

AMENDED IN SENATE SEPTEMBER 4, 2009
AMENDED IN SENATE SEPTEMBER 3, 2009
AMENDED IN SENATE AUGUST 18, 2009
AMENDED IN SENATE JULY 15, 2009
AMENDED IN SENATE JULY 9, 2009
AMENDED IN SENATE JULY 1, 2009
AMENDED IN SENATE JUNE 25, 2009
AMENDED IN SENATE JUNE 17, 2009
AMENDED IN SENATE JUNE 11, 2009
AMENDED IN ASSEMBLY JUNE 1, 2009
AMENDED IN ASSEMBLY MAY 14, 2009
AMENDED IN ASSEMBLY APRIL 30, 2009

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, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 1383, as amended, Jones. Medi-Cal: hospital payments: quality assurance fees.

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. The Medi-Cal program is partially governed and funded as part of the federal Medicare Program. 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 make supplemental payments for certain services, as specified, to private hospitals, nondesignated public hospitals, and designated public hospitals, as defined, for subject federal fiscal years, which this bill would define to mean federal fiscal years that end after the latest effective date all federal approvals or waivers necessary for the implementation of these supplemental payments and begin before December 31, 2010. This bill would also require the department to pay direct grants in support of health care expenditures to designated public hospitals for each subject federal fiscal year, as specified.

This bill would require the department to make enhanced payments to managed health care plans, as defined, and would require the state to make enhanced payments to mental health plans, as defined, for each subject federal fiscal year, as specified. This bill would require the managed health care plans and mental health plans that received enhanced payments to make supplemental payments to subject hospitals, as defined, pursuant to specified formulas.

This bill would provide that the above-described payments shall be made only from the quality assurance fee that is due and payable on or before December 31, 2010, and related matching federal funds.

This bill would require the Director of Health Care Services to submit any state plan amendment or waiver request that may be necessary to implement the above provisions.

This bill would provide for the imposition, as a condition of participation in state-funded health insurance programs, other than the Medi-Cal program, of a quality assurance fee, as specified, on certain

general acute care hospitals through, and including, December 31, 2010. The bill would further provide that, effective January 1, 2011, the aggregate quality assurance fee, as defined, including certain quality assurance fee rates, shall be assessed only upon enactment of a subsequent statute. This bill would require the department to seek federal approval, as defined, for assessment of the fee.

This bill would provide that no hospital shall be required to pay the quality assurance fee to the department unless and until the state receives and maintains federal approval of the quality assurance fee for the above-described additional payments from the federal Centers for Medicare and Medicaid Services (CMS). The bill would require hospitals, for calendar quarters prior to federal approval of the fee, and in the calendar quarter in which the department receives notice of federal approval of the fee, to certify to the best of its knowledge, on a form provided by the department, that the hospital is prepared to pay the fee. The bill would provide that within 30 days of when federal approval is received, the hospitals shall pay the amount they certified they were prepared to pay multiplied by certain applicable fee percentages, except that, in the event that the director has made modifications to the fee model to secure federal approval, the hospital shall pay the above-described amount adjusted to reflect the director's modifications.

This bill would create the Hospital Quality Assurance Revenue Fund in the State Treasury and require the money collected from the quality assurance fee be deposited into the fund. This bill would provide that the moneys in the fund shall, upon appropriation by the Legislature, be available only for certain purposes, including providing the above-described supplemental payments and health care coverage for children.

This bill would appropriate \$1,000,000 from the Private Hospital Supplemental Fund *and \$1,000,000 from the Federal Trust Fund* to the department to pay the department's staffing and administrative costs associated with the above-described provisions, including for workload associated with seeking the necessary federal approvals to implement the above-described provisions and \$13,500,000,000 from the Hospital Quality Assurance Revenue Fund to the department for the above-described purposes to be available for expenditure until January 1, 2013. If the department obtains federal approval, the bill would require the department to use money in the Hospital Quality Assurance Revenue Fund to reimburse \$1,000,000 to the Private Hospital Supplemental Fund. If the department does not obtain federal approval,

the bill would require any unexpended moneys from the \$1,000,000 appropriated to the department from the Private Hospital Supplemental Fund pursuant to this bill to revert to the Private Hospital Supplemental Fund.

This bill would require the department to provide the Joint Legislative Budget Committee and the fiscal and appropriate policy committee of the Legislature a status update of the implementation of the above-described provisions, on January 1, 2010, and quarterly thereafter.

This bill would provide that the above provisions shall not be implemented with respect to the 2009–10 and 2010–11 federal fiscal years until the earlier of April 30, 2010, or the date the federal government approves a federal waiver for a demonstration that will replace the Medi-Cal Hospital/Uninsured Care Demonstration Project Act.

This bill would, under specified conditions, provide that the above provisions shall become inoperative if, among other things, CMS denies approval for, or does not approve before January 1, 2012, the implementation of the above provisions. This bill would, in the event certain conditions occur, also authorize the director to decide not to implement or to discontinue implementation of the above-described provisions and to retroactively invalidate the requirements for supplemental payments or other payments made pursuant to this bill.

This bill would repeal the above provisions on January 1, 2013.

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

Vote: $\frac{2}{3}$. Appropriation: yes. Fiscal committee: yes.

State-mandated local program: no.

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

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

4

5 Article 5.21. Medi-Cal Hospital Provider Rate Stabilization
6 Act
7

8 14167.1. (a) "Acute psychiatric days" means the total number
9 of Short-Doyle administrative days, Short-Doyle acute care days,
10 acute psychiatric administrative days, and acute psychiatric acute

1 days identified in the Final Medi-Cal Utilization Statistics for the
2 2008–09 state fiscal year as calculated by the department on
3 September 15, 2008.

4 (b) “Converted hospital” means a private hospital that becomes
5 a designated public hospital or a nondesignated public hospital
6 after the implementation date, a nondesignated public hospital that
7 becomes a private hospital or a designated public hospital after
8 the implementation date, or a designated public hospital that
9 becomes a private hospital or a nondesignated public hospital after
10 the implementation date.

11 (c) “Current Section 1115 Waiver” means California’s Medi-Cal
12 Hospital/Uninsured Care Section 1115 Waiver Demonstration in
13 effect on the effective date of the article.

14 (d) “Designated public hospital” shall have the meaning given
15 in subdivision (d) of Section 14166.1 as that section may be
16 amended from time to time.

17 (e) “General acute care days” means the total number of
18 Medi-Cal general acute care days paid by the department to a
19 hospital in the 2008 calendar year, as reflected in the state paid
20 claims files on July 10, 2009.

21 (f) “High acuity days” means Medi-Cal coronary care unit days,
22 pediatric intensive care unit days, intensive care unit days, neonatal
23 intensive care unit days, and burn unit days paid by the department
24 during the 2008 calendar year, as reflected in the state paid claims
25 files on July 10, 2009.

26 (g) “Hospital inpatient services” means all services covered
27 under Medi-Cal and furnished by hospitals to patients who are
28 admitted as hospital inpatients and reimbursed on a fee-for-service
29 basis by the department directly or through its fiscal intermediary.
30 Hospital inpatient services include outpatient services furnished
31 by a hospital to a patient who is admitted to that hospital within
32 24 hours of the provision of the outpatient services that are related
33 to the condition for which the patient is admitted. Hospital inpatient
34 services include physician services only where the service is
35 furnished to a hospital inpatient, the physician is compensated by
36 the hospital for the service, and the service is billed to Medi-Cal
37 by the hospital under a provider number assigned to the hospital.
38 Hospital inpatient services do not include services for which a
39 managed health care plan is financially responsible.

1 (h) “Hospital outpatient services” means all services covered
2 under Medi-Cal furnished by hospitals to patients who are
3 registered as hospital outpatients and reimbursed by the department
4 on a fee-for-service basis directly or through its fiscal intermediary.
5 Hospital outpatient services include physician services only where
6 the service is furnished to a hospital outpatient, the physician is
7 compensated by the hospital for the service, and the service is
8 billed to Medi-Cal by the hospital under a provider number
9 assigned to the hospital. Hospital outpatient services do not include
10 services for which a managed health care plan is financially
11 responsible, or services rendered by a hospital-based federally
12 qualified health center for which reimbursement is received
13 pursuant to Section 14132.100.

14 (i) (1) “Implementation date” means the latest effective date
15 of all federal approvals or waivers necessary for the implementation
16 of this article and Article 5.22 (commencing with Section
17 14167.31), including, but not limited to, any approvals on
18 amendments to contracts between the department and managed
19 health care plans or mental health plans necessary for the
20 implementation of this article. The effective date of a federal
21 approval of a contract amendment shall be the earliest date to
22 which the computation of payments under the contract amendment
23 is applicable that may be prior to the date on which the contract
24 amendment is executed.

25 (2) If federal approval is sought initially for only the 2008–09
26 federal fiscal year and separately secured for subsequent federal
27 fiscal years, the implementation date for the 2008–09 federal fiscal
28 year shall occur when all necessary federal approvals have been
29 secured for that federal fiscal year.

30 (j) “Individual hospital acute psychiatric supplemental payment”
31 means the total amount of acute psychiatric hospital supplemental
32 payments to a subject hospital for a quarter for which the
33 supplemental payments are made. The “individual hospital acute
34 psychiatric supplemental payment” shall be calculated for subject
35 hospitals by multiplying the number of acute psychiatric days for
36 the individual hospital for which a mental health plan was
37 financially responsible by four hundred eighty-five dollars (\$485)
38 and dividing the result by 4.

39 (k) “Individual hospital managed care supplemental payment”
40 means the total amount of managed care hospital supplemental

1 payments to a subject hospital for a month for which the
2 supplemental payments are made.

3 (1) The “individual hospital managed care supplemental
4 payment” shall be calculated for private hospitals and designated
5 public hospitals by multiplying the number of Medi-Cal managed
6 care days for the individual hospital by one thousand three hundred
7 forty-one dollars and eighty-nine cents (\$1,341.89) and dividing
8 the result by 12.

9 (2) The “individual hospital managed care supplemental
10 payment” shall be calculated for nondesignated public hospitals
11 by multiplying the number of Medi-Cal managed care days for the
12 individual hospital by three hundred seventy-five dollars (\$375)
13 and dividing the result by 12.

14 (l) (1) “Managed health care plan” means a health care delivery
15 system that manages the provision of health care and receives
16 prepaid capitated payments from the state in return for providing
17 services to Medi-Cal beneficiaries.

18 (2) (A) Managed health care plans, include, but are not limited
19 to, county organized health systems, prepaid health plans, and
20 entities contracting with the department to provide services
21 pursuant to two-plan models and geographic managed care. Entities
22 providing these services contract with the department pursuant to
23 any of the following:

24 (i) Article 2.7 (commencing with Section 14087.3).

25 (ii) Article 2.8 (commencing with Section 14087.5).

26 (iii) Article 2.81 (commencing with Section 14087.96)

27 (iv) Article 2.91 (commencing with Section 14089).

28 (v) Article 1 (commencing with Section 14200) of Chapter 8.

29 (vi) Article 7 (commencing with Section 14490) of Chapter 8.

30 (B) Managed health care plans do not include any mental health
31 plan contracting to provide mental health care for Medi-Cal
32 beneficiaries pursuant to Part 2.5 (commencing with Section 5775)
33 of Division 5.

34 (m) “Medi-Cal managed care days” means the total number of
35 general acute care days, including well baby days, listed for the
36 county organized health system and prepaid health plans identified
37 in the Final Medi-Cal Utilization Statistics for the 2008–09 state
38 fiscal year, as calculated by the department on September 15, 2008,
39 except that the general acute care days, including well baby days,
40 for the Santa Barbara Health Care Initiative shall be derived from

1 the Final Medi-Cal Utilization Statistics for the 2007–08 state
2 fiscal year.

3 (n) “Medicaid inpatient utilization rate” means Medicaid
4 inpatient utilization rate as defined in Section 1396r-4 of Title 42
5 of the United States Code and as set forth in the final
6 disproportionate share hospital eligibility list for the 2008–09 state
7 fiscal year released by the department on October 22, 2008.

8 (o) “Mental health plan” means a mental health plan that
9 contracts with the State Department of Mental Health to furnish
10 or arrange for the provision of mental health services to Medi-Cal
11 beneficiaries pursuant to Part 2.5 (commencing with Section 5775)
12 of Division 5.

13 (p) “New hospital” means a hospital that was not in operation
14 under current or prior ownership as a private hospital, a
15 nondesignated public hospital, or a designated public hospital for
16 any portion of the 2008–09 state fiscal year.

17 (q) “Nondesignated public hospital” means a public hospital
18 that is licensed under subdivision (a) of Section 1250 of the Health
19 and Safety Code, is not designated as a specialty hospital in the
20 hospital’s annual financial disclosure report for the hospital’s latest
21 fiscal year ending in 2007, and satisfies the definition in paragraph
22 (25) of subdivision (a) of Section 14105.98, excluding designated
23 public hospitals.

24 (r) “Outpatient base amount” means the total amount of
25 payments for hospital outpatient services made to a hospital in the
26 2007 calendar year, as reflected in state paid claims files on January
27 26, 2008.

28 (s) “Private hospital” means a hospital that meets all of the
29 following conditions:

30 (1) Is licensed pursuant to subdivision (a) of Section 1250 of
31 the Health and Safety Code.

32 (2) Is in the Charitable Research Hospital peer group, as set
33 forth in the 1991 Hospital Peer Grouping Report published by the
34 department, or is not designated as a specialty hospital in the
35 hospital’s Office of Statewide Health Planning and Development
36 Annual Financial Disclosure Report for the hospitals latest fiscal
37 year ending in 2007.

38 (3) Does not satisfy the Medicare criteria to be classified as a
39 long-term care hospital.

1 (4) Is a nonpublic hospital, nonpublic converted hospital, or
2 converted hospital as those terms are defined in paragraphs (26)
3 to (28), inclusive, respectively, of subdivision (a) of Section
4 14105.98.

5 (t) "Subject federal fiscal year" means a federal fiscal year that
6 ends after the implementation date and begins before December
7 31, 2010.

8 (u) "Subject hospital" shall mean a hospital that meets all of the
9 following conditions:

10 (1) Is licensed pursuant to subdivision (a) of Section 1250 of
11 the Health and Safety Code.

12 (2) Is in the Charitable Research Hospital peer group, as set
13 forth in the 1991 Hospital Peer Grouping Report published by the
14 department, or is not designated as a specialty hospital in the
15 hospital's Office of Statewide Health Planning and Development
16 Annual Financial Disclosure Report for the hospitals latest fiscal
17 year ending in 2007.

18 (3) Does not satisfy the Medicare criteria to be classified as a
19 long-term care hospital.

20 (v) "Subject month" means a calendar month beginning on or
21 after the implementation date and ending before January 1, 2011.

22 (w) "Upper payment limit" means a federal upper payment limit
23 on the amount of the Medicaid payment for which federal financial
24 participation is available for a class of service and a class of health
25 care providers, as specified in Part 447 of Title 42 of the Code of
26 Federal Regulations.

27 14167.2. (a) Private hospitals shall be paid supplemental
28 amounts for the provision of hospital outpatient services as set
29 forth in this section. The supplemental amounts shall be in addition
30 to any other amounts payable to hospitals with respect to those
31 services and shall not affect any other payments to hospitals.

32 (b) Except as set forth in subdivisions (e) and (f), each private
33 hospital shall be paid an amount for each subject federal fiscal
34 year equal to a percentage of the hospital's outpatient base amount.
35 The percentage shall be the same for each hospital for a subject
36 federal fiscal year and shall result in payments to hospitals which
37 equals the applicable federal upper payment limit.

38 (c) In the event federal financial participation for a subject
39 federal fiscal year is not available for all of the supplemental
40 amounts payable to private hospitals under subdivision (b) due to

1 the application of a federal upper limit or for any other reason,
2 both of the following shall apply:

3 (1) The total amount payable to private hospitals under
4 subdivision (b) for the subject federal fiscal year shall be reduced
5 to the amount for which federal financial participation is available.

6 (2) The amount payable under subdivision (b) to each private
7 hospital for the subject federal fiscal year shall be equal to the
8 amount computed under subdivision (b) multiplied by the ratio of
9 the total amount for which federal financial participation is
10 available to the total amount computed under subdivision (b).

11 (d) The supplemental amounts set forth in this section are
12 inclusive of federal financial participation.

13 (e) No payments shall be made under this section to a new
14 hospital.

15 (f) No payments shall be made under this section to a converted
16 hospital for the subject federal fiscal year in which the hospital
17 becomes a converted hospital or for subsequent subject federal
18 fiscal years.

19 14167.3. (a) Private hospitals shall be paid supplemental
20 amounts for the provision of hospital inpatient services and
21 subacute services as set forth in this section. The supplemental
22 amounts shall be in addition to any other amounts payable to
23 hospitals with respect to those services and shall not affect any
24 other payments to hospitals.

25 (b) Except as set forth in subdivisions (g) and (h), each private
26 hospital shall be paid the following amounts as applicable for the
27 provision of hospital inpatient services for each subject federal
28 fiscal year:

29 (1) Six hundred forty-seven dollars and seventy cents (\$647.70)
30 multiplied by the hospital's general acute care days.

31 (2) Four hundred eighty-five dollars (\$485) multiplied by the
32 hospital's acute psychiatric days that were paid directly by the
33 department and were not the financial responsibility of a mental
34 health plan.

35 (3) One thousand three hundred fifty dollars (\$1,350) multiplied
36 by the number of the hospital's high acuity days if the hospital's
37 Medicaid inpatient utilization rate is less than 41.1 percent, at least
38 five percent of the hospital's general acute care days are high acuity
39 days, and the hospital is not a small and rural hospital as defined
40 in Section 124840 of the Health and Safety Code. This amount

1 shall be in addition to the amounts specified in paragraphs (1) and
2 (2).

3 (4) One thousand three hundred fifty dollars (\$1,350) multiplied
4 by the number of the hospital's high acuity days if the hospital
5 qualifies to receive the amount set forth in paragraph (3) and has
6 been designated as a Level I, Level II, Adult/Ped Level I, or
7 Adult/Ped Level II trauma center by the emergency medical
8 services authority established pursuant to Section 1797.1 of the
9 Health and Safety Code. This amount shall be in addition to the
10 amounts specified in paragraphs (1), (2), and (3).

11 (c) A private hospital that provides Medi-Cal subacute services
12 during a subject federal fiscal year and has a Medicaid inpatient
13 utilization rate that is greater than 5.0 percent and less than 26.10
14 percent shall be paid for the provision of subacute services during
15 each subject federal fiscal year a supplemental amount equal to
16 50 percent of the Medi-Cal subacute payments made to the hospital
17 during the 2008 calendar year.

18 (d) (1) In the event federal financial participation for a subject
19 federal fiscal year is not available for all of the supplemental
20 amounts payable to private hospitals under subdivision (b) due to
21 the application of a federal limit or for any other reason, both of
22 the following shall apply:

23 (A) The total amount payable to private hospitals under
24 subdivision (b) for the subject federal fiscal year shall be reduced
25 to reflect the amount for which federal financial participation is
26 available.

27 (B) The amount payable under subdivision (b) to each private
28 hospital for the subject federal fiscal year shall be equal to the
29 amount computed under subdivision (b) multiplied by the ratio of
30 the total amount for which federal financial participation is
31 available to the total amount computed under subdivision (b).

32 (2) In the event federal financial participation for a subject
33 federal fiscal year is not available for all of the supplemental
34 amounts payable to private hospitals under subdivision (c) due to
35 the application of a federal upper limit or for any other reason,
36 both of the following shall apply:

37 (A) The total amount payable to private hospitals under
38 subdivision (c) for the subject federal fiscal year shall be reduced
39 to reflect the amount for which federal financial participation is
40 available.

(B) The amount payable under subdivision (c) to each private hospital for the subject federal fiscal year shall be equal to the amount computed under subdivision (c) multiplied by the ratio of the total amount for which federal financial participation is available to the total amount computed under subdivision (c).

(e) In the event the amount otherwise payable to a hospital under this section for a subject federal fiscal year exceeds the amount for which federal financial participation is available for that hospital, the amount due to the hospital for that federal fiscal year shall be reduced to the amount for which federal financial participation is available.

(f) The amounts set forth in this section are inclusive of federal financial participation.

(g) No payments shall be made under this section to a new hospital.

(h) No payments shall be made under this section to a converted hospital for the subject federal fiscal year in which the hospital becomes a converted hospital or for subsequent subject federal fiscal years.

14167.4. (a) Nondesignated public hospitals shall be paid supplemental amounts for the provision of hospital inpatient services as set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services and shall not affect any other payments to hospitals.

(b) Except as set forth in subdivisions (f) and (g), each nondesignated public hospital shall be paid the following amounts for each subject federal fiscal year:

(1) Two hundred eighteen dollars and eighty-two cents (\$218.82) multiplied by the hospital's general acute care days.

(2) Four hundred eighty-five dollars (\$485) multiplied by the hospital's acute psychiatric days that were paid directly by the department and were not the financial responsibility of a mental health plan.

(c) In the event federal financial participation for a subject federal fiscal year is not available for all of the supplemental amounts payable to nondesignated public hospitals under subdivision (b) due to the application of a federal upper payment limit or for any other reason, both of the following shall apply:

1 (1) The total amount payable to nondesignated public hospitals
2 under subdivision (b) for the subject federal fiscal year shall be
3 reduced to the amount for which federal financial participation is
4 available.

5 (2) The amount payable under subdivision (b) to each
6 nondesignated public hospital for the subject federal fiscal year
7 shall be equal to the amount computed under subdivision (b)
8 multiplied by the ratio of the total amount for which federal
9 financial participation is available to the total amount computed
10 under subdivision (b).

11 (d) In the event the amount otherwise payable to a hospital under
12 this section for a subject federal fiscal year exceeds the amount
13 for which federal financial participation is available for that
14 hospital, the amount due to the hospital for that federal fiscal year
15 shall be reduced to the amount for which federal financial
16 participation is available.

17 (e) The amounts set forth in this section are inclusive of federal
18 financial participation.

19 (f) No payments shall be made under this section to a new
20 hospital.

21 (g) No payments shall be made under this section to a converted
22 hospital for the subject federal fiscal year in which the hospital
23 becomes a converted hospital or for subsequent subject federal
24 fiscal years.

25 14167.5. (a) Designated public hospitals shall be paid direct
26 grants in support of health care expenditures, which shall not
27 constitute Medi-Cal payments, and which shall be funded by the
28 quality assurance fee set forth in Article 5.22 (commencing with
29 Section 14167.31). The aggregate amount of the grants to
30 designated public hospitals for each subject federal fiscal year
31 shall be three hundred ten million dollars (\$310,000,000).

32 (b) The director shall allocate the amount specified in
33 subdivision (a) among the designated public hospitals in accordance
34 with this subdivision. In determining the allocation, the director
35 shall rely on data from the Interim Hospital Payment Rate
36 Workbooks. For purposes of this section, "Interim Hospital
37 Payment Rate Workbook" means the Interim Hospital Payment
38 Rate Workbook, developed by the department and approved by
39 the federal Centers for Medicare and Medicaid Services for use in
40 connection with the Medi-Cal Hospital/Uninsured Care 1115

1 Waiver Demonstration, as submitted by each designated public
2 hospital, or the governmental entity with which the hospital is
3 affiliated, on or around June 2009 for the period of July 1, 2007,
4 to June 30, 2008, inclusive.

5 (1) Each designated public hospital's share of 80 percent of the
6 amount specified in subdivision (a) shall be determined by applying
7 a fraction, the numerator of which is the certified public
8 expenditures reported by the designated public hospital as
9 allowable Medi-Cal inpatient expenditures on Schedule 2.1,
10 Column 5, Step 5 of the Interim Hospital Payment Rate Workbook,
11 and the denominator of which is the total amount of certified public
12 expenditures reported as allowable Medi-Cal inpatient expenditures
13 by all designated public hospitals on Schedule 2.1, Column 5, Step
14 5 of the Interim Hospital Payment Rate Workbooks.

15 (2) Each designated public hospital's share of 20 percent of the
16 amount described in subdivision (a) shall be determined by
17 applying a fraction, the numerator of which is the sum of the
18 uninsured days of inpatient hospital services reported by the
19 designated public hospital on Schedule 1, Column 5a, lines 25
20 through 33 of the Interim Hospital Payment Rate Workbook, and
21 the denominator of which is the total uninsured days of inpatient
22 hospital services reported by all designated public hospitals on
23 Schedule 1, Column 5a, lines 25 through 33 of the Interim Hospital
24 Payment Rate Workbooks.

25 (c) In the event federal financial participation for a subject
26 federal fiscal year is not available for all of the supplemental
27 amounts payable to private hospitals under Section 14167.3, due
28 to the limitations on supplemental payments based on a partial-year
29 federal upper payment limit, the amount payable to each designated
30 public hospital under subdivision (b) shall equal the designated
31 public hospital's allocated grant amount under subdivision (b)
32 multiplied by a fraction, the numerator of which is the total number
33 of months in the subject federal fiscal year for which federal
34 financial participation is available for supplemental payment
35 amounts to private hospitals up to the federal upper payment limit,
36 and the denominator of which is 12.

37 (d) Designated public hospitals shall be paid supplemental
38 Medi-Cal amounts for acute inpatient psychiatric services that are
39 paid directly by the department and are not the financial
40 responsibility of a mental health plan, as set forth in this

1 subdivision. The supplemental amounts shall be in addition to any
2 other amounts payable to designated public hospitals, or a
3 governmental entity with which the hospital is affiliated, with
4 respect to those services and shall not affect any other payments
5 to hospitals or to any governmental entity with which the hospital
6 is affiliated.

7 (1) Each designated public hospital shall be paid an amount for
8 each subject federal fiscal year equal to four hundred eighty-five
9 dollars (\$485) multiplied by the hospital's acute psychiatric days
10 that were paid directly by the department and were not the financial
11 responsibility of a mental health plan, inclusive of federal financial
12 participation.

13 (2) In the event federal financial participation for a subject
14 federal fiscal year is not available for all of the supplemental
15 amounts payable to designated public hospitals under paragraph
16 (1) due to the application of a federal upper payment limit or for
17 any other reason, both of the following shall apply:

18 (A) The total amount payable to designated public hospitals
19 under paragraph (1) for the subject federal fiscal year shall be
20 reduced to the amount for which federal financial participation is
21 available.

22 (B) The amount payable under paragraph (1) to each designated
23 public hospital for the subject federal fiscal year shall be equal to
24 the amount computed under paragraph (1) multiplied by the ratio
25 of the total amount for which federal financial participation is
26 available to the total amount computed under paragraph (1).

27 (3) In the event the amount otherwise payable to a designated
28 public hospital under this subdivision for a subject federal fiscal
29 year exceeds the amount for which federal financial participation
30 is available for that hospital, the amount due to the hospital for
31 that federal fiscal year shall be reduced to the amount for which
32 federal financial participation is available.

33 14167.6. (a) The department shall enhance payments to
34 Medi-Cal managed health care plans for the subject federal fiscal
35 years as set forth in this section.

36 (b) The enhanced payments shall be made as part of the monthly
37 capitated payments made by the department to managed health
38 care plans.

1 (c) The department shall determine the amount of the enhanced
2 payments to managed health care plans for each subject month
3 consistent with the following objectives:

4 (1) Pay to managed health care plans in the aggregate the sum
5 of the individual hospital managed care supplemental payments
6 for each month.

7 (2) Result in payment of the individual hospital managed care
8 supplemental payment to each subject hospital in accordance with
9 Section 14167.10.

10 (3) Result in rates that may be certified as actuarially sound.

11 (4) Result in rates that are approved by the federal government
12 for purposes of federal financial participation.

13 (d) The department shall make enhanced payments to managed
14 health care plans exclusively for the purpose of making
15 supplemental payments to hospitals, in order to support the
16 availability of hospital services and ensure access for Medi-Cal
17 beneficiaries. Managed health care plans shall pass through
18 enhanced payments to hospitals in a manner determined by the
19 department. The enhanced payments to managed health care plans
20 shall be made as follows:

21 (1) The enhanced payments shall commence during the second
22 month following the month during which the quality assurance
23 fee set forth in Article 5.22 (commencing with Section 14167.31)
24 is due and payable from hospitals if the quality assurance fee
25 includes funds for enhanced payments to managed health care
26 plans. The last enhanced payments made pursuant to this section
27 shall be made during December 2010.

28 (2) The enhanced payments made during the first month in
29 which enhanced payments are made pursuant to this section shall
30 include the sum of the enhanced payments for all prior months for
31 which payments are due.

32 (3) The enhanced payments made during December 2010 shall
33 include payments for December 2010 to September 2011, inclusive,
34 to the extent that federal financial participation is available for the
35 enhanced payments.

36 (e) Payments to managed health care plans that would be paid
37 in the absence of the payments made pursuant to this section shall
38 not be reduced as a consequence of payment under this section.

39 (f) (1) Each managed health care plan shall expend, in the form
40 of supplemental payments to hospitals, 100 percent of any rate

1 enhanced payments it receives under this section, pursuant to
2 Section 14167.10.

3 (2) Interest earned by the managed health care plans during
4 timely implementation of subdivision (b) of Section 14167.10 shall
5 be in lieu of any administrative fee that the department might
6 otherwise pay to the plans for implementation of this article.

7 (3) The department may issue change orders to amend contracts
8 with managed health care plans on either a quarterly or semiannual
9 basis to adjust monthly capitation payments to coincide with
10 updated enrollment data so that the amounts paid to hospitals
11 pursuant to this section equals, or nearly equals, the amounts set
12 forth in subdivision (a) of Section 14167.10.

13 (g) In the event federal financial participation is not available
14 for all of the enhanced managed care payments determined for a
15 month pursuant to this section for any reason, the enhanced
16 payments mandated by this section for that month shall be reduced
17 proportionately to the amount for which federal financial
18 participation is available.

19 (h) Enhanced payments to a managed health care plan pursuant
20 to this section shall not be taken into consideration by the
21 department or the Department of Managed Health Care in
22 determining the percentage of total costs attributed to
23 administrative costs for the purposes of determining compliance
24 with any administrative costs limit, including, but not limited to,
25 those described in Sections 14087.1 and 14464, Section 1378 of
26 the Health and Safety Code, and Section 1300.78 of Title 28 of
27 the California Code of Regulations.

28 (i) Notwithstanding Chapter 3.5 (commencing with Section
29 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
30 the department shall implement this section by means of policy
31 letters or similar instructions, without taking further regulatory
32 action.

33 14167.7. (a) The amount of any payments made under this
34 article to private hospitals, including the amount of payments made
35 under Sections 14167.2 and 14167.3 and additional payments to
36 private hospitals by managed health care plans pursuant to Section
37 14167.6, shall not be included in the calculation of the low-income
38 percent or the OBRA 1993 payment limitation, as defined in
39 paragraph (24) of subdivision (a) of Section 14105.98, for purposes

1 of determining payments to private hospitals pursuant to Section
2 14166.11.

3 (b) The amount of any payments made to a hospital under this
4 article shall not be included in the calculation of stabilization
5 funding under Article 5.20 (commencing with Section 14166).

6 14167.8. The payments to a hospital under this article shall not
7 be made for a subject federal fiscal year or any portion of a subject
8 federal fiscal year during which the hospital is closed. A hospital
9 shall be deemed to be closed on the first day of any period during
10 which the hospital has no acute inpatients for at least 30
11 consecutive days. A hospital's payments under this article for a
12 subject federal fiscal year during which a hospital is closed for a
13 portion of the subject federal fiscal year shall be reduced by
14 applying a fraction, expressed as a percentage, the numerator of
15 which shall be the number of days after the implementation date
16 during the subject federal fiscal year that the hospital is closed and
17 the denominator of which is the number of days in the subject
18 federal fiscal year after the implementation date.

19 14167.9. Subject to the limitations in Section 14167.4, the
20 following shall apply:

21 (a) The payments to hospitals under Sections 14167.2, 14167.3,
22 14167.4, and 14167.5 for the 2008–09 federal fiscal year shall be
23 made on or before the 45th day following the day on which federal
24 approval is granted.

25 (b) The payments to hospitals under Sections 14167.2, 14167.3,
26 14167.4, and 14167.5 for the 2009–10 federal fiscal year shall be
27 made on a quarterly basis. The amounts payable to a hospital for
28 each quarter shall be one-fourth of the amount payable to the
29 hospital for the entire federal fiscal year, except as may be adjusted
30 by the department under Section 14167.8. Payments to hospitals
31 for each quarter during the 2009–10 federal fiscal year shall be
32 made the later of the last day of the second month of the quarter
33 or the 45th day following the day on which federal approval is
34 granted.

35 (c) The payments to hospitals under Sections 14167.2, 14167.3,
36 14167.4, and 14167.5 for the 2010–11 federal fiscal year shall be
37 made on or before the later of December 31, 2010, or the 45th day
38 following the day on which federal approval is granted.

39 (d) For purposes of this subdivision, "federal approval" shall
40 have the meaning set forth in subdivision (h) of Section 14167.31.

1 14167.10. (a) (1) At the same time that the department makes
2 an enhanced payment to a managed health care plan under Section
3 14167.6, the department shall notify the plan of each hospital to
4 which the plan shall make supplemental managed care payments
5 as a consequence of receiving the enhanced payment and the
6 amount of the supplemental payment. The department shall
7 determine the amount of the supplemental payment due to each
8 subject hospital so that the total supplemental managed care
9 payments to the hospital from all managed health care plans
10 resulting from payments made to the managed health care plans
11 for the subject month under Section 14167.6 equals or
12 approximately equals the hospital's individual hospital managed
13 care supplemental payment.

14 (2) In the case of the enhanced payments made to a managed
15 health care plan during the first month in which the payments are
16 made to the plan, the amounts of supplemental payments due to
17 each hospital pursuant to paragraph (1) shall be multiplied by the
18 number of months for which the enhanced payments were made.

19 (3) The notice provided by the department in connection with
20 the enhanced managed care payments to each managed health care
21 plan during December 2010 shall also direct the managed health
22 care plan to make monthly supplemental payments to hospitals for
23 months, if any, from January 2011 to September 2011, inclusive,
24 for which federal financial participation is available as described
25 in paragraph (3) of subdivision (d) of Section 14167.6 and the
26 amount of the supplemental payments as calculated pursuant to
27 this subdivision.

28 (b) Each managed health care plan receiving payments under
29 Section 14167.6 shall make supplemental payments to hospitals
30 within 30 days of receiving the payments under Section 14167.6,
31 except that if the managed health care plan receives enhanced
32 payments during December 2010, which include payments relating
33 to some or all of the month of January 2011 to September 2011,
34 inclusive, the managed health care plan shall make payments
35 relating to the months of January 2011 to September 2011,
36 inclusive, during each month to which the payment relates. The
37 payments shall be made to those hospitals and in those amounts
38 set forth by the department in its notice provided pursuant to
39 subdivision (a).

1 (c) The supplemental payments made to hospitals pursuant to
2 this section shall be in addition to any other amounts payable to
3 hospitals by a managed health care plan or otherwise and shall not
4 affect any other payments to hospitals.

5 (d) For each subject federal fiscal year, the sum of all
6 supplemental payments made by a managed health care plan to
7 subject hospitals pursuant to this section shall equal, or
8 approximately equal, all enhanced payments received by the
9 managed health care plan from the department pursuant to Section
10 14167.6.

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

14 (f) The obligations of a Medi-Cal managed health care plan to
15 make payments to a hospital for services furnished by the hospital
16 that are not covered by a contract between the managed health
17 care plan and the hospital, including the amounts of payments
18 required apart from payments under this article, shall not be
19 affected by any payments made under this article.

20 (g) In the event federal financial participation for a month is
21 not available for all of the enhanced managed health care plan
22 payments pursuant to Section 14167.6 for any reason, the
23 supplemental payments made to hospitals under this section shall
24 be reduced proportionately to the amount for which federal
25 financial participation is available, and the department's notice
26 under subdivision (a) shall reflect that reduction.

27 (h) No payments shall be made under this section to a new
28 hospital.

29 (i) Any delegation or attempted delegation by a managed health
30 care plan of its obligation to make payments under this section
31 shall not relieve the plan from its obligation to make those
32 payments. Managed health care plans shall submit the
33 documentation the department may require to demonstrate
34 compliance with this subdivision. The documentation shall
35 demonstrate actual payments to hospitals, and not assignment to
36 subcontractors of the managed health care plan's obligation of the
37 duty to pay hospitals. The department and each managed health
38 care plan shall make available to each subject hospital, within 15
39 days of receipt of the hospital's written request, documentation
40 demonstrating the amount that the plan paid to the subject hospital

1 for a subject month and the amount due from the plan to the subject
2 hospital for the subject month.

3 (j) If the department determines that a managed health care plan
4 has failed to pay any enhanced payment amounts it received
5 pursuant to Section 14167.6 to hospitals as required by this section,
6 the department shall immediately recover the amounts determined
7 by an offset to the capitation payments made to the managed health
8 care plan and by any other legal means available. At least 30
9 calendar days prior to seeking any recovery, the department shall
10 notify the managed health care plan to explain the nature of the
11 department's determination, to establish the amount of the
12 enhanced payment amount in excess of supplemental payments to
13 hospitals, and to describe the recovery process. The department
14 may terminate any or all contracts between the department and a
15 managed health care plan that fails to make payments as required
16 by this section.

17 (k) The department shall pay to a managed health care plan or
18 plans, as the director determines is or are appropriate, any amounts
19 recovered under subdivision (i) for the purpose of making payments
20 to hospitals pursuant to this section and shall direct the managed
21 health care plan or plans receiving those amounts to make specific
22 payments to specific hospitals to ensure that hospitals receive the
23 amounts set forth in this section.

24 (l) Managed health care plans shall in no event be obligated
25 under this section to make supplemental payments to hospitals that
26 exceed the enhanced payments made to the managed care health
27 plans under Section 14167.6.

28 14167.11. (a) The department shall increase payments to
29 mental health plans for the subject federal fiscal years as set forth
30 in this section.

31 (b) For each fiscal quarter that begins on or after the
32 implementation date, the state shall make enhanced payments to
33 each mental health plan. The amount of those enhanced payments
34 to a mental health plan shall be the sum of all individual hospital
35 acute psychiatric supplemental payments for subject hospitals
36 located in each county in which the mental health plan operates.

37 (c) The state shall make enhanced payments to mental health
38 plans exclusively for the purpose of making supplemental payments
39 to hospitals, in order to support the availability of hospital mental
40 health services and ensure access for Medi-Cal beneficiaries to

1 hospital mental health services. The enhanced payments to mental
2 health plans shall be made as follows:

3 (1) The enhanced payments shall commence on or before the
4 later of the last day of the second month of the quarter in which
5 federal approval is granted or the 45th day following the day on
6 which federal approval is granted. Subsequent enhanced payments
7 shall be made on the last day of the second month of each quarter.
8 The last enhanced payments made pursuant to this section shall
9 be made during November 2010.

10 (2) The enhanced payments made for the first quarter for which
11 enhanced payments are made under this section shall include the
12 sum of enhanced payments for all prior quarters for which
13 payments are due under subdivision (b).

14 (3) The enhanced payments made during November 2010 shall
15 include payments computed under subdivision (b) for all quarters
16 in the 2010–11 federal fiscal year to the extent that federal financial
17 participation is available for the payments.

18 (d) (1) Each mental health plan shall expend, in the form of
19 additional payments to hospitals, 100 percent of any enhanced
20 payments it receives under this section, pursuant to Section
21 14167.12.

22 (2) At the discretion of the director, the plans shall receive an
23 administrative fee, in an amount determined by the department,
24 that is in addition to the enhanced payments, that is reflective of
25 actual administrative costs and that shall be paid from the fund
26 created in Article 5.22 (commencing with Section 14167.31).

27 (e) In the event federal financial participation for a subject
28 federal fiscal year is not available for all of the enhanced acute
29 psychiatric payments determined for a quarter pursuant to this
30 section for any reason, the enhanced payments mandated by this
31 section for that quarter shall be reduced proportionately to the
32 amount for which federal financial participation is available.

33 (f) Payments to mental health plans that would be paid in the
34 absence of the payments made pursuant to this section shall not
35 be reduced as a consequence of the payments under this section.

36 (g) In the event the director determines that payment of the
37 individual acute psychiatric supplemental payments may be made
38 by the department directly to the hospitals under this section and
39 Section 14167.12 without the need for transmitting the funds
40 through the mental health plans, those direct payments shall be

1 made notwithstanding any other provision of this article or Article
2 5.22 (commencing with Section 14167.31).

3 (h) The department may, as necessary, allocate money
4 appropriated to it from the Hospital Quality Assurance Revenue
5 Fund to the State Department of Mental Health for the purposes
6 of making increased payments to mental health plans pursuant to
7 this article.

8 14167.12. (a) At the same time that the state makes an
9 enhanced payment to a mental health plan under Section 14167.11,
10 the state shall notify the mental health plan that the plan shall make
11 payments in the amount of the individual hospital acute psychiatric
12 supplemental payment to each subject hospital located in each
13 county in which the mental health plan operates as a consequence
14 of receiving the enhanced payment and the amount of the individual
15 hospital acute psychiatric supplemental payment due to each
16 hospital, subject to the following:

17 (1) In the case of the enhanced payments made to a mental
18 health plan during the first quarter in which the payments are made
19 to the plan, the notice shall direct mental health plans to make
20 supplemental payments to each hospital in an amount equal to
21 each hospital's individual hospital acute psychiatric supplemental
22 payment multiplied by the number of quarters for which the
23 enhance payments were made.

24 (2) The notice provided by the department in connection with
25 the enhanced payments to each mental health plan during
26 November 2010 shall also direct the mental health plan to make
27 quarterly supplemental payments to hospitals for quarters, if any,
28 between January 2011 and September 2011, inclusive, for which
29 federal financial participation is available as described in paragraph
30 (3) of subdivision (c) of Section 14167.11 and the amount of the
31 supplemental payments as calculated pursuant to this subdivision.

32 (b) Each mental health plan receiving payments under Section
33 14167.11 shall make supplemental payments to hospitals within
34 30 days of receiving the payments under Section 14167.11, except
35 that if the mental health plan receives enhanced payments during
36 November 2010, which include payments relating to some or all
37 of the quarters between January 2011 and September 2011,
38 inclusive, the mental health plan shall make payments relating to
39 the quarters between January 2011 and September 2011, inclusive,
40 on or before the end of each quarter to which the payment relates.

1 The payments shall be made to those hospitals and in those
2 amounts set forth by the department in its notice provided pursuant
3 to subdivision (a).

4 (c) The supplemental payments made to hospitals pursuant to
5 this section shall be in addition to any other amounts payable to
6 hospitals by a mental health plan or otherwise and shall not affect
7 any other payments to hospitals.

8 (d) For each subject federal fiscal year, the sum of all
9 supplemental payments made by a mental health plan to subject
10 hospitals pursuant to this section shall equal all enhanced payments
11 received by the mental health plan from the state pursuant to
12 Section 14167.11.

13 (e) Mental health plans shall not take into account payments
14 made pursuant to this article in negotiating the amount of payments
15 to hospitals that are not made pursuant to this article.

16 (f) A mental health plan is obligated to make payments under
17 this section only to the extent of the payments it receives under
18 Section 14167.11. A mental health plan may retain any interest it
19 earns on funds it receives under Section 14167.11 prior to making
20 payments of the funds to hospitals under this section.

21 (g) No payments shall be made under this section to a new
22 hospital.

23 (h) In the event federal financial participation for a quarter is
24 not available for all of the enhanced mental health payments made
25 pursuant to Section 14167.11 for any reason, the supplemental
26 payments to hospitals under this section shall be reduced
27 proportionately to the amount for which federal financial
28 participation is available and the department's notice under
29 subdivision (a) shall reflect the reduction.

30 14167.13. (a) Payment rates for hospital outpatient services,
31 furnished by private hospitals, nondesignated public hospitals, and
32 designated public hospitals before January 1, 2011, exclusive of
33 amounts payable under this article, shall not be reduced below the
34 rates in effect on the effective date of this article.

35 (b) Rates payable to hospitals for hospital inpatient services
36 furnished before January 1, 2011, under contracts negotiated
37 pursuant to the Selective Provider Contracting Program shall not
38 be reduced below the contract rates in effect on the effective date
39 of this article. This subdivision shall not prohibit changes to the
40 supplemental payments paid to individual hospitals under Sections

1 14166.12, 14166.17, and 14166.23. The aggregate supplemental
2 payments under Sections 14166.12, 14166.17, and 14166.23 that
3 are not derived from the funding made available under Section
4 14166.20, or intergovernmental transfers described in paragraph
5 (4) of subdivision (d) of Section 14166.12, and paragraph (4) of
6 subdivision (d) of Section 14166.17, for the 2009–10 and 2010–11
7 state fiscal years, shall not be less than the aggregate payments
8 under each of these sections during the 2008–09 state fiscal year
9 that are not derived from the funding made available under Section
10 14166.20, or intergovernmental transfers described in paragraph
11 (4) of subdivision (d) of Section 14166.12, and paragraph (4) of
12 subdivision (d) of Section 14166.17.

13 (c) Payments to private hospitals and nondesignated public
14 hospitals for hospital inpatient services furnished before January
15 1, 2011, that are not reimbursed under a contract negotiated
16 pursuant to the Selective Provider Contracting Program, exclusive
17 of amounts payable under this article, shall not be less than the
18 amount of payments that would have been made under the payment
19 methodology in effect on the effective date of this article.

20 (d) Payments to hospitals under Sections 14166.6, 14166.11,
21 and 14166.16 for the 2009–10 and 2010–11 state fiscal years shall
22 not be less than the payments due under the methodology set forth
23 in those sections in effect on the effective date of this article.

24 (e) Reimbursement to designated public hospitals, or the
25 governmental units with which they are affiliated, for services
26 furnished before January 1, 2011, pursuant to Sections 14166.4
27 and 14166.7, shall not be reduced below the level of reimbursement
28 provided for in the applicable methodologies in effect on the
29 effective date of this article.

30 (f) Payments for subacute services furnished by private hospitals,
31 nondesignated public hospitals, and designated public hospitals
32 before January 1, 2011, exclusive of amounts payable under this
33 article, shall not be reduced below the payments that would be
34 made under rates or methodologies in effect on the effective date
35 of this article.

36 (g) Solely for purposes of this ~~section~~ *article*, a rate reduction
37 or a change in a rate methodology made on or before the effective
38 date of this article that is enjoined by a court shall be included in
39 the determination of a rate or a rate methodology in effect on the
40 effective date of this article until all appeals or judicial review

1 have been exhausted and the rate reduction or change in rate
2 methodology has been permanently enjoined or otherwise
3 permanently prevented from being implemented.

4 14167.14. (a) The director shall do all of the following:

5 (1) Submit any state plan amendment or waiver request that
6 may be necessary to implement this article.

7 (2) Seek federal approval for the use of the entire federal upper
8 payment limits applicable to hospital services for payments under
9 this article for the 2008–09, 2009–10, and 2010–11 federal fiscal
10 years.

11 (3) Seek federal approvals or waivers as may be necessary to
12 implement this article and to obtain federal financial participation
13 to the maximum extent possible for the payments under this article.

14 (4) Amend the contracts between the managed health care plans
15 and the department as necessary to incorporate the provisions of
16 Sections 14167.6 and 14167.10 and promptly seek all necessary
17 federal approvals of those amendments. The department shall
18 pursue amendments to the contracts as soon as possible after the
19 effective date of this article and Article 5.22 (commencing with
20 Section 14167.31), and shall not wait for federal approval of this
21 article or Article 5.22 (commencing with Section 14167.31) prior
22 to pursuing amendments to the contracts. The amendments to the
23 contracts shall, among other provisions, set forth an agreement to
24 increase payment rates to managed health care plans under Section
25 14166.6 and increase payments to hospitals under Section 14166.10
26 effective April 2009 or as soon thereafter as possible, conditioned
27 on obtaining all federal approvals necessary for federal financial
28 participation for the enhanced payments to the managed health
29 care plans.

30 (b) In implementing this article, the department may utilize the
31 services of the Medi-Cal fiscal intermediary through a change
32 order to the fiscal intermediary contract to administer this program,
33 consistent with the requirements of Sections 14104.6, 14104.7,
34 14104.8, and 14104.9. Contracts entered into for purposes of
35 implementing this article or Article 5.22 (commencing with Section
36 14167.31) shall not be subject to Part 2 (commencing with Section
37 10100) of Division 2 of the Public Contract Code.

38 (c) This article shall become inoperative if either of the
39 following occur:

1 (1) In the event, and on the effective date, of a final judicial
2 determination made by any court of appellate jurisdiction or a final
3 determination by the federal Department of Health and Human
4 Services or the federal Centers for Medicare and Medicaid Services
5 that any element of this article cannot be implemented.

6 (2) In the event both of the following conditions exist:

7 (A) The federal Centers for Medicare and Medicaid Services
8 denies approval for, or does not approve before January 1, 2012,
9 the implementation of Article 5.22 (commencing with Section
10 14167.31) or this article.

11 (B) Either or both articles cannot be modified by the department
12 pursuant to subdivision (e) of Section 14167.35 in order to meet
13 the requirements of federal law or to obtain federal approval.

14 (d) If this article becomes inoperative pursuant to paragraph (1)
15 of subdivision (c) and the determination applies to any period or
16 periods of time prior to the effective date of the determination, the
17 department shall have authority to recoup all payments made
18 pursuant to this article during that period or those periods of time.

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

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

29 (2) Any amount computed to be payable to the hospital pursuant
30 to this section for a project year shall be withheld by the department
31 and shall be paid to the hospital only after the case or proceeding
32 is finally resolved, including the final disposition of all appeals.

33 (f) No payment shall be made under this article until all
34 necessary federal approvals for the payment and for the fee
35 provisions in Article 5.22 (commencing with Section 14167.31)
36 have been obtained and the fee has been imposed and collected.
37 Payments under this article shall be made only to the extent that
38 the fee established in Article 5.22 (commencing with Section
39 14167.31) is collected and available to support the payments.

(g) Supplemental payments for the 2008–09 federal fiscal year shall not reduce the maximum federal funds available annually pursuant to the Special Terms and Conditions, as amended October 5, 2007, of the Current Section 1115 Waiver.

(h) (1) The director shall negotiate the federal approvals required to implement this article and Article 5.22 (commencing with Section 14167.31) for the 2009–10 and 2010–11 federal fiscal years concurrently with the negotiation of a federal waiver that will replace the Current Section 1115 Waiver, with a goal of obtaining federal approvals that do not adversely impact the federal funds that would otherwise be available for services to Medi-Cal beneficiaries and the uninsured. The director may initiate the concurrent negotiations required by this subdivision by submitting a concept paper to the federal Centers for Medicare and Medicaid Services outlining the key elements of the replacement waiver consistent with the goals set forth in this subdivision.

(2) In negotiating the terms of a federal waiver that will replace the Current 1115 Waiver, the department shall explore opportunities for reform of the Medi-Cal program and strengthen California’s health care safety net. Subject to subsequent legislative approval, the department shall explore program reforms, that may include, but need not be limited to, strategies to accomplish payment system reforms for hospital inpatient and outpatient care, including incentive based payments, new payment methodologies such as diagnostic-related group-based (DRG-based), or similar methodologies, patient safety protocols, and quality measurement.

(3) This article and Article 5.22 (commencing with Section 14167.31) shall not be implemented with respect to the 2009–10 and 2010–11 federal fiscal years until the earlier of April 30, 2010, or the date the federal government approves a federal waiver for a demonstration that will replace the Current Section 1115 Waiver.

(i) A hospital’s receipt of payments under this article for services rendered prior to the effective date of this article is conditioned on the hospital’s continued participation in Medi-Cal for at least 30 days after the effective date of this article.

(j) All payments made by the department to hospitals, managed health care plans, and mental health plans under this article shall be made only from the following:

1 (1) The quality assurance fee set forth in Article 5.22
2 (commencing with Section 14167.31) and due and payable on or
3 before December 31, 2010.

4 (2) Federal reimbursement and any other related federal funds.
5 14167.15. Notwithstanding any other provision of this article
6 or Article 5.22 (commencing with Section 14167.31), the director
7 may proportionately reduce the amount of any supplemental
8 payments, enhanced payments, or grants under this article to the
9 extent that the payment or grant would result in the reduction of
10 other amounts payable to a hospital or managed health care plan
11 or mental health plan due to the application of federal law.

12 14167.16. The director may, pursuant to Section 14167.39,
13 decide not to implement or to discontinue implementation of this
14 article and Article 5.22 (commencing with Section 14167.31), and
15 to retroactively invalidate the requirements for supplemental
16 payments or other payments under this article.

17 14167.17. This article shall remain in effect only until January
18 1, 2013, and as of that date is repealed, unless a later enacted
19 statute, that is enacted before January 1, 2013, deletes or extends
20 that date.

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

24
25 Article 5.22. Quality Assurance Fee Act

26
27 14167.31. (a) "Aggregate quality assurance fee" means the
28 sum of all of the following:

29 (1) The annual fee-for-service days for an individual hospital
30 multiplied by the fee-for-service per diem quality assurance fee
31 rate.

32 (2) The annual managed care days for an individual hospital
33 multiplied by the managed care per diem quality assurance fee
34 rate.

35 (3) The annual Medi-Cal days for an individual hospital
36 multiplied by the Medi-Cal per diem quality assurance fee rate.

37 (b) "Annual fee-for-service days" means the number of
38 fee-for-service days of each hospital subject to the quality assurance
39 fee in the 2007 calendar year, as reported on the days data source.

1 (c) “Annual managed care days” means the number of managed
2 care days of each hospital subject to the quality assurance fee in
3 the 2007 calendar year, as reported on the days data source.

4 (d) “Annual Medi-Cal days” means the number of Medi-Cal
5 days of each hospital subject to the quality assurance fee in the
6 2007 calendar year, as reported on the days data source.

7 (e) “Days data source” means the following:

8 (1) For a hospital that did not submit an Annual Financial
9 Disclosure Report to the Office of Statewide Health Planning and
10 Development for a fiscal year ending during 2007, but submitted
11 that report for a fiscal period ending in 2008 that includes at least
12 10 months of 2007, the Annual Financial Disclosure Report
13 submitted by the hospital to the Office of Statewide Health
14 Planning and Development for the fiscal period in 2008 that
15 includes at least 10 months of 2007.

16 (2) For a hospital owned by Kaiser Foundation Hospitals that
17 submitted corrections to reported patient days to the Office of
18 Statewide Health Planning and Development for its fiscal year
19 ending in 2007 before July 31, 2009, the corrected data.

20 (3) For all other hospitals, the hospital’s Annual Financial
21 Disclosure Report in the Office of Statewide Health Planning and
22 Development files as of October 31, 2008, for its fiscal year ending
23 during 2007.

24 (f) “Designated public hospital” shall have the meaning given
25 in subdivision (d) of Section 14166.1 as that section may be
26 amended from time to time.

27 (g) “Exempt facility” means any of the following:

28 (1) A public hospital as defined in paragraph (25) of subdivision
29 (a) of Section 14105.98.

30 (2) With the exception of a hospital that is in the Charitable
31 Research Hospital peer group, as set forth in the 1991 Hospital
32 Peer Grouping Report published by the department, a hospital that
33 is a hospital designated as a specialty hospital in the hospital’s
34 Office of Statewide Health Planning and Development Hospital
35 Annual Disclosure Report for the hospital’s fiscal year ending in
36 the 2007 calendar year.

37 (3) A hospital that satisfies the Medicare criteria to be a
38 long-term care hospital.

39 (4) A small and rural hospital as specified in Section 124840
40 of the Health and Safety Code designated as that in the hospital’s

Office of Statewide Health Planning and Development Hospital Annual Disclosure Report for the hospital's fiscal year ending in the 2007 calendar year.

(h) (1) "Federal approval" means the last approval by the federal government required for the implementation of this article and Article 5.21 (commencing with Section 14167.1).

(2) If federal approval is sought initially for only the 2008–09 federal fiscal year and separately secured for subsequent federal fiscal years, the implementation date, as defined in subdivision (i) of Section 14167.1, for the 2008–09 federal fiscal year shall occur when all necessary federal approvals have been secured for that federal fiscal year.

(i) "Fee-for-service per diem quality assurance fee rate" means a fixed fee on fee-for-service days of two hundred thirty-three dollars and sixty-six cents (\$233.66) per day.

(j) "Fee-for-service days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "chemical dependency care and rehabilitation care," and the payer category is reported as "Medicare traditional," "county indigent programs–traditional," "other third parties–traditional," "other indigent," and "other payers," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(k) "Fee percentage" means, for a subject federal fiscal year, a fraction, expressed as a percentage, the numerator of which is the amount of payments under Sections 14167.2, 14167.3, and 14167.4, subdivision (b) of Section 14167.5, and Section 14167.6 for which federal financial participation is available and the denominator of which is three billion seven hundred eleven million seven hundred eight thousand seven hundred forty dollars (\$3,711,708, 740).

(l) "General acute care hospital" shall mean any hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

(m) "Hospital community" means any hospital industry organization or system that represents children's hospitals, nondesignated public hospitals, designated public hospitals, private safety-net hospitals, and other public or private hospitals.

(n) "Managed care days" means inpatient hospital days in the 2007 calendar year as reported on the days data source where the service type is reported as "acute care," "psychiatric care," and

1 “chemical dependency care and rehabilitation care,” and the payer
2 category is reported as “Medicare managed care,” “county indigent
3 programs–managed care,” and “other third parties–managed care,”
4 for purposes of the Annual Financial Disclosure Report submitted
5 by hospitals to the Office of Statewide Health Planning and
6 Development.

7 (o) “Managed care per diem quality assurance fee rate” means
8 a fixed fee on managed care days of twenty-seven dollars and
9 twenty-five cents (\$27.25) per day.

10 (p) “Medi-Cal days” means inpatient hospital days in the 2007
11 calendar year as reported on the days data source where the service
12 type is reported as “acute care,” “psychiatric care,” and “chemical
13 dependency care and rehabilitation care,” and the payer category
14 is reported as “Medi-Cal–traditional” and “Medi-Cal–managed
15 care,” for purposes of the Annual Financial Disclosure Report
16 submitted by hospitals to the Office of Statewide Health Planning
17 and Development.

18 (q) “Medi-Cal per diem quality assurance fee rate” means a
19 fixed fee on Medi-Cal days of two hundred ninety-three dollars
20 (\$293) per day.

21 (r) “Nondesignated public hospital” means a public hospital
22 that is licensed under subdivision (a) of Section 1250 of the Health
23 and Safety Code and is defined in paragraph (25) of subdivision
24 (a) of Section 14105.98, excluding designated public hospitals.

25 (s) “Prior fiscal year data” means any data taken from sources
26 that the department determines are the most accurate and reliable
27 at the time the determination is made, or may be calculated from
28 the most recent audited data using appropriate update factors. The
29 data may be from prior fiscal years, current fiscal years, or
30 projections of future fiscal years.

31 (t) “Private hospital” means a hospital licensed under subdivision
32 (a) of Section 1250 of the Health and Safety Code that is a
33 nonpublic hospital, nonpublic converted hospital, or converted
34 hospital as those terms are defined in paragraphs (26) to (28),
35 inclusive, respectively, of subdivision (a) of Section 14105.98.

36 (u) “Subject federal fiscal year” means a federal fiscal year
37 ending after the implementation date, as defined in Section
38 14167.1, and beginning before December 31, 2010.

39 (v) “Upper payment limit” means a federal upper payment limit
40 on the amount of the Medicaid payment for which federal financial

1 participation is available for a class of service and a class of health
2 care providers, as specified in Part 447 of Title 42 of the Code of
3 Federal Regulations.

4 14167.32. (a) There shall be imposed on each general acute
5 care hospital that is not an exempt facility a quality assurance fee,
6 as a condition of participation in state-funded health insurance
7 programs, other than the Medi-Cal program.

8 (b) The quality assurance fee shall be computed starting on the
9 effective date of this article and continue through and including
10 December 31, 2010. Effective January 1, 2011, the aggregate
11 quality assurance fee, including the fee-for-service, managed care,
12 and Medi-Cal per diem quality assurance fee rates, shall be assessed
13 only if a subsequent statute establishes how the revenue will be
14 apportioned, including through enhanced Medi-Cal payments to
15 hospitals.

16 (c) The department shall calculate the amount of the aggregate
17 quality assurance fee for each general acute care hospital that is
18 not an exempt facility within 30 days after the effective date of
19 this article. Within 20 days of calculating the aggregate quality
20 assurance fee, the department shall send notice to each general
21 acute care hospital that is not an exempt facility of the amount of
22 the hospital's aggregate quality assurance fee.

23 (d) For calendar quarters prior to federal approval of the
24 implementation of this article and the calendar quarter in which
25 the department receives notice of federal approval of the
26 implementation of this article, the following provisions shall apply:

27 (1) For the partial calendar quarter ending September 30, 2009,
28 20 days after the effective date of this article, each general acute
29 care hospital that is not an exempt facility shall certify to the best
30 of its knowledge, on a form provided by the department, that the
31 hospital is prepared to pay the aggregate quality assurance fee for
32 that hospital.

33 (2) For each calendar quarter beginning on or after October 1,
34 2009, and ending on or before September 30, 2010, within 30 days
35 following the beginning of each calendar quarter, each general
36 acute care hospital that is not an exempt facility shall certify to the
37 best of its knowledge, on a form provided by the department, that
38 the hospital is prepared to pay the aggregate quality assurance fee
39 for that hospital divided by four.

(3) For the calendar quarter beginning October 1, 2010, on or before November 1, 2010, each general acute care hospital that is not an exempt facility shall certify to the best of its knowledge, on a form provided by the department, that the hospital is prepared to pay the aggregate quality assurance fee for that hospital.

(4) Each certification required by this subdivision shall be cumulative, and in addition, to any prior certification.

(e) Upon receipt of federal approval, the following shall become operative:

(1) Within 10 days following receipt of the notice of federal approval from the federal government, the department shall send notice to each hospital subject to the quality assurance fee, and publish on its Internet Web site, the following information:

(A) The date that the state received notice of federal approval.

(B) The fee percentage for each subject federal fiscal year.

(2) The notice to each hospital subject to the quality assurance fee shall also state the following:

(A) Within 30 days after the date the department received notice of federal approval, the hospital shall pay the amount of the quality assurance fee the hospital has certified or will certify for calendar quarters, up to, and including, the quarter in which the department receives notice of approval by the federal government of the implementation of this article, pursuant to subdivision (d), multiplied by the applicable fee percentage or percentages, except that, in the event that the director has made modifications to the fee model to secure federal approval pursuant to subdivision (f) or (g) of Section 14167.35, the above-described amount, adjusted to reflect the director's modifications.

(B) The total amount of the fee that will be payable by the hospital within 30 days after the date the department received notice of federal approval.

(3) Within 30 days after the date the department received notice of federal approval, each general acute care hospital that is not an exempt facility shall pay the amounts stated in the department's notice pursuant to paragraph (2).

(4) Within 30 days following the beginning of each calendar quarter, commencing with the quarter following the last quarter governed by subdivision (d) and ending with, and including, the calendar quarter ending December 31, 2010, each general acute care hospital that is not an exempt facility shall pay to the

department the amounts that the hospital would certify to pay for the relevant quarter pursuant to subdivision (d), multiplied by the applicable fee percentage, provided that, if modifications were made to the fee model by the director in order to secure federal approval pursuant to subdivision (f) or (g) of Section 14167.35, then the hospital shall pay the amount resulting from the modifications.

(f) The quality assurance fee, as paid pursuant to this subdivision, shall be paid by each hospital subject to the fee to the department for deposit in the Hospital Quality Assurance Revenue Fund. Deposits may be accepted at any time and will be credited toward the fiscal year for which they were assessed.

(g) Subdivisions (d) and (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 this article or Article 5.21 (commencing with Section 14167.1), and either or both article cannot be modified by the department pursuant to subdivision (e) of Section 14167.35 in order to meet the requirements of federal law or to obtain federal approval. If subdivisions (d) and (e) become inoperative pursuant to this subdivision, each hospital subject to the quality assurance fee shall be released from any certifications made pursuant to subdivision (d).

(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) (1) Interest shall be assessed on quality assurance fees not paid on the date due at the greater of 10 percent per annum or the 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 Hospital Quality Assurance Revenue Fund.

(2) In the event that any fee payment is more than 60 days overdue, a penalty equal to the interest charge described in paragraph (1) shall be assessed and due for each month for which the payment is not received after 60 days.

(j) When a hospital fails to pay all or part of the quality assurance 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 or other state payments to the hospital in accordance with Section 12419.5 of the Government Code 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, except penalties, deducted by the department under this subdivision shall be deposited in the Hospital Quality Assurance Revenue Fund. The remedy provided by this section is in addition to other remedies available under law.

(k) The payment of the quality assurance fee shall not 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 quality assurance fee.

(m) This subdivision creates a contractually enforceable promise on behalf of the state to use the proceeds of the quality assurance fee, including any federal matching funds, solely and exclusively for the purposes set forth in this article as they existed on the effective date of this article, to limit the amount of the proceeds of the quality assurance fee to be used to pay for the health care coverage of children to the amounts specified in this article and to make any payments for the department's costs of administration to the amounts set forth in this article on the effective date of this article to maintain and continue prior reimbursement levels as set forth in Article 5.21 (commencing with Section 14167.1) on the effective date of that article, and to otherwise comply with all its obligations set forth in Article 5.21 (commencing with Section 14167.1) and this article.

(n) For the purpose of this article, references to the receipt of notice by the state of federal approval of the implementation of this article shall refer to the last date that the state receives notice of all federal approval or waivers required for implementation of this article and Article 5.21 (commencing with Section 14167.1), subject to Section 14167.14.

(o) (1) Effective January 1, 2011, the rates payable to hospitals and managed health care plans under Medi-Cal shall be the rates then payable without the supplemental and enhanced payments set forth in Article 5.21 (commencing with Section 14167.1).

1 (2) The supplemental payments and other payments under
2 Article 5.21 (commencing with Section 14167.1) shall be regarded
3 as quality assurance payments, the implementation or suspension
4 of which does not affect a determination of the adequacy of any
5 rates under federal law.

6 14167.35. (a) The Hospital Quality Assurance Revenue Fund
7 is hereby created in the State Treasury.

8 (b) (1) All fees required to be paid to the state pursuant to this
9 article shall be paid in the form of remittances payable to the
10 department.

11 (2) The department shall directly transmit the fee payments and
12 any related federal reimbursement to the Treasurer to be deposited
13 in the Hospital Quality Assurance Revenue Fund. Notwithstanding
14 Section 16305.7 of the Government Code, any interest and
15 dividends earned on deposits in the fund shall be retained in the
16 fund for purposes specified in subdivision (c).

17 (c) All funds in the Hospital Quality Assurance Revenue Fund,
18 together with any interest and dividends earned on money in the
19 fund, shall, upon appropriation by the Legislature, be used
20 exclusively to enhance federal financial participation for hospital
21 services under the Medi-Cal program, to provide additional
22 reimbursement to, and to support quality improvement efforts of,
23 hospitals, and to minimize uncompensated care provided by
24 hospitals to uninsured patients, in the following order of priority:

25 (1) To pay for the department's staffing and administrative costs
26 directly attributable to implementing Article 5.21 (commencing
27 with Section 14167.1) and this article, including any administrative
28 fees that the director determines shall be paid to mental health
29 plans pursuant to subdivision (d) of Section 14167.11 and
30 repayment of the loan made to the department from the Private
31 Hospital Supplemental Fund pursuant to the act that added this
32 section.

33 (2) To pay for the health care coverage for children in the
34 amount of eighty million dollars (\$80,000,000) for each quarter
35 for which payments are made under Article 5.21 (commencing
36 with Section 14167.1). In any quarter for which payments reflect
37 room under the upper payment limit that was available from prior
38 or subsequent quarters, the prior or subsequent quarters shall
39 constitute quarters for purposes of the payment for health care
40 coverage for children required by this paragraph.

1 (3) To make increased payments to hospitals pursuant to Article
2 5.21 (commencing with Section 14167.1).

3 (4) To make enhanced payments to managed health care plans
4 pursuant to Article 5.21 (commencing with Section 14167.1).

5 (5) To make increased payments to mental health plans pursuant
6 to Article 5.21 (commencing with Section 14167.1).

7 (d) Any amounts of the quality assurance fee collected in excess
8 of the funds required to implement subdivision (c), including any
9 funds recovered under subdivision (d) of Section 14167.14 or
10 subdivision (e) of Section 14167.36, shall be refunded to general
11 acute care hospitals, pro rata with the amount of quality assurance
12 fee paid by the hospital, subject to the limitations of federal law.
13 If federal rules prohibit the refund described in this subdivision,
14 the excess funds shall be deposited in the Distressed Hospital Fund
15 to be used for the purposes described in Section 14166.23, and
16 shall be supplemental to and not supplant existing funds.

17 (e) Any methodology or other provision specified in Article
18 5.21 (commencing with Section 14167.1) and this article may be
19 modified by the department, in consultation with the hospital
20 community, to the extent necessary to meet the requirements of
21 federal law or regulations to obtain federal approval or to enhance
22 the probability that federal approval can be obtained, provided the
23 modifications do not violate the spirit and intent of Article 5.21
24 (commencing with Section 14167.1) or this article and are not
25 inconsistent with the conditions of implementation set forth in
26 Section 14167.36.

27 (f) The department, in consultation with the hospital community,
28 shall make adjustments, as necessary, to the amounts calculated
29 pursuant to Section 14167.32 in order to ensure compliance with
30 the federal requirements set forth in Section 433.68 of Title 42 of
31 the Code of Federal Regulations or elsewhere in federal law.

32 (g) The department shall request approval from the federal
33 Centers for Medicare and Medicaid Services for the implementation
34 of this article. In making this request, the department shall seek
35 specific approval from the federal Centers for Medicare and
36 Medicaid Services to exempt providers identified in this article as
37 exempt from the fees specified, including the submission, as may
38 be necessary, of a request for waiver of the broad based
39 requirement, waiver of the uniform fee requirement, or both,

1 pursuant to paragraphs (1) and (2) of subdivision (e) of Section
2 433.68 of Title 42 of the Code of Federal Regulations.

3 (h) (1) For purposes of this section, a modification pursuant to
4 this section shall be implemented only if the modification, change,
5 or adjustment does not do either of the following:

6 (A) Reduces or increases the supplemental payments or grants
7 made under Article 5.21 (commencing with Section 14167.1) in
8 the aggregate for the 2008–09, 2009–10, and 2010–11 federal
9 fiscal years to a hospital by more than 2 percent of the amount that
10 would be determined under this article without any change or
11 adjustment.

12 (B) Reduces or increases the amount of the fee payable by a
13 hospital in total under this article for the 2008–09, 2009–10, and
14 2010–11 federal fiscal years by more than 2 percent of the amount
15 that would be determined under this article without any change or
16 adjustment.

17 (2) The department shall provide the Joint Legislative Budget
18 Committee and the fiscal and appropriate policy committees of
19 the Legislature a status update of the implementation of Article
20 5.21 (commencing with Section 14167.1) and this article on
21 January 1, 2010, and quarterly thereafter. Information on any
22 adjustments or modifications to the provisions of this article or
23 Article 5.21 (commencing with Section 14167.1) that may be
24 required for federal approval shall be provided coincident with the
25 consultation required under subdivisions (f) and (g).

26 (i) Notwithstanding Chapter 3.5 (commencing with Section
27 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
28 the department may implement this article or Article 5.21
29 (commencing with Section 14167.1) by means of provider
30 bulletins, all plan letters, or other similar instruction, without taking
31 regulatory action. The department shall also provide notification
32 to the Joint Legislative Budget Committee and to the appropriate
33 policy and fiscal committees of the Legislature within five working
34 days when the above-described action is taken in order to inform
35 the Legislature that the action is being implemented.

36 14167.36. (a) This article shall only be implemented so long
37 as the following conditions are met:

38 (1) Subject to Section 14167.35, the quality assurance fee is
39 established in a manner that is fundamentally consistent with this
40 article.

1 (2) The quality assurance fee, including any interest on the fee
2 after collection by the department, is deposited in a segregated
3 fund apart from the General Fund.

4 (3) The proceeds of the quality assurance fee, including any
5 ~~interest, penalties~~ *interest* and related federal reimbursement, may
6 only be used for the purposes set forth in this article.

7 (b) No hospital shall be required to pay the quality assurance
8 fee to the department unless and until the state receives and
9 maintains federal approval of the quality assurance fee and Article
10 5.21 (commencing with Section 14167.1) from the federal Centers
11 for Medicare and Medicaid Services.

12 (c) Hospitals shall be required to pay the quality assurance fee
13 to the department as set forth in this article only as long as all of
14 the following conditions are met:

15 (1) The federal Centers for Medicare and Medicaid Services
16 allows the use of the quality assurance fee as set forth in this article.

17 (2) Article 5.21 (commencing with Section 14167.1) is enacted
18 and remains in effect and hospitals are reimbursed the increased
19 rates beginning on the implementation date, as defined in Section
20 14167.1.

21 (3) The full amount of the quality assurance fee assessed and
22 collected pursuant to this article remains available only for the
23 purposes specified in this article.

24 (4) On and after January 1, 2011, a subsequent statute is
25 effective that establishes how the revenue from the quality
26 assurance fee due and payable on and after January 1, 2011 will
27 be apportioned, including through enhanced Medi-Cal payments
28 to hospitals.

29 (d) This article shall become inoperative if either of the
30 following occur:

31 (1) In the event, and on the effective date, of a final judicial
32 determination made by any court of appellate jurisdiction or a final
33 determination by the federal Department of Health and Human
34 Services or the federal Centers for Medicare and Medicaid Services
35 that any element of this article cannot be implemented.

36 (2) In the event both of the following conditions exist:

37 (A) The federal Centers for Medicare and Medicaid Services
38 denies approval for, or does not approve before January 1, 2012,
39 the implementation of Article 5.21 (commencing with Section
40 14167.1) or this article.

1 (B) Either or both articles cannot be modified by the department
2 pursuant to subdivision (e) of Section 14167.35 in order to meet
3 the requirements of federal law or to obtain federal approval.

4 (e) If this article becomes inoperative pursuant to paragraph (1)
5 of subdivision (d) and the determination applies to any period or
6 periods of time prior to the effective date of the determination, the
7 department may recoup all payments made pursuant to Article
8 5.21 (commencing with Section 14167.1) during that period or
9 those periods of time.

10 (f) This article and Article 5.21 (commencing with Section
11 14167.1) shall not be implemented with respect to the 2009–10
12 and 2010–11 federal fiscal years until the earlier of April 30, 2010,
13 or the date the federal government approves a federal waiver for
14 a demonstration that will replace the Current Section 1115 Waiver,
15 as defined in subdivision (c) of Section 14167.1.

16 14167.37. Each report or informational submission required
17 from providers pursuant to this article shall contain a legal
18 verification to be signed by the provider verifying that the
19 information provided is true and correct to the best of the provider's
20 knowledge, and that any information in supporting documents
21 submitted by the provider is true and correct.

22 14167.38. Notwithstanding any other provision of this article
23 or Article 5.21 (commencing with Section 14167.1), supplemental
24 payments or other payments under Article 5.21 (commencing with
25 Section 14167.1) shall only be required and payable in any quarter
26 for which a fee payment obligation exists. In any quarter where
27 payments under Article 5.21 (commencing with Section 14167.1)
28 are based on upper payment limit room resulting from other
29 quarters, no payment shall be made that reflects the room resulting
30 from other quarters unless the fee payment is similarly increased.

31 14167.39. (a) The director may decide not to implement or to
32 discontinue implementation of this article and Article 5.21
33 (commencing with Section 14167.1), and to retroactively invalidate
34 the requirements for supplemental payments or other payments
35 under Article 5.21 (commencing with Section 14167.1), in the
36 event that any of the following occur:

37 (1) A lawsuit related to this article or Article 5.21 (commencing
38 with Section 14167.1) is filed against the state that the director
39 determines, after appropriate consultation with the hospital

1 community, has a substantial possibility of resulting in a financial
2 disadvantage to the state.

3 (2) A lawsuit related to this article or Article 5.21 (commencing
4 with Section 14167.1) is filed against the state and a preliminary
5 injunction or other order has been issued that results in a financial
6 disadvantage to the state.

7 (3) A lawsuit related to this article or Article 5.21 (commencing
8 with Section 14167.1) is filed against the state and the anticipated
9 cost of defending the lawsuit has a substantial possibility of
10 resulting in a significant cost to the General Fund.

11 (4) The director determines that the implementation of this
12 article or Article 5.21 (commencing with Section 14167.1) has
13 resulted, or will result, in a financial disadvantage to the state.

14 (b) For purposes of this section, a loss of federal financial
15 participation or a cost to the General Fund resulting from
16 implementation of this article or Article 5.21 (commencing with
17 Section 14167.1) shall constitute a financial disadvantage to the
18 state.

19 (c) (1) The discretion granted in this section to the director shall
20 include discretion to take action retroactively to recoup any
21 payments made under Article 5.21 (commencing with Section
22 14167.1) if any of the following apply:

23 (A) Recoupment of payments made under Article 5.21
24 (commencing with Section 14167.1) is ordered by a court.

25 (B) Federal financial participation is not available for payments
26 made under Article 5.21 (commencing with Section 14167.1).

27 (C) Recoupment of payments made under Article 5.21
28 (commencing with Section 14167.1) is necessary to prevent a
29 General Fund impact resulting from the implementation of a court
30 order or the unavailability of federal financial participation.

31 (2) In the event payments are recouped for a particular quarter,
32 fees paid by a hospital for that quarter pursuant to this article shall
33 be refunded to the extent that the hospital meets both of the
34 following conditions:

35 (A) The hospital has actually paid the fee for the subject quarter
36 and for all prior quarters.

37 (B) The hospital has returned the payment received pursuant to
38 Article 5.21 (commencing with Section 14167.1) for that quarter,
39 or has had that payment recouped through a withholding of funds

1 owed by Medi-Cal or other state payments, or recouped through
2 other means.

3 (d) In the event the department determines that recoupment of
4 supplemental payments is necessary to implement any provision
5 of this section, the department may recoup payments made pursuant
6 to Article 5.21 (commencing with Section 14167.1) from fees paid
7 by the hospital pursuant to this article.

8 (e) Concurrent with invoking any provision of this section, the
9 director shall notify the fiscal and appropriate policy committees
10 of the Legislature of the intended action and the specific reason
11 or reasons for the proposed action.

12 14167.40. This article shall remain in effect only until January
13 1, 2013, and as of that date is repealed, unless a later enacted
14 statute, that is enacted before January 1, 2013, deletes or extends
15 that date.

16 SEC. 3. (a) There is hereby appropriated to the State
17 Department of Health Care Services the following sums:

18 (1) To pay for the department's staffing and administrative costs
19 associated with Article 5.21 (commencing with Section 14167.1)
20 and Article 5.22 (commencing with Section 14167.31) of Chapter
21 7 of Part 3 of Division 9 of the Welfare and Institutions Code,
22 including for workload associated with seeking the necessary
23 federal approvals from the federal Centers for Medicare and
24 Medicaid Services to implement Article 5.21 (commencing with
25 Section 14167.1) and Article 5.22 (commencing with Section
26 14167.31) of Chapter 7 of Part 3 of Division 9 of the Welfare and
27 Institutions Code, one million dollars (\$1,000,000) from the Private
28 Hospital Supplemental Fund established pursuant to Section
29 14166.12 of the Welfare and Institutions Code *and one million*
30 *dollars (\$1,000,000) from the Federal Trust Fund.*

31 (2) For the purposes specified in subdivisions (c) and (d) of
32 Section 14167.35 of the Welfare and Institutions Code, the sum
33 of thirteen billion five hundred million dollars (\$13,500,000,000)
34 from the Hospital Quality Assurance Revenue Fund, to be available
35 for expenditure until January 1, 2013.

36 (b) (1) If the department obtains federal approval for the
37 implementation of Article 5.21 (commencing with Section 14167.1)
38 and Article 5.22 (commencing with Section 14167.31) of Chapter
39 7 of Part 3 of Division 9 of the Welfare and Institutions Code,
40 moneys in the Hospital Quality Assurance Revenue Fund shall be

1 used to reimburse the one million dollars (\$1,000,000) appropriated
2 from the Private Hospital Supplemental Fund pursuant to paragraph
3 (1) of subdivision (a).

4 (2) If the department does not obtain federal approval for the
5 implementation of Article 5.21 (commencing with Section 14167.1)
6 and Article 5.22 (commencing with Section 14167.31) of Chapter
7 7 of Part 3 of Division 9 of the Welfare and Institutions Code, any
8 unexpended moneys from the one million dollars (\$1,000,000)
9 appropriated to the department from the Private Hospital
10 Supplemental Fund pursuant to paragraph (1) of subdivision (a)
11 shall revert to the Private Hospital Supplemental Fund.

12 SEC. 4. This act is an urgency statute necessary for the
13 immediate preservation of the public peace, health, or safety within
14 the meaning of Article IV of the Constitution and shall go into
15 immediate effect. The facts constituting the necessity are:

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