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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 *14166.20, 14166.221, 14166.24, 14166.75, 14167.1, 14167.2, 14167.3, 14167.4, 14167.5, 14167.6, 14167.10, 14167.11, 14167.12, 14167.14, 14167.15, 14167.31, 14167.32, 14167.35, and 14167.36* of, *to add Sections 14158.1, 14167.18, 14167.352, 14167.353, 14167.354, and 14167.355* to, *to repeal Article 5.21 (commencing with Section 14167.1) and Article 5.22 (commencing with Section 14167.31), 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. This bill would expand the definition of a nondesignated public hospital.

Existing law prescribes 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 *and increased payments, respectively, and would change the definition of a managed cared plan*. The bill would require the department to determine the amount of increased capitation payments for each Medi-Cal managed care plan and to consider certain factors in making that determination. The bill would prohibit the amount of increased capitation payments to each Medi-Cal managed health care 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.

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 *expand the definitions of a nondesignated public hospital and private hospital, and modify the formulas used in calculating the amount of the quality assurance fee imposed on 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.

This bill would provide that the department may impose and collect the quality assurance fee and make the supplemental payments, pursuant to the above-described provisions that require federal approval, based upon conditional federal approval, but only if and to the extent that the conditional federal approval is sufficient, as specified. This bill would provide that if final federal approval is denied, any fees collected shall be refunded and any payments made shall be recouped, as prescribed.

This bill would provide that if the above-described conditional federal approval is not obtained on or before December 1, 2010, then provisions

relating to the quality assurance fee and the supplemental payments shall become inoperative, and shall be repealed on December 1, 2010.

Existing law establishes the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, which revises hospital supplemental payment methodologies under the Medi-Cal program in order to maximize the use of federal funds consistent with federal Medicaid law and to stabilize the distribution of funding for hospitals that provide care to Medi-Cal beneficiaries and uninsured patients. This demonstration project provides for funding, in supplementation of Medi-Cal reimbursement, to various hospitals, including designated public hospitals, nondesignated public hospitals, and private hospitals, as defined, in accordance with certain provisions relating to disproportionate share hospitals. Under existing law, the department has the discretion to claim for any additional and all demonstration project funding, including federal funds, as specified.

This bill would provide that a portion, equal to an amount determined in accordance with the above-described Medi-Cal quality assurance fee provisions, of additional federal funding claimed pursuant to the above-described provision shall be allocated to the designated public hospitals.

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

Vote: 2/3. Appropriation: ~~yes~~-no. Fiscal committee: yes. State-mandated local program: no.

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

1 *SECTION 1. Section 14158.1 is added to the Welfare and*
 2 *Institutions Code, to read:*
 3 *14158.1. Effective for expenditures incurred after enactment*
 4 *of any new demonstration project under Article 5.4 (commencing*
 5 *with Section 14180), any federal financial participation that is*
 6 *available under the federal Medicaid Program, or any related*
 7 *waiver or demonstration project, based on the certified public*
 8 *expenditures of designated public hospitals, as defined in*
 9 *subdivision (d) of Section 14166.1, or the governmental entities*
 10 *with which they are affiliated, shall be paid to designated public*
 11 *hospitals or the governmental entities with which they are*
 12 *affiliated.*

1 *SEC. 2. Section 14166.20 of the Welfare and Institutions Code*
2 *is amended to read:*

3 14166.20. (a) With respect to each project year, the total
4 amount of stabilization funding shall be the sum of the following:

5 (1) (A) Federal Medicaid funds available in the Health Care
6 Support Fund, established pursuant to Section 14166.21, reduced
7 by the amount necessary to meet the baseline funding amount, or
8 the adjusted baseline funding amount, as appropriate, for project
9 years after the 2005–06 project year for each designated public
10 hospital, project year private DSH hospitals in the aggregate, and
11 nondesignated public hospitals in the aggregate as determined in
12 Sections 14166.5, 14166.13, and 14166.18, respectively, taking
13 into account all other payments to each hospital under this article.
14 This amount shall be not less than zero.

15 (B) For purposes of subparagraph (A), federal Medicaid funds
16 available in the Health Care Support Fund shall not include health
17 care coverage initiative amounts identified under paragraph (2) of
18 subdivision (e) of Section 14166.9.

19 (C) *The federal financial participation amount arising from the*
20 *certified public expenditures that has been paid to designated*
21 *public hospitals, or the governmental entities with which they are*
22 *affiliated, pursuant to subdivision (f) of Section 14166.221, shall*
23 *be disregarded for purposes of this section.*

24 (2) The state general funds that were made available due to the
25 receipt of federal funding for previously state-funded programs
26 through the safety net care pool and any federal Medicaid hospital
27 reimbursements resulting from these expenditures, unless otherwise
28 recognized under paragraph (1), to the extent those funds are in
29 excess of the amount necessary to meet the baseline funding
30 amount, or the adjusted baseline funding amount, as appropriate,
31 for project years after the 2005–06 project year for each designated
32 public hospital, for project year private DSH hospitals in the
33 aggregate, and for nondesignated public hospitals in the aggregate,
34 as determined in Sections 14166.5, 14166.13, and 14166.18,
35 respectively.

36 (3) To the extent not included in paragraph (1) or (2), the amount
37 of the increase in state General Fund expenditures for Medi-Cal
38 inpatient hospital services for the project year for project year
39 private DSH hospitals and nondesignated public hospitals,
40 including amounts expended in accordance with paragraph (1) of

1 subdivision (c) of Section 14166.23, that exceeds the expenditure
2 amount for the same purpose and the same hospitals necessary to
3 provide the aggregate baseline funding amounts applicable to the
4 project determined pursuant to Sections 14166.13 and 14166.18,
5 and any direct grants to designated public hospitals for services
6 under the demonstration project.

7 (4) To the extent not included in paragraph (2), federal Medicaid
8 funds received by the state as a result of the General Fund
9 expenditures described in paragraph (3).

10 (5) The federal Medicaid funds received by the state as a result
11 of federal financial participation with respect to Medi-Cal payments
12 for inpatient hospital services made to project year private DSH
13 hospitals and to nondesignated public hospitals for services
14 rendered during the project year, the state share of which was
15 derived from intergovernmental transfers or certified public
16 expenditures of any public entity that does not own or operate a
17 public hospital.

18 (6) Federal safety net care pool funds claimed and received for
19 inpatient hospital services rendered under the health care coverage
20 initiative identified under paragraph (3) of subdivision (e) of
21 Section 14166.9.

22 (b) With respect to the 2005–06, 2006–07, and subsequent
23 project years, the stabilization funding determined under
24 subdivision (a) shall be allocated as follows:

25 (1) Eight million dollars (\$8,000,000) shall be paid to San Mateo
26 Medical Center. All or a portion of this amount may be paid as
27 disproportionate share hospital payments in addition to the
28 hospital’s allocation that would otherwise be determined under
29 Section 14166.6. The amount provided for in this paragraph shall
30 be disregarded in the application of the limitations described in
31 paragraph (3) of subdivision (a) of Section 14166.6, and in
32 paragraph (1) of subdivision (a) of Section 14166.7.

33 (2) (A) Ninety-six million two hundred twenty-eight thousand
34 dollars (\$96,228,000) shall be allocated to designated public
35 hospitals to be paid in accordance with Section 14166.75.

36 (B) Forty-two million two hundred twenty-eight thousand dollars
37 (\$42,228,000) shall be allocated to private DSH hospitals to be
38 paid in accordance with Section 14166.14.

1 (C) Five hundred forty-four thousand dollars (\$544,000) shall
2 be allocated to nondesignated public hospitals to be paid in
3 accordance with Section 14166.17.

4 (D) In the event that stabilization funding is less than one
5 hundred forty-seven million dollars (\$147,000,000), the amounts
6 allocated to designated public hospitals, private DSH hospitals,
7 and nondesignated public hospitals under this paragraph shall be
8 reduced proportionately.

9 (3) (A) An amount equal to the lesser of 10 percent of the total
10 amount determined under subdivision (a) or twenty-three million
11 five hundred thousand dollars (\$23,500,000), but at least fifteen
12 million three hundred thousand dollars (\$15,300,000), shall be
13 made available for additional payments to distressed hospitals that
14 participate in the selective provider contracting program under
15 Article 2.6 (commencing with Section 14081), including designated
16 public hospitals, in amounts to be determined by the California
17 Medical Assistance Commission. The additional payments to
18 designated public hospitals shall be negotiated by the California
19 Medical Assistance Commission, but shall be paid by the
20 department in the form of a direct grant rather than as Medi-Cal
21 payments.

22 (B) Notwithstanding subparagraph (A) and solely for the
23 2006–07 fiscal year, if the amount that otherwise would be made
24 available for additional payments to distressed hospitals under
25 subparagraph (A) is equal to or greater than eighteen million three
26 hundred thousand dollars (\$18,300,000), that amount shall be
27 reduced by eighteen million three hundred thousand dollars
28 (\$18,300,000) and the state’s obligation to make these payments
29 shall be reduced by this amount. In the event the amount that
30 otherwise would be made available under subparagraph (A) is less
31 than eighteen million three hundred thousand dollars (\$18,300,000),
32 but greater than or equal to the minimum amount of fifteen million
33 three hundred thousand dollars (\$15,300,000), then the amount
34 available under this paragraph shall be zero and the state’s
35 obligation to make these payments shall be zero.

36 (C) Notwithstanding subparagraph (A) and solely for the
37 2008–09 and 2009–10 fiscal years, the amount to be made available
38 shall be reduced by fifteen million three hundred thousand dollars
39 (\$15,300,000) in each of the two years. The funds generated from
40 this reduction shall be retained in the General Fund.

1 (4) An amount equal to 0.64 percent of the total amount
2 determined under subdivision (a), to nondesignated public hospitals
3 to be paid in accordance with Section 14166.19.

4 (5) The amount remaining after subtracting the amount
5 determined in paragraphs (1) and (2), subparagraph (A) of
6 paragraph (3), and paragraph (4), without taking into account
7 subparagraphs (B) and (C) of paragraph (3), shall be allocated as
8 follows:

9 (A) Sixty percent to designated public hospitals to be paid in
10 accordance with Section 14166.75.

11 (B) Forty percent to project year private DSH hospitals to be
12 paid in accordance with Section 14166.14.

13 (c) By April 1 of the year following the project year for which
14 the payment is made, and after taking into account final amounts
15 otherwise paid or payable to hospitals under this article, the director
16 shall calculate in accordance with subdivision (a), allocate in
17 accordance with subdivision (b), and pay to hospitals in accordance
18 with Sections 14166.75, 14166.14, and 14166.19, as applicable,
19 the stabilization funding.

20 (d) For purposes of determining amounts paid or payable to
21 hospitals under subdivision (c), the department shall apply the
22 following:

23 (1) In determining amounts paid or payable to designated public
24 hospitals that are based on allowable costs incurred by the hospital,
25 or the governmental entity with which it is affiliated, the following
26 shall apply:

27 (A) If the final payment amount is based on the hospital's
28 Medicare cost report, the department shall rely on the cost report
29 filed with the Medicare fiscal intermediary for the project year for
30 which the calculation is made, reduced by a percentage that
31 represents the average percentage change from total reported costs
32 to final costs for the three most recent cost reporting periods for
33 which final determinations have been made, taking into account
34 all administrative and judicial appeals. Protested amounts shall
35 not be considered in determining the average percentage change
36 unless the same or similar costs are included in the project year
37 cost report.

38 (B) If the final payment amount is based on costs not included
39 in subparagraph (A), the reported costs as of the date the

1 determination is made under subdivision (c), shall be reduced by
2 10 percent.

3 (C) In addition to adjustments required in subparagraphs (A)
4 and (B), the department shall adjust amounts paid or payable to
5 designated public hospitals by any applicable deferrals or
6 disallowances identified by the federal Centers for Medicare and
7 Medicaid Services as of the date the determination is made under
8 subdivision (c) not otherwise reflected in subparagraphs (A) and
9 (B).

10 (2) Amounts paid or payable to project year private DSH
11 hospitals and nondesignated public hospitals shall be determined
12 by the most recently available Medi-Cal paid claims data increased
13 by a percentage to reflect an estimate of amounts remaining unpaid.

14 (e) The department shall consult with hospital representatives
15 regarding the appropriate calculation of stabilization funding before
16 stabilization funds are paid to hospitals. The calculation may be
17 comprised of multiple steps involving interim computations and
18 assumptions as may be necessary to determine the total amount
19 of stabilization funding under subdivision (a) and the allocations
20 under subdivision (b). No later than 30 days after this consultation,
21 the department shall establish a final determination of stabilization
22 funding that shall not be modified for any reason other than
23 mathematical errors or mathematical omissions on the part of the
24 department.

25 (f) The department shall distribute 75 percent of the estimated
26 stabilization funding on an interim basis throughout the project
27 year.

28 (g) The allocation and payment of stabilization funding shall
29 not reduce the amount otherwise paid or payable to a hospital under
30 this article or any other provision of law, unless the reduction is
31 required by the demonstration project's Special Terms and
32 Conditions or by federal law.

33 (h) It is the intent of the Legislature that the amendments made
34 to Sections 14166.12 and to this section by the act that added this
35 subdivision in the 2007–08 Regular Session shall not be construed
36 to amend or otherwise alter the ongoing structure of the
37 department's Medicaid Demonstration Project and Waiver
38 approved by the federal Centers for Medicare and Medicaid
39 Services to begin on September 1, 2005.

1 *SEC. 3. Section 14166.221 of the Welfare and Institutions Code*
2 *is amended to read:*

3 14166.221. (a) It is the intent of the Legislature for the
4 department to maximize the receipt of federal funds for California's
5 Medi-Cal program, including this demonstration project, by
6 identifying state resources which will enable the state to obtain
7 additional federal reimbursement during this unprecedented fiscal
8 crisis. It is further the intent of the Legislature that any program
9 identified by the department for the purposes specified in this
10 section shall not be modified or altered in any manner unless
11 subsequent statutory authority is expressly provided by the
12 Legislature.

13 (b) Notwithstanding Section 14166.22, in order to maximize
14 federal claiming under the demonstration project, the department
15 shall have broad discretion to claim federal reimbursement
16 consistent with all applicable federal claiming rules for the
17 following expenditures in an order of priority determined by the
18 department:

19 (1) Expenditures in programs funded in whole or in part by
20 realignment funds under Chapter 6 (commencing with Section
21 17600) of Part 5, including, but not limited to, the County Medical
22 Services Program.

23 (2) Expenditures in programs funded in whole or in part by the
24 County Mental Health Services Act.

25 (3) Other public expenditures, to the extent the department
26 determines the expenditures to be appropriate for claiming under
27 the demonstration project.

28 (4) Expenditures in any programs referenced in subdivision (a)
29 of Section 14166.22 or other state-only funded programs as the
30 department, in its discretion, determines should be used for the
31 purposes of this section. These programs may include programs
32 administered by other state agencies or departments.

33 (c) The department shall have discretion to claim under this
34 section for any and all additional demonstration project funding
35 made available pursuant to any amendments to the demonstration
36 project made on or after October 1, 2008, or pursuant to any federal
37 laws that increase the amount of available funding, including, but
38 not limited to, the federal American Recovery and Reinvestment
39 Act of 2009 (Public Law 111-5). This additional funding shall
40 include federal funds made available due to an increase in the

1 federal medical assistance percentage in addition to any other
2 increase in the amount of federal funding.

3 (d) Any amounts received in the 2008–09, 2009–10, and
4 2010–11 fiscal years from the federal government pursuant to
5 additional demonstration project funding as specified in this section
6 shall be deposited in the Federal Trust Fund. ~~Notwithstanding~~
7 *Notwithstanding* Section 28.00 of the Budget Act of 2009, the
8 Department of Finance may authorize expenditure of these funds
9 in a manner consistent with federal law and that offsets General
10 Fund expenditures otherwise authorized in the Budget Act of 2009
11 for the Medi-Cal program, and as appropriated in Item
12 4260-101-0001, or for the Health Care Support Fund. For any
13 adjustments made under the authority provided for by this section,
14 the Department of Finance shall provide notification in writing to
15 the chairperson of the Joint Legislative Budget Committee not less
16 than 30 days prior to the effective date of the adjustment, or not
17 sooner than whatever lesser time the chairperson of the Joint
18 Legislative Budget Committee, or his or her designee, may in each
19 instance determine. The notification to the chairperson of the joint
20 committee shall include, at a minimum, the amounts of the
21 proposed appropriation adjustments, a description of any
22 assumptions used in making the adjustments, the relevant federal
23 authority, and any other clarifying description as relevant.

24 (e) If the federal Centers for Medicare and Medicaid Services
25 or any federal or state court issues a ruling that any or all federal
26 dollars obtained by claiming for expenditures from any particular
27 program referenced in subdivision (b) cannot be used to increase
28 state revenues, the department may discontinue use of those
29 expenditures for claiming under this section and substitute other
30 expenditures from other programs referenced in subdivision (b)
31 at its discretion.

32 ~~(f) Notwithstanding Chapter 3.5 (commencing with Section~~
33 ~~11340) of Part 1 of Division 3 of Title 2 of the Government Code,~~
34 ~~the department may implement this section by means of a provider~~
35 ~~bulletin, or other similar instruction, without taking regulatory~~
36 ~~action. The department shall also provide notification to the Joint~~
37 ~~Legislative Budget Committee within five working days if that~~
38 ~~action is taken in order to inform the Legislature that the action is~~
39 ~~being implemented.~~

1 (f) (1) A portion of the additional federal funding described in
2 subdivision (c) shall be allocated to the designated public hospitals
3 and shall be identical in amount to the fee proceeds retained by
4 the state under Section 14167.5.

5 (2) Funding under this subdivision shall be made available to
6 the designated public hospitals in increments that reflect the
7 quarters of the subject federal fiscal year for which payments are
8 made to private hospitals from the Hospital Quality Assurance
9 Revenue Fund established pursuant to Section 14167.35.

10 (3) The department shall claim the federal funds made available
11 to the designated public hospitals under this subdivision upon
12 receipt of the necessary expenditure reports and certifications
13 from the designated public hospitals, or the governmental entities
14 with which they are affiliated, and distribute those funds pursuant
15 to Section 14167.5 so that receipt of the federal funds by the
16 designated public hospitals is aligned with the payment schedule
17 set forth in subdivision (c) of Section 14167.9.

18 (g) The department shall implement subdivision (f) of this section
19 and subdivision (e) of Section 14167.5 only if and to the extent
20 that all of the following are satisfied:

21 (1) The state has determined, after consultation with the
22 designated public hospitals, that the designated public hospitals,
23 or the governmental entities with which they are affiliated, have
24 incurred sufficient expenditures during the 2009 and 2010 project
25 years, or that portion of the 2011 project year to the extent federal
26 funds are available under Section 15900 or under an extension of
27 the demonstration project, so that each designated public hospital
28 receives the total amount, taking into account grant funds under
29 Section 14167.5 and payments under this section, that it would
30 have received for each installment under subdivision (c) of Section
31 14167.9 had subdivision (e) of Section 14167.5 not been
32 implemented.

33 (2) The implementation of subdivision (f) of this section and
34 subdivision (e) of Section 14167.5 does not result in the receipt
35 by any designated public hospital, or the governmental entity with
36 which it is affiliated, of less than what would otherwise be paid to
37 that hospital or entity pursuant to Part 3.5 (commencing with
38 Section 15900), the sections referred to in Section 14166.35, or
39 Article 5.21 (commencing with Section 14167.1).

1 (3) In determining the amount retained by the state under
2 subdivision (e) of Section 14167.5 and made available to the
3 designated public hospitals in subdivision (f), the department makes
4 adjustments to the reported expenditures for possible audit
5 disallowances, consistent with the type of adjustments applied in
6 prior project years to reduce the likelihood of a federal
7 recoupment.

8 (4) The department is satisfied that the expenditures claimed
9 under paragraph (3) of subdivision (f) represent valid expenditures
10 for the purposes of federal financial participation under the Special
11 Terms and Conditions for the demonstration project based on
12 federal law and guidance provided by the federal Centers for
13 Medicare and Medicaid Services.

14 (5) Notwithstanding subdivision (b), the department has claimed
15 federal reimbursement for the state-only expenditures in the
16 programs referenced in subdivision (a) of Section 14166.22 and
17 in the programs authorized by paragraph (4) of subdivision (b) of
18 Section 14166.221, to the maximum extent authorized under the
19 Special Terms and Conditions for the demonstration project.

20 (6) Federal financial participation is available and
21 implementation of these provisions does not jeopardize the federal
22 financial participation for other programs.

23 SEC. 4. Section 14166.24 of the Welfare and Institutions Code
24 is amended to read:

25 14166.24. (a) Any determination of the amount due a
26 designated public hospital that is based in whole or in part on costs
27 reported to or audited by a Medicare fiscal intermediary shall not
28 be deemed final for purposes of this article unless the hospital has
29 received a final determination of Medicare payment for the cost
30 reporting for Medicare purposes. Designated public hospitals shall
31 be entitled to pursue all administrative and judicial review available
32 under the Medicare program ~~Program~~ and any final determination
33 shall be incorporated into the department's final determination of
34 payment due the hospital under this article.

35 (b) If as a result of an audit performed by the department or any
36 state or federal agency, the department determines that any hospital
37 participating in the demonstration project has been overpaid under
38 the demonstration project, the department shall recoup the
39 overpayment in accordance with ~~Sections~~ Section 14172.5 or
40 14115.5. The hospital may appeal the overpayment determinations

1 and any related audit determination in accordance with the appeal
2 procedures set forth in Sections 51016 to 51047, inclusive, of Title
3 22 of the California Code of Regulations. The hospital may seek
4 judicial review of the final administrative decision as set forth in
5 Section 14171.

6 (c) The department shall promptly consult with the affected
7 governmental entity regarding a dispute between a designated
8 public hospital and the department regarding the validity of the
9 hospital's certified public expenditures. If the department
10 determines that the hospital's certification is valid, the department
11 shall submit the claim to obtain federal reimbursement for the
12 certified expenditure in question.

13 (d) (1) Upon receipt of a notice of disallowance or deferral
14 from the federal government related to the certified public
15 expenditures or intergovernmental transfers of any governmental
16 entity participating in the demonstration project, the department
17 shall promptly notify the affected governmental entity. The
18 governmental entity that certified the public expenditure shall be
19 the entity responsible for the federal portion of that expenditure.

20 (2) The department and the affected governmental entity shall
21 promptly consult regarding the proposed disallowance or deferral.

22 (3) After consulting with the governmental entity, the
23 department shall determine whether the disallowance or response
24 to a deferral should be filed with the federal government. If the
25 department determines the appeal or response has merit, the
26 department shall timely appeal. If necessary, the department may
27 request an extension of the deadline to file an appeal or response
28 to a deferral. The affected governmental entity may provide the
29 department with the legal and factual basis for the appeal or
30 response.

31 (e) *Notwithstanding any other provision of law, if the department*
32 *has exercised the authority set forth in subdivision (f) of Section*
33 *14166.221 and subdivision (e) of Section 14167.5, then all of the*
34 *following shall occur:*

35 (1) (A) *The state shall be solely responsible for the repayment*
36 *of the federal portion of any federal disallowance associated with*
37 *any certified public expenditures for the 2009, 2010, and 2011*
38 *project years, and paragraph (1) of subdivision (d) of Section*
39 *14166.24 shall be disregarded, up to the total amount of the grant*
40 *funds retained by the state under subdivision (e) of Section 14167.5.*

1 (B) *If the hospitals have additional certified public expenditures*
2 *for which federal funds have not been received but for which*
3 *federal funds could have been received under the demonstration*
4 *project had additional federal funds been available, including*
5 *federal funds made available under an extension of the*
6 *demonstration project, the state shall first be allowed to respond*
7 *to a deferral or disallowance based on the certified public*
8 *expenditures of designated public hospitals, or the governmental*
9 *entities with which they are affiliated, by substituting the additional*
10 *certified public expenditures for those deferred or disallowed.*

11 (2) *The department shall not recoup any overpayment from a*
12 *designated public hospital, or a governmental entity with which*
13 *it is affiliated, with respect to payments under this article for the*
14 *2009, 2010, and 2011 project years, until the state has repaid all*
15 *federal funds due up to the amount of the grant funds retained by*
16 *the state under subdivision (e) of Section 14167.5.*

17 SEC. 5. *Section 14166.75 of the Welfare and Institutions Code*
18 *is amended to read:*

19 14166.75. (a) For services provided during the 2005–06 and
20 2006–07 project years, the amount allocated to designated public
21 hospitals pursuant to subparagraph (A) of paragraph (2) and
22 subparagraph (A) of paragraph (5) of subdivision (b) of Section
23 14166.20 shall be allocated, in accordance with this section, among
24 the designated public hospitals. For services provided during the
25 2007–08, 2008–09, and 2009–10 project years, amounts allocated
26 to designated public hospitals as stabilization funding pursuant to
27 any provision of this article, unless otherwise specified, shall be
28 allocated among the designated public hospitals in accordance
29 with this section. All amounts allocated to designated public
30 hospitals in accordance with this section shall be paid as direct
31 grants, which shall not constitute Medi-Cal payments.

32 (b) The baseline funding amount, as determined under Section
33 14166.5, for San Mateo Medical Center shall be increased by eight
34 million dollars (\$8,000,000) for purposes of this section.

35 (c) The following payments shall be made from the amount
36 identified in subdivision (a), in addition to any other payments due
37 to the University of California hospitals and health system and
38 County of Los Angeles hospitals under this section:

1 (1) The lower of eleven million dollars (\$11,000,000) or 3.67
2 percent of the amount identified in subdivision (a) to the University
3 of California hospitals and health system.

4 (2) For each of the 2005–06 and 2006–07 project years, in the
5 event that the one hundred eighty million dollars (\$180,000,000)
6 identified in paragraph 41 of the Special Terms and Conditions
7 for the demonstration project is available in the safety net care
8 pool for the project year, the lower of twenty-three million dollars
9 (\$23,000,000) or 7.67 percent of the amount identified in
10 subdivision (a) to the County of Los Angeles, Department of Health
11 Services, hospitals. If an amount less than the one hundred eighty
12 million dollars (\$180,000,000) is available during the project year,
13 the amount determined under this paragraph shall be reduced
14 proportionately.

15 (d) For the 2005–06 and 2006–07 project years, the amount
16 identified in subdivision (a), as reduced by the amounts identified
17 in subdivision (c), shall be distributed among the designated public
18 hospitals pursuant to this subdivision.

19 (1) Designated public hospitals that are donor hospitals, and
20 their associated donated certified public expenditures, shall be
21 identified as follows:

22 (A) An initial pro rata allocation of the amount subject to this
23 subdivision shall be made to each designated public hospital, based
24 upon the hospital’s baseline funding amount determined pursuant
25 to Section 14166.5, and as further adjusted in subdivision (b). This
26 initial allocation shall be used for purposes of the calculations
27 under subparagraph (C) and paragraph (3).

28 (B) The federal financial participation amount arising from the
29 certified public expenditures of each designated public hospital,
30 including the expenditures of the governmental entity, nonhospital
31 clinics, and other provider types with which it is affiliated, that
32 were claimed by the department from the federal disproportionate
33 share hospital allotment pursuant to subparagraphs (A) and (C) of
34 paragraph (2) of subdivision (a) of Section 14166.9, and from the
35 safety net care pool funds pursuant to paragraph (3) of subdivision
36 (a) of Section 14166.9, shall be determined.

37 (C) The amount of federal financial participation received by
38 each designated public hospital, and by the governmental entity,
39 nonhospital clinics, and other provider types with which it is
40 affiliated, based on certified public expenditures from the federal

1 disproportionate share hospital allotment pursuant to paragraph
2 (1) of subdivision (b) of Section 14166.6, and from the safety net
3 care pool payments pursuant to subdivision (a) of Section 14166.7
4 shall be identified. With respect to this identification, if a payment
5 adjustment for a hospital has been made pursuant to paragraph (2)
6 of subdivision (f) of Section 14166.6, or paragraph (2) of
7 subdivision (b) of Section 14166.7, the amount of federal financial
8 participation received by the hospital based on certified public
9 expenditures shall be determined as though no such payment
10 adjustment had been made. The resulting amount shall be increased
11 by amounts distributed to the hospital pursuant to subdivision (c)
12 of this section, paragraph (1) of subdivision (b) of Section
13 14166.20, and the initial allocation determined for the hospitals
14 in subparagraph (A).

15 (D) If the amount in subparagraph (B) is greater than the amount
16 determined in subparagraph (C), the hospital is a donor hospital,
17 and the difference between the two amounts is deemed to be that
18 donor hospital's associated donated certified public expenditures
19 amount.

20 (2) Seventy percent of the total amount subject to this
21 subdivision shall be allocated pro rata among the designated public
22 hospitals based upon each hospital's baseline funding amount
23 determined pursuant to Section 14166.5, and as further adjusted
24 in subdivision (b).

25 (3) The lesser of the remaining 30 percent of the total amount
26 subject to this subdivision or the total amounts of donated certified
27 public expenditures for all donor hospitals, shall be distributed pro
28 rata among the donor hospitals based upon the donated certified
29 public expenditures amount determined for each donor hospital.
30 Any amounts not distributed pursuant to this paragraph shall be
31 distributed in the same manner as set forth in paragraph (2).

32 (e) For the 2007–08 and subsequent project years, the amount
33 identified in subdivision (a), as reduced by the amounts identified
34 in subdivision (c), shall be distributed among the designated public
35 hospitals pursuant to this subdivision.

36 (1) Each designated public hospital that renders inpatient
37 hospital services under the health care coverage initiative program
38 authorized pursuant to Part 3.5 (commencing with Section 15900)
39 shall be allocated an amount equal to the amount of the federal
40 safety net pool funds claimed and received with respect to the

1 services rendered by the hospital, including services rendered to
2 enrollees of a managed care organization, to the extent the amount
3 was included in the determination of total stabilization funding for
4 the project year pursuant to Section 14166.20.

5 (2) Each designated public hospital for which, during the project
6 year, the sum of the allowable costs incurred in rendering inpatient
7 hospital services to Medi-Cal beneficiaries and the allowable costs
8 incurred with respect to supplemental reimbursement for physician
9 and nonphysician practitioner services rendered to Medi-Cal
10 hospital inpatients, as specified in Section 14166.4, exceeds the
11 allowable costs incurred for those services rendered in the prior
12 year, shall be allocated an amount equal to 60 percent of the
13 difference in the allowable costs, multiplied by the applicable
14 federal medical assistance percentage. The allocations under this
15 paragraph, however, shall be reduced pro rata as necessary to
16 ensure that the total of those allocations does not exceed 80 percent
17 of the amount subject to this subdivision after the allocations in
18 paragraph (1). For purposes of this paragraph, the most recent cost
19 data that are available at the time of the department's
20 determinations for the project year pursuant to Section 14166.20
21 shall be used.

22 (3) The remaining amount subject to this subdivision that is not
23 otherwise allocated pursuant to paragraphs (1) and (2) shall be
24 allocated as set forth below:

25 (A) Designated public hospitals that are donor hospitals, and
26 their associated donated certified public expenditures, shall be
27 identified as follows:

28 (i) An initial pro rata allocation of the amount subject to this
29 paragraph shall be made to each designated public hospital, based
30 upon the total allowable costs incurred by each hospital, or
31 governmental entity with which it is affiliated, in rendering hospital
32 services to the uninsured during the project year as reported
33 pursuant to Section 14166.8. This initial allocation shall be used
34 for purposes of the calculations under clause (iii) and subparagraph
35 (C).

36 (ii) The federal financial participation amount arising from the
37 certified public expenditures of each designated public hospital,
38 including the expenditures of the governmental entity, nonhospital
39 clinics, and other provider types with which it is affiliated, that
40 were claimed by the department from the federal disproportionate

1 share hospital allotment pursuant to subparagraphs (A) and (C) of
2 paragraph (2) of subdivision (a) of Section 14166.9, and from the
3 safety net care pool funds pursuant to paragraph (3) of subdivision
4 (a) of Section 14166.9, shall be determined.

5 (iii) The amount of federal financial participation received by
6 each designated public hospital, and by the governmental entity,
7 nonhospital clinics, and other provider types with which it is
8 affiliated, based on certified public expenditures from the federal
9 disproportionate share hospital allotment pursuant to paragraph
10 (1) of subdivision (b) of Section 14166.6, and from the safety net
11 care pool payments pursuant to subdivision (a) of Section 14166.7
12 shall be identified. With respect to this identification, if a payment
13 adjustment for a hospital has been made pursuant to paragraph (2)
14 of subdivision (f) of Section 14166.6, or paragraph (2) of
15 subdivision (b) of Section 14166.7, the amount of federal financial
16 participation received by the hospital based on certified public
17 expenditures shall be determined as though no payment adjustment
18 had been made. The resulting amount shall be increased by
19 amounts distributed to the hospital pursuant to subdivision (c),
20 paragraphs (1) and (2) of this subdivision, paragraph (1) of
21 subdivision (b) of Section 14166.20, and the initial allocation
22 determined for the hospitals in clause (i).

23 (iv) If the amount in clause (ii) is greater than the amount
24 determined in clause (iii), the hospital is a donor hospital, and the
25 difference between the two amounts is deemed to be that donor
26 hospital's associated donated certified public expenditures amount.

27 (B) Fifty percent of the total amount subject to this paragraph
28 shall be allocated pro rata among the designated public hospitals
29 in the same manner described in clause (i) of subparagraph (A).

30 (C) The lesser of the remaining 50 percent of the total amount
31 subject to this paragraph, the total amounts of donated certified
32 public expenditures for all donor hospitals or that amount that is
33 30 percent of the amount subject to this subdivision after the
34 allocations in paragraph (1), shall be distributed pro rata among
35 the donor hospitals based upon the donated certified public
36 expenditures amount determined for each donor hospital. Any
37 amounts not distributed pursuant to this subparagraph shall be
38 distributed in the same manner as set forth in subparagraph (B).

39 (D) *The federal financial participation amount arising from the*
40 *certified public expenditures that has been paid to designated*

1 *public hospitals, or the governmental entities with which they are*
 2 *affiliated, pursuant to subdivision (f) of Section 14166.221 shall*
 3 *be disregarded for purposes of this paragraph.*

4 (f) The department shall consult with designated public hospital
 5 representatives regarding the appropriate distribution of
 6 stabilization funding before stabilization funds are allocated and
 7 paid to hospitals. No later than 30 days after this consultation, the
 8 department shall issue a final allocation of stabilization funding
 9 under this section that shall not be modified for any reason other
 10 than mathematical errors or mathematical omissions on the part
 11 of the department.

12 **SECTION 1.**

13 *SEC. 6.* Section 14167.1 of the Welfare and Institutions Code
 14 is amended to read:

15 14167.1. ~~(a)~~ *For purposes of this article, the following*
 16 *definitions shall apply:*

17 (a) “Acute psychiatric days” means the total number of
 18 Short-Doyle administrative days, Short-Doyle acute care days,
 19 acute psychiatric administrative days, and acute psychiatric acute
 20 days identified in the Final Medi-Cal Utilization Statistics for the
 21 2008–09 state fiscal year as calculated by the department on
 22 September 15, 2008.

23 (b) “Converted hospital” means a private hospital that becomes
 24 a designated public hospital or a nondesignated public hospital
 25 after the implementation date, a nondesignated public hospital that
 26 becomes a private hospital or a designated public hospital after
 27 the implementation date, or a designated public hospital that
 28 becomes a private hospital or a nondesignated public hospital after
 29 the implementation date.

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

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

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

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

6 (g) “Hospital inpatient services” means all services covered
7 under Medi-Cal and furnished by hospitals to patients who are
8 admitted as hospital inpatients and reimbursed on a fee-for-service
9 basis by the department directly or through its fiscal intermediary.
10 Hospital inpatient services include outpatient services furnished
11 by a hospital to a patient who is admitted to that hospital within
12 24 hours of the provision of the outpatient services that are related
13 to the condition for which the patient is admitted. ~~Hospital inpatient~~
14 ~~services include physician services only where the service is~~
15 ~~furnished to a hospital inpatient, the physician is compensated by~~
16 ~~the hospital for the service, and the service is billed to Medi-Cal~~
17 ~~by the hospital under a provider number assigned to the hospital.~~
18 Hospital inpatient services do not include services for which a
19 managed health care plan is financially responsible.

20 (h) “Hospital outpatient services” means all services covered
21 under Medi-Cal furnished by hospitals to patients who are
22 registered as hospital outpatients and reimbursed by the department
23 on a fee-for-service basis directly or through its fiscal intermediary.
24 Hospital outpatient services include physician services only where
25 the service is furnished to a hospital outpatient, the physician is
26 compensated by the hospital for the service, and the service is
27 billed to Medi-Cal by the hospital under a provider number
28 assigned to the hospital. Hospital outpatient services do not include
29 services for which a managed health care plan is financially
30 responsible, or services rendered by a hospital-based federally
31 qualified health center for which reimbursement is received
32 pursuant to Section 14132.100.

33 (i) (1) “Implementation date” means the latest effective date
34 of all federal approvals or waivers necessary for the implementation
35 of this article and Article 5.22 (commencing with Section
36 14167.31), including, but not limited to, any approvals on
37 amendments to contracts between the department and managed
38 health care plans or mental health plans necessary for the
39 implementation of this article. The effective date of a federal
40 approval of a contract amendment shall be the earliest date to

1 which the computation of payments under the contract amendment
 2 is applicable that may be prior to the date on which the contract
 3 amendment is executed. *approval or waiver shall be the earlier*
 4 *of the stated effective date or the first day of the first quarter to*
 5 *which the computation of the payments or fee under the federal*
 6 *approval or waiver is applicable, which may be prior to the date*
 7 *that the federal approval or waiver is granted or the applicable*
 8 *contract is amended.*

9 (2) If federal approval is sought initially for only the 2008–09
 10 federal fiscal year and separately secured for subsequent federal
 11 fiscal years, the implementation date for the 2008–09 federal fiscal
 12 year shall occur when all necessary federal approvals have been
 13 secured for that federal fiscal year.

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

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

27 ~~(2) (A) Managed health care plans include, but are not limited~~
 28 ~~to, county organized health systems, prepaid health plans, and~~

29 (2) (A) *Managed health care plans include county organized*
 30 *health systems and* entities contracting with the department to
 31 provide services pursuant to two-plan models and geographic
 32 managed care. Entities providing these services contract with the
 33 department pursuant to any of the following:

- 34 (i) Article 2.7 (commencing with Section 14087.3).
- 35 (ii) Article 2.8 (commencing with Section 14087.5).
- 36 (iii) Article 2.81 (commencing with Section 14087.96).
- 37 (iv) Article 2.91 (commencing with Section 14089).
- 38 ~~(v) Article 1 (commencing with Section 14200) of Chapter 8.~~
- 39 ~~(vi) Article 7 (commencing with Section 14490) of Chapter 8.~~

1 (B) Managed health care plans do not include any mental *of the*
2 *following*:

3 (i) *Mental health plan* contracting to provide mental health care
4 for Medi-Cal beneficiaries pursuant to Part 2.5 (commencing with
5 Section 5775) of Division 5.

6 (ii) *Health plan not covering inpatient services such as primary*
7 *case management plans operating pursuant to Section 14088.85.*

8 (iii) *Long-Term Care Demonstration Projects for All-Inclusive*
9 *Care for the Elderly operating pursuant to Chapter 8.75*
10 *(commencing with Section 14590).*

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

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

25 (n) “Mental health plan” means a mental health plan that
26 contracts with the State Department of Mental Health to furnish
27 or arrange for the provision of mental health services to Medi-Cal
28 beneficiaries pursuant to Part 2.5 (commencing with Section 5775)
29 of Division 5.

30 (o) “New hospital” means a hospital that was not in operation
31 under current or prior ownership as a private hospital, a
32 nondesignated public hospital, or a designated public hospital for
33 any portion of the 2008–09 state fiscal year.

34 (p) “Nondesignated public hospital” means either of the
35 following:

36 (1) A public hospital that is licensed under subdivision (a) of
37 Section 1250 of the Health and Safety Code, is not designated as
38 a specialty hospital in the hospital’s annual financial disclosure
39 report for the hospital’s latest fiscal year ending in 2007, and

1 satisfies the definition in paragraph (25) of subdivision (a) of
2 Section 14105.98, excluding designated public hospitals.

3 (2) A tax-exempt nonprofit hospital that is licensed under
4 subdivision (a) of Section 1250 of the Health and Safety Code, is
5 not designated as a specialty hospital in the hospital's annual
6 financial disclosure report for the hospital's latest fiscal year ending
7 in 2007, is operating a hospital owned by a local health care district,
8 and is affiliated with the health care district hospital owner by
9 means of the district's status as the nonprofit corporation's sole
10 corporate member.

11 (q) "Outpatient base amount" means the total amount of
12 payments for hospital outpatient services made to a hospital in the
13 2007 calendar year, as reflected in state paid claims files on January
14 26, 2008.

15 (r) "Private hospital" means a hospital that meets all of the
16 following conditions:

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

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

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

27 (4) Is a nonpublic hospital, nonpublic converted hospital, or
28 converted hospital as those terms are defined in paragraphs (26)
29 to (28), inclusive, respectively, of subdivision (a) of Section
30 14105.98.

31 (s) "Subject federal fiscal year" means a federal fiscal year that
32 ends after the implementation date and begins before December
33 31, 2010.

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

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

38 (2) Is in the Charitable Research Hospital peer group, as set
39 forth in the 1991 Hospital Peer Grouping Report published by the
40 department, or is not designated as a specialty hospital in the

1 hospital's Office of Statewide Health Planning and Development
2 Annual Financial Disclosure Report for the hospital's latest fiscal
3 year ending in 2007.

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

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

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

13 ~~SEC. 2.~~

14 *SEC. 7.* Section 14167.2 of the Welfare and Institutions Code
15 is amended to read:

16 14167.2. (a) Private hospitals shall be paid supplemental
17 amounts for the provision of hospital outpatient services as set
18 forth in this section. The supplemental amounts shall be in addition
19 to any other amounts payable to hospitals with respect to those
20 services and shall not affect any other payments to hospitals.

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

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 subdivision (b) due to
30 the application of a federal upper limit or for any other reason,
31 both of the following shall apply:

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

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

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

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

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

9 ~~SEC. 3.~~

10 *SEC. 8.* Section 14167.3 of the Welfare and Institutions Code
11 is amended to read:

12 14167.3. (a) Private hospitals shall be paid supplemental
13 amounts for the provision of hospital inpatient services and
14 subacute services as set forth in this section. The supplemental
15 amounts shall be in addition to any other amounts payable to
16 hospitals with respect to those services and shall not affect any
17 other payments to hospitals.

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

22 (1) Six hundred forty dollars and forty-six cents (\$640.46)
23 multiplied by the hospital's general acute care days.

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

28 (3) One thousand three hundred fifty dollars (\$1,350) multiplied
29 by the number of the hospital's high acuity days if the hospital's
30 Medicaid inpatient utilization rate is less than 41.1 percent and
31 greater than 5 percent and at least 5 percent of the hospital's general
32 acute care days are high acuity days. This amount shall be in
33 addition to the amounts specified in paragraphs (1) and (2).

34 (4) One thousand three hundred fifty dollars (\$1,350) multiplied
35 by the number of the hospital's high acuity days if the hospital
36 qualifies to receive the amount set forth in paragraph (3) and has
37 been designated as a Level I, Level II, Adult/Ped Level I, or
38 Adult/Ped Level II trauma center by the emergency medical
39 services authority established pursuant to Section 1797.1 of the

1 Health and Safety Code. This amount shall be in addition to the
2 amounts specified in paragraphs (1), (2), and (3).

3 (c) A private hospital that provides Medi-Cal subacute services
4 during a subject federal fiscal year and has a Medicaid inpatient
5 utilization rate that is greater than 5.0 percent and less than 41.1
6 percent shall be paid for the provision of subacute services during
7 each subject federal fiscal year a supplemental amount equal to
8 40 percent of the Medi-Cal subacute payments made to the hospital
9 during the 2008 calendar year.

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

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

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

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

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

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

38 (e) In the event the amount otherwise payable to a hospital under
39 this section for a subject federal fiscal year exceeds the amount
40 for which federal financial participation is available for that

1 hospital, the amount due to the hospital for that federal fiscal year
2 shall be reduced to the amount for which federal financial
3 participation is available.

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

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

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

12 *SEC. 9. Section 14167.4 of the Welfare and Institutions Code*
13 *is amended to read:*

14 14167.4. (a) Nondesignated public hospitals shall be paid
15 supplemental amounts for the provision of hospital inpatient
16 services as set forth in this section. The supplemental amounts
17 shall be in addition to any other amounts payable to hospitals with
18 respect to those services and shall not affect any other payments
19 to hospitals.

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

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

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

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

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

38 (2) The amount payable under subdivision (b) to each
39 nondesignated public hospital for the subject federal fiscal year
40 shall be equal to the amount computed under subdivision (b)

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

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

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

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

14 (g) (1) No payments shall be made under this section to a
15 converted hospital for the subject federal fiscal year in which the
16 hospital becomes a converted hospital or for subsequent subject
17 federal fiscal years.

18 (2) *Notwithstanding paragraph (1), the director shall seek*
19 *federal approval to allow payments to be made under this section*
20 *for the period beginning July 1, 2010, and ending December 31,*
21 *2010, to a converted hospital which is a hospital described in*
22 *paragraph (2) of subdivision (p) of Section 14167.1, and shall*
23 *make payments under this section consistent with any approvals,*
24 *subject to all of the following:*

25 (A) *Federal approval shall be sought after all final federal*
26 *approvals necessary to implement this article and Article 5.22*
27 *(commencing with Section 14167.31) are received by the*
28 *department.*

29 (B) *The director shall have determined prior to seeking federal*
30 *approval that obtaining federal approval and implementing the*
31 *payments described in this paragraph will not jeopardize the*
32 *implementation of this article or Article 5.22 (commencing with*
33 *Section 14167.31), or delay any payments to hospitals and*
34 *managed health care plans under this article or Article 5.22*
35 *(commencing with Section 14167.31), or the collection of the*
36 *quality assurance fee from hospitals under Article 5.22*
37 *(commencing with Section 14167.31), beyond December 31, 2010.*

38 (C) *The director shall withdraw any request for federal approval*
39 *made under this paragraph if, after submitting the request, the*
40 *director has determined that obtaining federal approval and*

1 *implementing the payments described in this paragraph will*
2 *jeopardize the implementation of this article or Article 5.22*
3 *(commencing with Section 14167.31) or delay any payments to*
4 *hospitals and managed health care plans under this article or*
5 *Article 5.22, (commencing with Section 14167.31) or the collection*
6 *of the quality assurance fee from hospitals under Article 5.22,*
7 *(commencing with Section 14167.31) beyond December 31, 2010.*

8 ~~SEC. 4.~~

9 *SEC. 10.* Section 14167.5 of the Welfare and Institutions Code
10 is amended to read:

11 14167.5. (a) Designated public hospitals shall be paid direct
12 grants in support of health care expenditures, which shall not
13 constitute Medi-Cal payments, and which shall be funded by the
14 quality assurance fee set forth in Article 5.22 (commencing with
15 Section 14167.31). The aggregate amount of the grants to
16 designated public hospitals for each subject federal fiscal year
17 shall be two hundred ninety-five million dollars (\$295,000,000).

18 (b) The director shall allocate the amount specified in
19 subdivision (a) among the designated public hospitals in accordance
20 with this subdivision. In determining the allocation, the director
21 shall rely on data from the Interim Hospital Payment Rate
22 Workbooks. For purposes of this section, "Interim Hospital
23 Payment Rate Workbook" means the Interim Hospital Payment
24 Rate Workbook, developed by the department and approved by
25 the federal Centers for Medicare and Medicaid Services for use in
26 connection with the Medi-Cal Hospital/Uninsured Care 1115
27 Waiver Demonstration, as submitted by each designated public
28 hospital, or the governmental entity with which the hospital is
29 affiliated, on or around June 2009 for the period of July 1, 2007,
30 to June 30, 2008, inclusive.

31 (1) Each designated public hospital's share of 80 percent of the
32 amount specified in subdivision (a) shall be determined by applying
33 a fraction, the numerator of which is the certified public
34 expenditures reported by the designated public hospital as
35 allowable Medi-Cal inpatient expenditures on Schedule 2.1,
36 Column 5, Step 5 of the Interim Hospital Payment Rate Workbook,
37 and the denominator of which is the total amount of certified public
38 expenditures reported as allowable Medi-Cal inpatient expenditures
39 by all designated public hospitals on Schedule 2.1, Column 5, Step
40 5 of the Interim Hospital Payment Rate Workbooks.

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

11 (c) In the event federal financial participation for a subject
12 federal fiscal year is not available for all of the supplemental
13 amounts payable to private hospitals under Section 14167.3, due
14 to the limitations on supplemental payments based on a partial-year
15 federal upper payment limit, the amount payable to each designated
16 public hospital under subdivision (b) shall equal the designated
17 public hospital's allocated grant amount under subdivision (b)
18 multiplied by a fraction, the numerator of which is the total number
19 of months in the subject federal fiscal year for which federal
20 financial participation is available for supplemental payment
21 amounts to private hospitals up to the federal upper payment limit,
22 and the denominator of which is 12.

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

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

39 (2) In the event federal financial participation for a subject
40 federal fiscal year is not available for all of the supplemental

1 amounts payable to designated public hospitals under paragraph
 2 (1) due to the application of a federal upper payment limit or for
 3 any other reason, both of the following shall apply:

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

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

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

19 *(e) Notwithstanding subdivision (a) and subject to subdivisions*
 20 *(f) and (g) of Section 14166.221, the state may retain for the state's*
 21 *use the funds described in subdivision (a) that would otherwise be*
 22 *payable pursuant to subdivision (c) of Section 14167.9 in an*
 23 *aggregate amount not to exceed four hundred twenty million*
 24 *dollars (\$420,000,000) for the period in which this article and*
 25 *Article 5.22 (commencing with Section 14167.31) are in effect,*
 26 *provided that the state allocates to the designated public hospitals*
 27 *an equal amount of federal funds available under the Medi-Cal*
 28 *Hospital/Uninsured Care Demonstration Project pursuant to*
 29 *subdivision (c) of Section 14166.221, and the state has determined,*
 30 *after consultation with the designated public hospitals, that the*
 31 *designated public hospitals, or the governmental entities with*
 32 *which they are affiliated, have incurred sufficient expenditures so*
 33 *that the full amount allocated can be received as federal matching*
 34 *funds. Federal funds allocated to the designated public hospitals*
 35 *under this subdivision and claimed under subdivision (f) of Section*
 36 *14166.221 shall be distributed among the designated public*
 37 *hospitals in accordance with subdivision (b).*

38 ~~SEC. 5.~~

39 *SEC. 11.* Section 14167.6 of the Welfare and Institutions Code
 40 is amended to read:

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

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

7 (c) The aggregate amount of increased capitation payments to
8 all Medi-Cal managed health care plans for a subject federal fiscal
9 year shall be seven hundred twenty-nine million eight hundred
10 ~~twenty-nine thousand two hundred two dollars (\$729,829,202)~~
11 ~~multiplied by the fee percentage of the subject federal fiscal year:~~
12 ~~twenty-nine thousand two hundred five dollars (\$729,829,205)~~
13 ~~multiplied by the percentage of the subject federal fiscal year for~~
14 ~~which federal approval is obtained for this article and Article 5.22~~
15 ~~(commencing with Section 14167.31).~~

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

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

31 (f) (1) The increased capitation payments to managed health
32 care plans under this section shall be made to support the
33 availability of hospital services and ensure access to hospital
34 services for Medi-Cal beneficiaries. The increased capitation
35 payments to managed health care plans shall be made as follows:

36 ~~(1) The increased capitation payments shall commence during~~
37 ~~the second month following the month during which the quality~~
38 ~~assurance fee set forth in Article 5.22 (commencing with Section~~
39 ~~14167.31) is due and payable from hospitals if the quality assurance~~
40 ~~fee includes funds for increased capitation payments to managed~~

1 health care plans. The last increased capitation payments made
2 pursuant to this section shall be made during December 2010.

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

8 *managed health care plans shall commence no later than
9 December 31, 2010, and shall include, but not be limited to, the
10 sum of the increased payments for all prior months for which
11 payments are due.*

12 (2) *To secure the necessary funding for the payment or payments
13 made pursuant to paragraph (1), the department shall have
14 discretion to accumulate funds in the Hospital Quality Assurance
15 Fee Fund for the purpose of funding managed care capitation
16 payments under this article regardless of the date on which
17 capitation payments are scheduled to be paid in order to secure
18 the necessary total funding for managed care payments by
19 December 1, 2010. To the extent feasible, the funds shall be
20 accumulated as follows, provided that the department may adjust
21 the following dates and amounts as necessary to accumulate
22 sufficient funding by December 1, 2010:*

23 (A) *Thirty percent of total necessary funding shall be
24 accumulated from all quality assurance fees deposited to the fund
25 in September 2010.*

26 (B) *Thirty percent of total necessary funding shall be
27 accumulated from the first installment of quality assurance fees
28 deposited in the fund in October 2010.*

29 (C) *Thirty percent of total necessary funding shall be
30 accumulated from the second installment of quality assurance fees
31 received from the hospitals in October 2010.*

32 (D) *Ten percent of total funding necessary shall be retained
33 from the November 2010 quality assurance fees received from the
34 hospitals.*

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

1 (h) (1) Each managed health care plan shall expend 100 percent
2 of any increased capitation payments it receives under this section,
3 on hospital services.

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

7 (3) *For entities contracting with the department pursuant to*
8 *Article 2.91 (commencing with Section 14089), any incremental*
9 *increase in capitation rates pursuant to this section shall not be*
10 *subject to negotiation and approval by the California Medical*
11 *Assistance Commission.*

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

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

23 ~~SEC. 6.~~

24 *SEC. 12.* Section 14167.9 of the Welfare and Institutions Code
25 is repealed.

26 ~~SEC. 7.~~

27 *SEC. 13.* Section 14167.9 is added to the Welfare and
28 Institutions Code, to read:

29 14167.9. Subject to the limitations in Section 14167.14, the
30 following shall apply:

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

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

38 (B) The subsequent payments shall be made in six consecutive
39 semimonthly payments that shall be made on or before the later
40 of each of the 14th and 30th days of October, November, and

1 December 2010, or the 30th day after the notice described in
 2 Section 14167.32 is sent to each hospital.

3 (3) The amount of each payment made pursuant to this
 4 subdivision shall be one-seventh of the amount of payments
 5 calculated for each hospital under Sections 14167.2, 14167.3,
 6 14167.4, and subdivision (d) of Section 14167.5.

7 (b) Notwithstanding subdivision (a), all amounts due to hospitals
 8 under Sections 14167.2, 14167.3, 14167.4, and subdivision (d) of
 9 Section 14167.5 that have not been paid to hospitals before
 10 December 30, 2010, pursuant to subdivision (a), shall be paid to
 11 hospitals no later than December 30, 2010.

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

15 (2) (A) (i) The first six payments shall be made in consecutive
 16 semimonthly payments that shall be made on or before the later
 17 of each of the first and 15th days of October, November, and
 18 December 2010, or the 30th day after the notice described in
 19 Section 14167.32 is sent to each hospital.

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

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

25 (ii) The amount of the seventh payment shall be the total amount
 26 due to hospitals under subdivisions (a), (b), and (c) of Section
 27 14167.5 minus the amounts previously paid to the hospitals under
 28 subparagraph (A).

29 ~~SEC. 8.~~

30 *SEC. 14.* Section 14167.10 of the Welfare and Institutions
 31 Code is amended to read:

32 14167.10. (a) Each managed health care plan receiving
 33 increased capitation payments under Section 14167.6 shall expend
 34 the capitation rate increases in a manner consistent with actuarial
 35 certification, enrollment, and utilization on hospital services within
 36 ~~30 days of receiving the increased capitation payments.~~ *services.*
 37 *Each managed health care plan shall expend increased capitation*
 38 *payments on hospital service within 30 days of receiving the*
 39 *increased capitation payments to the extent they are made for a*

1 *subject month that is prior to the date on which the payments are*
2 *received by the managed health care plan.*

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

9 (c) Any delegation or attempted delegation by a managed health
10 care plan of its obligation to expend the capitation rate increases
11 under this section shall not relieve the plan from its obligation to
12 expend those capitation rate increases. Managed health care plans
13 shall submit the documentation the department may require to
14 demonstrate compliance with this subdivision. The documentation
15 shall demonstrate actual expenditure of the capitation rate increases
16 for hospital services, and not assignment to subcontractors of the
17 managed health care plan's obligation of the duty to expend the
18 capitation rate increases.

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

24 ~~SEC. 9.~~

25 *SEC. 15.* Section 14167.11 of the Welfare and Institutions
26 Code is amended to read:

27 14167.11. (a) The department shall increase payments to
28 mental health plans for the subject federal fiscal years as set forth
29 in this section.

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

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

1 beneficiaries to hospital mental health services. The increased
2 ~~capitation~~ payments to mental health plans shall be made as
3 follows:

4 (1) The increased ~~capitation~~ payments shall commence on or
5 before the later of the last day of the second month of the quarter
6 in which federal approval is granted or the 45th day following the
7 day on which federal approval is granted. Subsequent increased
8 ~~capitation~~ payments shall be made on the last day of the second
9 month of each quarter. The last increased ~~capitation~~ payments
10 made pursuant to this section shall be made during November
11 2010.

12 (2) The increased ~~capitation~~ payments made for the first quarter
13 for which increased ~~capitation~~ payments are made under this
14 section shall include the sum of increased ~~capitation~~ payments for
15 all prior quarters for which payments are due under subdivision
16 (b).

17 (3) The increased ~~capitation~~ payments made during November
18 2010 shall include payments computed under subdivision (b) for
19 all quarters in the 2010–11 federal fiscal year to the extent that
20 federal financial participation is available for the payments.

21 (4) *If all necessary federal approvals are not received on or*
22 *before September 1, 2010, the department shall make semimonthly*
23 *payments starting within one month of receipt of all necessary*
24 *federal approvals until December 31, 2010.*

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

29 (2) At the discretion of the director, the plans shall receive an
30 administrative fee, in an amount determined by the department,
31 that is in addition to the increased ~~capitation~~ payments, that is
32 reflective of actual administrative costs and that shall be paid from
33 the fund created in Article 5.22 (commencing with Section
34 14167.31).

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

1 proportionately to the amount for which federal financial
2 participation is available.

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

6 (g) In the event the director determines that payment of the
7 individual acute psychiatric supplemental payments may be made
8 by the department directly to the hospitals under this section and
9 Section 14167.12 without the need for transmitting the funds
10 through the mental health plans, those direct payments shall be
11 made *in accordance with Section 14167.9* notwithstanding any
12 other provision of this article or Article 5.22 (commencing with
13 Section 14167.31).

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

19 ~~SEC. 10.~~

20 *SEC. 16.* Section 14167.12 of the Welfare and Institutions
21 Code is amended to read:

22 14167.12. (a) At the same time that the state makes an
23 increased-~~capitation~~ payment to a mental health plan under Section
24 14167.11, the state shall notify the mental health plan that the plan
25 shall make payments in the amount of the individual hospital acute
26 psychiatric supplemental payment to each subject hospital located
27 in each county in which the mental health plan operates as a
28 consequence of receiving the increased-~~capitation~~ payment and
29 the amount of the individual hospital acute psychiatric
30 supplemental payment due to each hospital, subject to the
31 following:

32 (1) In the case of the increased-~~capitation~~ payments made to a
33 mental health plan during the first quarter in which the payments
34 are made to the plan, the notice shall direct mental health plans to
35 make supplemental payments to each hospital in an amount equal
36 to each hospital's individual hospital acute psychiatric
37 supplemental payment multiplied by the number of quarters for
38 which the enhance payments were made.

39 (2) The notice provided by the department in connection with
40 the increased-~~capitation~~ payments to each mental health plan during

1 November 2010 shall also direct the mental health plan to make
2 quarterly supplemental payments to hospitals for quarters, if any,
3 between January 2011 and September 2011, inclusive, for which
4 federal financial participation is available as described in paragraph
5 (3) of subdivision (c) of Section 14167.11 and the amount of the
6 supplemental payments as calculated pursuant to this subdivision.

7 (b) Each mental health plan receiving payments under Section
8 14167.11 shall make supplemental payments to hospitals within
9 30 days of receiving the payments under Section 14167.11, except
10 that if the mental health plan receives increased ~~capitation~~
11 payments during November 2010, which include payments relating
12 to some or all of the quarters between January 2011 and September
13 2011, inclusive, the mental health plan shall make payments
14 relating to the quarters between January 2011 and September 2011,
15 inclusive, on or before the end of each quarter to which the payment
16 relates. The payments shall be made to those hospitals and in those
17 amounts set forth by the department in its notice provided pursuant
18 to subdivision (a).

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

23 (d) For each subject federal fiscal year, the sum of all
24 supplemental payments made by a mental health plan to subject
25 hospitals pursuant to this section shall equal all increased ~~capitation~~
26 payments received by the mental health plan from the state pursuant
27 to Section 14167.11.

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

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

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

38 (h) In the event federal financial participation for a quarter is
39 not available for all of the increased ~~capitation~~ mental health
40 payments made pursuant to Section 14167.11 for any reason, the

1 supplemental payments to hospitals under this section shall be
2 reduced proportionately to the amount for which federal financial
3 participation is available and the department's notice under
4 subdivision (a) shall reflect the reduction.

5 ~~SEC. 11.~~

6 *SEC. 17.* Section 14167.14 of the Welfare and Institutions
7 Code is amended to read:

8 14167.14. (a) The director shall do all of the following:

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

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

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

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

34 (b) In implementing this article, the department may utilize the
35 services of the Medi-Cal fiscal intermediary through a change
36 order to the fiscal intermediary contract to administer this program,
37 consistent with the requirements of Sections 14104.6, 14104.7,
38 14104.8, and 14104.9. Contracts entered into for purposes of
39 implementing this article or Article 5.22 (commencing with Section

1 14167.31) shall not be subject to Part 2 (commencing with Section
2 10100) of Division 2 of the Public Contract Code.

3 (c) This article shall become inoperative if either of the
4 following occurs:

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

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

11 (A) The federal Centers for Medicare and Medicaid Services
12 denies approval for, or does not approve before January 1, 2012,
13 the implementation of Article 5.22 (commencing with Section
14 14167.31) or this article.

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

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

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

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

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

37 (f) ~~No~~ *Subject to Section 14167.352, no* payment shall be made
38 under this article until all necessary federal approvals for the
39 payment and for the fee provisions in Article 5.22 (commencing
40 with Section 14167.31) have been obtained and the fee has been

1 imposed and collected. ~~Payments~~ *Notwithstanding any other*
2 *provision of law, payments* under this article shall be made only
3 to the extent that the fee established in Article 5.22 (commencing
4 with Section 14167.31) is collected and available to ~~support~~ *cover*
5 *the nonfederal share of the payments.*

6 (g) Supplemental payments for the 2008–09 federal fiscal year
7 shall not reduce the maximum federal funds available annually
8 pursuant to the Special Terms and Conditions, as amended October
9 5, 2007, of the Current Section 1115 Waiver.

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

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

32 (3) This article and Article 5.22 (commencing with Section
33 14167.31) shall not be implemented with respect to the 2009–10
34 and 2010–11 federal fiscal years until the earlier of April 30, 2010,
35 or the date the federal government approves a federal waiver for
36 a demonstration that will replace the Current Section 1115 Waiver.

37 (i) A hospital’s receipt of payments under this article for services
38 rendered prior to the effective date of this article is conditioned
39 on the hospital’s continued participation in Medi-Cal for at least
40 30 days after the effective date of this article.

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

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

7 (2) Federal reimbursement and any other related federal funds.
 8 ~~SEC. 12.~~

9 *SEC. 18.* Section 14167.15 of the Welfare and Institutions
 10 Code is amended to read:

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

19 *SEC. 19.* Section 14167.18 is added to the Welfare and
 20 Institutions Code, to read:

21 14167.18. *Notwithstanding any other provision of law, if*
 22 *conditional federal approval under Section 14167.352 has not*
 23 *been obtained on or before December 1, 2010, then this article*
 24 *shall become inoperative, and as of December 1, 2010, are*
 25 *repealed, unless a later enacted statute, that is enacted before*
 26 *December 1, 2010, deletes or extends that date.*

27 ~~SEC. 13.~~

28 *SEC. 20.* Section 14167.31 of the Welfare and Institutions
 29 Code is amended to read:

30 14167.31. ~~(a) (1)~~ *For the purposes of this article, the following*
 31 *definitions shall apply:*

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

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

9 (B) The annual managed care days for an individual hospital
10 multiplied by the prepaid health plan hospital managed care per
11 diem quality assurance fee rate.

12 (C) The annual Medi-Cal managed care days for an individual
13 hospital multiplied by the prepaid health plan hospital Medi-Cal
14 managed care per diem quality assurance fee rate.

15 (D) The annual Medi-Cal fee-for-service days for an individual
16 hospital multiplied by the Medi-Cal per diem quality assurance
17 fee rate.

18 (3) “Aggregate quality assurance fee after the application of the
19 fee percentage” shall be determined separately for each subject
20 federal fiscal year and means the aggregate annual quality
21 assurance fee multiplied by the fee percentage for the subject
22 federal fiscal year.

23 (4) “Aggregate quality assurance fee” means the sum of the
24 aggregate quality assurance fee after the application of the fee
25 percentage for a hospital for each subject federal fiscal year.

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

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

32 (d) “Annual Medi-Cal days” means the number of Medi-Cal
33 days of each hospital subject to the quality assurance fee in the
34 2007 calendar year, as reported on the days data source.

35 (e) “Converted hospital” shall ~~have the meaning given~~ *mean a*
36 *hospital described* in subdivision (b) of Section 14167.1.

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

38 (1) For a hospital that did not submit an Annual Financial
39 Disclosure Report to the Office of Statewide Health Planning and
40 Development for a fiscal year ending during 2007, but submitted

1 that report for a fiscal period ending in 2008 that includes at least
 2 10 months of 2007, the Annual Financial Disclosure Report
 3 submitted by the hospital to the Office of Statewide Health
 4 Planning and Development for the fiscal period in 2008 that
 5 includes at least 10 months of 2007.

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

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

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

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

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

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

21 *(A) A hospital, as defined in paragraph (25) of subdivision (a)*
 22 *of Section 14105.98.*

23 *(B) A tax-exempt nonprofit hospital that is licensed under*
 24 *subdivision (a) of Section 1250 of the Health and Safety Code and*
 25 *operating a hospital owned by a local health care district, and is*
 26 *affiliated with the health care district hospital owner by means of*
 27 *the district’s status as the nonprofit corporation’s sole corporate*
 28 *member.*

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

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

38 (4) A small and rural hospital as specified in Section 124840
 39 of the Health and Safety Code designated as that in the hospital’s
 40 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 (i) (1) “Federal approval” means the last approval by the federal
4 government required for the implementation of this article and
5 Article 5.21 (commencing with Section 14167.1).

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

12 (j) “Fee-for-service per diem quality assurance fee rate” means
13 a fixed fee on fee-for-service days of two hundred fifteen dollars
14 and thirty cents (\$215.30) per day.

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

23 (l) “Fee percentage” means, for each subject federal fiscal year,
24 a fraction, expressed as a percentage, the numerator of which is
25 the amount of payments for the subject federal fiscal year under
26 Sections 14167.2, 14167.3, and 14167.4, subdivision (d) of Section
27 14167.5, and Section 14167.6 for which federal financial
28 participation is available and the denominator of which is two
29 billion nine hundred eighty-two million one hundred ~~twenty-one~~
30 *twenty* thousand five hundred sixty dollars—~~(\$2,982,121,560)~~
31 *(\$2,982,120,560)*.

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

35 (n) “Hospital community” means any hospital industry
36 organization or system that represents children’s hospitals,
37 nondesignated public hospitals, designated public hospitals, private
38 safety-net hospitals, and other public or private hospitals.

39 (o) “Managed care days” means inpatient hospital days in the
40 2007 calendar year as reported on the days data source where the

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

8 (p) “Managed care per diem quality assurance fee rate” means
9 a fixed fee on managed care days of twenty-two dollars and fifty
10 cents (\$22.50) per day.

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

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

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

35 (t) “Medi-Cal per diem quality assurance fee rate” means a fixed
36 fee on Medi-Cal days of two hundred thirty-two dollars (\$232)
37 per day.

38 ~~(u) “Nondesignated public hospital” means a public hospital~~
39 ~~that is licensed under subdivision (a) of Section 1250 of the Health~~

1 and Safety Code and is defined in paragraph (25) of subdivision
2 (a) of Section 14105.98, excluding designated public hospitals.

3 (u) “Nondesignated public hospital” means either of the
4 following:

5 (1) A public hospital that is licensed under subdivision (a) of
6 Section 1250 of the Health and Safety Code, is not designated as
7 a specialty hospital in the hospital’s annual financial disclosure
8 report for the hospital’s latest fiscal year ending in 2007, and
9 satisfies the definition in paragraph (25) of subdivision (a) of
10 Section 14105.98, excluding designated public hospitals.

11 (2) A tax-exempt nonprofit hospital that is licensed under
12 subdivision (a) of Section 1250 of the Health and Safety Code, is
13 not designated as a specialty hospital in the hospital’s annual
14 financial disclosure report for the hospital’s latest fiscal year
15 ending in 2007, is operating a hospital owned by a local health
16 care district, and is affiliated with the health care district hospital
17 owner by means of the district’s status as the nonprofit
18 corporation’s sole corporate member.

19 (v) “Prepaid health plan hospital” means a hospital ~~that is in the~~
20 ~~Prepaid Health Plan Hospital peer group described in the 1991~~
21 ~~Hospital Peer Grouping Report published by the department.~~ owned
22 by a nonprofit public benefit corporation that shares a common
23 board of directors with a nonprofit health care service plan.

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

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

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

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

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

3 (z) “Private hospital” means a hospital that meets all of the
 4 following conditions:

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

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

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

15 (4) Is a nonpublic hospital, nonpublic converted hospital, or
 16 converted hospital as those terms are defined in paragraphs (26)
 17 to (28), inclusive, respectively, of subdivision (a) of Section
 18 14105.98.

19 (aa) “Subject federal fiscal year” means a federal fiscal year
 20 ending after the implementation date, as defined in Section
 21 14167.1, and beginning before December 31, 2010.

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

27 ~~SEC. 14.~~

28 *SEC. 21.* Section 14167.32 of the Welfare and Institutions
 29 Code is amended to read:

30 14167.32. (a) There shall be imposed on each general acute
 31 care hospital that is not an exempt facility a quality assurance fee,
 32 as a condition of participation in state-funded health insurance
 33 programs, other than the Medi-Cal program, provided that a quality
 34 assurance fee *under this article* shall not be imposed on a converted
 35 hospital for a subject federal fiscal year in which the hospital
 36 becomes a converted hospital or for subsequent federal fiscal years.

37 (b) The quality assurance fee shall be computed starting on the
 38 implementation date, as defined in Section 14167.1, and continue
 39 through and including December 31, 2010.

- 1 (c) ~~Upon~~ *Subject to Section 14167.352, upon* receipt of federal
2 approval, the following shall become operative:
- 3 (1) Within 30 days following receipt of the notice of federal
4 approval from the federal government, the department shall send
5 notice to each hospital subject to the quality assurance fee, and
6 publish on its Internet Web site, the following information:
- 7 (A) The date that the state received notice of federal approval.
8 (B) The fee percentage or percentages for each subject federal
9 fiscal year.
- 10 (2) The notice to each hospital subject to the quality assurance
11 fee shall also state the following:
- 12 (A) The aggregate quality assurance fee after the application of
13 the fee percentage for each subject federal fiscal year.
14 (B) The aggregate quality assurance fee.
15 (C) The amount of each installment payment due from the
16 hospital with respect to the aggregate quality assurance fee.
17 (D) The date on which each installment payment is due.
- 18 (3) (A) The hospitals shall pay the aggregate quality assurance
19 fee in seven equal installments.
20 (B) (i) The first installment payment shall be made on or before
21 the later of September 14, 2010, or the 14th day after the notice
22 described in this section is sent to each hospital.
23 (ii) The additional installment payments shall be made in six
24 consecutive semimonthly payments that shall be due and payable
25 on or before the later of each of the first and 15th days of October,
26 November, and December 2010, or the 14th day after the notice
27 described in this section is sent to each hospital.
- 28 (4) Notwithstanding paragraph (3), the amount of each hospital's
29 aggregate quality assurance fee that has not been paid by the
30 hospital before December 15, 2010, pursuant to paragraph (3),
31 shall be paid by the hospital no later than December 15, 2010.
- 32 (d) The quality assurance fee, as paid pursuant to this
33 subdivision, shall be paid by each hospital subject to the fee to the
34 department for deposit in the Hospital Quality Assurance Revenue
35 Fund. Deposits may be accepted at any time and will be credited
36 toward the fiscal year for which they were assessed.
- 37 (e) This section shall become inoperative if the federal Centers
38 for Medicare and Medicaid Services denies approval for, or does
39 not approve before January 1, 2012, the implementation of this
40 article or Article 5.21 (commencing with Section 14167.1), and

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

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

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

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

21 (h) When a hospital fails to pay all or part of the quality
22 assurance fee ~~within 10 days of~~ *on or before* the date that payment
23 is due, the department may *the following day immediately begin*
24 *to* deduct the unpaid assessment and interest owed from any
25 Medi-Cal payments or other state payments to the hospital in
26 accordance with Section 12419.5 of the Government Code until
27 the full amount is recovered. All amounts, except penalties,
28 deducted by the department under this subdivision shall be
29 deposited in the Hospital Quality Assurance Revenue Fund. The
30 remedy provided to the department by this section is in addition
31 to other remedies available under law.

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

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

37 (k) This subdivision creates a contractually enforceable promise
38 on behalf of the state to use the proceeds of the quality assurance
39 fee, including any federal matching funds, solely and exclusively
40 for the purposes set forth in this article as they existed on the

1 effective date of this article, to limit the amount of the proceeds
2 of the quality assurance fee to be used to pay for the health care
3 coverage of children to the amounts specified in this article and
4 to make any payments for the department's costs of administration
5 to the amounts set forth in this article on the effective date of this
6 article to maintain and continue prior reimbursement levels as set
7 forth in Article 5.21 (commencing with Section 14167.1) on the
8 effective date of that article, and to otherwise comply with all its
9 obligations set forth in Article 5.21 (commencing with Section
10 14167.1) and this article: *provided that the following amendments*
11 *to this article or Article 5.21 (commencing with Section 14167.1)*
12 *made during the 2010 portion of the 2009–10 Regular Session*
13 *shall control for purposes of this section:*

14 (1) *Amendments affecting the timing of the fee to be imposed*
15 *or the payments to be made to a hospital or hospital group.*

16 (2) *Amendments affecting the amount of fee to be imposed on*
17 *a hospital or hospital group, or the amount or method of payments*
18 *to be made to any hospital or hospital group that are contained*
19 *in Assembly Bill 1653, if enacted in the 2009–10 Regular Session,*
20 *or arise from, or have as a basis, a decision, advice, or*
21 *determination by the federal Centers for Medicare and Medicaid*
22 *Services relating to federal approval of the Quality Assurance Fee*
23 *or the payments set forth in this article or Article 5.21 (commencing*
24 *with Section 14167.1).*

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

31 (m) (1) Effective January 1, 2011, the rates payable to hospitals
32 and managed health care plans under Medi-Cal shall be the rates
33 then payable without the supplemental and increased capitation
34 payments set forth in Article 5.21 (commencing with Section
35 14167.1).

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

1 ~~SEC. 15.~~

2 *SEC. 22.* Section 14167.35 of the Welfare and Institutions
3 Code is amended to read:

4 14167.35. (a) The Hospital Quality Assurance Revenue Fund
5 is hereby created in the State Treasury.

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

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

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

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

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

39 ~~(3) To make increased payments to hospitals pursuant to Article~~
40 ~~5.21 (commencing with Section 14167.1).~~

1 (3) *To pay funds from the Hospital Quality Assurance Fund*
2 *pursuant to Section 14167.5 that would have been used for grant*
3 *payments and that are retained by the state, and to make increased*
4 *payments to hospitals, including grants, pursuant to Article 5.21*
5 *(commencing with Section 14167.1), both of which shall be of*
6 *equal priority.*

7 (4) To make increased capitation payments to managed health
8 care plans pursuant to Article 5.21 (commencing with Section
9 14167.1).

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

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

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

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

37 (g) The department shall request approval from the federal
38 Centers for Medicare and Medicaid Services for the implementation
39 of this article. In making this request, the department shall seek
40 specific approval from the federal Centers for Medicare and

1 Medicaid Services to exempt providers identified in this article as
 2 exempt from the fees specified, including the submission, as may
 3 be necessary, of a request for waiver of the broad based
 4 requirement, waiver of the uniform fee requirement, or both,
 5 pursuant to paragraphs (1) and (2) of subdivision (e) of Section
 6 433.68 of Title 42 of the Code of Federal Regulations.

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

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

16 (B) Reduces or increases the amount of the fee payable by a
 17 hospital in total under this article for the 2008–09, 2009–10, and
 18 2010–11 federal fiscal years by more than 2 percent of the amount
 19 that would be determined under this article without any change or
 20 adjustment.

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

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

1 SEC. 23. Section 14167.352 is added to the Welfare and
2 Institutions Code, to read:

3 14167.352. (a) Notwithstanding any other provision of this
4 article or Article 5.21 (commencing with Section 14167.1)
5 requiring federal approvals, the department may impose and
6 collect the quality assurance fee and may make payments under
7 this article and Article 5.21 (commencing with Section 14167.1),
8 including increased capitation payments, based upon conditional
9 federal approval, but only if and to the extent that conditional
10 federal approval is sufficient as set forth in subdivision (b).

11 (b) In order for conditional federal approval to be sufficient
12 under this section, the director shall find that the conditional
13 federal approval meets all of the following requirements:

14 (1) The approval is in writing and signed by an official of the
15 federal Centers for Medicare and Medicaid Services or an official
16 of the United States Department of Health and Human Services.

17 (2) The approval indicates that the state's receipt of the quality
18 assurance fee will not result in a reduction of federal financial
19 participation with respect to the Medi-Cal program, subject only
20 to conditions that are set forth in the conditional approval.

21 (3) The conditional approval indicates that federal financial
22 participation will be available for the payments under Sections
23 14167.2, 14167.3, 14167.4, and 14167.6, and subdivision (d) of
24 Section 14167.5, including, but not limited to, supplemental
25 payments and increased capitation payments, subject only to any
26 applicable federal limitations on reimbursement and conditions,
27 such as formal approval of state plan or waiver amendments, that
28 are set forth in the conditional approval.

29 (4) The director, after consultation with the hospital community,
30 has determined, in the exercise of his or her sole discretion, that
31 the conditional federal approval provides a sufficient level of
32 assurance to justify advanced implementation of the fee and
33 payment provisions.

34 (c) Nothing in this section shall be construed as modifying the
35 requirement under Section 14167.14 that payments shall be made
36 only to the extent a sufficient amount of funds collected as the
37 quality assurance fee are available to cover the nonfederal share
38 of those payments.

39 (d) (1) Upon notice from the federal government that final
40 federal approval for the fee model under this article or for any

1 *payment method under Article 5.21 (commencing with Section*
2 *14167.1) has been denied, any fees collected pursuant to this*
3 *section shall be refunded and any payments made pursuant to this*
4 *article or Article 5.21 (commencing with Section 14167.1) shall*
5 *be recouped, including, but not limited to, supplemental payments,*
6 *increased capitation payments, payments to hospitals by health*
7 *care plans resulting from the increased capitation payments,*
8 *grants, increased payments, and payments for the health care*
9 *coverage of children. To the extent fees were paid by a hospital*
10 *that also received payments under this section, the payments may*
11 *first be recouped from fees that would otherwise be refunded to*
12 *the hospital prior to the use of any other recoupment method*
13 *allowed under law.*

14 *(e) Any payment made pursuant to this section shall be a*
15 *conditional payment until all final federal approvals necessary to*
16 *fully implement this article and Article 5.21 (commencing with*
17 *Section 14167.1) have been received.*

18 *(f) The director shall have broad authority under this section*
19 *to collect the quality assurance fee for an interim period pending*
20 *receipt of all necessary federal approvals. This authority shall*
21 *include discretion to determine both of the following:*

22 *(1) Whether the quality assurance fee should be collected on a*
23 *full or pro rata basis during the interim period.*

24 *(2) The dates on which payments of the quality assurance fee*
25 *are due.*

26 *(g) The department may draw against the Hospital Quality*
27 *Assurance Revenue Fund for all administrative costs associated*
28 *with implementation under this article or Article 5.21 (commencing*
29 *with Section 14167.1).*

30 *(h) This section shall be implemented only to the extent federal*
31 *financial participation is not jeopardized by implementation prior*
32 *to the receipt of all necessary final federal approvals.*

33 *SEC. 24. Section 14167.353 is added to the Welfare and*
34 *Institutions Code, to read:*

35 *14167.353. (a) Notwithstanding any other provision of law,*
36 *the director shall have discretion to modify any timeline or*
37 *timelines in this article or Article 5.21 (commencing with Section*
38 *14167.1) if all federal approvals required by the applicable articles*
39 *are not secured on a conditional or final basis by September 1,*
40 *2010, and the director determines that it is impossible from an*

1 operational perspective to implement a timeline or timelines
2 without the modification.

3 (b) The department shall notify the fiscal and policy committees
4 of the Legislature prior to implementing a modified timeline or
5 timelines under subdivision (a).

6 (c) The department shall consult with representatives of the
7 hospital community in developing a modified timeline or timelines
8 pursuant to this section.

9 (d) The discretion to modify timelines under this section shall
10 include, but not be limited to, discretion to accelerate payments
11 to plans or hospitals.

12 SEC. 25. Section 14167.354 is added to the Welfare and
13 Institutions Code, to read:

14 14167.354. (a) (1) Upon receipt of conditional federal
15 approval that the director determines is sufficient for
16 implementation under Section 14167.352, or upon the receipt of
17 all final federal approvals necessary for the implementation of
18 this article and Article 5.21 (commencing with Section 14167.1)
19 if sufficient conditional approval is not received by the department,
20 the following shall occur:

21 (A) To the maximum extent possible, and consistent with the
22 availability of funds in the Hospital Quality Assurance Revenue
23 Fund, the department shall make all of the payments under Sections
24 14167.2, 14167.3, 14167.4, and 14167.6, and subdivision (d) of
25 Section 14167.5, including, but not limited to, supplemental
26 payments and increased capitation payments, prior to January 1,
27 2011.

28 (B) The department shall make supplemental payments to
29 hospitals under Article 5.21 (commencing with Section 14167.1)
30 consistent with the timeframe described in Section 14167.9 or a
31 modified timeline developed pursuant to Section 14167.353.

32 (2) (A) In determining the amount available for the nonfederal
33 share of payments in a particular payment cycle, the department
34 shall deduct no more than the following amounts to account for
35 the priority payments to the state under paragraph (2) of
36 subdivision (c) of Section 14167.35:

37 (i) Eighty million dollars (\$80,000,000) for children's health
38 coverage for each quarter for which some or all supplemental
39 payments to hospitals have already been made.

1 (ii) Eighty million dollars (\$80,000,000) for children’s health
2 coverage for each quarter for which supplemental payments are
3 being calculated to be paid to hospitals, subject to the availability
4 of funding, in the current payment cycle.

5 (iii) Eighty million dollars (\$80,000,000) for children’s health
6 coverage for each quarter for which room under the upper payment
7 limit for private hospitals for hospital inpatient services was used
8 or will be used in calculating payments in the current payment
9 cycles where the quarters were not already accounted for in clause
10 (i) or (ii).

11 (B) Notwithstanding any other provision of law, in determining
12 the amount available for the nonfederal share of payments in a
13 payment cycle described in subparagraph (A), the department
14 shall not consider any payments for children’s health care
15 coverage previously made under paragraph (2) of subdivision (c)
16 of Section 14167.35.

17 (3) (A) In determining the amount available in a particular
18 payment cycle, the department shall deduct no more than the
19 following amounts whether made directly to the designated public
20 hospitals or retained by the state:

21 (i) Seventy-three million seven hundred fifty thousand dollars
22 (\$73,750,000) for each quarter for which some or all supplemental
23 payments to hospitals have already been made.

24 (ii) Seventy-three million seven hundred fifty thousand dollars
25 (\$73,750,000) for each quarter for which supplemental payments
26 are being calculated to be paid to hospitals, subject to the
27 availability of funding, in the current payment cycle.

28 (iii) Seventy-three million seven hundred fifty thousand dollars
29 (\$73,750,000) for each quarter for which room under the upper
30 payment limit for private hospitals for hospital inpatient services
31 was used or will be used in calculating payments in the current
32 payment cycles where the quarters were not already accounted
33 for in clause (i) or (ii).

34 (B) Notwithstanding any other provision of law, in determining
35 the amount available for a payment cycle described in
36 subparagraph (A), the department shall not consider any payments
37 of direct grants previously made to the designated public hospitals
38 or transferred to the state from the Quality Assurance Revenue
39 Fund under Section 14167.5 to account for the direct grants
40 described in Section 14167.5.

1 (b) Notwithstanding any other provision of this article or Article
2 5.21 (commencing with Section 14167.1), if the director determines,
3 on or after December 15, 2010, that there are insufficient funds
4 available in the Hospital Quality Assurance Revenue Fund to make
5 all scheduled payments under Article 5.21 (commencing with
6 Section 14167.1) by the end of the 2010 calendar year, he or she
7 shall consult with representatives of the hospital community to
8 develop an acceptable plan for making additional payments to
9 providers in the first two quarters of 2011 to maximize the use of
10 delinquent fee payments or other deposits or interest projected to
11 become available in the fund after December 15, 2010, but before
12 June 30, 2011.

13 (c) Nothing in this section shall require the department to
14 continue to make payments under Article 5.21 (commencing with
15 Section 14167.1) if, after the consultation required under
16 subdivision (b), the director determines in the exercise of his or
17 her sole discretion that a workable plan for the continued payments
18 cannot be developed.

19 (d) Subdivisions (b) and (c) shall be implemented only if and to
20 the extent federal financial participation is available for continued
21 supplemental payments to providers.

22 (e) If any payment or payments made pursuant to this section
23 are found to be inconsistent with federal law, the department shall
24 recoup the payments by means of withholding or any other
25 available remedy.

26 (f) Nothing in this section shall be read as affecting the
27 department's ongoing authority to continue, after December 31,
28 2010, to collect quality assurance fees imposed on or before
29 December 31, 2010.

30 SEC. 26. Section 14167.355 is added to the Welfare and
31 Institutions Code, to read:

32 14167.355. Notwithstanding any other provision of law, if
33 conditional federal approval under Section 14167.352 has not
34 been obtained on or before December 1, 2010, then this article
35 shall become inoperative, and as of December 1, 2010, are
36 repealed, unless a later enacted statute, that is enacted before
37 December 1, 2010, deletes or extends that date.

38 ~~SEC. 16.~~

39 SEC. 27. Section 14167.36 of the Welfare and Institutions
40 Code is amended to read:

1 14167.36. (a) This article shall only be implemented so long
2 as the following conditions are met:

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

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

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

12 (b) No hospital shall be required to pay the quality assurance
13 fee to the department unless and until the state receives and
14 maintains federal approval of the quality assurance fee and Article
15 5.21 (commencing with Section 14167.1) from the federal Centers
16 for Medicare and Medicaid Services.

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

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

22 (2) Article 5.21 (commencing with Section 14167.1) is enacted
23 and remains in effect and hospitals are reimbursed the increased
24 rates beginning on the implementation date, as defined in Section
25 14167.1.

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

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

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

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

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

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

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

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

16 (g) (1) *In the event that all necessary final federal approvals*
17 *are not received as described and anticipated under this article*
18 *or under Article 5.21 (commencing with Section 14167.1), the*
19 *director shall have the discretion and authority to develop*
20 *procedures for recoupment from managed health care plans, and*
21 *from hospitals under contract with managed health care plans, of*
22 *any amounts received pursuant to this article or Article 5.21*
23 *(commencing with Section 14167.1).*

24 (2) *Any procedure instituted pursuant to this subdivision shall*
25 *be developed in consultation with representatives from managed*
26 *health care plans and representatives of the hospital community.*

27 (3) *Any procedure instituted pursuant to this subdivision shall*
28 *be in addition to all other remedies made available under the law,*
29 *pursuant to contracts between the department and the managed*
30 *health care plans, or pursuant to contracts between the managed*
31 *health care plans and the hospitals.*

32 ~~SEC. 17:~~

33 SEC. 28. This act is an urgency statute necessary for the
34 immediate preservation of the public peace, health, or safety within
35 the meaning of Article IV of the Constitution and shall go into
36 immediate effect. The facts constituting the necessity are:

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

O