Assembly Bill No. 1383

Passed the Assembly September 12, 2009

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Chief Clerk of the Assembly

Passed the Senate September 12, 2009

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Secretary of the Senate

This bill was received by the Governor this _____ day of _____, 2009, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

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.

LEGISLATIVE COUNSEL'S DIGEST

AB 1383, 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 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 repeal the above provisions on January 1, 2013.

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.

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

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

Article 5.21. Medi-Cal Hospital Provider Rate Stabilization Act

14167.1. (a) "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 furnished to a hospital inpatient, the physician is compensated by the hospital for the service, and the service is billed to Medi-Cal by the hospital under a provider number assigned to the hospital. Hospital inpatient services do not include services for which a managed health care plan is financially responsible.

(h) "Hospital outpatient services" means all services covered under Medi-Cal furnished by hospitals to patients who are

registered as hospital outpatients and reimbursed by the department on a fee-for-service basis directly or through its fiscal intermediary. Hospital outpatient services include physician services only where the service is furnished to a hospital outpatient, the physician is compensated by the hospital for the service, and the service is billed to Medi-Cal by the hospital under a provider number assigned to the hospital. Hospital outpatient services do not include services for which a managed health care plan is financially responsible, or services rendered by a hospital-based federally qualified health center for which reimbursement is received pursuant to Section 14132.100.

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

(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 for the 2008–09 federal fiscal year shall occur when all necessary federal approvals have been secured for that federal fiscal year.

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

(k) "Individual hospital managed care supplemental payment" means the total amount of managed care hospital supplemental payments to a subject hospital for a month for which the supplemental payments are made.

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

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

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

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

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

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

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

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

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

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

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

(m) "Medi-Cal managed care days" means the total number of general acute care days, including well baby days, listed for the county organized health system and prepaid health plans identified in the Final Medi-Cal Utilization Statistics for the 2008–09 state fiscal year, as calculated by the department on September 15, 2008, except that the general acute care days, including well baby days, for the Santa Barbara Health Care Initiative shall be derived from the Final Medi-Cal Utilization Statistics for the 2007–08 state fiscal year.

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

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

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

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

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

(s) "Private hospital" means a hospital that meets all of the following conditions:

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

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

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

(4) Is a nonpublic hospital, nonpublic converted hospital, or converted hospital as those terms are defined in paragraphs (26)

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

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

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

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

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

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

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

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

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

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

(c) 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 upper limit or for any other reason, both of the following shall apply:

(1) The total amount payable to private 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 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).

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

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

(f) 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.

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

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

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

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

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

(A) The total amount payable to private hospitals under subdivision (c) 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 (c) to each private hospital for the subject federal fiscal year shall be equal to the

amount computed under subdivision (c) multiplied by the ratio of the total amount for which federal financial participation is available to the total amount computed under subdivision (c).

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

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

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

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

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

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

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

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

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

(1) 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 Workbooks. For purposes of this section, “Interim Hospital Payment Rate Workbook” means the Interim Hospital Payment Rate Workbook, developed by the department and approved by the federal Centers for Medicare and Medicaid Services for use in connection with the Medi-Cal Hospital/Uninsured Care 1115 Waiver Demonstration, as submitted by each designated public hospital, or the governmental entity with which the hospital is

affiliated, on or around June 2009 for the period of July 1, 2007, to June 30, 2008, inclusive.

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

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

(c) 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 Section 14167.3, due to the limitations on supplemental payments based on a partial-year federal upper payment limit, the amount payable to each designated public hospital under subdivision (b) shall equal the designated public hospital's allocated grant amount under subdivision (b) multiplied by a fraction, the numerator of which is the total number of months in the subject federal fiscal year for which federal 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of policy letters or similar instructions, without taking further regulatory 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 or the 45th day following the day on which federal approval is granted.

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

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

14167.10. (a) (1) At the same time that the department makes an enhanced payment to a managed health care plan under Section

14167.6, the department shall notify the plan of each hospital to which the plan shall make supplemental managed care payments as a consequence of receiving the enhanced payment and the amount of the supplemental payment. The department shall determine the amount of the supplemental payment due to each subject hospital so that the total supplemental managed care payments to the hospital from all managed health care plans resulting from payments made to the managed health care plans for the subject month under Section 14167.6 equals or approximately equals the hospital's individual hospital managed care supplemental payment.

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

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

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

(c) The supplemental payments made to hospitals pursuant to this section shall be in addition to any other amounts payable to

hospitals by a managed health care plan or otherwise and shall not affect any other payments to hospitals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Each mental health plan receiving payments under Section 14167.11 shall make supplemental payments to hospitals within 30 days of receiving the payments under Section 14167.11, except that if the mental health plan receives enhanced payments during November 2010, which include payments relating to some or all of the quarters between January 2011 and September 2011, inclusive, the mental health plan shall make payments relating to the quarters between January 2011 and September 2011, inclusive, on or before the end of each quarter to which the payment relates. The payments shall be made to those hospitals and in those

amounts set forth by the department in its notice provided pursuant to subdivision (a).

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

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

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

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

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

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

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

(b) Rates payable to hospitals for hospital inpatient services furnished before January 1, 2011, under contracts negotiated pursuant to the Selective Provider Contracting Program shall not be reduced below the contract rates in effect on the effective date of this article. This subdivision shall not prohibit changes to the supplemental payments paid to individual hospitals under Sections 14166.12, 14166.17, and 14166.23. The aggregate supplemental

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

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

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

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

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

(g) Solely for purposes of this article, a rate reduction or a change in a rate methodology made on or before the effective date of this article that is enjoined by a court shall be included in the determination of a rate or a rate methodology in effect on the effective date of this article until all appeals or judicial review have been exhausted and the rate reduction or change in rate

methodology has been permanently enjoined or otherwise permanently prevented from being implemented.

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

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

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

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

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

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

(c) 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 Services or the federal Centers for Medicare and Medicaid Services that any element of this article cannot be implemented.

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

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

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

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

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

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

(2) Any amount computed to be payable to the hospital pursuant to this section for a project year shall be withheld by the department and shall be paid to the hospital only after the case or proceeding 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 on the hospital's continued participation in Medi-Cal for at least 30 days after the effective date of this article.

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

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

(2) Federal reimbursement and any other related federal funds.

14167.15. Notwithstanding any other provision of this article or Article 5.22 (commencing with Section 14167.31), the director may proportionately reduce the amount of any supplemental payments, enhanced payments, or grants under this article to the extent that the payment or grant would result in the reduction of other amounts payable to a hospital or managed health care plan or mental health plan due to the application of federal law.

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

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

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

Article 5.22. Quality Assurance Fee Act

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

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

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

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

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

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

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

(e) "Days data source" means the following:

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

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

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

(f) "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.

(g) "Exempt facility" means any of the following:

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

(2) With the exception of a hospital that is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, a hospital that is a hospital designated as a specialty hospital 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.

(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.

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

(n) "Managed care days" means inpatient hospital days in the 2007 calendar year as reported on the days data source where the service type is reported as "acute care," "psychiatric care," and "chemical dependency care and rehabilitation care," and the payer category is reported as "Medicare managed care," "county indigent programs–managed care," and "other third parties–managed care,"

for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

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

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

(q) "Medi-Cal per diem quality assurance fee rate" means a fixed fee on Medi-Cal days of two hundred ninety-three dollars ($293) per day.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Within 30 days following the beginning of each calendar quarter, commencing with the quarter following the last quarter governed by subdivision (d) and ending with, and including, the calendar quarter ending December 31, 2010, each general acute care hospital that is not an exempt facility shall pay to the department the amounts that the hospital would certify to pay for the relevant quarter pursuant to subdivision (d), multiplied by the applicable fee percentage, provided that, if modifications were made to the fee model by the director in order to secure federal approval pursuant to subdivision (f) or (g) of Section 14167.35, then the hospital shall pay the amount resulting from the modifications.

(f) The quality assurance fee, as paid pursuant to this subdivision, shall be paid by each hospital subject to the fee to the

department for deposit in the Hospital Quality Assurance Revenue Fund. Deposits may be accepted at any time and will be credited toward the fiscal year for which they were assessed.

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

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

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

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

(j) When a hospital fails to pay all or part of the quality assurance fee within 60 days of the date that payment is due, the department may deduct the unpaid assessment and interest owed from any Medi-Cal payments or other state payments to the hospital in accordance with Section 12419.5 of the Government Code until the full amount is recovered. Any deduction shall be made only after written notice to the hospital and may be taken over a period of time. All amounts, except penalties, deducted by the department under this subdivision shall be deposited in the Hospital Quality

Assurance Revenue Fund. The remedy provided by this section is in addition to other remedies available under law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Reduces or increases the supplemental payments or grants made under Article 5.21 (commencing with Section 14167.1) in

the aggregate for the 2008–09, 2009–10, and 2010–11 federal fiscal years to a hospital by more than 2 percent of the amount that would be determined under this article without any change or adjustment.

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

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

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

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

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

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

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this article or Article 5.21 (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 Services or the federal Centers for Medicare and Medicaid Services that any element of this article cannot be implemented.

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

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

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

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

(f) This article and Article 5.21 (commencing with Section 14167.1) 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, as defined in subdivision (c) of Section 14167.1.

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

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

14167.39. (a) This article and Article 5.21(commencing with Section 14167.1) shall become inoperative and the requirements 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.

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

(C) Recoupment of payments made under Article 5.21 (commencing with Section 14167.1) is necessary to prevent a General Fund cost that is estimated to be equal to or greater than one-quarter of a percent of the General Fund expenditures authorized in the most recent annual Budget Act and that results

from implementation of a court order or the unavailability of federal financial participation.

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

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

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

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

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

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

SEC. 3. Article 5.225 (commencing with Section 14167.41) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and 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.

Approved _____, 2009

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Governor