

AMENDED IN SENATE SEPTEMBER 12, 2009
AMENDED IN SENATE SEPTEMBER 11, 2009
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 Article 5.225 (commencing with Section 14167.41) to, and 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.~~ *Medi-Cal.*

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 Medicaid 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. 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 committees 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, retroactively invalidate the requirements for supplemental payments or other payments made pursuant to this bill.

This bill, would specify that a quality assurance fee is to be imposed pursuant to a subsequent statute, effective January 1, 2011, and subject to federal approval in a manner necessary to obtain federal matching funds, that shall be due and payable to the department by each general acute care hospital at a specified rate for the purpose of making Medi-Cal payments to hospitals.

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: $\frac{2}{3}$ -majority. Appropriation: ~~yes~~-no. 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:

Article 5.21. Medi-Cal Hospital Provider Rate Stabilization
Act

14167.1. (a) “Acute psychiatric days” means the total number of Short-Doyle administrative days, Short-Doyle acute care days, acute psychiatric administrative days, and acute psychiatric acute days identified in the Final Medi-Cal Utilization Statistics for the 2008–09 state fiscal year as calculated by the department on September 15, 2008.

(b) “Converted hospital” means a private hospital that becomes a designated public hospital or a nondesignated public hospital after the implementation date, a nondesignated public hospital that becomes a private hospital or a designated public hospital after the implementation date, or a designated public hospital that becomes a private hospital or a nondesignated public hospital after the implementation date.

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

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

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

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

(g) “Hospital inpatient services” means all services covered under Medi-Cal and furnished by hospitals to patients who are admitted as hospital inpatients and reimbursed on a fee-for-service basis by the department directly or through its fiscal intermediary. Hospital inpatient services include outpatient services furnished by a hospital to a patient who is admitted to that hospital within 24 hours of the provision of the outpatient services that are related to the condition for which the patient is admitted. Hospital inpatient services include physician services only where the service is

1 furnished to a hospital inpatient, the physician is compensated by
2 the hospital for the service, and the service is billed to Medi-Cal
3 by the hospital under a provider number assigned to the hospital.
4 Hospital inpatient services do not include services for which a
5 managed health care plan is financially responsible.

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

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

30 (2) If federal approval is sought initially for only the 2008–09
31 federal fiscal year and separately secured for subsequent federal
32 fiscal years, the implementation date for the 2008–09 federal fiscal
33 year shall occur when all necessary federal approvals have been
34 secured for that federal fiscal year.

35 (j) “Individual hospital acute psychiatric supplemental payment”
36 means the total amount of acute psychiatric hospital supplemental
37 payments to a subject hospital for a quarter for which the
38 supplemental payments are made. The “individual hospital acute
39 psychiatric supplemental payment” shall be calculated for subject
40 hospitals by multiplying the number of acute psychiatric days for

1 the individual hospital for which a mental health plan was
2 financially responsible by four hundred eighty-five dollars (\$485)
3 and dividing the result by 4.

4 (k) “Individual hospital managed care supplemental payment”
5 means the total amount of managed care hospital supplemental
6 payments to a subject hospital for a month for which the
7 supplemental payments are made.

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

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

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

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

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

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

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

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

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

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

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

39 (m) “Medi-Cal managed care days” means the total number of
40 general acute care days, including well baby days, listed for the

1 county organized health system and prepaid health plans identified
2 in the Final Medi-Cal Utilization Statistics for the 2008–09 state
3 fiscal year, as calculated by the department on September 15, 2008,
4 except that the general acute care days, including well baby days,
5 for the Santa Barbara Health Care Initiative shall be derived from
6 the Final Medi-Cal Utilization Statistics for the 2007–08 state
7 fiscal year.

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

13 (o) “Mental health plan” means a mental health plan that
14 contracts with the State Department of Mental Health to furnish
15 or arrange for the provision of mental health services to Medi-Cal
16 beneficiaries pursuant to Part 2.5 (commencing with Section 5775)
17 of Division 5.

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

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

29 (r) “Outpatient base amount” means the total amount of
30 payments for hospital outpatient services made to a hospital in the
31 2007 calendar year, as reflected in state paid claims files on January
32 26, 2008.

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

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

37 (2) Is in the Charitable Research Hospital peer group, as set
38 forth in the 1991 Hospital Peer Grouping Report published by the
39 department, or is not designated as a specialty hospital in the
40 hospital’s Office of Statewide Health Planning and Development

1 Annual Financial Disclosure Report for the hospitals latest fiscal
2 year ending in 2007.

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

5 (4) Is a nonpublic hospital, nonpublic converted hospital, or
6 converted hospital as those terms are defined in paragraphs (26)
7 to (28), inclusive, respectively, of subdivision (a) of Section
8 14105.98.

9 (t) "Subject federal fiscal year" means a federal fiscal year that
10 ends after the implementation date and begins before December
11 31, 2010.

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

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

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

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

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

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

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

36 (b) Except as set forth in subdivisions (e) and (f), each private
37 hospital shall be paid an amount for each subject federal fiscal
38 year equal to a percentage of the hospital's outpatient base amount.
39 The percentage shall be the same for each hospital for a subject

1 federal fiscal year and shall result in payments to hospitals which
2 equals the applicable federal upper payment limit.

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

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

11 (2) The amount payable under subdivision (b) to each private
12 hospital for the subject federal fiscal year shall be equal to the
13 amount computed under subdivision (b) multiplied by the ratio of
14 the total amount for which federal financial participation is
15 available to the total amount computed under subdivision (b).

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

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

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

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

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

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

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

(3) One thousand three hundred fifty dollars (\$1,350) multiplied by the number of the hospital's high acuity days if the hospital's Medicaid inpatient utilization rate is less than 41.1 percent, at least five percent of the hospital's general acute care days are high acuity days, and the hospital is not a small and rural hospital as defined in Section 124840 of the Health and Safety Code. This amount shall be in addition to the amounts specified in paragraphs (1) and (2).

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

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

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

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

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

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

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

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

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

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

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

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

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

26 14167.4. (a) Nondesignated public hospitals shall be paid
27 supplemental amounts for the provision of hospital inpatient
28 services as set forth in this section. The supplemental amounts
29 shall be in addition to any other amounts payable to hospitals with
30 respect to those services and shall not affect any other payments
31 to hospitals.

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

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

37 (2) Four hundred eighty-five dollars (\$485) multiplied by the
38 hospital's acute psychiatric days that were paid directly by the
39 department and were not the financial responsibility of a mental
40 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) The total amount payable to nondesignated public hospitals under subdivision (b) for the subject federal fiscal year shall be reduced to the amount for which federal financial participation is available.

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

(d) 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.

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

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

(g) 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.

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

(b) The director shall allocate the amount specified in subdivision (a) among the designated public hospitals in accordance with this subdivision. In determining the allocation, the director shall rely on data from the Interim Hospital Payment Rate

1 Workbooks. For purposes of this section, “Interim Hospital
2 Payment Rate Workbook” means the Interim Hospital Payment
3 Rate Workbook, developed by the department and approved by
4 the federal Centers for Medicare and Medicaid Services for use in
5 connection with the Medi-Cal Hospital/Uninsured Care 1115
6 Waiver Demonstration, as submitted by each designated public
7 hospital, or the governmental entity with which the hospital is
8 affiliated, on or around June 2009 for the period of July 1, 2007,
9 to June 30, 2008, inclusive.

10 (1) Each designated public hospital’s share of 80 percent of the
11 amount specified in subdivision (a) shall be determined by applying
12 a fraction, the numerator of which is the certified public
13 expenditures reported by the designated public hospital as
14 allowable Medi-Cal inpatient expenditures on Schedule 2.1,
15 Column 5, Step 5 of the Interim Hospital Payment Rate Workbook,
16 and the denominator of which is the total amount of certified public
17 expenditures reported as allowable Medi-Cal inpatient expenditures
18 by all designated public hospitals on Schedule 2.1, Column 5, Step
19 5 of the Interim Hospital Payment Rate Workbooks.

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

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

amounts to private hospitals up to the federal upper payment limit, and the denominator of which is 12.

(d) Designated public hospitals shall be paid supplemental Medi-Cal amounts for acute inpatient psychiatric services that are paid directly by the department and are not the financial responsibility of a mental health plan, as set forth in this subdivision. The supplemental amounts shall be in addition to any other amounts payable to designated public hospitals, or a governmental entity with which the hospital is affiliated, with respect to those services and shall not affect any other payments to hospitals or to any governmental entity with which the hospital is affiliated.

(1) Each designated public hospital shall be paid an amount for each subject federal fiscal year equal to 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, inclusive of federal financial participation.

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

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

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

(3) In the event the amount otherwise payable to a designated public hospital under this subdivision 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.

1 14167.6. (a) The department shall enhance payments to
2 Medi-Cal managed health care plans for the subject federal fiscal
3 years as set forth in this section.

4 (b) The enhanced payments shall be made as part of the monthly
5 capitated payments made by the department to managed health
6 care plans.

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

10 (1) Pay to managed health care plans in the aggregate the sum
11 of the individual hospital managed care supplemental payments
12 for each month.

13 (2) Result in payment of the individual hospital managed care
14 supplemental payment to each subject hospital in accordance with
15 Section 14167.10.

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

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

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

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

34 (2) The enhanced payments made during the first month in
35 which enhanced payments are made pursuant to this section shall
36 include the sum of the enhanced payments for all prior months for
37 which payments are due.

38 (3) The enhanced payments made during December 2010 shall
39 include payments for December 2010 to September 2011, inclusive,

1 to the extent that federal financial participation is available for the
2 enhanced payments.

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

6 (f) (1) Each managed health care plan shall expend, in the form
7 of supplemental payments to hospitals, 100 percent of any rate
8 enhanced payments it receives under this section, pursuant to
9 Section 14167.10.

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

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

20 (g) In the event federal financial participation is not available
21 for all of the enhanced managed care payments determined for a
22 month pursuant to this section for any reason, the enhanced
23 payments mandated by this section for that month shall be reduced
24 proportionately to the amount for which federal financial
25 participation is available.

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

35 (i) Notwithstanding Chapter 3.5 (commencing with Section
36 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
37 the department shall implement this section by means of policy
38 letters or similar instructions, without taking further regulatory
39 action.

14167.7. (a) The amount of any payments made under this article to private hospitals, including the amount of payments made under Sections 14167.2 and 14167.3 and additional payments to private hospitals by managed health care plans pursuant to Section 14167.6, shall not be included in the calculation of the low-income percent or the OBRA 1993 payment limitation, as defined in paragraph (24) of subdivision (a) of Section 14105.98, for purposes of determining payments to private hospitals pursuant to Section 14166.11.

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

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

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

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

(b) The payments to hospitals under Sections 14167.2, 14167.3, 14167.4, and 14167.5 for the 2009–10 federal fiscal year shall be made on a quarterly basis. The amounts payable to a hospital for each quarter shall be one-fourth of the amount payable to the hospital for the entire federal fiscal year, except as may be adjusted by the department under Section 14167.8. Payments to hospitals for each quarter during the 2009–10 federal fiscal year shall be made the later of the last day of the second month of the quarter

1 or the 45th day following the day on which federal approval is
2 granted.

3 (c) The payments to hospitals under Sections 14167.2, 14167.3,
4 14167.4, and 14167.5 for the 2010–11 federal fiscal year shall be
5 made on or before the later of December 31, 2010, or the 45th day
6 following the day on which federal approval is granted.

7 (d) For purposes of this subdivision, “federal approval” shall
8 have the meaning set forth in subdivision (h) of Section 14167.31.

9 14167.10. (a) (1) At the same time that the department makes
10 an enhanced payment to a managed health care plan under Section
11 14167.6, the department shall notify the plan of each hospital to
12 which the plan shall make supplemental managed care payments
13 as a consequence of receiving the enhanced payment and the
14 amount of the supplemental payment. The department shall
15 determine the amount of the supplemental payment due to each
16 subject hospital so that the total supplemental managed care
17 payments to the hospital from all managed health care plans
18 resulting from payments made to the managed health care plans
19 for the subject month under Section 14167.6 equals or
20 approximately equals the hospital’s individual hospital managed
21 care supplemental payment.

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

27 (3) The notice provided by the department in connection with
28 the enhanced managed care payments to each managed health care
29 plan during December 2010 shall also direct the managed health
30 care plan to make monthly supplemental payments to hospitals for
31 months, if any, from January 2011 to September 2011, inclusive,
32 for which federal financial participation is available as described
33 in paragraph (3) of subdivision (d) of Section 14167.6 and the
34 amount of the supplemental payments as calculated pursuant to
35 this subdivision.

36 (b) Each managed health care plan receiving payments under
37 Section 14167.6 shall make supplemental payments to hospitals
38 within 30 days of receiving the payments under Section 14167.6,
39 except that if the managed health care plan receives enhanced
40 payments during December 2010, which include payments relating

1 to some or all of the month of January 2011 to September 2011,
2 inclusive, the managed health care plan shall make payments
3 relating to the months of January 2011 to September 2011,
4 inclusive, during each month to which the payment relates. The
5 payments shall be made to those hospitals and in those amounts
6 set forth by the department in its notice provided pursuant to
7 subdivision (a).

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

12 (d) For each subject federal fiscal year, the sum of all
13 supplemental payments made by a managed health care plan to
14 subject hospitals pursuant to this section shall equal, or
15 approximately equal, all enhanced payments received by the
16 managed health care plan from the department pursuant to Section
17 14167.6.

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

21 (f) The obligations of a Medi-Cal managed health care plan to
22 make payments to a hospital for services furnished by the hospital
23 that are not covered by a contract between the managed health
24 care plan and the hospital, including the amounts of payments
25 required apart from payments under this article, shall not be
26 affected by any payments made under this article.

27 (g) In the event federal financial participation for a month is
28 not available for all of the enhanced managed health care plan
29 payments pursuant to Section 14167.6 for any reason, the
30 supplemental payments made to hospitals under this section shall
31 be reduced proportionately to the amount for which federal
32 financial participation is available, and the department's notice
33 under subdivision (a) shall reflect that reduction.

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

36 (i) Any delegation or attempted delegation by a managed health
37 care plan of its obligation to make payments under this section
38 shall not relieve the plan from its obligation to make those
39 payments. Managed health care plans shall submit the
40 documentation the department may require to demonstrate

1 compliance with this subdivision. The documentation shall
2 demonstrate actual payments to hospitals, and not assignment to
3 subcontractors of the managed health care plan's obligation of the
4 duty to pay hospitals. The department and each managed health
5 care plan shall make available to each subject hospital, within 15
6 days of receipt of the hospital's written request, documentation
7 demonstrating the amount that the plan paid to the subject hospital
8 for a subject month and the amount due from the plan to the subject
9 hospital for the subject month.

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

24 (k) The department shall pay to a managed health care plan or
25 plans, as the director determines is or are appropriate, any amounts
26 recovered under subdivision (i) for the purpose of making payments
27 to hospitals pursuant to this section and shall direct the managed
28 health care plan or plans receiving those amounts to make specific
29 payments to specific hospitals to ensure that hospitals receive the
30 amounts set forth in this section.

31 (l) Managed health care plans shall in no event be obligated
32 under this section to make supplemental payments to hospitals that
33 exceed the enhanced payments made to the managed care health
34 plans under Section 14167.6.

35 14167.11. (a) The department shall increase payments to
36 mental health plans for the subject federal fiscal years as set forth
37 in this section.

38 (b) For each fiscal quarter that begins on or after the
39 implementation date, the state shall make enhanced payments to
40 each mental health plan. The amount of those enhanced payments

1 to a mental health plan shall be the sum of all individual hospital
2 acute psychiatric supplemental payments for subject hospitals
3 located in each county in which the mental health plan operates.

4 (c) The state shall make enhanced payments to mental health
5 plans exclusively for the purpose of making supplemental payments
6 to hospitals, in order to support the availability of hospital mental
7 health services and ensure access for Medi-Cal beneficiaries to
8 hospital mental health services. The enhanced payments to mental
9 health plans shall be made as follows:

10 (1) The enhanced payments shall commence on or before the
11 later of the last day of the second month of the quarter in which
12 federal approval is granted or the 45th day following the day on
13 which federal approval is granted. Subsequent enhanced payments
14 shall be made on the last day of the second month of each quarter.
15 The last enhanced payments made pursuant to this section shall
16 be made during November 2010.

17 (2) The enhanced payments made for the first quarter for which
18 enhanced payments are made under this section shall include the
19 sum of enhanced payments for all prior quarters for which
20 payments are due under subdivision (b).

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

25 (d) (1) Each mental health plan shall expend, in the form of
26 additional payments to hospitals, 100 percent of any enhanced
27 payments it receives under this section, pursuant to Section
28 14167.12.

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

34 (e) In the event federal financial participation for a subject
35 federal fiscal year is not available for all of the enhanced acute
36 psychiatric payments determined for a quarter pursuant to this
37 section for any reason, the enhanced payments mandated by this
38 section for that quarter shall be reduced proportionately to the
39 amount for which federal financial participation is available.

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

4 (g) In the event the director determines that payment of the
5 individual acute psychiatric supplemental payments may be made
6 by the department directly to the hospitals under this section and
7 Section 14167.12 without the need for transmitting the funds
8 through the mental health plans, those direct payments shall be
9 made notwithstanding any other provision of this article or Article
10 5.22 (commencing with Section 14167.31).

11 (h) The department may, as necessary, allocate money
12 appropriated to it from the Hospital Quality Assurance Revenue
13 Fund to the State Department of Mental Health for the purposes
14 of making increased payments to mental health plans pursuant to
15 this article.

16 14167.12. (a) At the same time that the state makes an
17 enhanced payment to a mental health plan under Section 14167.11,
18 the state shall notify the mental health plan that the plan shall make
19 payments in the amount of the individual hospital acute psychiatric
20 supplemental payment to each subject hospital located in each
21 county in which the mental health plan operates as a consequence
22 of receiving the enhanced payment and the amount of the individual
23 hospital acute psychiatric supplemental payment due to each
24 hospital, subject to the following:

25 (1) In the case of the enhanced payments made to a mental
26 health plan during the first quarter in which the payments are made
27 to the plan, the notice shall direct mental health plans to make
28 supplemental payments to each hospital in an amount equal to
29 each hospital's individual hospital acute psychiatric supplemental
30 payment multiplied by the number of quarters for which the
31 enhance payments were made.

32 (2) The notice provided by the department in connection with
33 the enhanced payments to each mental health plan during
34 November 2010 shall also direct the mental health plan to make
35 quarterly supplemental payments to hospitals for quarters, if any,
36 between January 2011 and September 2011, inclusive, for which
37 federal financial participation is available as described in paragraph
38 (3) of subdivision (c) of Section 14167.11 and the amount of the
39 supplemental payments as calculated pursuant to this subdivision.

1 (b) Each mental health plan receiving payments under Section
2 14167.11 shall make supplemental payments to hospitals within
3 30 days of receiving the payments under Section 14167.11, except
4 that if the mental health plan receives enhanced payments during
5 November 2010, which include payments relating to some or all
6 of the quarters between January 2011 and September 2011,
7 inclusive, the mental health plan shall make payments relating to
8 the quarters between January 2011 and September 2011, inclusive,
9 on or before the end of each quarter to which the payment relates.
10 The payments shall be made to those hospitals and in those
11 amounts set forth by the department in its notice provided pursuant
12 to subdivision (a).

13 (c) The supplemental payments made to hospitals pursuant to
14 this section shall be in addition to any other amounts payable to
15 hospitals by a mental health plan or otherwise and shall not affect
16 any other payments to hospitals.

17 (d) For each subject federal fiscal year, the sum of all
18 supplemental payments made by a mental health plan to subject
19 hospitals pursuant to this section shall equal all enhanced payments
20 received by the mental health plan from the state pursuant to
21 Section 14167.11.

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

25 (f) A mental health plan is obligated to make payments under
26 this section only to the extent of the payments it receives under
27 Section 14167.11. A mental health plan may retain any interest it
28 earns on funds it receives under Section 14167.11 prior to making
29 payments of the funds to hospitals under this section.

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

32 (h) In the event federal financial participation for a quarter is
33 not available for all of the enhanced mental health payments made
34 pursuant to Section 14167.11 for any reason, the supplemental
35 payments to hospitals under this section shall be reduced
36 proportionately to the amount for which federal financial
37 participation is available and the department's notice under
38 subdivision (a) shall reflect the reduction.

39 14167.13. (a) Payment rates for hospital outpatient services,
40 furnished by private hospitals, nondesignated public hospitals, and

1 designated public hospitals before January 1, 2011, exclusive of
2 amounts payable under this article, shall not be reduced below the
3 rates in effect on the effective date of this article.

4 (b) Rates payable to hospitals for hospital inpatient services
5 furnished before January 1, 2011, under contracts negotiated
6 pursuant to the Selective Provider Contracting Program shall not
7 be reduced below the contract rates in effect on the effective date
8 of this article. This subdivision shall not prohibit changes to the
9 supplemental payments paid to individual hospitals under Sections
10 14166.12, 14166.17, and 14166.23. The aggregate supplemental
11 payments under Sections 14166.12, 14166.17, and 14166.23 that
12 are not derived from the funding made available under Section
13 14166.20, or intergovernmental transfers described in paragraph
14 (4) of subdivision (d) of Section 14166.12, and paragraph (4) of
15 subdivision (d) of Section 14166.17, for the 2009–10 and 2010–11
16 state fiscal years, shall not be less than the aggregate payments
17 under each of these sections during the 2008–09 state fiscal year
18 that are not derived from the funding made available under Section
19 14166.20, or intergovernmental transfers described in paragraph
20 (4) of subdivision (d) of Section 14166.12, and paragraph (4) of
21 subdivision (d) of Section 14166.17.

22 (c) Payments to private hospitals and nondesignated public
23 hospitals for hospital inpatient services furnished before January
24 1, 2011, that are not reimbursed under a contract negotiated
25 pursuant to the Selective Provider Contracting Program, exclusive
26 of amounts payable under this article, shall not be less than the
27 amount of payments that would have been made under the payment
28 methodology in effect on the effective date of this article.

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

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

39 (f) Payments for subacute services furnished by private hospitals,
40 nondesignated public hospitals, and designated public hospitals

1 before January 1, 2011, exclusive of amounts payable under this
2 article, shall not be reduced below the payments that would be
3 made under rates or methodologies in effect on the effective date
4 of this article.

5 (g) Solely for purposes of this article, a rate reduction or a
6 change in a rate methodology made on or before the effective date
7 of this article that is enjoined by a court shall be included in the
8 determination of a rate or a rate methodology in effect on the
9 effective date of this article until all appeals or judicial review
10 have been exhausted and the rate reduction or change in rate
11 methodology has been permanently enjoined or otherwise
12 permanently prevented from being implemented.

13 14167.14. (a) The director shall do all of the following:

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

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

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

23 (4) Amend the contracts between the managed health care plans
24 and the department as necessary to incorporate the provisions of
25 Sections 14167.6 and 14167.10 and promptly seek all necessary
26 federal approvals of those amendments. The department shall
27 pursue amendments to the contracts as soon as possible after the
28 effective date of this article and Article 5.22 (commencing with
29 Section 14167.31), and shall not wait for federal approval of this
30 article or Article 5.22 (commencing with Section 14167.31) prior
31 to pursuing amendments to the contracts. The amendments to the
32 contracts shall, among other provisions, set forth an agreement to
33 increase payment rates to managed health care plans under Section
34 14166.6 and increase payments to hospitals under Section 14166.10
35 effective April 2009 or as soon thereafter as possible, conditioned
36 on obtaining all federal approvals necessary for federal financial
37 participation for the enhanced payments to the managed health
38 care plans.

39 (b) In implementing this article, the department may utilize the
40 services of the Medi-Cal fiscal intermediary through a change

1 order to the fiscal intermediary contract to administer this program,
2 consistent with the requirements of Sections 14104.6, 14104.7,
3 14104.8, and 14104.9. Contracts entered into for purposes of
4 implementing this article or Article 5.22 (commencing with Section
5 14167.31) shall not be subject to Part 2 (commencing with Section
6 10100) of Division 2 of the Public Contract Code.

7 (c) This article shall become inoperative if either of the
8 following occur:

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

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

15 (A) The federal Centers for Medicare and Medicaid Services
16 denies approval for, or does not approve before January 1, 2012,
17 the implementation of Article 5.22 (commencing with Section
18 14167.31) or this article.

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

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

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

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

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

(f) No payment shall be made under this article until all necessary federal approvals for the payment and for the fee provisions in Article 5.22 (commencing with Section 14167.31) have been obtained and the fee has been imposed and collected. Payments under this article shall be made only to the extent that the fee established in Article 5.22 (commencing with Section 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

1 on the hospital's continued participation in Medi-Cal for at least
2 30 days after the effective date of this article.

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

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

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

17 14167.16. The director may, pursuant to Section 14167.39,
18 decide not to implement or to discontinue implementation of this
19 article and Article 5.22 (commencing with Section 14167.31), and
20 to retroactively invalidate the requirements for supplemental
21 payments or other payments under this article.

22 14167.17. This article shall remain in effect only until January
23 1, 2013, and as of that date is repealed, unless a later enacted
24 statute, that is enacted before January 1, 2013, deletes or extends
25 that date.

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

29
30 Article 5.22. Quality Assurance Fee Act
31

32 14167.31. (a) "Aggregate quality assurance fee" means the
33 sum of all of the following:

34 (1) The annual fee-for-service days for an individual hospital
35 multiplied by the fee-for-service per diem quality assurance fee
36 rate.

37 (2) The annual managed care days for an individual hospital
38 multiplied by the managed care per diem quality assurance fee
39 rate.

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

3 (b) “Annual fee-for-service days” means the number of
4 fee-for-service days of each hospital subject to the quality assurance
5 fee in the 2007 calendar year, as reported on the days data source.

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

9 (d) “Annual Medi-Cal days” means the number of Medi-Cal
10 days of each hospital subject to the quality assurance fee in the
11 2007 calendar year, as reported on the days data source.

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

13 (1) For a hospital that did not submit an Annual Financial
14 Disclosure Report to the Office of Statewide Health Planning and
15 Development for a fiscal year ending during 2007, but submitted
16 that report for a fiscal period ending in 2008 that includes at least
17 10 months of 2007, the Annual Financial Disclosure Report
18 submitted by the hospital to the Office of Statewide Health
19 Planning and Development for the fiscal period in 2008 that
20 includes at least 10 months of 2007.

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

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

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

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

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

35 (2) With the exception of a hospital that is in the Charitable
36 Research Hospital peer group, as set forth in the 1991 Hospital
37 Peer Grouping Report published by the department, a hospital that
38 is a hospital designated as a specialty hospital in the hospital’s
39 Office of Statewide Health Planning and Development Hospital

Annual Disclosure Report for the hospital's fiscal year ending in the 2007 calendar year.

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

(4) A small and rural hospital as specified in Section 124840 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.

1 (m) “Hospital community” means any hospital industry
2 organization or system that represents children’s hospitals,
3 nondesignated public hospitals, designated public hospitals, private
4 safety-net hospitals, and other public or private hospitals.

5 (n) “Managed care days” means inpatient hospital days in the
6 2007 calendar year as reported on the days data source where the
7 service type is reported as “acute care,” “psychiatric care,” and
8 “chemical dependency care and rehabilitation care,” and the payer
9 category is reported as “Medicare managed care,” “county indigent
10 programs–managed care,” and “other third parties–managed care,”
11 for purposes of the Annual Financial Disclosure Report submitted
12 by hospitals to the Office of Statewide Health Planning and
13 Development.

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

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

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

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

32 (s) “Prior fiscal year data” means any data taken from sources
33 that the department determines are the most accurate and reliable
34 at the time the determination is made, or may be calculated from
35 the most recent audited data using appropriate update factors. The
36 data may be from prior fiscal years, current fiscal years, or
37 projections of future fiscal years.

38 (t) “Private hospital” means a hospital licensed under subdivision
39 (a) of Section 1250 of the Health and Safety Code that is a
40 nonpublic hospital, nonpublic converted hospital, or converted

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

3 (u) “Subject federal fiscal year” means a federal fiscal year
4 ending after the implementation date, as defined in Section
5 14167.1, and beginning before December 31, 2010.

6 (v) “Upper payment limit” means a federal upper payment limit
7 on the amount of the Medicaid payment for which federal financial
8 participation is available for a class of service and a class of health
9 care providers, as specified in Part 447 of Title 42 of the Code of
10 Federal Regulations.

11 14167.32. (a) There shall be imposed on each general acute
12 care hospital that is not an exempt facility a quality assurance fee,
13 as a condition of participation in state-funded health insurance
14 programs, other than the Medi-Cal program.

15 (b) The quality assurance fee shall be computed starting on the
16 effective date of this article and continue through and including
17 December 31, 2010.

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

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

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

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

1 the hospital is prepared to pay the aggregate quality assurance fee
2 for that hospital divided by four.

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

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

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

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

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

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

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

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

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

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

38 (4) Within 30 days following the beginning of each calendar
39 quarter, commencing with the quarter following the last quarter
40 governed by subdivision (d) and ending with, and including, the

1 calendar quarter ending December 31, 2010, each general acute
2 care hospital that is not an exempt facility shall pay to the
3 department the amounts that the hospital would certify to pay for
4 the relevant quarter pursuant to subdivision (d), multiplied by the
5 applicable fee percentage, provided that, if modifications were
6 made to the fee model by the director in order to secure federal
7 approval pursuant to subdivision (f) or (g) of Section 14167.35,
8 then the hospital shall pay the amount resulting from the
9 modifications.

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

15 (g) Subdivisions (d) and (e) shall become inoperative if the
16 federal Centers for Medicare and Medicaid Services denies
17 approval for, or does not approve before January 1, 2012, the
18 implementation of this article or Article 5.21 (commencing with
19 Section 14167.1), and either or both article cannot be modified by
20 the department pursuant to subdivision (e) of Section 14167.35 in
21 order to meet the requirements of federal law or to obtain federal
22 approval. If subdivisions (d) and (e) become inoperative pursuant
23 to this subdivision, each hospital subject to the quality assurance
24 fee shall be released from any certifications made pursuant to
25 subdivision (d).

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

32 (i) (1) Interest shall be assessed on quality assurance fees not
33 paid on the date due at the greater of 10 percent per annum or the
34 rate at which the department assesses interest on Medi-Cal program
35 overpayments to hospitals that are not repaid when due. Interest
36 shall begin to accrue the day after the date the payment was due
37 and shall be deposited in the Hospital Quality Assurance Revenue
38 Fund.

39 (2) In the event that any fee payment is more than 60 days
40 overdue, a penalty equal to the interest charge described in

1 paragraph (1) shall be assessed and due for each month for which
2 the payment is not received after 60 days.

3 (j) When a hospital fails to pay all or part of the quality
4 assurance fee within 60 days of the date that payment is due, the
5 department may deduct the unpaid assessment and interest owed
6 from any Medi-Cal payments or other state payments to the hospital
7 in accordance with Section 12419.5 of the Government Code until
8 the full amount is recovered. Any deduction shall be made only
9 after written notice to the hospital and may be taken over a period
10 of time. All amounts, except penalties, deducted by the department
11 under this subdivision shall be deposited in the Hospital Quality
12 Assurance Revenue Fund. The remedy provided by this section is
13 in addition to other remedies available under law.

14 (k) The payment of the quality assurance fee shall not be
15 considered as an allowable cost for Medi-Cal cost reporting and
16 reimbursement purposes.

17 (l) The department shall work in consultation with the hospital
18 community to implement the quality assurance fee.

19 (m) This subdivision creates a contractually enforceable promise
20 on behalf of the state to use the proceeds of the quality assurance
21 fee, including any federal matching funds, solely and exclusively
22 for the purposes set forth in this article as they existed on the
23 effective date of this article, to limit the amount of the proceeds
24 of the quality assurance fee to be used to pay for the health care
25 coverage of children to the amounts specified in this article and
26 to make any payments for the department's costs of administration
27 to the amounts set forth in this article on the effective date of this
28 article to maintain and continue prior reimbursement levels as set
29 forth in Article 5.21 (commencing with Section 14167.1) on the
30 effective date of that article, and to otherwise comply with all its
31 obligations set forth in Article 5.21 (commencing with Section
32 14167.1) and this article.

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

39 (o) (1) Effective January 1, 2011, the rates payable to hospitals
40 and managed health care plans under Medi-Cal shall be the rates

1 then payable without the supplemental and enhanced payments
2 set forth in Article 5.21 (commencing with Section 14167.1).

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

8 14167.35. (a) The Hospital Quality Assurance Revenue Fund
9 is hereby created in the State Treasury.

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

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

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

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

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

1 constitute quarters for purposes of the payment for health care
2 coverage for children required by this paragraph.

3 (3) To make increased payments to hospitals pursuant to Article
4 5.21 (commencing with Section 14167.1).

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

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

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

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

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

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

1 requirement, waiver of the uniform fee requirement, or both,
2 pursuant to paragraphs (1) and (2) of subdivision (e) of Section
3 433.68 of Title 42 of the Code of Federal Regulations.

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

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

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

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

27 (i) Notwithstanding subdivision (h), in consultation with the
28 hospital community, the department, as necessary to receive federal
29 approval for the implementation of this article, may do the
30 following:

31 (1) Increase or decrease the managed care per diem quality
32 assurance fee rate by an amount not to exceed five dollars (\$5).

33 (2) Decrease the fee-for-service per diem quality assurance fee
34 rate by an amount not to exceed six dollars (\$6).

35 (3) Increase the Medi-Cal per diem quality assurance fee rate
36 by an amount not to exceed two dollars (\$2).

37 (j) Notwithstanding Chapter 3.5 (commencing with Section
38 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
39 the department may implement this article or Article 5.21
40 (commencing with Section 14167.1) by means of provider

bulletins, all plan letters, or other similar instruction, without taking regulatory action. The department shall also provide notification to the Joint Legislative Budget Committee and to the appropriate policy and fiscal committees of the Legislature within five working days when the above-described action is taken in order to inform the Legislature that the action is being implemented.

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

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

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

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

(b) 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 and Article 5.21 (commencing with Section 14167.1) from the federal Centers for Medicare and Medicaid Services.

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

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

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

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

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

(1) In the event, and on the effective date, of a final judicial determination made by any court of appellate jurisdiction or a final determination by the federal Department of Health and Human

1 Services or the federal Centers for Medicare and Medicaid Services
2 that any element of this article cannot be implemented.

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

4 (A) The federal Centers for Medicare and Medicaid Services
5 denies approval for, or does not approve before January 1, 2012,
6 the implementation of Article 5.21 (commencing with Section
7 14167.1) or this article.

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

11 (e) If this article becomes inoperative pursuant to paragraph (1)
12 of subdivision (d) and the determination applies to any period or
13 periods of time prior to the effective date of the determination, the
14 department may recoup all payments made pursuant to Article
15 5.21 (commencing with Section 14167.1) during that period or
16 those periods of time.

17 (f) This article and Article 5.21 (commencing with Section
18 14167.1) shall not be implemented with respect to the 2009–10
19 and 2010–11 federal fiscal years until the earlier of April 30, 2010,
20 or the date the federal government approves a federal waiver for
21 a demonstration that will replace the Current Section 1115 Waiver,
22 as defined in subdivision (c) of Section 14167.1.

23 14167.37. Each report or informational submission required
24 from providers pursuant to this article shall contain a legal
25 verification to be signed by the provider verifying that the
26 information provided is true and correct to the best of the provider's
27 knowledge, and that any information in supporting documents
28 submitted by the provider is true and correct.

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

38 14167.39. (a) This article and Article 5.21(commencing with
39 Section 14167.1) shall become inoperative and the requirements
40 for supplemental payments or other payments under Article 5.21

(commencing with Section 14167.1) shall be retroactively invalidated, on the first day of the first month of the calendar quarter following notification to the Joint Legislative Budget Committee by the Department of Finance, that any of the following have occurred:

(1) A final judicial determination by the California Supreme Court or any California Court of Appeal that the revenues collected pursuant to this article that are deposited in the Hospital Quality Assurance Fund are either of the following:

(A) “General Fund proceeds of taxes appropriated pursuant to Article XIII B of the California Constitution,” as used in subdivision (b) of Section 8 of Article XVI of the California Constitution.

(B) “Allocated local proceeds of taxes,” as used in subdivision (b) of Section 8 of Article XVI of the California Constitution.

(2) The department has sought but has not received federal financial participation for the supplemental payments and other costs required by this article for which federal financial participation has been sought.

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

(4) The director, in consultation with the Department of Finance, determines that the implementation of this article or Article 5.21 (commencing with Section 14167.1) has resulted in a financial disadvantage to the state.

(b) For purposes of this section, “financial disadvantage to the state” means either:

(1) A loss of federal financial participation.

(2) A cost to the General Fund, that is equal to or greater than one-quarter of a percent of the General Fund expenditures authorized in the most recent annual Budget Act.

(c) (1) The director shall have the authority to recoup any payments made under Article 5.21 (commencing with Section 14167.1) if any of the following apply:

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

1 (B) Federal financial participation is not available for payments
2 made under Article 5.21 (commencing with Section 14167.1) for
3 which federal financial participation has been sought.

4 (C) Recoupment of payments made under Article 5.21
5 (commencing with Section 14167.1) is necessary to prevent a
6 General Fund cost that is estimated to be equal to or greater than
7 one-quarter of a percent of the General Fund expenditures
8 authorized in the most recent annual Budget Act and that results
9 from implementation of a court order or the unavailability of
10 federal financial participation.

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

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

17 (B) The hospital has returned the payment received pursuant to
18 Article 5.21 (commencing with Section 14167.1) for that quarter,
19 or has had that payment recouped through a withholding of funds
20 owed by Medi-Cal or other state payments, or recouped through
21 other means.

22 (d) In the event the department determines that recoupment of
23 supplemental payments is necessary to implement any provision
24 of this section, the department may recoup payments made pursuant
25 to Article 5.21 (commencing with Section 14167.1) from fees paid
26 by the hospital pursuant to this article.

27 (e) Concurrent with invoking any provision of this section, the
28 director shall notify the fiscal and appropriate policy committees
29 of the Legislature of the intended action and the specific reason
30 or reasons for the proposed action.

31 14167.40. This article shall remain in effect only until January
32 1, 2013, and as of that date is repealed, unless a later enacted
33 statute, that is enacted before January 1, 2013, deletes or extends
34 that date.

35 SEC. 3. Article 5.225 (commencing with Section 14167.41)
36 is added to Chapter 7 of Part 3 of Division 9 of the Welfare and
37 Institutions Code, to read:

Article 5.225. Quality Assurance Fee Act

14167.41. (a) Effective January 1, 2011, there shall be imposed, pursuant to subdivision (b), a quality assurance fee in a manner necessary to obtain federal Medicaid matching funds that shall be due and payable to the department by each general acute care hospital at the rate of twenty-seven dollars and twenty-five cents (\$27.25) per managed care day, as defined by the department, for the purpose of making Medi-Cal payments to hospitals.

(b) The quality assurance fee required by this article shall be imposed pursuant to the authority of a subsequent statute enacted to take effect on or after January 1, 2011, that also does both of the following:

(1) Establishes how the revenue from the quality assurance fee on managed care days required by this article is apportioned among hospitals.

(2) Imposes a quality assurance fee for all other applicable hospital days.

(c) The subsequent statute described in subdivision (b) shall provide for a supplemental payment for Medi-Cal managed care inpatient days that shall not be less than the supplemental per diem rate for Medi-Cal managed care inpatient days set forth in Article 5.21 (commencing with Section 14167.1).

(d) This article shall be implemented only if, and to the extent that, all necessary federal approvals have been obtained.

(e) This article shall be implemented only if, and to the extent that, no increased cost to the General Fund results from implementation of this article.

~~SEC. 4. (a) There is hereby appropriated to the State Department of Health Care Services the following sums:~~

~~(1) To pay for the department's staffing and administrative costs associated with Article 5.21 (commencing with Section 14167.1) and Article 5.22 (commencing with Section 14167.31) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, including for workload associated with seeking the necessary federal approvals from the federal Centers for Medicare and Medicaid Services to implement Article 5.21 (commencing with Section 14167.1) and Article 5.22 (commencing with Section 14167.31) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, one million dollars (\$1,000,000) from the Private~~

~~Hospital Supplemental Fund established pursuant to Section 14166.12 of the Welfare and Institutions Code and one million dollars (\$1,000,000) from the Federal Trust Fund.~~

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

~~(b) (1) If the department obtains federal approval for the implementation of Article 5.21 (commencing with Section 14167.1) and Article 5.22 (commencing with Section 14167.31) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, moneys in the Hospital Quality Assurance Revenue Fund shall be used to reimburse the one million dollars (\$1,000,000) appropriated from the Private Hospital Supplemental Fund pursuant to paragraph (1) of subdivision (a).~~

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

~~SEC. 5. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:~~

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