year, by the later of 30 days after phase 1 approval or August 15, 2009.~~

~~(ii) The total amount of the fee that will be payable by the hospital on the date described in clause (i).~~

~~(C) By the later of 30 days after phase 1 approval or August 15, 2009, each hospital shall pay the amounts stated in the department's notice pursuant to subparagraph (B).~~

~~(e) For calendar quarters in phase 2, the following provisions shall apply:~~

~~(1) For calendar quarters prior to phase 2 approval, and for the calendar quarter when the department receives notice of phase 2 approval, the following provisions shall apply:~~

~~(A) For each calendar quarter beginning on or after October 1, 2009, and ending on or before September 30, 2010, within 45 days following the beginning of each calendar quarter, each hospital~~

~~shall certify to the best of its knowledge, on a form provided by the department, that the hospital is prepared to pay an amount equal to the coverage dividend fee for that hospital for the subject federal fiscal year divided by four, in addition to any amounts that it has previously certified it was prepared to pay, within 30 days after phase 2 approval.~~

~~(B) For the calendar quarter beginning on October 1, 2010, each hospital shall, on or before November 15, 2010, certify to the best of its knowledge, on a form provided by the department, that the hospital is prepared to pay an amount equal to the coverage dividend fee for that hospital for the subject federal fiscal year, in addition to any amounts that it has previously certified it was prepared to pay, within 30 days after phase 2 approval.~~

~~(2) Upon phase 2 approval, all of the following shall become operative:~~

~~(A) Within 10 days following the notice of phase 2 approval, the department shall send notice to providers, and publish on its Internet Web site, the following information:~~

~~(i) The date that the state received notice of phase 2 approval.~~

~~(ii) The amount of the fee that shall be assessed and collected sufficient to support the purposes of this article and Article 5.21 (commencing with Section 14167.1).~~

~~(B) The notice to each hospital subject to the coverage dividend fee shall also state all of the following:~~

~~(i) That the hospital shall, within 30 days after the date the department received notice of phase 2 approval, pay the amounts of the coverage dividend fee that the hospital had previously certified it was prepared to pay pursuant to paragraph (1).~~

~~(ii) The total amount of the fee that will be payable by the hospital on the date described in clause (i).~~

~~(C) Within 30 days after the date the department receives notice of phase 2 approval, each hospital shall pay the amounts stated in the department's notice pursuant to this paragraph.~~

~~(D) Paragraph (1) shall become inoperative beginning the first day of the first calendar quarter following the quarter in which the department receives notice of phase 2 approval.~~

~~(E) Within 45 days following the beginning of each calendar quarter, commencing with the quarter following the last quarter governed by paragraph (1) and ending with, and including, the calendar quarter ending December 31, 2010, each hospital shall~~

~~pay to the department the amounts that the hospital would have certified to pay for the relevant quarter pursuant to paragraph (1).~~

~~(f) The coverage dividend fee, as paid pursuant to this subdivision, shall be paid by each hospital subject to the fee and paid to the department for deposit in the Coverage Dividend Revenue Fund created pursuant to Section 14167.35. Deposits into the fund may be accepted at any time and shall be credited toward the fiscal year for which they were assessed.~~

~~(g) (1) Subdivision (d) shall become inoperative if the federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before January 1, 2012, the implementation of Article 5.21 (commencing with Section 14167.1) or this article for phase 1, and neither article can be modified by the department pursuant to subdivision (g) of Section 14167.35 in order to meet the requirements of federal law or to obtain federal approval.~~

~~(2) Subdivision (e) shall become inoperative if the federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before January 1, 2012, the implementation of Article 5.21 (commencing with Section 14167.1) or this article for phase 2, and neither article can be modified by the department pursuant to subdivision (g) of Section 14167.35 in order to meet the requirements of federal law or to obtain federal approval.~~

~~(3) If subdivision (d) or (e) becomes inoperative pursuant to this subdivision, each hospital subject to the coverage dividend fee shall be released from any certifications made pursuant to subdivision (d) or (e).~~

~~(h) In no case shall the aggregate fees collected in a subject federal fiscal year pursuant to this section exceed the maximum percentage of the annual aggregate net patient revenue for hospitals subject to the fee that is prescribed pursuant to federal law and regulations as necessary to preclude a finding that an indirect guarantee has been created.~~

~~(i) Interest shall be assessed on coverage dividend fees not paid on the date due at the same rate at which the department assesses interest on Medi-Cal program overpayments to hospitals that are not repaid when due. Interest shall begin to accrue the day after the date the payment was due and shall be deposited in the Coverage Dividend Revenue Fund.~~

~~(j) When a hospital fails to pay all or part of the coverage dividend fee within 60 days of the date that payment is due, the~~

~~department may deduct the unpaid assessment and interest owed from any Medi-Cal payments to the hospital until the full amount is recovered. Any deduction shall be made only after written notice to the hospital and may be taken over a period of time. All amounts deducted by the department pursuant to this subdivision shall be deposited in the Coverage Dividend Revenue Fund.~~

~~(k) In accordance with the provisions of the Medicaid state plan, the payment of the coverage dividend fee shall be considered as an allowable cost for Medi-Cal cost reporting and reimbursement purposes.~~

~~(*l*) The department shall work in consultation with the hospital community to implement the coverage dividend fee.~~

~~(m) The department shall offer to enter into a contract with each hospital subject to the coverage dividend fee, or to amend existing contracts with the hospital, that obligates the department to use the proceeds of the coverage dividend fee solely for the purposes set forth in this article and to comply with all of its obligations set forth in Article 5.21 (commencing with Section 14167.1) and this article, including, but not limited to, its obligation to continue prior reimbursement levels. Each contract shall also provide that the hospital's obligation to pay the coverage dividend fee shall be contingent on the department performing its obligations under the contract. Each contract shall be binding on the department and enforceable by the hospitals regardless of whether the hospitals have given adequate consideration in return for the department's obligations.~~

~~(n) Any amounts of the coverage dividend fee collected in excess of the funds required to implement subdivision (c) of Section 14167.35 shall be refunded to the hospitals subject to the coverage dividend fee, in a manner consistent with federal law.~~

~~14167.35. (a) The Coverage Dividend Revenue Fund is hereby created in the State Treasury. Notwithstanding Section 16305.7 of the Government Code, any interest earned on deposits in the fund shall be retained in the fund for purposes specified in subdivision (c).~~

~~(b) All fees and interest required to be paid to the state pursuant to this article shall be paid in the form of remittances payable to the department. The department shall directly transmit the payments to the Treasurer to be deposited in the Coverage Dividend Revenue Fund.~~

~~(c) All funds in the Coverage Dividend Revenue Fund, together with any interest, and penalties, shall be used only for the following purposes in the following order of priority, subject to the requirements of subdivision (d):~~

~~(1) To make increased payments to hospitals pursuant to Article 5.21 (commencing with Section 14167.1).~~

~~(2) To pay for the expansion of health care coverage for children. The maximum amount of the coverage dividend fee that may be used for this purpose shall be eighty million dollars ($80,000,000) for each quarter during the 2008–09 federal fiscal year that begins after the actual date on which all federal approvals are obtained that are necessary to implement Article 5.21 (commencing with Section 14167.1) and this article for phase 1, and each quarter that begins after the actual date on which all federal approvals are obtained that are necessary to implement Article 5.21 (commencing with Section 14167.1) and this article for phase 2 and ends on or before December 31, 2010.~~

~~(3) To be used to make the increased payments to managed health care plans pursuant to Article 5.21 (commencing with Section 14167.1). The amount used for making increased payments to managed health care plans shall be limited to the maximum amount approved by the federal Centers for Medicare and Medicaid Services for purposes of federal financial participation.~~

~~(d) No portion of the Coverage Dividend Revenue Fund shall be used in support of the administration of the department except that these fees may be used in combination with federal funds to fund the actual cost of collecting the fee.~~

~~(e) Notwithstanding Section 13340 of the Government Code, the Coverage Dividend Revenue Fund shall be continuously appropriated to the department for the purposes described in subdivision (c) without regard to fiscal year.~~

~~(f) In seeking federal approval pursuant to Section 14167.37, the department shall seek specific approval from the federal Centers for Medicare and Medicaid Services to exempt providers identified in this article as exempt from the fees specified, including the submission, as may be necessary, of a request for waiver of the broad-based requirement, waiver of the uniform tax requirement, or both, pursuant to Section 433.68(e)(1) and (e)(2) of Title 42 of the Code of Federal Regulations. The department shall separately seek approval for phase 1 and for phase 2.~~

~~(g) Any methodology specified in Article 5.21 (commencing with Section 14167.1) and this article may be modified by the department, in consultation with the hospital community, to the extent necessary to meet the requirements of federal law or regulations or to obtain federal approval, provided the modifications do not violate the intent of Article 5.21 (commencing with Section 14167.1) or this article and are not inconsistent with the conditions of implementation set forth in subdivisions (a) and (c) of Section 14167.36.~~

~~(h) The department, in consultation with the hospital community, shall make retrospective adjustments, as necessary, to the amounts calculated pursuant to Section 14167.32 in order to ensure compliance with the federal limits set forth in Section 433.68 of Title 42 of the Code of Federal Regulations or elsewhere in federal law.~~

~~14167.36. (a) This article shall only be implemented so long as the following conditions are met:~~

~~(1) The coverage dividend fee is established in a manner consistent with this article.~~

~~(2) The coverage dividend fee is deposited, including any interest on the fee after collection by the department, in a segregated fund apart from the General Fund.~~

~~(3) The proceeds of the coverage dividend fee, including any interest, penalties, and related federal reimbursement, are only used for the purposes set forth in this article.~~

~~(b) No hospital shall be required to pay the coverage dividend fee to the department unless and until the state receives and maintains federal approval of the coverage dividend fee and Article 5.21 (commencing with Section 14167.1) from the federal Centers for Medicare and Medicaid Services for the period for which the coverage dividend fee is assessed.~~

~~(c) Hospitals shall be required to pay the coverage dividend fee to the department as set forth in this article only as long as all of the following conditions are met:~~

~~(1) The federal Centers for Medicare and Medicaid Services allows the use of the coverage dividend fee as set forth in this article for the period for which the coverage dividend fee is assessed.~~

~~(2) The Medi-Cal Hospital Provider Rate Stabilization Act (Article 5.21 (commencing with Section 14167.1)) is enacted and~~

~~remains in effect and hospitals are reimbursed the increased rates beginning on the implementation date, as defined in subdivision (e) of Section 14167.1.~~

~~(3) The full amount of the coverage dividend fee assessed and collected pursuant to this article remains available only for the purposes specified in this article.~~

~~(d) This article shall become inoperative in the event, and on the effective date, of a final judicial determination made by any state or federal court that is not appealed, or by a court of appellate jurisdiction that is not further appealed, in any action by any party, or a final determination by the administrator of the federal Centers for Medicare and Medicaid Services, that the coverage dividend fee assessed and collected pursuant to this article cannot be implemented.~~

~~14167.37. (a) The director shall seek federal approval for the implementation of each element of this article. If, after seeking phase 1 approval, federal approval is denied, this article shall become inoperative during the period between the date that this article becomes effective and September 30, 2009. If, after seeking phase 2 approval, federal approval is denied, this article shall become inoperative during the period between October 1, 2009, and December 31, 2010.~~

~~(b) Each and every report or informational submission required from providers pursuant to this article shall contain a legal verification to be signed by the provider verifying that the information provided is true and correct, and that any information in supporting documents submitted by the provider is true and correct.~~

~~14167.38. (a) It is the intent of the Legislature to enact additional legislation that will specify more precisely the calculation of the amount of the coverage dividend fee due from individual hospitals under this article.~~

~~(b) No coverage dividend fee shall be made due or payable pursuant to this article until the legislation described in subdivision (a) has been enacted.~~

~~14167.39. This article shall remain in effect only until the earlier of the following dates and as of that date is repealed:~~

~~(a) January 1, 2013.~~

~~(b) The date the director executes a declaration, which shall be submitted to the Secretary of State, the Assembly and Senate~~

~~Committees on Health, the Assembly and Senate Committees on Appropriations, the Assembly Committee on Budget, and the Senate Committee on Budget and Fiscal Review, stating any one of the following:~~

~~(1) One or more of the conditions listed in subdivision (a) of Section 14167.36 have not been met.~~

~~(2) A final judicial or administrative determination described in subdivision (d) of Section 14167.36 has been made.~~

~~(3) Federal approval for implementation of this article has been denied.~~

SEC. 3. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make the necessary statutory changes to increase Medi-Cal payments to hospitals and improve access, at the earliest possible time, so as to allow this act to be operative as soon as approval from the federal Centers for Medicare and Medicaid Services is obtained by the State Department of Health Care Services, it is necessary that this act take effect immediately.

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