

AMENDED IN SENATE AUGUST 2, 2010

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, *14167.2*, *14167.3*, *14167.5*, *14167.6*, *14167.10*, *14167.11*, *14167.12*, *14167.14*, *14167.15*, *14167.31*, and ~~14167.32~~ *14167.32*, *14167.35*, and *14167.36* of, and to add Article 5.227 (commencing with Section 14168) to Chapter 7 of Part 3 of Division 9 of, and to repeal and add Section *14167.9* 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: *mental health 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, *as defined*.

This bill would make various changes to the formulas used to determine the amount of supplemental payments made to private and designated public hospitals.

Existing law proscribes certain deadlines by which the above-described supplemental payments are required to be made to hospitals depending upon the federal fiscal year for which the payment is to be made.

This bill would require the department to make to hospitals the supplemental payments for the 2008–09, 2009–10, and 2010–11 federal fiscal years in 7 payments, as specified.

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 *and mental health plans* as increased capitation payments. The bill would require the ~~department, through its actuary, department to calculate the maximum~~ *determine the amount of increased capitation payments for each Medi-Cal managed care payments that can be paid to hospitals under federal law for each subject federal fiscal year plan and to consider certain factors in making that determination.* ~~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 prohibit the amount of increased capitation payments to each Medi-Cal managed care health plan from exceeding an amount that results in capitation payments that are certified by the state's actuary as meeting federal requirements.* 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~~ *formulas* used in calculating the amount of the quality assurance fee imposed on acute care hospitals pursuant to the above-described provisions.

The bill would provide that the quality assurance fee shall not be imposed on a converted hospital, as defined, for a subject federal fiscal year in which the hospital becomes a converted hospital or for subsequent federal fiscal years.

Prior to federal approval of implementation of the above-described provisions, existing law requires each general acute care hospital that is not an exempt facility to certify to the best of its knowledge that the hospital is prepared to pay the aggregate quality assurance fee, as defined.

This bill would delete the above-described certification requirement. The bill would require hospitals to pay the quality assurance fee in 7 equal installments, as specified and subject to federal approval of the above-described provisions.

Existing law authorizes the department, as necessary to receive federal approval for the implementation of the above-described provisions, to increase or decrease certain amounts used to calculate the quality assurance fee.

This bill would delete the above-described authorization.

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: $\frac{2}{3}$. Appropriation: yes. Fiscal committee: yes.
 State-mandated local program: no.

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

1 SECTION 1. Section 14167.1 of the Welfare and Institutions
 2 Code is amended to read:
 3 14167.1. (a) “Acute psychiatric days” means the total number
 4 of Short-Doyle administrative days, Short-Doyle acute care days,
 5 acute psychiatric administrative days, and acute psychiatric acute
 6 days identified in the Final Medi-Cal Utilization Statistics for the
 7 2008–09 state fiscal year as calculated by the department on
 8 September 15, 2008.
 9 (b) (1) “Converted hospital” means a private hospital that
 10 becomes a designated public hospital or a nondesignated public
 11 hospital after the implementation date, a nondesignated public
 12 hospital that becomes a private hospital or a designated public
 13 hospital after the implementation date, or a designated public
 14 hospital that becomes a private hospital or a nondesignated public
 15 hospital after the implementation date.
 16 (2) *A private hospital shall be considered a converted hospital*
 17 *if both of the following apply:*

1 (A) *After the implementation date, the hospital's ownership is*
2 *transferred to a nonprofit corporation and that corporation's sole*
3 *corporate member is a health care district governed by Division*
4 *23 (commencing with Section 32000) of the Health and Safety*
5 *Code.*

6 (B) *The hospital is operating a hospital owned by a health care*
7 *district.*

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

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

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

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

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

37 (h) "Hospital outpatient services" means all services covered
38 under Medi-Cal furnished by hospitals to patients who are
39 registered as hospital outpatients and reimbursed by the department
40 on a fee-for-service basis directly or through its fiscal intermediary.

1 Hospital outpatient services include physician services only where
2 the service is furnished to a hospital outpatient, the physician is
3 compensated by the hospital for the service, and the service is
4 billed to Medi-Cal by the hospital under a provider number
5 assigned to the hospital. Hospital outpatient services do not include
6 services for which a managed health care plan is financially
7 responsible, or services rendered by a hospital-based federally
8 qualified health center for which reimbursement is received
9 pursuant to Section 14132.100.

10 (i) (1) “Implementation date” means the latest effective date
11 of all federal approvals or waivers necessary for the implementation
12 of this article and Article 5.22 (commencing with Section
13 14167.31), including, but not limited to, any approvals on
14 amendments to contracts between the department and managed
15 health care plans or mental health plans necessary for the
16 implementation of this article. The effective date of a federal
17 approval of a contract amendment shall be the earliest date to
18 which the computation of payments under the contract amendment
19 is applicable that may be prior to the date on which the contract
20 amendment is executed.

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

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

35 ~~(k) “Individual hospital managed care supplemental payment”~~
36 ~~means the total amount of managed care hospital supplemental~~
37 ~~payments to a subject hospital for a month for which the~~
38 ~~supplemental payments are made.~~

39 ~~(1) The “individual hospital managed care supplemental~~
40 ~~payment” shall be calculated for private hospitals and designated~~

1 public hospitals by multiplying the number of Medi-Cal managed
2 care days for the individual hospital by one thousand three hundred
3 forty-one dollars and eighty-nine cents (\$1,341.89) and dividing
4 the result by 12.

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

10 ~~(f)~~

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

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

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

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

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

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

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

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

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

31 ~~(m)~~

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

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

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

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

18 ~~(q) “Nondesignated public hospital” means either of the~~
 19 ~~following:~~

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

26 ~~(2) A tax-exempt nonprofit hospital that is licensed under~~
 27 ~~subdivision (a) of Section 1250 of the Health and Safety Code, is~~
 28 ~~not designated as a specialty hospital in the hospital’s annual~~
 29 ~~financial disclosure report for the hospital’s latest fiscal year ending~~
 30 ~~in 2007, is operating a hospital owned by a local health care district,~~
 31 ~~and is affiliated with the health care district hospital owner by~~
 32 ~~means of the district’s status as the nonprofit corporation’s sole~~
 33 ~~corporate member.~~

34 (p) “Nondesignated public hospital” means a public hospital
 35 that is licensed under subdivision (a) of Section 1250 of the Health
 36 and Safety Code, is not designated as a specialty hospital in the
 37 hospital’s annual financial disclosure report for the hospital’s
 38 latest fiscal year ending in 2007, and satisfies the definition in
 39 paragraph (25) of subdivision (a) of Section 14105.98, excluding
 40 designated public hospitals.

1 ~~(p)~~

2 ~~(q)~~ “Outpatient base amount” means the total amount of
3 payments for hospital outpatient services made to a hospital in the
4 2007 calendar year, as reflected in state paid claims files on January
5 26, 2008.

6 ~~(s)~~

7 ~~(r)~~ “Private hospital” means a hospital that meets all of the
8 following conditions:

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

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

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

19 (4) Is a nonpublic hospital, nonpublic converted hospital, or
20 converted hospital as those terms are defined in paragraphs (26)
21 to (28), inclusive, respectively, of subdivision (a) of Section
22 14105.98.

23 ~~(t)~~

24 ~~(s)~~ “Subject federal fiscal year” means a federal fiscal year that
25 ends after the implementation date and begins before December
26 31, 2010.

27 ~~(u)~~

28 ~~(t)~~ “Subject hospital” shall mean a hospital that meets all of the
29 following conditions:

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

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

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

40 ~~(v)~~

1 (u) “Subject month” means a calendar month beginning on or
2 after the implementation date and ending before January 1, 2011.

3 (w)

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

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

11 ~~14167.6. (a) The department shall increase capitation payments~~
12 ~~to Medi-Cal managed health care plans for the subject federal~~
13 ~~fiscal years as set forth in this section.~~

14 ~~(b) The increased capitation payments shall be made as part of~~
15 ~~the monthly capitated payments made by the department to~~
16 ~~managed health care plans.~~

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

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

26 ~~(e) The increased capitation payments to managed health care~~
27 ~~plans under this section shall be made to support the availability~~
28 ~~of hospital services and ensure access to hospital services for~~
29 ~~Medi-Cal beneficiaries. The increased capitation payments to~~
30 ~~managed health care plans shall be made as follows:~~

31 ~~(1) The increased capitation payments shall commence during~~
32 ~~the second month following the month during which the quality~~
33 ~~assurance fee set forth in Article 5.22 (commencing with Section~~
34 ~~14167.31) is due and payable from hospitals if the quality assurance~~
35 ~~fee includes funds for increased capitation payments to managed~~
36 ~~health care plans. The last increased capitation payments made~~
37 ~~pursuant to this section shall be made during December 2010.~~

38 ~~(2) The increased capitation payments made during the first~~
39 ~~month in which increased capitation payments are made pursuant~~
40 ~~to this section shall include the sum of the increased capitation~~

1 ~~payments for all prior months for which payments are due and~~
2 ~~actuarial certification was received.~~

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

7 ~~(g) (1) Each managed health care plan shall expend 100 percent~~
8 ~~of any increased capitation payments it receives under this section~~
9 ~~on hospital services.~~

10 ~~(2) The department may issue change orders to amend contracts~~
11 ~~with managed health care plans as needed to adjust monthly~~
12 ~~capitation payments in order to implement this section.~~

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

19 ~~(i) Notwithstanding Chapter 3.5 (commencing with Section~~
20 ~~11340) of Part 1 of Division 3 of Title 2 of the Government Code,~~
21 ~~the department shall implement this section by means of policy~~
22 ~~letters or similar instructions, without taking further regulatory~~
23 ~~action.~~

24 *SEC. 2. Section 14167.2 of the Welfare and Institutions Code*
25 *is amended to read:*

26 14167.2. (a) Private hospitals shall be paid supplemental
27 amounts for the provision of hospital outpatient services as set
28 forth in this section. The supplemental amounts shall be in addition
29 to any other amounts payable to hospitals with respect to those
30 services and shall not affect any other payments to hospitals.

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

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

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

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

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

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

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

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

19 *SEC. 3. Section 14167.3 of the Welfare and Institutions Code*
 20 *is amended to read:*

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

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

31 (1) Six hundred ~~forty-seven~~ *forty* dollars and ~~seventy~~ *forty-six*
 32 cents ~~(\$647.70)~~ *(\$640.46)* multiplied by the hospital's general
 33 acute care days.

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

38 (3) One thousand three hundred fifty dollars (\$1,350) multiplied
 39 by the number of the hospital's high acuity days if the hospital's
 40 Medicaid inpatient utilization rate is less than 41.1 ~~percent~~, *percent*

1 *and greater than 5 percent and* at least 5 percent of the hospital's
2 general acute care days are high acuity days, ~~and the hospital is~~
3 ~~not a small and rural hospital as defined in Section 124840 of the~~
4 ~~Health and Safety Code~~ days. This amount shall be in addition to
5 the amounts specified in paragraphs (1) and (2).

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

14 (c) A private hospital that provides Medi-Cal subacute services
15 during a subject federal fiscal year and has a Medicaid inpatient
16 utilization rate that is greater than 5.0 percent and less than ~~26.10~~
17 *41.1* percent shall be paid for the provision of subacute services
18 during each subject federal fiscal year a supplemental amount
19 equal to ~~50~~ 40 percent of the Medi-Cal subacute payments made
20 to the hospital during the 2008 calendar year.

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

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

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

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

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

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

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

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

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

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

24 *SEC. 4. Section 14167.5 of the Welfare and Institutions Code*
25 *is amended to read:*

26 14167.5. (a) Designated public hospitals shall be paid direct
27 grants in support of health care expenditures, which shall not
28 constitute Medi-Cal payments, and which shall be funded by the
29 quality assurance fee set forth in Article 5.22 (commencing with
30 Section 14167.31). The aggregate amount of the grants to
31 designated public hospitals for each subject federal fiscal year
32 shall be ~~three hundred ten~~ *two hundred ninety-five* million dollars
33 ~~(\$310,000,000)~~ *(\$295,000,000)*.

34 (b) The director shall allocate the amount specified in
35 subdivision (a) among the designated public hospitals in accordance
36 with this subdivision. In determining the allocation, the director
37 shall rely on data from the Interim Hospital Payment Rate
38 Workbooks. For purposes of this section, "Interim Hospital
39 Payment Rate Workbook" means the Interim Hospital Payment
40 Rate Workbook, developed by the department and approved by

1 the federal Centers for Medicare and Medicaid Services for use in
2 connection with the Medi-Cal Hospital/Uninsured Care 1115
3 Waiver Demonstration, as submitted by each designated public
4 hospital, or the governmental entity with which the hospital is
5 affiliated, on or around June 2009 for the period of July 1, 2007,
6 to June 30, 2008, inclusive.

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

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

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

39 (d) Designated public hospitals shall be paid supplemental
40 Medi-Cal amounts for acute inpatient psychiatric services that are

1 paid directly by the department and are not the financial
 2 responsibility of a mental health plan, as set forth in this
 3 subdivision. The supplemental amounts shall be in addition to any
 4 other amounts payable to designated public hospitals, or a
 5 governmental entity with which the hospital is affiliated, with
 6 respect to those services and shall not affect any other payments
 7 to hospitals or to any governmental entity with which the hospital
 8 is affiliated.

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

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

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

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

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

35 *SEC. 5. Section 14167.6 of the Welfare and Institutions Code*
 36 *is amended to read:*

37 14167.6. (a) The department shall ~~enhance~~ *increase* capitation
 38 payments to Medi-Cal managed health care plans for the subject
 39 federal fiscal years as set forth in this section.

1 (b) The ~~enhanced~~ *increased capitation* payments shall be made
2 as part of the monthly capitated payments made by the department
3 to managed health care plans.

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

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

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

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

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

16 (c) *The aggregate amount of increased capitation payments to*
17 *all Medi-Cal managed health care plans for a subject federal fiscal*
18 *year shall be seven hundred twenty-nine million eight hundred*
19 *twenty-nine thousand two hundred two dollars (\$729,829,202)*
20 *multiplied by the fee percentage of the subject federal fiscal year.*

21 (d) *The department shall determine the amount of the increased*
22 *capitation payments for each managed health care plan. The*
23 *department shall consider the composition of Medi-Cal enrollees*
24 *in the plan, the anticipated utilization of hospital services by the*
25 *plan's Medi-Cal enrollees, and other factors that the department*
26 *determines are reasonable and appropriate to ensuring access to*
27 *high quality hospital services by the plan's enrollees.*

28 (e) *The amount of increased capitation payments to each*
29 *Medi-Cal managed care health plan shall not exceed an amount*
30 *that results in capitation payments that are certified by the state's*
31 *actuary as meeting federal requirements, taking into account the*
32 *requirement that all of the increased capitation payments under*
33 *this section shall be paid by the Medi-Cal managed health care*
34 *plans to hospitals for hospital services to Medi-Cal enrollees of*
35 *the plan.*

36 (f)

37 (f) ~~The department shall make enhanced increased capitation~~
38 ~~payments to managed health care plans exclusively for the purpose~~
39 ~~of making supplemental payments to hospitals, in order under this~~
40 ~~section shall be made to support the availability of hospital services~~

1 and ensure access to *hospital services* for Medi-Cal beneficiaries.
 2 ~~Managed health care plans shall pass through enhanced payments~~
 3 ~~to hospitals in a manner determined by the department.~~ The
 4 ~~enhanced increased capitation~~ payments to managed health care
 5 plans shall be made as follows:

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

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

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

23 (e)

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

28 (f)

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

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

37 (3)

38 (2) The department may issue change orders to amend contracts
 39 with managed health care plans ~~on either a quarterly or semiannual~~
 40 ~~basis as needed~~ to adjust monthly capitation payments to coincide

1 with updated enrollment data so that the amounts paid to hospitals
2 pursuant to this section equals, or nearly equals, the amounts set
3 forth in subdivision (a) of Section 14167.10 in order to implement
4 this section.

5 (g)

6 (i) In the event federal financial participation is not available
7 for all of the ~~enhanced managed care~~ *increased capitation* payments
8 determined for a month pursuant to this section for any reason, the
9 ~~enhanced~~ *increased capitation* payments mandated by this section
10 for that month shall be reduced proportionately to the amount for
11 which federal financial participation is available.

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

21 (i)

22 (j) Notwithstanding Chapter 3.5 (commencing with Section
23 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
24 the department shall implement this section by means of policy
25 letters or similar instructions, without taking further regulatory
26 action.

27 *SEC. 6. Section 14167.9 of the Welfare and Institutions Code*
28 *is repealed.*

29 ~~14167.9. Subject to the limitations in Section 14167.4, the~~
30 ~~following shall apply:~~

31 (a) ~~The payments to hospitals under Sections 14167.2, 14167.3,~~
32 ~~14167.4, and 14167.5 for the 2008–09 federal fiscal year shall be~~
33 ~~made on or before the 45th day following the day on which federal~~
34 ~~approval is granted.~~

35 (b) ~~The payments to hospitals under Sections 14167.2, 14167.3,~~
36 ~~14167.4, and 14167.5 for the 2009–10 federal fiscal year shall be~~
37 ~~made on a quarterly basis. The amounts payable to a hospital for~~
38 ~~each quarter shall be one-fourth of the amount payable to the~~
39 ~~hospital for the entire federal fiscal year, except as may be adjusted~~
40 ~~by the department under Section 14167.8. Payments to hospitals~~

1 for each quarter during the 2009–10 federal fiscal year shall be
 2 made the later of the last day of the second month of the quarter
 3 or the 45th day following the day on which federal approval is
 4 granted.

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

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

11 SEC. 7. Section 14167.9 is added to the Welfare and Institutions
 12 Code, to read:

13 14167.9. Subject to the limitations in Section 14167.14, the
 14 following shall apply:

15 (a) (1) The department shall make to hospitals the payments
 16 described in Sections 14167.2, 14167.3, 14167.4, and subdivision
 17 (d) of Section 14167.5 for the 2008–09, 2009–10, and 2010–11
 18 federal fiscal years in seven payments.

19 (2) (A) The first payment shall be made on or before the later
 20 of September 30, 2010, or the 30 day after the notice described in
 21 Section 14167.32 is sent to each hospital.

22 (B) The subsequent payments shall be made in six consecutive
 23 semimonthly payments that shall be made on or before the later
 24 of each of the 14 and 30 days of October, November, and December
 25 2010, or the 30 day after the notice described in Section 14167.32
 26 is sent to each hospital.

27 (3) The amount of each payment made pursuant to this
 28 subdivision shall be one-seventh of the amount of payments
 29 calculated for each hospital under Sections 14167.2, 14167.3,
 30 14167.4, and subdivision (d) of Section 14167.5.

31 (b) Notwithstanding subdivision (a), all amounts due to hospitals
 32 under Sections 14167.2, 14167.3, 14167.4, and subdivision (d) of
 33 Section 14167.5 that have not been paid to hospitals before
 34 December 30, 2010, pursuant to subdivision (a), shall be paid to
 35 hospitals no later than December 30, 2010.

36 (c) (1) The department shall make to hospitals the payments
 37 described in subdivisions (a), (b), and (c) of Section 14167.5 in
 38 seven payments.

39 (2) (A) (i) The first six payments shall be made in consecutive
 40 semimonthly payments that shall be made on or before the later

1 of each of the first and 15th days of October, November, and
2 December 2010, or the 30th day after the notice described in
3 Section 14167.32 is sent to each hospital.

4 (ii) The amount of each of the first six payments shall be
5 one-seventh of the amount of payments calculated for each hospital
6 under subdivisions (a), (b), and (c) of Section 14167.5.

7 (B) (i) The seventh payment shall be made on or before
8 December 30, 2010.

9 (ii) The amount of the seventh payment shall be the total amount
10 due to hospitals under subdivisions (a), (b), and (c) of Section
11 14167.5 minus the amounts previously paid to the hospitals under
12 subparagraph (A).

13 ~~SEC. 3.~~

14 SEC. 8. Section 14167.10 of the Welfare and Institutions Code
15 is amended to read:

16 14167.10. (a) Each managed health care plan receiving
17 increased capitation payments under Section 14167.6 shall expend
18 the capitation rate increases in a manner consistent with actuarial
19 certification, enrollment, and utilization on hospital services within
20 30 days of receiving the increased capitation payments.

21 (b) For each subject federal fiscal year, the sum of all
22 expenditures made by a managed health care plan for hospital
23 services pursuant to this section shall equal, or approximately
24 equal, all increased capitation payments received by the managed
25 health care plan, consistent with actuarial certification, enrollment,
26 and utilization, from the department pursuant to Section 14167.6.

27 (c) Any delegation or attempted delegation by a managed health
28 care plan of its obligation to expend the capitation rate increases
29 under this section shall not relieve the plan from its obligation to
30 expend those capitation rate increases. Managed health care plans
31 shall submit the documentation the department may require to
32 demonstrate compliance with this subdivision. The documentation
33 shall demonstrate actual expenditure of the capitation rate increases
34 for hospital services, and not assignment to subcontractors of the
35 managed health care plan's obligation of the duty to expend the
36 capitation rate increases.

37 (d) Consistent with actuarial certification, enrollment, and
38 utilization, managed health care plans shall in no event be obligated
39 under this section to expend the capitation rate increases on hospital

1 services that exceed the increased capitation payments made to
2 the managed health care plans under Section 14167.6.

3 *SEC. 9. Section 14167.11 of the Welfare and Institutions Code*
4 *is amended to read:*

5 14167.11. (a) The department shall increase payments to
6 mental health plans for the subject federal fiscal years as set forth
7 in this section.

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

15 (c) The state shall make ~~enhanced~~ *increased capitation* payments
16 to mental health plans exclusively for the purpose of making
17 supplemental payments to hospitals, in order to support the
18 availability of hospital mental health services and ensure access
19 for Medi-Cal beneficiaries to hospital mental health services. The
20 ~~enhanced~~ *increased capitation* payments to mental health plans
21 shall be made as follows:

22 (1) The ~~enhanced~~ *increased capitation* payments shall
23 commence on or before the later of the last day of the second month
24 of the quarter in which federal approval is granted or the 45th day
25 following the day on which federal approval is granted. Subsequent
26 ~~enhanced~~ *increased capitation* payments shall be made on the last
27 day of the second month of each quarter. The last ~~enhanced~~
28 *increased capitation* payments made pursuant to this section shall
29 be made during November 2010.

30 (2) The ~~enhanced~~ *increased capitation* payments made for the
31 first quarter for which ~~enhanced~~ *increased capitation* payments
32 are made under this section shall include the sum of ~~enhanced~~
33 *increased capitation* payments for all prior quarters for which
34 payments are due under subdivision (b).

35 (3) The ~~enhanced~~ *increased capitation* payments made during
36 November 2010 shall include payments computed under
37 subdivision (b) for all quarters in the 2010–11 federal fiscal year
38 to the extent that federal financial participation is available for the
39 payments.

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

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

11 (e) In the event federal financial participation for a subject
12 federal fiscal year is not available for all of the ~~enhanced~~ *increased*
13 *capitation* acute psychiatric payments determined for a quarter
14 pursuant to this section for any reason, the ~~enhanced~~ *increased*
15 *capitation* payments mandated by this section for that quarter shall
16 be reduced proportionately to the amount for which federal
17 financial participation is available.

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

21 (g) In the event the director determines that payment of the
22 individual acute psychiatric supplemental payments may be made
23 by the department directly to the hospitals under this section and
24 Section 14167.12 without the need for transmitting the funds
25 through the mental health plans, those direct payments shall be
26 made notwithstanding any other provision of this article or Article
27 5.22 (commencing with Section 14167.31).

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

33 *SEC. 10. Section 14167.12 of the Welfare and Institutions Code*
34 *is amended to read:*

35 14167.12. (a) At the same time that the state makes an
36 ~~enhanced~~ *increased capitation* payment to a mental health plan
37 under Section 14167.11, the state shall notify the mental health
38 plan that the plan shall make payments in the amount of the
39 individual hospital acute psychiatric supplemental payment to each
40 subject hospital located in each county in which the mental health

1 plan operates as a consequence of receiving the ~~enhanced~~ *increased*
2 *capitation* payment and the amount of the individual hospital acute
3 psychiatric supplemental payment due to each hospital, subject to
4 the following:

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

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

21 (b) Each mental health plan receiving payments under Section
22 14167.11 shall make supplemental payments to hospitals within
23 30 days of receiving the payments under Section 14167.11, except
24 that if the mental health plan receives ~~enhanced~~ *increased*
25 *capitation* payments during November 2010, which include
26 payments relating to some or all of the quarters between January
27 2011 and September 2011, inclusive, the mental health plan shall
28 make payments relating to the quarters between January 2011 and
29 September 2011, inclusive, on or before the end of each quarter
30 to which the payment relates. The payments shall be made to those
31 hospitals and in those amounts set forth by the department in its
32 notice provided pursuant to subdivision (a).

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

37 (d) For each subject federal fiscal year, the sum of all
38 supplemental payments made by a mental health plan to subject
39 hospitals pursuant to this section shall equal all ~~enhanced~~ *increased*

1 *capitation* payments received by the mental health plan from the
2 state pursuant to Section 14167.11.

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

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

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

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

20 *SEC. 11. Section 14167.14 of the Welfare and Institutions Code*
21 *is amended to read:*

22 14167.14. (a) The director shall do all of the following:

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

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

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

32 (4) Amend the contracts between the managed health care plans
33 and the department as necessary to incorporate the provisions of
34 Sections 14167.6 and 14167.10 and promptly seek all necessary
35 federal approvals of those amendments. The department shall
36 pursue amendments to the contracts as soon as possible after the
37 effective date of this article and Article 5.22 (commencing with
38 Section 14167.31), and shall not wait for federal approval of this
39 article or Article 5.22 (commencing with Section 14167.31) prior
40 to pursuing amendments to the contracts. The amendments to the

1 contracts shall, among other provisions, set forth an agreement to
2 increase payment rates to managed health care plans under Section
3 14166.6 and increase payments to hospitals under Section 14166.10
4 effective April 2009 or as soon thereafter as possible, conditioned
5 on obtaining all federal approvals necessary for federal financial
6 participation for the ~~enhanced~~ *increased capitation* payments to
7 the managed health care plans.

8 (b) In implementing this article, the department may utilize the
9 services of the Medi-Cal fiscal intermediary through a change
10 order to the fiscal intermediary contract to administer this program,
11 consistent with the requirements of Sections 14104.6, 14104.7,
12 14104.8, and 14104.9. Contracts entered into for purposes of
13 implementing this article or Article 5.22 (commencing with Section
14 14167.31) shall not be subject to Part 2 (commencing with Section
15 10100) of Division 2 of the Public Contract Code.

16 (c) This article shall become inoperative if either of the
17 following ~~occur~~ *occurs*:

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

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

24 (A) The federal Centers for Medicare and Medicaid Services
25 denies approval for, or does not approve before January 1, 2012,
26 the implementation of Article 5.22 (commencing with Section
27 14167.31) or this article.

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

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

36 (e) In the event any hospital, or any party on behalf of a hospital,
37 shall initiate a case or proceeding in any state or federal court in
38 which the hospital seeks any relief of any sort whatsoever,
39 including, but not limited to, monetary relief, injunctive relief,
40 declaratory relief, or a writ, based in whole or in part on a

1 contention that any or all of this article is unlawful and may not
2 be lawfully implemented, both of the following shall apply:

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

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

10 (f) No payment shall be made under this article until all
11 necessary federal approvals for the payment and for the fee
12 provisions in Article 5.22 (commencing with Section 14167.31)
13 have been obtained and the fee has been imposed and collected.
14 Payments under this article shall be made only to the extent that
15 the fee established in Article 5.22 (commencing with Section
16 14167.31) is collected and available to support the payments.

17 (g) Supplemental payments for the 2008–09 federal fiscal year
18 shall not reduce the maximum federal funds available annually
19 pursuant to the Special Terms and Conditions, as amended October
20 5, 2007, of the Current Section 1115 Waiver.

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

33 (2) In negotiating the terms of a federal waiver that will replace
34 the Current 1115 Waiver, the department shall explore
35 opportunities for reform of the Medi-Cal program and strengthen
36 California’s health care safety net. Subject to subsequent legislative
37 approval, the department shall explore program reforms, that may
38 include, but need not be limited to, strategies to accomplish
39 payment system reforms for hospital inpatient and outpatient care,
40 including incentive based payments, new payment methodologies

1 such as diagnostic-related group-based (DRG-based), or similar
 2 methodologies, patient safety protocols, and quality measurement.

3 (3) This article and Article 5.22 (commencing with Section
 4 14167.31) shall not be implemented with respect to the 2009–10
 5 and 2010–11 federal fiscal years until the earlier of April 30, 2010,
 6 or the date the federal government approves a federal waiver for
 7 a demonstration that will replace the Current Section 1115 Waiver.

8 (i) A hospital’s receipt of payments under this article for services
 9 rendered prior to the effective date of this article is conditioned
 10 on the hospital’s continued participation in Medi-Cal for at least
 11 30 days after the effective date of this article.

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

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

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

19 *SEC. 12. Section 14167.15 of the Welfare and Institutions Code*
 20 *is amended to read:*

21 14167.15. Notwithstanding any other provision of this article
 22 or Article 5.22 (commencing with Section 14167.31), the director
 23 may proportionately reduce the amount of any supplemental
 24 payments, ~~enhanced~~ *increased capitation* payments, or grants
 25 under this article to the extent that the payment or grant would
 26 result in the reduction of other amounts payable to a hospital or
 27 managed health care plan or mental health plan due to the
 28 application of federal law.

29 ~~SEC. 4.~~

30 *SEC. 13. Section 14167.31 of the Welfare and Institutions*
 31 *Code is amended to read:*

32 14167.31. (a) (1) “Aggregate *annual* quality assurance fee”
 33 means, *with respect to a hospital that is not a prepaid health plan*
 34 *hospital*, the sum of all of the following:

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

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

- 1 (C) The annual Medi-Cal days for an individual hospital
2 multiplied by the Medi-Cal per diem quality assurance fee rate.
- 3 ~~(2) “Aggregate quality assurance fee after the application of the~~
4 ~~microfee percentage” means the sum of all of the following:~~
- 5 ~~(A) The annual fee-for-service days for an individual hospital~~
6 ~~multiplied by the fee-for-service per diem quality assurance fee~~
7 ~~rate and multiplied by the microfee percentage.~~
- 8 ~~(B) The annual managed care days for an individual hospital~~
9 ~~multiplied by the managed care per diem quality assurance fee~~
10 ~~rate.~~
- 11 ~~(C) The annual Medi-Cal days for an individual hospital~~
12 ~~multiplied by the Medi-Cal per diem quality assurance fee rate~~
13 ~~and multiplied by the microfee percentage.~~
- 14 ~~(2) “Aggregate quality assurance fee” means, with respect to~~
15 ~~a hospital that is a prepaid health plan hospital, the sum of all of~~
16 ~~the following:~~
- 17 ~~(A) The annual fee-for-service days for an individual hospital~~
18 ~~multiplied by the fee-for-service per diem quality assurance fee~~
19 ~~rate.~~
- 20 ~~(B) The annual managed care days for an individual hospital~~
21 ~~multiplied by the prepaid health plan hospital managed care per~~
22 ~~diem quality assurance fee rate.~~
- 23 ~~(C) The annual Medi-Cal managed care days for an individual~~
24 ~~hospital multiplied by the prepaid health plan hospital Medi-Cal~~
25 ~~managed care per diem quality assurance fee rate.~~
- 26 ~~(D) The annual Medi-Cal fee-for-service days for an individual~~
27 ~~hospital multiplied by the Medi-Cal per diem quality assurance~~
28 ~~fee rate.~~
- 29 ~~(3) “Aggregate quality assurance fee after the application of~~
30 ~~the fee percentage” shall be determined separately for each subject~~
31 ~~federal fiscal year and means the aggregate annual quality~~
32 ~~assurance fee multiplied by the fee percentage for the subject~~
33 ~~federal fiscal year.~~
- 34 ~~(4) “Aggregate quality assurance fee” means the sum of the~~
35 ~~aggregate quality assurance fee after the application of the fee~~
36 ~~percentage for a hospital for each subject federal fiscal year.~~
- 37 (b) “Annual fee-for-service days” means the number of
38 fee-for-service days of each hospital subject to the quality assurance
39 fee in the 2007 calendar year, as reported on the days data source.

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

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

7 (e) “*Converted hospital*” shall have the meaning given in
8 subdivision (b) of Section 14167.1.

9 ~~(e)~~

10 (f) “Days data source” means the following:

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

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

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

27 ~~(f)~~

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

31 ~~(g)~~

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

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

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

1 Annual Disclosure Report for the hospital’s fiscal year ending in
2 the 2007 calendar year.

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

5 (4) A small and rural hospital as specified in Section 124840
6 of the Health and Safety Code designated as that in the hospital’s
7 Office of Statewide Health Planning and Development Hospital
8 Annual Disclosure Report for the hospital’s fiscal year ending in
9 the 2007 calendar year.

10 (h)

11 (i) (1) “Federal approval” means the last approval by the federal
12 government required for the implementation of this article and
13 Article 5.21 (commencing with Section 14167.1).

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

20 (i)

21 (j) “Fee-for-service per diem quality assurance fee rate” means
22 a fixed fee on fee-for-service days of two hundred ~~thirty-three~~
23 *fifteen* dollars and ~~sixty-six cents~~ (~~\$233.66~~) *thirty cents* (*\$215.30*)
24 per day.

25 (j)

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

34 (k) ~~“Fee percentage” or “fee percentages” means a percentage~~
35 ~~or percentages that consists or consist of the macrofee percentage~~
36 ~~or percentages and the microfee percentage or percentages.~~

37 (1) (A) ~~“Microfee percentage” or “microfee percentages” means~~
38 ~~a percentage or percentages that is or are calculated by the~~
39 ~~department to equal, for a subject federal fiscal year, a fraction,~~
40 ~~expressed as a percentage, the numerator of which is the sum of~~

1 two billion two hundred fifty-two million two hundred ninety-one
 2 thousand three hundred fifty-three dollars (\$2,252,291,353) plus
 3 the maximum amount of managed care payments for the subject
 4 federal fiscal year calculated by the department pursuant to
 5 subdivision (e) of Section 14167.6 and the denominator of which
 6 is three billion seven hundred eleven million seven hundred eight
 7 thousand seven hundred forty dollars (\$3,711,708,740).

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

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

17 (2) “Macrofee percentage” or “macrofee percentages” means a
 18 fraction, expressed as a percentage, the numerator of which is the
 19 amount of payments under Sections 14167.2, 14167.3, 14167.4,
 20 subdivision (b) of Section 14167.5, and Section 14167.6 for which
 21 federal financial participation is available and the denominator of
 22 which is the sum of two billion two hundred fifty-two million two
 23 hundred ninety-one thousand three hundred fifty-three dollars
 24 (\$2,252,291,353) plus the maximum amount of managed care
 25 payments for a subject federal fiscal year calculated by the
 26 department pursuant to subdivision (e) of Section 14167.6.

27 (l) “Fee percentage” means, for each subject federal fiscal
 28 year, a fraction, expressed as a percentage, the numerator of which
 29 is the amount of payments for the subject federal fiscal year under
 30 Sections 14167.2, 14167.3, and 14167.4, subdivision (d) of Section
 31 14167.5, and Section 14167.6 for which federal financial
 32 participation is available and the denominator of which is two
 33 billion nine hundred eighty-two million one hundred twenty-one
 34 thousand five hundred sixty dollars (\$2,982,121,560).

35 (t)

36 (m) “General acute care hospital” means any hospital licensed
 37 pursuant to subdivision (a) of Section 1250 of the Health and Safety
 38 Code.

39 (m)

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

5 (~~n~~)

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

15 (~~o~~)

16 (p) “Managed care per diem quality assurance fee rate” means
17 a fixed fee on managed care days of ~~twenty-seven~~ *twenty-two*
18 dollars and ~~twenty-five cents (\$27.25)~~ *fifty cents (\$22.50)* per day.

19 (~~p~~)

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

28 (r) “*Medi-Cal fee-for-service days*” means *inpatient hospital*
29 *days in the 2007 calendar year as reported on the days data source*
30 *where the service type is reported as “acute care,” “psychiatric*
31 *care,” and “chemical dependency care and rehabilitation care,”*
32 *and the payer category is reported as “Medi-Cal traditional” for*
33 *purposes of the Annual Financial Disclosure Report submitted by*
34 *hospitals to the Office of Statewide Health Planning and*
35 *Development.*

36 (s) “*Medi-Cal managed care days*” means *inpatient hospital*
37 *days in the 2007 calendar year as reported on the days data source*
38 *where the service type is reported as “acute care,” “psychiatric*
39 *care,” and “chemical dependency care and rehabilitation care,”*
40 *and the payer category is reported as “Medi-Cal managed care”*

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

4 ~~(q)~~

5 (t) “Medi-Cal per diem quality assurance fee rate” means a fixed
6 fee on Medi-Cal days of two hundred ~~ninety-three dollars (\$293)~~
7 *thirty-two dollars (\$232) per day.*

8 ~~(r)~~

9 (u) “Nondesignated public hospital” means a public hospital
10 that is licensed under subdivision (a) of Section 1250 of the Health
11 and Safety Code and is defined in paragraph (25) of subdivision
12 (a) of Section 14105.98, excluding designated public hospitals.

13 (v) “Prepaid health plan hospital” means a hospital that is in
14 the Prepaid Health Plan Hospital peer group described in the
15 1991 Hospital Peer Grouping Report published by the department.

16 (w) “Prepaid health plan hospital managed care per diem
17 quality assurance fee rate” means a fixed fee on non-Medi-Cal
18 managed care days for prepaid health plan hospitals of twelve
19 dollars and sixty cents (\$12.60) per day.

20 (x) “Prepaid health plan hospital Medi-Cal managed care per
21 diem quality assurance fee rate” means a fixed fee on Medi-Cal
22 managed care days for prepaid health plan hospitals of one
23 hundred twenty-nine dollars and ninety-two cents (\$129.92) per
24 day.

25 ~~(s)~~

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

32 ~~(t)~~

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

38 ~~(u)~~

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

4 ~~(v)~~

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

10 ~~SEC. 5.~~

11 ~~SEC. 14.~~ Section 14167.32 of the Welfare and Institutions
12 Code is amended to read:

13 14167.32. (a) There shall be imposed on each general acute
14 care hospital that is not an exempt facility a quality assurance fee,
15 as a condition of participation in state-funded health insurance
16 programs, other than the Medi-Cal program, *provided that a quality*
17 *assurance fee shall not be imposed on a converted hospital for a*
18 *subject federal fiscal year in which the hospital becomes a*
19 *converted hospital or for subsequent federal fiscal years.*

20 (b) The quality assurance fee shall be computed starting on the
21 ~~effective date of this article~~ *implementation date, as defined in*
22 *Section 14167.1*, and continue through and including December
23 31, 2010.

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

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

35 ~~(1) For the partial calendar quarter ending September 30, 2009,~~
36 ~~20 days after the effective date of this article, each general acute~~
37 ~~care hospital that is not an exempt facility shall certify to the best~~
38 ~~of its knowledge, on a form provided by the department, that the~~
39 ~~hospital is prepared to pay the aggregate quality assurance fee for~~
40 ~~that hospital.~~

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

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

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

15 ~~(e)~~

16 ~~(c) Upon receipt of federal approval, the following shall become~~
 17 ~~operative:~~

18 ~~(1) Within 30 days following receipt of the notice of federal~~
 19 ~~approval from the federal government, the department shall send~~
 20 ~~notice to each hospital subject to the quality assurance fee, and~~
 21 ~~publish on its Internet Web site, the following information:~~

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

23 ~~(B) The fee percentage or percentages for each subject federal~~
 24 ~~fiscal year.~~

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

27 ~~(A) Within 30 days after the date the department received notice~~
 28 ~~of federal approval, the hospital shall pay the amount of the quality~~
 29 ~~assurance fee the hospital has certified or will certify for calendar~~
 30 ~~quarters, up to, and including, the quarter in which the department~~
 31 ~~receives notice of approval by the federal government of the~~
 32 ~~implementation of this article, pursuant to subdivision (d), except~~
 33 ~~that the term “aggregate quality assurance fee” used in subdivision~~
 34 ~~(d) shall be replaced with the term “aggregate quality assurance~~
 35 ~~fee after the application of the microfee percentage,” multiplied~~
 36 ~~by the applicable macrofee percentage or percentages, except that,~~
 37 ~~in the event that the director has made modifications to the fee~~
 38 ~~model to secure federal approval pursuant to subdivision (f) or (g)~~
 39 ~~of Section 14167.35, the above-described amount, adjusted to~~
 40 ~~reflect the director’s modifications.~~

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

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

8 ~~(4) Within 30 days following the beginning of each calendar~~
9 ~~quarter, commencing with the quarter following the last quarter~~
10 ~~governed by subdivision (d) and ending with, and including, the~~
11 ~~calendar quarter ending December 31, 2010, each general acute~~
12 ~~care hospital that is not an exempt facility shall pay to the~~
13 ~~department the amounts that the hospital would certify to pay for~~
14 ~~the relevant quarter pursuant to subdivision (d), except that the~~
15 ~~term "aggregate quality assurance fee" used in subdivision (d)~~
16 ~~shall be replaced with the term "aggregate quality assurance fee~~
17 ~~after the application of the microfee percentage," multiplied by~~
18 ~~the applicable macrofee percentage, provided that, if modifications~~
19 ~~were made to the fee model by the director in order to secure~~
20 ~~federal approval pursuant to subdivision (f) or (g) of Section~~
21 ~~14167.35, then the hospital shall pay the amount resulting from~~
22 ~~the modifications.~~

23 *(A) The aggregate quality assurance fee after the application*
24 *of the fee percentage for each subject federal fiscal year.*

25 *(B) The aggregate quality assurance fee.*

26 *(C) The amount of each installment payment due from the*
27 *hospital with respect to the aggregate quality assurance fee.*

28 *(D) The date on which each installment payment is due.*

29 *(3) (A) The hospitals shall pay the aggregate quality assurance*
30 *fee in seven equal installments.*

31 *(B) (i) The first installment payment shall be made on or before*
32 *the later of September 14, 2010, or the 14th day after the notice*
33 *described in this section is sent to each hospital.*

34 *(ii) The additional installment payments shall be made in six*
35 *consecutive semimonthly payments that shall be due and payable*
36 *on or before the later of each of the first and 15th days of October,*
37 *November, and December 2010, or the 14th day after the notice*
38 *described in this section is sent to each hospital.*

39 *(4) Notwithstanding paragraph (3), the amount of each*
40 *hospital's aggregate quality assurance fee that has not been paid*

1 *by the hospital before December 15, 2010, pursuant to paragraph*
 2 *(3), shall be paid by the hospital no later than December 15, 2010.*

3 ~~(f)~~

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

9 ~~(g) Subdivisions (d) and (e)~~

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

21 ~~(h)~~

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

28 ~~(i)~~

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

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

40 ~~(j)~~

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

14 ~~(k)~~

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

18 ~~(l)~~

19 (j) The department shall work in consultation with the hospital
20 community to implement the quality assurance fee.

21 ~~(m)~~

22 (k) This subdivision creates a contractually enforceable promise
23 on behalf of the state to use the proceeds of the quality assurance
24 fee, including any federal matching funds, solely and exclusively
25 for the purposes set forth in this article as they existed on the
26 effective date of this article, to limit the amount of the proceeds
27 of the quality assurance fee to be used to pay for the health care
28 coverage of children to the amounts specified in this article and
29 to make any payments for the department's costs of administration
30 to the amounts set forth in this article on the effective date of this
31 article to maintain and continue prior reimbursement levels as set
32 forth in Article 5.21 (commencing with Section 14167.1) on the
33 effective date of that article, and to otherwise comply with all its
34 obligations set forth in Article 5.21 (commencing with Section
35 14167.1) and this article.

36 ~~(n)~~

37 (l) For the purpose of this article, references to the receipt of
38 notice by the state of federal approval of the implementation of
39 this article shall refer to the last date that the state receives notice
40 of all federal approval or waivers required for implementation of

1 this article and Article 5.21 (commencing with Section 14167.1),
2 subject to Section 14167.14.

3 ~~(e)~~

4 (m) (1) Effective January 1, 2011, the rates payable to hospitals
5 and managed health care plans under Medi-Cal shall be the rates
6 then payable without the supplemental and ~~enhanced~~ increased
7 capitation payments set forth in Article 5.21 (commencing with
8 Section 14167.1).

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

14 *SEC. 15. Section 14167.35 of the Welfare and Institutions Code*
15 *is amended to read:*

16 14167.35. (a) The Hospital Quality Assurance Revenue Fund
17 is hereby created in the State Treasury.

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

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

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

35 (1) To pay for the department’s staffing and administrative costs
36 directly attributable to implementing Article 5.21 (commencing
37 with Section 14167.1) and this article, including any administrative
38 fees that the director determines shall be paid to mental health
39 plans pursuant to subdivision (d) of Section 14167.11 and
40 repayment of the loan made to the department from the Private

1 Hospital Supplemental Fund pursuant to the act that added this
2 section.

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

11 (3) To make increased payments to hospitals pursuant to Article
12 5.21 (commencing with Section 14167.1).

13 (4) To make ~~enhanced~~ *increased capitation* payments to
14 managed health care plans pursuant to Article 5.21 (commencing
15 with Section 14167.1).

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

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

28 (e) Any methodology or other provision specified in Article
29 5.21 (commencing with Section 14167.1) and this article may be
30 modified by the department, in consultation with the hospital
31 community, to the extent necessary to meet the requirements of
32 federal law or regulations to obtain federal approval or to enhance
33 the probability that federal approval can be obtained, provided the
34 modifications do not violate the spirit and intent of Article 5.21
35 (commencing with Section 14167.1) or this article and are not
36 inconsistent with the conditions of implementation set forth in
37 Section 14167.36.

38 (f) The department, in consultation with the hospital community,
39 shall make adjustments, as necessary, to the amounts calculated
40 pursuant to Section 14167.32 in order to ensure compliance with

1 the federal requirements set forth in Section 433.68 of Title 42 of
 2 the Code of Federal Regulations or elsewhere in federal law.

3 (g) The department shall request approval from the federal
 4 Centers for Medicare and Medicaid Services for the implementation
 5 of this article. In making this request, the department shall seek
 6 specific approval from the federal Centers for Medicare and
 7 Medicaid Services to exempt providers identified in this article as
 8 exempt from the fees specified, including the submission, as may
 9 be necessary, of a request for waiver of the broad based
 10 requirement, waiver of the uniform fee requirement, or both,
 11 pursuant to paragraphs (1) and (2) of subdivision (e) of Section
 12 433.68 of Title 42 of the Code of Federal Regulations.

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

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

22 (B) Reduces or increases the amount of the fee payable by a
 23 hospital in total under this article for the 2008–09, 2009–10, and
 24 2010–11 federal fiscal years by more than 2 percent of the amount
 25 that would be determined under this article without any change or
 26 adjustment.

27 (2) The department shall provide the Joint Legislative Budget
 28 Committee and the fiscal and appropriate policy committees of
 29 the Legislature a status update of the implementation of Article
 30 5.21 (commencing with Section 14167.1) and this article on
 31 January 1, 2010, and quarterly thereafter. Information on any
 32 adjustments or modifications to the provisions of this article or
 33 Article 5.21 (commencing with Section 14167.1) that may be
 34 required for federal approval shall be provided coincident with the
 35 consultation required under subdivisions (f) and (g).

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

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

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

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

7 (j)

8 (i) Notwithstanding Chapter 3.5 (commencing with Section
9 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
10 the department may implement this article or Article 5.21
11 (commencing with Section 14167.1) by means of provider
12 bulletins, all plan letters, or other similar instruction, without taking
13 regulatory action. The department shall also provide notification
14 to the Joint Legislative Budget Committee and to the appropriate
15 policy and fiscal committees of the Legislature within five working
16 days when the above-described action is taken in order to inform
17 the Legislature that the action is being implemented.

18 *SEC. 16. Section 14167.36 of the Welfare and Institutions Code*
19 *is amended to read:*

20 14167.36. (a) This article shall only be implemented so long
21 as the following conditions are met:

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

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

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

31 (b) No hospital shall be required to pay the quality assurance
32 fee to the department unless and until the state receives and
33 maintains federal approval of the quality assurance fee and Article
34 5.21 (commencing with Section 14167.1) from the federal Centers
35 for Medicare and Medicaid Services.

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

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

1 (2) Article 5.21 (commencing with Section 14167.1) is enacted
2 and remains in effect and hospitals are reimbursed the increased
3 rates beginning on the implementation date, as defined in Section
4 14167.1.

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

8 (d) This article shall become inoperative if either of the
9 following ~~occur~~ occurs:

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

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

16 (A) The federal Centers for Medicare and Medicaid Services
17 denies approval for, or does not approve before January 1, 2012,
18 the implementation of Article 5.21 (commencing with Section
19 14167.1) or this article.

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

23 (e) If this article becomes inoperative pursuant to paragraph (1)
24 of subdivision (d) and the determination applies to any period or
25 periods of time prior to the effective date of the determination, the
26 department may recoup all payments made pursuant to Article
27 5.21 (commencing with Section 14167.1) during that period or
28 those periods of time.

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

35 ~~SEC. 6.~~

36 *SEC. 17.* Article 5.227 (commencing with Section 14168) is
37 added to Chapter 7 of Part 3 of Division 9 of the Welfare and
38 Institutions Code, to read:

1 Article 5.227. Quality Assurance Fee Act

2
3 14168. (a) (1) “Exempt facility” means any of the following:

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

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

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

14 (B) With the exception of a hospital that is in the Charitable
15 Research Hospital peer group, as set forth in the 1991 Hospital
16 Peer Grouping Report published by the department, a hospital that
17 is designated as a specialty hospital in the hospital’s Office of
18 Statewide Health Planning and Development Hospital Annual
19 Disclosure Report for the hospital’s fiscal year ending in the 2007
20 calendar year.

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

23 (D) A small and rural hospital as specified in Section 124840
24 of the Health and Safety Code, designated as that in the hospital’s
25 Office of Statewide Health Planning and Development Hospital
26 Annual Disclosure Report for the hospital’s fiscal year ending in
27 the 2007 calendar year.

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

31 (b) Effective January 1, 2011, there shall be imposed on each
32 general acute care hospital that is not an exempt facility a quality
33 assurance fee, as a condition of participation in a state-funded
34 health insurance program, other than the Medi-Cal program.

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

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

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

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

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

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

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

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

17 ~~SEC. 7.~~

18 *SEC. 18.* This act is an urgency statute necessary for the
19 immediate preservation of the public peace, health, or safety within
20 the meaning of Article IV of the Constitution and shall go into
21 immediate effect. The facts constituting the necessity are:

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