AMENDED IN SENATE JULY 15, 2010

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 1653

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

January 14, 2010

An act to *amend Sections 14167.1, 14167.6, 14167.10, 14167.31, and 14167.32 of, and to* add Article 5.227 (commencing with Section 14168) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to Medi-Cal, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 1653, as amended, Jones. Medi-Cal: hospitals: *managed health care plans:* quality assurance fee.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions.

Existing law, subject to federal approval, requires 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.

Existing law requires the department to make enhanced payments to managed health care plans, as defined, and requires the state to make enhanced payments to mental health plans, as defined, for each subject federal fiscal year, as specified. Existing law requires 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, instead, refer to the payments made by the department to the managed health care plans as increased capitation payments. The bill would require the department, through its actuary, to calculate the maximum amount of managed care payments that can be paid to hospitals under federal law for each subject federal fiscal year. Upon completion of the calculations by the department's actuary, the bill would require the department to increase capitation payments to managed health care plans by the amount calculated by the actuary. The bill would require each managed health care plan to expend 100% of any increased capitation payments it receives from the department on hospital services.

This bill would expand the definition of a nondesignated public hospital for purposes of the above-described provisions.

Existing law, subject to federal approval, also imposes, as a condition of participation in state-funded health insurance programs other than the Medi-Cal program, a quality assurance fee, as specified, on certain general acute care hospitals through and including December 31, 2010. Existing law creates the Hospital Quality Assurance Revenue Fund in the State Treasury and requires that the money collected from the quality assurance fee be deposited into the fund. Existing law provides 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 to hospitals and health care coverage for children.

This bill would modify the methodology used in calculating the amount of the quality assurance fee imposed on acute care hospitals pursuant to the above-described provisions.

Existing law, effective January 1, 2011, and subject to the authority of a subsequent statute enacted to take effect on or after January 1, 2011, that meets certain conditions, imposes 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 specified rates for the purpose of making Medi-Cal payments to hospitals

This bill would, effective January 1, 2011, impose on each general acute care hospital that is not an exempt facility, as defined, a quality assurance fee, as a condition of participation in state-funded health insurance programs, other than the Medi-Cal program. This bill would

require the quality assurance fee to be computed starting on the effective date of the bill and continue through and including June 30, 2011. The bill would require the proceeds from the fee to be used for the same purposes as the above-described quality assurance fee that is imposed on hospitals through and including December 31, 2010. The bill would provide that the method of calculation and collection of the quality assurance fee is to be determined in an unspecified manner.

This bill would require the director to seek federal approvals or waivers as may be necessary to implement the above-described provisions and to obtain federal financial participation to the maximum extent possible with the proceeds from the quality assurance fee paid pursuant to those provisions.

This bill would require the fee payments and any related federal reimbursement *under the above-described provisions that become effective January 1, 2011,* to be deposited in the Hospital Quality Assurance Revenue Fund. The bill would continuously appropriate these moneys in an unspecified manner.

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

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

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

SECTION 1. Section 14167.1 of the Welfare and Institutions Code is amended to read:

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~~ *either of the following:*

(1) 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.

(2) A tax-exempt nonprofit 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, is operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(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.

SEC. 2. Section 14167.6 of the Welfare and Institutions Code is amended to read:

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

(b) The ~~enhanced~~ *increased capitation* 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.~~

(c) The department, through its actuary, shall calculate the maximum amount of managed care payments that can be paid to hospitals under federal law for each subject federal fiscal year. The department's actuary shall certify those calculations as meeting federal requirements.

(d) Upon completion of the calculations by the department's actuary pursuant to subdivision (c), the department shall increase capitation payments to managed health care plans by the amount calculated in subdivision (c).

~~(d)~~

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

(1) The ~~enhanced~~ *increased capitation* 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~~ *increased capitation* payments to managed health care plans. The last ~~enhanced~~ *increased capitation* payments made pursuant to this section shall be made during December 2010.

(2) The ~~enhanced~~ *increased capitation* payments made during the first month in which ~~enhanced~~ *increased capitation* payments are made pursuant to this section shall include the sum of the ~~enhanced~~ *increased capitation* payments for all prior months for which payments are due *and actuarial certification was received*.

~~(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)~~

(f) Payments to managed health care plans that would be paid *consistent with actuarial certification and enrollment* in the absence of the payments made pursuant to this section shall not be reduced as a consequence of payment under this section.

~~(f)~~

(g) (1) Each managed health care plan shall expend~~, in the form of supplemental payments to hospitals,~~ 100 percent of any ~~rate enhanced~~ *increased capitation* payments it receives under this section~~, pursuant to Section 14167.10~~ on hospital services.

~~(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)~~

(2) The department may issue change orders to amend contracts with managed health care plans ~~on either a quarterly or semiannual basis~~ *as needed* 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~~ *in order to implement this section*.

~~(g)~~

(h) In the event federal financial participation is not available for all of the ~~enhanced managed care~~ *increased capitation* payments determined for a month pursuant to this section for any reason, the ~~enhanced~~ *increased capitation* 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.

SEC. 3. Section 14167.10 of the Welfare and Institutions Code is amended to read:

~~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.~~

14167.10. (a) Each managed health care plan receiving increased capitation payments under Section 14167.6 shall expend the capitation rate increases in a manner consistent with actuarial certification, enrollment, and utilization on hospital services within 30 days of receiving the increased capitation payments.

~~(d)~~

(b) For each subject federal fiscal year, the sum of all ~~supplemental payments~~ *expenditures* made by a managed health care plan ~~to subject hospitals~~ *for hospital services* pursuant to this section shall equal, or approximately equal, all ~~enhanced~~ *increased capitation* payments received by the managed health care plan, *consistent with actuarial certification, enrollment, and utilization,* 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)~~

(c) Any delegation or attempted delegation by a managed health care plan of its obligation to ~~make payments~~ *expend the capitation rate increases* under this section shall not relieve the plan from its obligation to ~~make those payments~~ *expend those capitation rate increases*. 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~~ *expenditure of the capitation rate increases for hospital services*, and not assignment to subcontractors of the managed health care plan's obligation of the duty to ~~pay hospitals~~ *expend the capitation rate increases*. ~~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.~~

(d) Consistent with actuarial certification, enrollment, and utilization, managed health care plans shall in no event be obligated under this section to expend the capitation rate increases on hospital services that exceed the increased capitation payments made to the managed health care plans under Section 14167.6.

SEC. 4. Section 14167.31 of the Welfare and Institutions Code is amended to read:

14167.31. (a) *(1)* "Aggregate quality assurance fee" means the sum of all of the following:

~~(1)~~

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

~~(2)~~

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

~~(3)~~

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

(2) "Aggregate quality assurance fee after the application of the microfee percentage" means the sum of all of the following:

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

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

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

(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)~~ *or "fee percentages" means a percentage or percentages that consists or consist of the macrofee percentage or percentages and the microfee percentage or percentages*.

(1) (A) "Microfee percentage" or "microfee percentages" means a percentage or percentages that is or are calculated by the department to equal, for a subject federal fiscal year, a fraction, expressed as a percentage, the numerator of which is the sum of two billion two hundred fifty-two million two hundred ninety-one thousand three hundred fifty-three dollars ($2,252,291,353) plus the maximum amount of managed care payments for the subject

federal fiscal year calculated by the department pursuant to subdivision (c) of Section 14167.6 and the denominator of which is three billion seven hundred eleven million seven hundred eight thousand seven hundred forty dollars ($3,711,708,740).

(B) The department shall apply the microfee percentage or percentages only to the fee-for-service per diem quality assurance fee rate and the Medi-Cal per diem quality assurance fee rate.

(C) If required in order to comply with federal law, the department may calculate different microfee percentages for the fee-for-service per diem quality assurance fee rate and the Medi-Cal per diem quality assurance fee rate, provided that the difference between the two microfee percentages shall be the minimum necessary to comply with federal law.

(2) "Macrofee percentage" or "macrofee percentages" means a fraction, expressed as a percentage, the numerator of which is the amount of payments under Sections 14167.2, 14167.3, 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 the sum of two billion two hundred fifty-two million two hundred ninety-one thousand three hundred fifty-three dollars ($2,252,291,353) plus the maximum amount of managed care payments for a subject federal fiscal year calculated by the department pursuant to subdivision (c) of Section 14167.6.

(*l*) "General acute care hospital" ~~shall mean~~ *means* 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.

SEC. 5. Section 14167.32 of the Welfare and Institutions Code is amended to read:

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 *or percentages* 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), *except that the term "aggregate quality assurance fee" used in subdivision (d) shall be replaced with the term "aggregate quality assurance fee after the application of the microfee percentage,"* multiplied by the applicable ~~fee~~ *macrofee* 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), *except that the term "aggregate quality assurance fee" used in subdivision (d) shall be replaced with the term "aggregate quality assurance fee after the application of the microfee percentage,"* multiplied by

the applicable ~~fee~~ *macrofee* 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.

~~SECTION 1.~~

SEC. 6. Article 5.227 (commencing with Section 14168) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.227. Quality Assurance Fee Act

14168. (a) (1) "Exempt facility" means any of the following:

(A) A public hospital*, which shall include either of the following:*

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

(ii) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code and operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(B) 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 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.

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

(D) 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.

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

(b) Effective January 1, 2011, 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 a state-funded health insurance program, other than the Medi-Cal program.

(c) (1) The quality assurance fee shall be computed starting on the effective date of this article and continue through and including June 30, 2011.

(2) The method of calculation and collection of the quality assurance fee shall be determined pursuant to ____.

(3) The quality assurance fee shall be used solely for the purposes specified in Article 5.21 (commencing with Section 14167.1) and Article 5.22 (commencing with Section 14167.31).

(d) The director shall do all of the following:

(1) Seek federal approvals or waivers as may be necessary to implement this article.

(2) Obtain federal financial participation to the maximum extent possible with the proceeds from the quality assurance fee paid pursuant to this article.

(e) (1) The fee payments and any related federal reimbursement shall be deposited in the Hospital Quality Assurance Revenue Fund.

(2) Notwithstanding Section 13340 of the Government Code, any moneys deposited in the Hospital Quality Assurance Revenue Fund pursuant to paragraph (1) shall be continuously appropriated, without regard to fiscal year, as follows:____.

~~SEC. 2.~~

SEC. 7. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make the necessary statutory changes to increase Medi-Cal payments to hospitals and improve access, at the earliest possible time, it is necessary that this act take effect immediately.

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