

AMENDED IN SENATE AUGUST 27, 2010  
AMENDED IN SENATE AUGUST 20, 2010  
AMENDED IN SENATE AUGUST 17, 2010  
AMENDED IN SENATE AUGUST 2, 2010  
AMENDED IN SENATE JULY 15, 2010

CALIFORNIA LEGISLATURE—2009—10 REGULAR SESSION

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**ASSEMBLY BILL**

**No. 1653**

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

January 14, 2010

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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); *of* 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. *Existing law provides that these provisions shall remain in effect only until January 1, 2013, and as of that date are repealed.*

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 ~~care~~ *care* 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~~ *prescribed* 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.

*This bill would make various changes to the provisions relating to the increased payments to mental health plans, including requiring the department to take into consideration prescribed factors when making these payments.*

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. *Existing law provides that these provisions shall remain in effect only until January 1, 2013, and as of that date are repealed.*

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~~ *receiving a letter from the federal Centers for Medicare and Medicaid Services or the United States Department of Health and Human Services that indicates likely* federal approval, but only if and to the extent that the ~~conditional~~ *federal approval letter* 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~~ *letter indicating likely* federal approval is not ~~obtained~~ *received* 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:  $\frac{2}{3}$ . Appropriation: 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 affiliated.

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

14 14166.20. (a) With respect to each project year, the total  
15 amount of stabilization funding shall be the sum of the following:

16 (1) (A) Federal Medicaid funds available in the Health Care  
17 Support Fund, established pursuant to Section 14166.21, reduced  
18 by the amount necessary to meet the baseline funding amount, or  
19 the adjusted baseline funding amount, as appropriate, for project  
20 years after the 2005–06 project year for each designated public  
21 hospital, project year private DSH hospitals in the aggregate, and  
22 nondesignated public hospitals in the aggregate as determined in  
23 Sections 14166.5, 14166.13, and 14166.18, respectively, taking  
24 into account all other payments to each hospital under this article.  
25 This amount shall be not less than zero.

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

30 (C) The federal financial participation amount arising from the  
31 certified public expenditures that has been paid to designated public  
32 hospitals, or the governmental entities with which they are  
33 affiliated, pursuant to subdivision ~~(f)~~ (g) of Section 14166.221,  
34 shall be disregarded for purposes of this section.

35 (2) The state general funds that were made available due to the  
36 receipt of federal funding for previously state-funded programs  
37 through the safety net care pool and any federal Medicaid hospital  
38 reimbursements resulting from these expenditures, unless otherwise

1 recognized under paragraph (1), to the extent those funds are in  
2 excess of the amount necessary to meet the baseline funding  
3 amount, or the adjusted baseline funding amount, as appropriate,  
4 for project years after the 2005–06 project year for each designated  
5 public hospital, for project year private DSH hospitals in the  
6 aggregate, and for nondesignated public hospitals in the aggregate,  
7 as determined in Sections 14166.5, 14166.13, and 14166.18,  
8 respectively.

9 (3) To the extent not included in paragraph (1) or (2), the amount  
10 of the increase in state General Fund expenditures for Medi-Cal  
11 inpatient hospital services for the project year for project year  
12 private DSH hospitals and nondesignated public hospitals,  
13 including amounts expended in accordance with paragraph (1) of  
14 subdivision (c) of Section 14166.23, that exceeds the expenditure  
15 amount for the same purpose and the same hospitals necessary to  
16 provide the aggregate baseline funding amounts applicable to the  
17 project determined pursuant to Sections 14166.13 and 14166.18,  
18 and any direct grants to designated public hospitals for services  
19 under the demonstration project.

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

23 (5) The federal Medicaid funds received by the state as a result  
24 of federal financial participation with respect to Medi-Cal payments  
25 for inpatient hospital services made to project year private DSH  
26 hospitals and to nondesignated public hospitals for services  
27 rendered during the project year, the state share of which was  
28 derived from intergovernmental transfers or certified public  
29 expenditures of any public entity that does not own or operate a  
30 public hospital.

31 (6) Federal safety net care pool funds claimed and received for  
32 inpatient hospital services rendered under the health care coverage  
33 initiative identified under paragraph (3) of subdivision (e) of  
34 Section 14166.9.

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

38 (1) Eight million dollars (\$8,000,000) shall be paid to San Mateo  
39 Medical Center. All or a portion of this amount may be paid as  
40 disproportionate share hospital payments in addition to the

1 hospital's allocation that would otherwise be determined under  
2 Section 14166.6. The amount provided for in this paragraph shall  
3 be disregarded in the application of the limitations described in  
4 paragraph (3) of subdivision (a) of Section 14166.6, and in  
5 paragraph (1) of subdivision (a) of Section 14166.7.

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

9 (B) Forty-two million two hundred twenty-eight thousand dollars  
10 (\$42,228,000) shall be allocated to private DSH hospitals to be  
11 paid in accordance with Section 14166.14.

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

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

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

33 (B) Notwithstanding subparagraph (A) and solely for the  
34 2006–07 fiscal year, if the amount that otherwise would be made  
35 available for additional payments to distressed hospitals under  
36 subparagraph (A) is equal to or greater than eighteen million three  
37 hundred thousand dollars (\$18,300,000), that amount shall be  
38 reduced by eighteen million three hundred thousand dollars  
39 (\$18,300,000) and the state's obligation to make these payments  
40 shall be reduced by this amount. In the event the amount that

1 otherwise would be made available under subparagraph (A) is less  
 2 than eighteen million three hundred thousand dollars (\$18,300,000),  
 3 but greater than or equal to the minimum amount of fifteen million  
 4 three hundred thousand dollars (\$15,300,000), then the amount  
 5 available under this paragraph shall be zero and the state's  
 6 obligation to make these payments shall be zero.

7 (C) Notwithstanding subparagraph (A) and solely for the  
 8 2008–09 and 2009–10 fiscal years, the amount to be made available  
 9 shall be reduced by fifteen million three hundred thousand dollars  
 10 (\$15,300,000) in each of the two years. The funds generated from  
 11 this reduction shall be retained in the General Fund.

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

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

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

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

24 (c) By April 1 of the year following the project year for which  
 25 the payment is made, and after taking into account final amounts  
 26 otherwise paid or payable to hospitals under this article, the director  
 27 shall calculate in accordance with subdivision (a), allocate in  
 28 accordance with subdivision (b), and pay to hospitals in accordance  
 29 with Sections 14166.75, 14166.14, and 14166.19, as applicable,  
 30 the stabilization funding.

31 (d) For purposes of determining amounts paid or payable to  
 32 hospitals under subdivision (c), the department shall apply the  
 33 following:

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

38 (A) If the final payment amount is based on the hospital's  
 39 Medicare cost report, the department shall rely on the cost report  
 40 filed with the Medicare fiscal intermediary for the project year for



1 which the calculation is made, reduced by a percentage that  
2 represents the average percentage change from total reported costs  
3 to final costs for the three most recent cost reporting periods for  
4 which final determinations have been made, taking into account  
5 all administrative and judicial appeals. Protested amounts shall  
6 not be considered in determining the average percentage change  
7 unless the same or similar costs are included in the project year  
8 cost report.

9 (B) If the final payment amount is based on costs not included  
10 in subparagraph (A), the reported costs as of the date the  
11 determination is made under subdivision (c), shall be reduced by  
12 10 percent.

13 (C) In addition to adjustments required in subparagraphs (A)  
14 and (B), the department shall adjust amounts paid or payable to  
15 designated public hospitals by any applicable deferrals or  
16 disallowances identified by the federal Centers for Medicare and  
17 Medicaid Services as of the date the determination is made under  
18 subdivision (c) not otherwise reflected in subparagraphs (A) and  
19 (B).

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

24 (e) The department shall consult with hospital representatives  
25 regarding the appropriate calculation of stabilization funding before  
26 stabilization funds are paid to hospitals. The calculation may be  
27 comprised of multiple steps involving interim computations and  
28 assumptions as may be necessary to determine the total amount  
29 of stabilization funding under subdivision (a) and the allocations  
30 under subdivision (b). No later than 30 days after this consultation,  
31 the department shall establish a final determination of stabilization  
32 funding that shall not be modified for any reason other than  
33 mathematical errors or mathematical omissions on the part of the  
34 department.

35 (f) The department shall distribute 75 percent of the estimated  
36 stabilization funding on an interim basis throughout the project  
37 year.

38 (g) The allocation and payment of stabilization funding shall  
39 not reduce the amount otherwise paid or payable to a hospital under  
40 this article or any other provision of law, unless the reduction is

1 required by the demonstration project’s Special Terms and  
2 Conditions or by federal law.

3 (h) It is the intent of the Legislature that the amendments made  
4 to Sections 14166.12 and to this section by the act that added this  
5 subdivision in the 2007–08 Regular Session shall not be construed  
6 to amend or otherwise alter the ongoing structure of the  
7 department’s Medicaid Demonstration Project and Waiver  
8 approved by the federal Centers for Medicare and Medicaid  
9 Services to begin on September 1, 2005.

10 SEC. 3. Section 14166.221 of the Welfare and Institutions  
11 Code is amended to read:

12 14166.221. (a) It is the intent of the Legislature for the  
13 department to maximize the receipt of federal funds for California’s  
14 Medi-Cal program, including this demonstration project, by  
15 identifying state resources which will enable the state to obtain  
16 additional federal reimbursement during this unprecedented fiscal  
17 crisis. It is further the intent of the Legislature that any program  
18 identified by the department for the purposes specified in this  
19 section shall not be modified or altered in any manner unless  
20 subsequent statutory authority is expressly provided by the  
21 Legislature.

22 (b) Notwithstanding Section 14166.22, in order to maximize  
23 federal claiming under the demonstration project, the department  
24 shall have broad discretion to claim federal reimbursement  
25 consistent with all applicable federal claiming rules for the  
26 following expenditures in an order of priority determined by the  
27 department:

28 (1) Expenditures in programs funded in whole or in part by  
29 realignment funds under Chapter 6 (commencing with Section  
30 17600) of Part 5, including, but not limited to, the County Medical  
31 Services Program.

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

34 (3) Other public expenditures, to the extent the department  
35 determines the expenditures to be appropriate for claiming under  
36 the demonstration project.

37 (4) Expenditures in any programs referenced in subdivision (a)  
38 of Section 14166.22 or other state-only funded programs as the  
39 department, in its discretion, determines should be used for the

1 purposes of this section. These programs may include programs  
2 administered by other state agencies or departments.

3 (c) The department shall have discretion to claim under this  
4 section for any and all additional demonstration project funding  
5 made available pursuant to any amendments to the demonstration  
6 project made on or after October 1, 2008, or pursuant to any federal  
7 laws that increase the amount of available funding, including, but  
8 not limited to, the federal American Recovery and Reinvestment  
9 Act of 2009 (Public Law 111-5). This additional funding shall  
10 include federal funds made available due to an increase in the  
11 federal medical assistance percentage in addition to any other  
12 increase in the amount of federal funding.

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

34 (e) If the federal Centers for Medicare and Medicaid Services  
35 or any federal or state court issues a ruling that any or all federal  
36 dollars obtained by claiming for expenditures from any particular  
37 program referenced in subdivision (b) cannot be used to increase  
38 state revenues, the department may discontinue use of those  
39 expenditures for claiming under this section and substitute other

1 expenditures from other programs referenced in subdivision (b)  
2 at its discretion.

3 *(f) Notwithstanding Chapter 3.5 (commencing with Section*  
4 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*  
5 *the department may implement this section by means of a provider*  
6 *bulletin, or other similar instruction, without taking regulatory*  
7 *action. The department shall also provide notification to the Joint*  
8 *Legislative Budget Committee within five working days if that*  
9 *action is taken in order to inform the Legislature that the action*  
10 *is being implemented.*

11 ~~(f)~~  
12 (g) (1) A portion of the additional federal funding described in  
13 subdivision (c) shall be allocated to the designated public hospitals  
14 and shall be identical in amount to the fee proceeds retained by  
15 the state under Section 14167.5.

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

21 (3) The department shall claim the federal funds made available  
22 to the designated public hospitals under this subdivision upon  
23 receipt of the necessary expenditure reports and certifications from  
24 the designated public hospitals, or the governmental entities with  
25 which they are affiliated, and distribute those funds pursuant to  
26 Section 14167.5 so that receipt of the federal funds by the  
27 designated public hospitals is aligned with the payment schedule  
28 set forth in subdivision (c) of Section 14167.9.

29 ~~(g)~~  
30 (h) The department shall implement subdivision~~(f)~~ (g) of this  
31 section and subdivision (e) of Section 14167.5 only if and to the  
32 extent that all of the following are satisfied:

33 (1) The state has determined, after consultation with the  
34 designated public hospitals, that the designated public hospitals,  
35 or the governmental entities with which they are affiliated, have  
36 incurred sufficient expenditures during the 2009 and 2010 project  
37 years, or that portion of the 2011 project year to the extent federal  
38 funds are available under Section 15900 or under an extension of  
39 the demonstration project, so that each designated public hospital  
40 receives the total amount, taking into account grant funds under

1 Section 14167.5 and payments under this section, that it would  
2 have received for each installment under subdivision (c) of Section  
3 14167.9 had subdivision (e) of Section 14167.5 not been  
4 implemented.

5 (2) The implementation of subdivision ~~(f)~~ (g) of this section  
6 and subdivision (e) of Section 14167.5 does not result in the receipt  
7 by any designated public hospital, or the governmental entity with  
8 which it is affiliated, of less than what would otherwise be paid to  
9 that hospital or entity pursuant to Part 3.5 (commencing with  
10 Section 15900), the sections referred to in Section 14166.35, or  
11 Article 5.21 (commencing with Section 14167.1).

12 (3) In determining the amount retained by the state under  
13 subdivision (e) of Section 14167.5 and made available to the  
14 designated public hospitals in subdivision ~~(f)~~ (g), the department  
15 makes adjustments to the reported expenditures for possible audit  
16 disallowances, consistent with the type of adjustments applied in  
17 prior project years to reduce the likelihood of a federal recoupment.

18 (4) The department is satisfied that the expenditures claimed  
19 under paragraph (3) of subdivision ~~(f)~~ (g) represent valid  
20 expenditures for the purposes of federal financial participation  
21 under the Special Terms and Conditions for the demonstration  
22 project based on federal law and guidance provided by the federal  
23 Centers for Medicare and Medicaid Services.

24 (5) Notwithstanding subdivision (b), the department has claimed  
25 federal reimbursement for the state-only expenditures in the  
26 programs referenced in subdivision (a) of Section 14166.22 and  
27 in the programs authorized by paragraph (4) of subdivision (b) of  
28 Section 14166.221, to the maximum extent authorized under the  
29 Special Terms and Conditions for the demonstration project.

30 (6) Federal financial participation is available and  
31 implementation of these provisions does not jeopardize the federal  
32 financial participation for other programs.

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

35 14166.24. (a) Any determination of the amount due a  
36 designated public hospital that is based in whole or in part on costs  
37 reported to or audited by a Medicare fiscal intermediary shall not  
38 be deemed final for purposes of this article unless the hospital has  
39 received a final determination of Medicare payment for the cost  
40 reporting for Medicare purposes. Designated public hospitals shall

1 be entitled to pursue all administrative and judicial review available  
2 under the Medicare Program and any final determination shall be  
3 incorporated into the department's final determination of payment  
4 due the hospital under this article.

5 (b) If as a result of an audit performed by the department or any  
6 state or federal agency, the department determines that any hospital  
7 participating in the demonstration project has been overpaid under  
8 the demonstration project, the department shall recoup the  
9 overpayment in accordance with Section 14172.5 or 14115.5. The  
10 hospital may appeal the overpayment determinations and any  
11 related audit determination in accordance with the appeal  
12 procedures set forth in Sections 51016 to 51047, inclusive, of Title  
13 22 of the California Code of Regulations. The hospital may seek  
14 judicial review of the final administrative decision as set forth in  
15 Section 14171.

16 (c) The department shall promptly consult with the affected  
17 governmental entity regarding a dispute between a designated  
18 public hospital and the department regarding the validity of the  
19 hospital's certified public expenditures. If the department  
20 determines that the hospital's certification is valid, the department  
21 shall submit the claim to obtain federal reimbursement for the  
22 certified expenditure in question.

23 (d) (1) Upon receipt of a notice of disallowance or deferral  
24 from the federal government related to the certified public  
25 expenditures or intergovernmental transfers of any governmental  
26 entity participating in the demonstration project, the department  
27 shall promptly notify the affected governmental entity. The  
28 governmental entity that certified the public expenditure shall be  
29 the entity responsible for the federal portion of that expenditure.

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

32 (3) After consulting with the governmental entity, the  
33 department shall determine whether the disallowance or response  
34 to a deferral should be filed with the federal government. If the  
35 department determines the appeal or response has merit, the  
36 department shall timely appeal. If necessary, the department may  
37 request an extension of the deadline to file an appeal or response  
38 to a deferral. The affected governmental entity may provide the  
39 department with the legal and factual basis for the appeal or  
40 response.

1 (e) Notwithstanding any other provision of law, if the department  
2 has exercised the authority set forth in subdivision ~~(f)~~ (g) of Section  
3 14166.221 and subdivision (e) of Section 14167.5, then all of the  
4 following shall occur:

5 (1) (A) The state shall be solely responsible for the repayment  
6 of the federal portion of any federal disallowance associated with  
7 any certified public expenditures for the 2009, 2010, and 2011  
8 project years, and paragraph (1) of subdivision (d) of Section  
9 14166.24 shall be disregarded, up to the total amount of the grant  
10 funds retained by the state under subdivision (e) of Section  
11 14167.5.

12 (B) If the hospitals have additional certified public expenditures  
13 for which federal funds have not been received but for which  
14 federal funds could have been received under the demonstration  
15 project had additional federal funds been available, including  
16 federal funds made available under an extension of the  
17 demonstration project, the state shall first be allowed to respond  
18 to a deferral or disallowance based on the certified public  
19 expenditures of designated public hospitals, or the governmental  
20 entities with which they are affiliated, by substituting the additional  
21 certified public expenditures for those deferred or disallowed.

22 (2) The department shall not recoup any overpayment from a  
23 designated public hospital, or a governmental entity with which it  
24 is affiliated, with respect to payments under this article for the  
25 2009, 2010, and 2011 project years, until the state has repaid all  
26 federal funds due up to the amount of the grant funds retained by  
27 the state under subdivision (e) of Section 14167.5.

28 SEC. 5. Section 14166.75 of the Welfare and Institutions Code  
29 is amended to read:

30 14166.75. (a) For services provided during the 2005–06 and  
31 2006–07 project years, the amount allocated to designated public  
32 hospitals pursuant to subparagraph (A) of paragraph (2) and  
33 subparagraph (A) of paragraph (5) of subdivision (b) of Section  
34 14166.20 shall be allocated, in accordance with this section, among  
35 the designated public hospitals. For services provided during the  
36 2007–08, 2008–09, and 2009–10 project years, amounts allocated  
37 to designated public hospitals as stabilization funding pursuant to  
38 any provision of this article, unless otherwise specified, shall be  
39 allocated among the designated public hospitals in accordance  
40 with this section. All amounts allocated to designated public

1 hospitals in accordance with this section shall be paid as direct  
2 grants, which shall not constitute Medi-Cal payments.

3 (b) The baseline funding amount, as determined under Section  
4 14166.5, for San Mateo Medical Center shall be increased by eight  
5 million dollars (\$8,000,000) for purposes of this section.

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

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

13 (2) For each of the 2005–06 and 2006–07 project years, in the  
14 event that the one hundred eighty million dollars (\$180,000,000)  
15 identified in paragraph 41 of the Special Terms and Conditions  
16 for the demonstration project is available in the safety net care  
17 pool for the project year, the lower of twenty-three million dollars  
18 (\$23,000,000) or 7.67 percent of the amount identified in  
19 subdivision (a) to the County of Los Angeles, Department of Health  
20 Services, hospitals. If an amount less than the one hundred eighty  
21 million dollars (\$180,000,000) is available during the project year,  
22 the amount determined under this paragraph shall be reduced  
23 proportionately.

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

28 (1) Designated public hospitals that are donor hospitals, and  
29 their associated donated certified public expenditures, shall be  
30 identified as follows:

31 (A) An initial pro rata allocation of the amount subject to this  
32 subdivision shall be made to each designated public hospital, based  
33 upon the hospital's baseline funding amount determined pursuant  
34 to Section 14166.5, and as further adjusted in subdivision (b). This  
35 initial allocation shall be used for purposes of the calculations  
36 under subparagraph (C) and paragraph (3).

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



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

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

24 (D) If the amount in subparagraph (B) is greater than the amount  
25 determined in subparagraph (C), the hospital is a donor hospital,  
26 and the difference between the two amounts is deemed to be that  
27 donor hospital's associated donated certified public expenditures  
28 amount.

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

34 (3) The lesser of the remaining 30 percent of the total amount  
35 subject to this subdivision or the total amounts of donated certified  
36 public expenditures for all donor hospitals, shall be distributed pro  
37 rata among the donor hospitals based upon the donated certified  
38 public expenditures amount determined for each donor hospital.  
39 Any amounts not distributed pursuant to this paragraph shall be  
40 distributed in the same manner as set forth in paragraph (2).

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

5 (1) Each designated public hospital that renders inpatient  
6 hospital services under the health care coverage initiative program  
7 authorized pursuant to Part 3.5 (commencing with Section 15900)  
8 shall be allocated an amount equal to the amount of the federal  
9 safety net pool funds claimed and received with respect to the  
10 services rendered by the hospital, including services rendered to  
11 enrollees of a managed care organization, to the extent the amount  
12 was included in the determination of total stabilization funding for  
13 the project year pursuant to Section 14166.20.

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

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

34 (A) Designated public hospitals that are donor hospitals, and  
35 their associated donated certified public expenditures, shall be  
36 identified as follows:

37 (i) An initial pro rata allocation of the amount subject to this  
38 paragraph shall be made to each designated public hospital, based  
39 upon the total allowable costs incurred by each hospital, or  
40 governmental entity with which it is affiliated, in rendering hospital

1 services to the uninsured during the project year as reported  
2 pursuant to Section 14166.8. This initial allocation shall be used  
3 for purposes of the calculations under clause (iii) and subparagraph  
4 (C).

5 (ii) The federal financial participation amount arising from the  
6 certified public expenditures of each designated public hospital,  
7 including the expenditures of the governmental entity, nonhospital  
8 clinics, and other provider types with which it is affiliated, that  
9 were claimed by the department from the federal disproportionate  
10 share hospital allotment pursuant to subparagraphs (A) and (C) of  
11 paragraph (2) of subdivision (a) of Section 14166.9, and from the  
12 safety net care pool funds pursuant to paragraph (3) of subdivision  
13 (a) of Section 14166.9, shall be determined.

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

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

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

39 (C) The lesser of the remaining 50 percent of the total amount  
40 subject to this paragraph, the total amounts of donated certified

1 public expenditures for all donor hospitals or that amount that is  
 2 30 percent of the amount subject to this subdivision after the  
 3 allocations in paragraph (1), shall be distributed pro rata among  
 4 the donor hospitals based upon the donated certified public  
 5 expenditures amount determined for each donor hospital. Any  
 6 amounts not distributed pursuant to this subparagraph shall be  
 7 distributed in the same manner as set forth in subparagraph (B).

8 (D) The federal financial participation amount arising from the  
 9 certified public expenditures that has been paid to designated public  
 10 hospitals, or the governmental entities with which they are  
 11 affiliated, pursuant to subdivision ~~(f)~~ (g) of Section 14166.221  
 12 shall be disregarded for purposes of this paragraph.

13 (f) The department shall consult with designated public hospital  
 14 representatives regarding the appropriate distribution of  
 15 stabilization funding before stabilization funds are allocated and  
 16 paid to hospitals. No later than 30 days after this consultation, the  
 17 department shall issue a final allocation of stabilization funding  
 18 under this section that shall not be modified for any reason other  
 19 than mathematical errors or mathematical omissions on the part  
 20 of the department.

21 SEC. 6. Section 14167.1 of the Welfare and Institutions Code  
 22 is amended to read:

23 14167.1. For purposes of this article, the following definitions  
 24 shall apply:

25 (a) “Acute psychiatric days” means the total number of  
 26 Short-Doyle administrative days, Short-Doyle acute care days,  
 27 acute psychiatric administrative days, and acute psychiatric acute  
 28 days identified in the Final Medi-Cal Utilization Statistics for the  
 29 2008–09 state fiscal year as calculated by the department on  
 30 September 15, 2008.

31 (b) “Converted hospital” means a private hospital that becomes  
 32 a designated public hospital or a nondesignated public hospital  
 33 after the implementation date, a nondesignated public hospital that  
 34 becomes a private hospital or a designated public hospital after  
 35 the implementation date, or a designated public hospital that  
 36 becomes a private hospital or a nondesignated public hospital after  
 37 the implementation date.

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

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

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

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

13 (g) “Hospital inpatient services” means all services covered  
14 under Medi-Cal and furnished by hospitals to patients who are  
15 admitted as hospital inpatients and reimbursed on a fee-for-service  
16 basis by the department directly or through its fiscal intermediary.  
17 Hospital inpatient services include outpatient services furnished  
18 by a hospital to a patient who is admitted to that hospital within  
19 24 hours of the provision of the outpatient services that are related  
20 to the condition for which the patient is admitted. Hospital inpatient  
21 services do not include services for which a managed health care  
22 plan is financially responsible.

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

36 (i) (1) “Implementation date” means the latest effective date  
37 of all federal approvals or waivers necessary for the implementation  
38 of this article and Article 5.22 (commencing with Section  
39 14167.31), including, but not limited to, any approvals on  
40 amendments to contracts between the department and managed

1 health care plans or mental health plans necessary for the  
2 implementation of this article. The effective date of a federal  
3 approval or waiver shall be the earlier of the stated effective date  
4 or the first day of the first quarter to which the computation of the  
5 payments or fee under the federal approval or waiver is applicable,  
6 which may be prior to the date that the federal approval or waiver  
7 is granted or the applicable contract is amended.

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

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

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

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

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

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

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

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

35 (B) Managed health care plans do not include any of the  
36 following:

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

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

3 (iii) Long-Term Care Demonstration Projects for All-Inclusive  
4 Care for the Elderly operating pursuant to Chapter 8.75  
5 (commencing with Section 14590).

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

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

20 (n) “Mental health plan” means a mental health plan that  
21 contracts with the State Department of Mental Health to furnish  
22 or arrange for the provision of mental health services to Medi-Cal  
23 beneficiaries pursuant to Part 2.5 (commencing with Section 5775)  
24 of Division 5.

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

29 (p) “Nondesignated public hospital” means either of the  
30 following:

31 (1) A public hospital that is licensed under subdivision (a) of  
32 Section 1250 of the Health and Safety Code, is not designated as  
33 a specialty hospital in the hospital’s annual financial disclosure  
34 report for the hospital’s latest fiscal year ending in 2007, and  
35 satisfies the definition in paragraph (25) of subdivision (a) of  
36 Section 14105.98, excluding designated public hospitals.

37 (2) A tax-exempt nonprofit hospital that is licensed under  
38 subdivision (a) of Section 1250 of the Health and Safety Code, is  
39 not designated as a specialty hospital in the hospital’s annual  
40 financial disclosure report for the hospital’s latest fiscal year ending

1 in 2007, is operating a hospital owned by a local health care district,  
2 and is affiliated with the health care district hospital owner by  
3 means of the district's status as the nonprofit corporation's sole  
4 corporate member.

5 (q) "Outpatient base amount" means the total amount of  
6 payments for hospital outpatient services made to a hospital in the  
7 2007 calendar year, as reflected in state paid claims files on January  
8 26, 2008.

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

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

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

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

21 (4) Is a nonpublic hospital, nonpublic converted hospital, or  
22 converted hospital as those terms are defined in paragraphs (26)  
23 to (28), inclusive, respectively, of subdivision (a) of Section  
24 14105.98.

25 (s) "Subject federal fiscal year" means a federal fiscal year that  
26 ends after the implementation date and begins before December  
27 31, 2010.

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

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

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

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



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

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

8 SEC. 7. Section 14167.2 of the Welfare and Institutions Code  
9 is amended to read:

10 14167.2. (a) Private hospitals shall be paid supplemental  
11 amounts for the provision of hospital outpatient services as set  
12 forth in this section. The supplemental amounts shall be in addition  
13 to any other amounts payable to hospitals with respect to those  
14 services and shall not affect any other payments to hospitals.

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

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

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

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

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

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

38 (f) No payments shall be made under this section to a converted  
39 hospital for the subject federal fiscal year in which the hospital

1 becomes a converted hospital or for subsequent subject federal  
2 fiscal years.

3 SEC. 8. Section 14167.3 of the Welfare and Institutions Code  
4 is amended to read:

5 14167.3. (a) Private hospitals shall be paid supplemental  
6 amounts for the provision of hospital inpatient services and  
7 subacute services as set forth in this section. The supplemental  
8 amounts shall be in addition to any other amounts payable to  
9 hospitals with respect to those services and shall not affect any  
10 other payments to hospitals.

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

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

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

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

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

35 (c) A private hospital that provides Medi-Cal subacute services  
36 during a subject federal fiscal year and has a Medicaid inpatient  
37 utilization rate that is greater than 5.0 percent and less than 41.1  
38 percent shall be paid for the provision of subacute services during  
39 each subject federal fiscal year a supplemental amount equal to

1 40 percent of the Medi-Cal subacute payments made to the hospital  
2 during the 2008 calendar year.

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

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

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

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

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

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

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

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

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

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

5 SEC. 9. Section 14167.4 of the Welfare and Institutions Code  
6 is amended to read:

7 14167.4. (a) Nondesignated public hospitals shall be paid  
8 supplemental amounts for the provision of hospital inpatient  
9 services as set forth in this section. The supplemental amounts  
10 shall be in addition to any other amounts payable to hospitals with  
11 respect to those services and shall not affect any other payments  
12 to hospitals.

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

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

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

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

27 (1) The total amount payable to nondesignated public hospitals  
28 under subdivision (b) for the subject federal fiscal year shall be  
29 reduced to the amount for which federal financial participation is  
30 available.

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

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

1 shall be reduced to the amount for which federal financial  
2 participation is available.

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

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

7 (g) (1) No payments shall be made under this section to a  
8 converted hospital for the subject federal fiscal year in which the  
9 hospital becomes a converted hospital or for subsequent subject  
10 federal fiscal years.

11 (2) Notwithstanding paragraph (1), the director shall seek federal  
12 approval to allow payments to be made under this section for the  
13 period beginning July 1, 2010, and ending December 31, 2010, to  
14 a converted hospital which is a hospital described in paragraph (2)  
15 of subdivision (p) of Section 14167.1, and shall make payments  
16 under this section consistent with any approvals, subject to all of  
17 the following:

18 (A) Federal approval shall be sought after all final federal  
19 approvals necessary to implement this article and Article 5.22  
20 (commencing with Section 14167.31) are received by the  
21 department.

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

31 (C) The director shall withdraw any request for federal approval  
32 made under this paragraph if, after submitting the request, the  
33 director has determined that obtaining federal approval and  
34 implementing the payments described in this paragraph will  
35 jeopardize the implementation of this article or Article 5.22  
36 (commencing with Section 14167.31) or delay any payments to  
37 hospitals and managed health care plans under this article or Article  
38 5.22, (commencing with Section 14167.31) or the collection of  
39 the quality assurance fee from hospitals under Article 5.22,  
40 (commencing with Section 14167.31) beyond December 31, 2010.

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

3 14167.5. (a) Designated public hospitals shall be paid direct  
4 grants in support of health care expenditures, which shall not  
5 constitute Medi-Cal payments, and which shall be funded by the  
6 quality assurance fee set forth in Article 5.22 (commencing with  
7 Section 14167.31). The aggregate amount of the grants to  
8 designated public hospitals for each subject federal fiscal year  
9 shall be two hundred ninety-five million dollars (\$295,000,000).

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

23 (1) Each designated public hospital’s share of 80 percent of the  
24 amount specified in subdivision (a) shall be determined by applying  
25 a fraction, the numerator of which is the certified public  
26 expenditures reported by the designated public hospital as  
27 allowable Medi-Cal inpatient expenditures on Schedule 2.1,  
28 Column 5, Step 5 of the Interim Hospital Payment Rate Workbook,  
29 and the denominator of which is the total amount of certified public  
30 expenditures reported as allowable Medi-Cal inpatient expenditures  
31 by all designated public hospitals on Schedule 2.1, Column 5, Step  
32 5 of the Interim Hospital Payment Rate Workbooks.

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

1 Schedule 1, Column 5a, lines 25 through 33 of the Interim Hospital  
2 Payment Rate Workbooks.

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

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

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

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

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

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

6 (3) In the event the amount otherwise payable to a designated  
7 public hospital under this subdivision for a subject federal fiscal  
8 year exceeds the amount for which federal financial participation  
9 is available for that hospital, the amount due to the hospital for  
10 that federal fiscal year shall be reduced to the amount for which  
11 federal financial participation is available.

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

31 SEC. 11. Section 14167.6 of the Welfare and Institutions Code  
32 is amended to read:

33 14167.6. (a) The department shall increase capitation payments  
34 to Medi-Cal managed health care plans for the subject federal  
35 fiscal years as set forth in this section.

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

39 (c) The aggregate amount of increased capitation payments to  
40 all Medi-Cal managed health care plans for a subject federal fiscal



1 year shall be seven hundred twenty-nine million eight hundred  
2 twenty-nine thousand two hundred five dollars (\$729,829,205)  
3 multiplied by the percentage of the subject federal fiscal year for  
4 which federal approval is obtained for this article and Article 5.22  
5 (commencing with Section 14167.31).

6 (d) The department shall determine the amount of the increased  
7 capitation payments for each managed health care plan. The  
8 department shall consider the composition of Medi-Cal enrollees  
9 in the plan, the anticipated utilization of hospital services by the  
10 plan's Medi-Cal enrollees, and other factors that the department  
11 determines are reasonable and appropriate to ensuring access to  
12 high-quality hospital services by the plan's enrollees.

13 (e) The amount of increased capitation payments to each  
14 Medi-Cal managed care health plan shall not exceed an amount  
15 that results in capitation payments that are certified by the state's  
16 actuary as meeting federal requirements, taking into account the  
17 requirement that all of the increased capitation payments under  
18 this section shall be paid by the Medi-Cal managed health care  
19 plans to hospitals for hospital services to Medi-Cal enrollees of  
20 the plan.

21 (f) (1) The increased capitation payments to managed health  
22 care plans under this section shall be made to support the  
23 availability of hospital services and ensure access to hospital  
24 services for Medi-Cal beneficiaries. The increased capitation  
25 payments to  
26 managed health care plans shall commence no later than December  
27 31, 2010, and shall include, but not be limited to, the sum of the  
28 increased payments for all prior months for which payments are  
29 due.

30 (2) To secure the necessary funding for the payment or payments  
31 made pursuant to paragraph (1), the department shall have  
32 discretion to accumulate funds in the Hospital Quality Assurance  
33 Fee Fund for the purpose of funding managed care capitation  
34 payments under this article regardless of the date on which  
35 capitation payments are scheduled to be paid in order to secure  
36 the necessary total funding for managed care payments by  
37 December 1, 2010. To the extent feasible, the funds shall be  
38 accumulated as follows, provided that the department may adjust  
39 the following dates and amounts as necessary to accumulate  
40 sufficient funding by December 1, 2010:

1 (A) Thirty percent of total necessary funding shall be  
2 accumulated from all quality assurance fees deposited to the fund  
3 in September 2010.

4 (B) Thirty percent of total necessary funding shall be  
5 accumulated from the first installment of quality assurance fees  
6 deposited in the fund in October 2010.

7 (C) Thirty percent of total necessary funding shall be  
8 accumulated from the second installment of quality assurance fees  
9 received from the hospitals in October 2010.

10 (D) Ten percent of total funding necessary shall be retained  
11 from the November 2010 quality assurance fees received from the  
12 hospitals.

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

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

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

23 (3) For entities contracting with the department pursuant to  
24 Article 2.91 (commencing with Section 14089), any incremental  
25 increase in capitation rates pursuant to this section shall not be  
26 subject to negotiation and approval by the California Medical  
27 Assistance Commission.

28 (i) In the event federal financial participation is not available  
29 for all of the increased capitation payments determined for a month  
30 pursuant to this section for any reason, the increased capitation  
31 payments mandated by this section for that month shall be reduced  
32 proportionately to the amount for which federal financial  
33 participation is available.

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

39 SEC. 12. Section 14167.9 of the Welfare and Institutions Code  
40 is repealed.

1 SEC. 13. Section 14167.9 is added to the Welfare and  
2 Institutions Code, to read:

3 14167.9. Subject to the limitations in Section 14167.14, the  
4 following shall apply:

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

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

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

17 (3) The amount of each payment made pursuant to this  
18 subdivision shall be one-seventh of the amount of payments  
19 calculated for each hospital under Sections 14167.2, 14167.3,  
20 14167.4, and subdivision (d) of Section 14167.5.

21 (b) Notwithstanding subdivision (a), all amounts due to hospitals  
22 under Sections 14167.2, 14167.3, 14167.4, and subdivision (d) of  
23 Section 14167.5 that have not been paid to hospitals before  
24 December 30, 2010, pursuant to subdivision (a), shall be paid to  
25 hospitals no later than December 30, 2010.

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

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

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

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

39 (ii) The amount of the seventh payment shall be the total amount  
40 due to hospitals under subdivisions (a), (b), and (c) of Section

1 14167.5 minus the amounts previously paid to the hospitals under  
2 subparagraph (A).

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

5 14167.10. (a) Each managed health care plan receiving  
6 increased capitation payments under Section 14167.6 shall expend  
7 the capitation rate increases in a manner consistent with actuarial  
8 certification, enrollment, and utilization on hospital services. Each  
9 managed health care plan shall expend increased capitation  
10 payments on hospital-service *services* within 30 days of receiving  
11 the increased capitation payments to the extent they are made for  
12 a subject month that is prior to the date on which the payments are  
13 received by the managed health care plan.

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

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

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

35 SEC. 15. Section 14167.11 of the Welfare and Institutions  
36 Code is amended to read:

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

1 (b) For each fiscal quarter that begins on or after the  
2 implementation date, the state shall make increased payments to  
3 each mental health plan. ~~The amount of those increased payments~~  
4 ~~to a mental health plan shall be the sum of all individual hospital~~  
5 ~~acute psychiatric supplemental payments for subject hospitals~~  
6 ~~located in each county in which the mental health plan operates.~~  
7 *The department shall consider the composition of Medi-Cal*  
8 *enrollees in the mental health plan, the anticipated utilization of*  
9 *hospital services by the mental health plan's Medi-Cal enrollees,*  
10 *and other factors that the department determines are reasonable*  
11 *and appropriate to ensure access to high-quality hospital services*  
12 *by the mental health plan's enrollees.*

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

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

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

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

34 (4) If all necessary federal approvals are not received on or  
35 before September 1, 2010, the department shall make semimonthly  
36 payments starting within one month of receipt of all necessary  
37 federal approvals until December 31, 2010.

38 (d) ~~(1)~~ Each mental health plan shall expend, in the form of  
39 additional payments to hospitals, ~~100 percent of any~~ *the* increased

1 payments it receives under this section, pursuant to Section  
2 14167.12.

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

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

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

17 ~~(g) In the event the director determines that payment of the~~  
18 ~~individual acute psychiatric supplemental payments may be made~~  
19 ~~by the department directly to the hospitals under this section and~~  
20 ~~Section 14167.12 without the need for transmitting the funds~~  
21 ~~through the mental health plans, those direct payments shall be~~  
22 ~~made in accordance with Section 14167.9 notwithstanding any~~  
23 ~~other provision of this article or Article 5.22 (commencing with~~  
24 ~~Section 14167.31).~~

25 *(g) Notwithstanding any other provision of this article or Article*  
26 *5.22 (commencing with Section 14167.31), individual acute*  
27 *psychiatric payments under this section and Section 14167.12 may*  
28 *be made directly by the department to hospitals in accordance*  
29 *with Section 14167.9 when federal law does not require that the*  
30 *payments be transmitted to the hospitals via mental health plans.*

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

36 SEC. 16. Section 14167.12 of the Welfare and Institutions  
37 Code is amended to read:

38 14167.12. (a) At the same time that the state makes an  
39 increased payment to a mental health plan under Section 14167.11,  
40 the state shall notify the mental health plan that the plan shall make

1 payments in the amount of the individual hospital acute psychiatric  
2 supplemental payment to each subject hospital located in each  
3 county in which the mental health plan operates as a consequence  
4 of receiving the increased payment and the amount of the individual  
5 hospital acute psychiatric supplemental payment due to each  
6 hospital, subject to the following:

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

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

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

34 (e)

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

39 (d)

1 (c) For each subject federal fiscal year, the sum of all  
2 ~~supplemental~~ payments made by a mental health plan to subject  
3 hospitals pursuant to this section shall equal all increased payments  
4 received by the mental health plan from the state pursuant to  
5 Section 14167.11.

6 ~~(e)~~

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

10 ~~(f)~~

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

16 ~~(g)~~

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

19 ~~(h)~~

20 (g) In the event federal financial participation for a quarter is  
21 not available for all of the increased mental health payments made  
22 pursuant to Section 14167.11 for any reason, the ~~supplemental~~  
23 payments to hospitals under this section shall be reduced  
24 proportionately to the amount for which federal financial  
25 participation is available and the department's notice under  
26 subdivision (a) shall reflect the reduction.

27 SEC. 17. Section 14167.14 of the Welfare and Institutions  
28 Code is amended to read:

29 14167.14. (a) The director shall do all of the following:

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

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

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

39 (4) Amend the contracts between the managed health care plans  
40 and the department as necessary to incorporate the provisions of



1 Sections 14167.6 and 14167.10 and promptly seek all necessary  
2 federal approvals of those amendments. The department shall  
3 pursue amendments to the contracts as soon as possible after the  
4 effective date of this article and Article 5.22 (commencing with  
5 Section 14167.31), and shall not wait for federal approval of this  
6 article or Article 5.22 (commencing with Section 14167.31) prior  
7 to pursuing amendments to the contracts. The amendments to the  
8 contracts shall, among other provisions, set forth an agreement to  
9 increase payment rates to managed health care plans under Section  
10 14166.6 and increase payments to hospitals under Section 14166.10  
11 effective April 2009 or as soon thereafter as possible, conditioned  
12 on obtaining all federal approvals necessary for federal financial  
13 participation for the increased capitation payments to the managed  
14 health care plans.

15 (b) In implementing this article, the department may utilize the  
16 services of the Medi-Cal fiscal intermediary through a change  
17 order to the fiscal intermediary contract to administer this program,  
18 consistent with the requirements of Sections 14104.6, 14104.7,  
19 14104.8, and 14104.9. Contracts entered into for purposes of  
20 implementing this article or Article 5.22 (commencing with Section  
21 14167.31) shall not be subject to Part 2 (commencing with Section  
22 10100) of Division 2 of the Public Contract Code.

23 (c) This article shall become inoperative if either of the  
24 following occurs:

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

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

31 (A) The federal Centers for Medicare and Medicaid Services  
32 denies approval for, or does not approve before January 1, 2012,  
33 the implementation of Article 5.22 (commencing with Section  
34 14167.31) or this article.

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

38 (d) If this article becomes inoperative pursuant to paragraph (1)  
39 of subdivision (c) and the determination applies to any period or  
40 periods of time prior to the effective date of the determination, the

1 department shall have authority to recoup all payments made  
2 pursuant to this article during that period or those periods of time.

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

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

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

17 (f) Subject to Section 14167.352, no payment shall be made  
18 under this article until all necessary federal approvals for the  
19 payment and for the fee provisions in Article 5.22 (commencing  
20 with Section 14167.31) have been obtained and the fee has been  
21 imposed and collected. Notwithstanding any other provision of  
22 law, payments under this article shall be made only to the extent  
23 that the fee established in Article 5.22 (commencing with Section  
24 14167.31) is collected and available to cover the nonfederal share  
25 of the payments.

26 (g) Supplemental payments for the 2008–09 federal fiscal year  
27 shall not reduce the maximum federal funds available annually  
28 pursuant to the Special Terms and Conditions, as amended October  
29 5, 2007, of the Current Section 1115 Waiver.

30 (h) (1) The director shall negotiate the federal approvals  
31 required to implement this article and Article 5.22 (commencing  
32 with Section 14167.31) for the 2009–10 and 2010–11 federal fiscal  
33 years concurrently with the negotiation of a federal waiver that  
34 will replace the Current Section 1115 Waiver, with a goal of  
35 obtaining federal approvals that do not adversely impact the federal  
36 funds that would otherwise be available for services to Medi-Cal  
37 beneficiaries and the uninsured. The director may initiate the  
38 concurrent negotiations required by this subdivision by submitting  
39 a concept paper to the federal Centers for Medicare and Medicaid

1 Services outlining the key elements of the replacement waiver  
2 consistent with the goals set forth in this subdivision.

3 (2) In negotiating the terms of a federal waiver that will replace  
4 the Current 1115 Waiver, the department shall explore  
5 opportunities for reform of the Medi-Cal program and strengthen  
6 California's health care safety net. Subject to subsequent legislative  
7 approval, the department shall explore program reforms, that may  
8 include, but need not be limited to, strategies to accomplish  
9 payment system reforms for hospital inpatient and outpatient care,  
10 including incentive based payments, new payment methodologies  
11 such as diagnostic-related group-based (DRG-based), or similar  
12 methodologies, patient safety protocols, and quality measurement.

13 (3) This article and Article 5.22 (commencing with Section  
14 14167.31) shall not be implemented with respect to the 2009–10  
15 and 2010–11 federal fiscal years until the earlier of April 30, 2010,  
16 or the date the federal government approves a federal waiver for  
17 a demonstration that will replace the Current Section 1115 Waiver.

18 (i) A hospital's receipt of payments under this article for services  
19 rendered prior to the effective date of this article is conditioned  
20 on the hospital's continued participation in Medi-Cal for at least  
21 30 days after the effective date of this article.

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

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

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

29 SEC. 18. Section 14167.15 of the Welfare and Institutions  
30 Code is amended to read:

31 14167.15. Notwithstanding any other provision of this article  
32 or Article 5.22 (commencing with Section 14167.31), the director  
33 may proportionately reduce the amount of any supplemental  
34 payments, increased capitation payments, or grants under this  
35 article to the extent that the payment or grant would result in the  
36 reduction of other amounts payable to a hospital or managed health  
37 care plan or mental health plan due to the application of federal  
38 law.

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

1 14167.18. Notwithstanding any other provision of law, if  
2 ~~conditional the letter that indicates likely federal approval under~~  
3 ~~in accordance with Section 14167.352 has not been obtained~~  
4 ~~received~~ on or before December 1, 2010, then this article shall  
5 become inoperative, and as of December 1, 2010, ~~are is~~ repealed,  
6 unless a later enacted statute, that is enacted before December 1,  
7 2010, deletes or extends that date.

8 SEC. 20. Section 14167.31 of the Welfare and Institutions  
9 Code is amended to read:

10 14167.31. For the purposes of this article, the following  
11 definitions shall apply:

12 (a) (1) “Aggregate annual quality assurance fee” means, with  
13 respect to a hospital that is not a prepaid health plan hospital, the  
14 sum of all of the following:

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

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

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

23 (2) “Aggregate annual quality assurance fee” means, with  
24 respect to a hospital that is a prepaid health plan hospital, the sum  
25 of all of the following:

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

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

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

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

38 (3) “Aggregate quality assurance fee after the application of the  
39 fee percentage” shall be determined separately for each subject  
40 federal fiscal year and means the aggregate annual quality

1 assurance fee multiplied by the fee percentage for the subject  
2 federal fiscal year.

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

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

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

12 (d) “Annual Medi-Cal days” means the number of Medi-Cal  
13 days of each hospital subject to the quality assurance fee in the  
14 2007 calendar year, as reported on the days data source.

15 (e) “Converted hospital” shall mean a hospital described in  
16 subdivision (b) of Section 14167.1.

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

18 (1) For a hospital that did not submit an Annual Financial  
19 Disclosure Report to the Office of Statewide Health Planning and  
20 Development for a fiscal year ending during 2007, but submitted  
21 that report for a fiscal period ending in 2008 that includes at least  
22 10 months of 2007, the Annual Financial Disclosure Report  
23 submitted by the hospital to the Office of Statewide Health  
24 Planning and Development for the fiscal period in 2008 that  
25 includes at least 10 months of 2007.

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

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

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

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

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

39 (A) A hospital, as defined in paragraph (25) of subdivision (a)  
40 of Section 14105.98.

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

7 (2) With the exception of a hospital that is in the Charitable  
8 Research Hospital peer group, as set forth in the 1991 Hospital  
9 Peer Grouping Report published by the department, a hospital that  
10 is a hospital designated as a specialty hospital in the hospital's  
11 Office of Statewide Health Planning and Development Hospital  
12 Annual Disclosure Report for the hospital's fiscal year ending in  
13 the 2007 calendar year.

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

16 (4) A small and rural hospital as specified in Section 124840  
17 of the Health and Safety Code designated as that in the hospital's  
18 Office of Statewide Health Planning and Development Hospital  
19 Annual Disclosure Report for the hospital's fiscal year ending in  
20 the 2007 calendar year.

21 (i) (1) "Federal approval" means the last approval by the federal  
22 government required for the implementation of this article and  
23 Article 5.21 (commencing with Section 14167.1).

24 (2) If federal approval is sought initially for only the 2008–09  
25 federal fiscal year and separately secured for subsequent federal  
26 fiscal years, the implementation date, as defined in subdivision (i)  
27 of Section 14167.1, for the 2008–09 federal fiscal year shall occur  
28 when all necessary federal approvals have been secured for that  
29 federal fiscal year.

30 (j) "Fee-for-service per diem quality assurance fee rate" means  
31 a fixed fee on fee-for-service days of two hundred fifteen dollars  
32 and thirty cents (\$215.30) per day.

33 (k) "Fee-for-service days" means inpatient hospital days where  
34 the service type is reported as "acute care," "psychiatric care," and  
35 "chemical dependency care and rehabilitation care," and the payer  
36 category is reported as "Medicare traditional," "county indigent  
37 programs–traditional," "other third parties–traditional," "other  
38 indigent," and "other payers," for purposes of the Annual Financial  
39 Disclosure Report submitted by hospitals to the Office of Statewide  
40 Health Planning and Development.

1 (l) “Fee percentage” means, for each subject federal fiscal year,  
2 a fraction, expressed as a percentage, the numerator of which is  
3 the amount of payments for the subject federal fiscal year under  
4 Sections 14167.2, 14167.3, and 14167.4, subdivision (d) of Section  
5 14167.5, and ~~Section 14167.6~~ *Sections 14167.6 and 14167.11,*  
6 *including payments made directly to hospitals pursuant to*  
7 *subdivision (g) of Section 14167.11,* for which federal financial  
8 participation is available and the denominator of which is two  
9 billion nine hundred eighty-two million one hundred twenty  
10 thousand five hundred sixty dollars (\$2,982,120,560).

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

14 (n) “Hospital community” means any hospital industry  
15 organization or system that represents children’s hospitals,  
16 nondesignated public hospitals, designated public hospitals, private  
17 safety-net hospitals, and other public or private hospitals.

18 (o) “Managed care days” means inpatient hospital days in the  
19 2007 calendar year as reported on the days data source where the  
20 service type is reported as “acute care,” “psychiatric care,” and  
21 “chemical dependency care and rehabilitation care,” and the payer  
22 category is reported as “Medicare managed care,” “county indigent  
23 programs–managed care,” and “other third parties–managed care,”  
24 for purposes of the Annual Financial Disclosure Report submitted  
25 by hospitals to the Office of Statewide Health Planning and  
26 Development.

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

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

38 (r) “Medi-Cal fee-for-service days” means inpatient hospital  
39 days in the 2007 calendar year as reported on the days data source  
40 where the service type is reported as “acute care,” “psychiatric

1 care,” and “chemical dependency care and rehabilitation care,”  
2 and the payer category is reported as “Medi-Cal traditional” for  
3 purposes of the Annual Financial Disclosure Report submitted by  
4 hospitals to the Office of Statewide Health Planning and  
5 Development.

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

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

17 (u) “Nondesignated public hospital” means either of the  
18 following:

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

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

33 (v) “Prepaid health plan hospital” means a hospital owned by  
34 a nonprofit public benefit corporation that shares a common board  
35 of directors with a nonprofit health care service plan.

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



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

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

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

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

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

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

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

27 (aa) “Subject federal fiscal year” means a federal fiscal year  
28 ending after the implementation date, as defined in Section  
29 14167.1, and beginning before December 31, 2010.

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

35 SEC. 21. Section 14167.32 of the Welfare and Institutions  
36 Code is amended to read:

37 14167.32. (a) There shall be imposed on each general acute  
38 care hospital that is not an exempt facility a quality assurance fee,  
39 as a condition of participation in state-funded health insurance  
40 programs, other than the Medi-Cal program, provided that a quality

1 assurance fee under this article shall not be imposed on a converted  
2 hospital for a subject federal fiscal year in which the hospital  
3 becomes a converted hospital or for subsequent federal fiscal years.

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

7 (c) Subject to Section 14167.352, upon receipt of federal  
8 approval, the following shall become operative:

9 (1) Within 30 days following receipt of the notice of federal  
10 approval from the federal government, the department shall send  
11 notice to each hospital subject to the quality assurance fee, and  
12 publish on its Internet Web site, the following information:

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

14 (B) The fee percentage or percentages for each subject federal  
15 fiscal year.

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

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

20 (B) The aggregate quality assurance fee.

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

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

24 (3) (A) The hospitals shall pay the aggregate quality assurance  
25 fee in seven equal installments.

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

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

34 (4) Notwithstanding paragraph (3), the amount of each hospital's  
35 aggregate quality assurance fee that has not been paid by the  
36 hospital before December 15, 2010, pursuant to paragraph (3),  
37 shall be paid by the hospital no later than December 15, 2010.

38 (d) The quality assurance fee, as paid pursuant to this  
39 subdivision, shall be paid by each hospital subject to the fee to the  
40 department for deposit in the Hospital Quality Assurance Revenue

1 Fund. Deposits may be accepted at any time and will be credited  
2 toward the fiscal year for which they were assessed.

3 (e) This section shall become inoperative if the federal Centers  
4 for Medicare and Medicaid Services denies approval for, or does  
5 not approve before January 1, 2012, the implementation of this  
6 article or Article 5.21 (commencing with Section 14167.1), and  
7 either or both articles cannot be modified by the department  
8 pursuant to subdivision (e) of Section 14167.35 in order to meet  
9 the requirements of federal law or to obtain federal approval.

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

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

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

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

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

- 1 (j) The department shall work in consultation with the hospital  
2 community to implement the quality assurance fee.
- 3 (k) This subdivision creates a contractually enforceable promise  
4 on behalf of the state to use the proceeds of the quality assurance  
5 fee, including any federal matching funds, solely and exclusively  
6 for the purposes set forth in this article as they existed on the  
7 effective date of this article, to limit the amount of the proceeds  
8 of the quality assurance fee to be used to pay for the health care  
9 coverage of children to the amounts specified in this article and  
10 to make any payments for the department’s costs of administration  
11 to the amounts set forth in this article on the effective date of this  
12 article to maintain and continue prior reimbursement levels as set  
13 forth in Article 5.21 (commencing with Section 14167.1) on the  
14 effective date of that article, and to otherwise comply with all its  
15 obligations set forth in Article 5.21 (commencing with Section  
16 14167.1) and this article provided that the following amendments  
17 to this article or Article 5.21 (commencing with Section 14167.1)  
18 made during the 2010 portion of the 2009–10 Regular Session  
19 shall control for purposes of this section:
- 20 (1) Amendments affecting the timing of the fee to be imposed  
21 or the payments to be made to a hospital or hospital group.
- 22 (2) Amendments affecting the amount of fee to be imposed on  
23 a hospital or hospital group, or the amount or method of payments  
24 to be made to any hospital or hospital group that are contained in  
25 Assembly Bill 1653, if enacted in the 2009–10 Regular Session,  
26 or arise from, or have as a basis, a decision, advice, or  
27 determination by the federal Centers for Medicare and Medicaid  
28 Services relating to federal approval of the Quality Assurance Fee  
29 or the payments set forth in this article or Article 5.21 (commencing  
30 with Section 14167.1).
- 31 (l) For the purpose of this article, references to the receipt of  
32 notice by the state of federal approval of the implementation of  
33 this article shall refer to the last date that the state receives notice  
34 of all federal approval or waivers required for implementation of  
35 this article and Article 5.21 (commencing with Section 14167.1),  
36 subject to Section 14167.14.
- 37 (m) (1) Effective January 1, 2011, the rates payable to hospitals  
38 and managed health care plans under Medi-Cal shall be the rates  
39 then payable without the supplemental and increased capitation

1 payments set forth in Article 5.21 (commencing with Section  
2 14167.1).

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

8 SEC. 22. Section 14167.35 of the Welfare and Institutions  
9 Code is amended to read:

10 14167.35. (a) The Hospital Quality Assurance Revenue Fund  
11 is hereby created in the State Treasury.

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

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

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

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

37 (2) To pay for the health care coverage for children in the  
38 amount of eighty million dollars (\$80,000,000) for each quarter  
39 for which payments are made under Article 5.21 (commencing  
40 with Section 14167.1). In any quarter for which payments reflect

1 room under the upper payment limit that was available from prior  
2 or subsequent quarters, the prior or subsequent quarters shall  
3 constitute quarters for purposes of the payment for health care  
4 coverage for children required by this paragraph.

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

11 (4) To make increased capitation payments to managed health  
12 care plans pursuant to Article 5.21 (commencing with Section  
13 14167.1).

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

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

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

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

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

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

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

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

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

34 (i) Notwithstanding Chapter 3.5 (commencing with Section  
35 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
36 the department may implement this article or Article 5.21  
37 (commencing with Section 14167.1) by means of provider  
38 bulletins, all plan letters, or other similar instruction, without taking  
39 regulatory action. The department shall also provide notification  
40 to the Joint Legislative Budget Committee and to the appropriate

1 policy and fiscal committees of the Legislature within five working  
2 days when the above-described action is taken in order to inform  
3 the Legislature that the action is being implemented.

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

6 14167.352. (a) Notwithstanding any other provision of this  
7 article or Article 5.21 (commencing with Section 14167.1)  
8 requiring federal approvals, the department may impose and collect  
9 the quality assurance fee and may make payments under this article  
10 and Article 5.21 (commencing with Section 14167.1), including  
11 increased capitation payments, based upon ~~conditional~~ *receiving*  
12 *a letter from the federal Centers for Medicare and Medicaid*  
13 *Services or the United States Department of Health and Human*  
14 *Services that indicates likely federal approval*, but only if and to  
15 the extent that ~~conditional federal approval~~ *the letter* is sufficient  
16 as set forth in subdivision (b).

17 (b) In order for ~~conditional federal approval~~ *the letter* to be  
18 sufficient under this section, the director shall find that the  
19 ~~conditional federal approval~~ *letter* meets all of the following  
20 requirements:

21 (1) ~~The approval~~ *letter* is in writing and signed by an official  
22 of the federal Centers for Medicare and Medicaid Services or an  
23 official of the United States Department of Health and Human  
24 Services.

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

29 (3) ~~The conditional approval indicates that federal financial~~  
30 ~~participation will be available for the payments under Sections~~  
31 ~~14167.2, 14167.3, 14167.4, and 14167.6, and subdivision (d) of~~  
32 ~~Section 14167.5, including, but not limited to, supplemental~~  
33 ~~payments and increased capitation payments, subject only to any~~  
34 ~~applicable federal limitations on reimbursement and conditions,~~  
35 ~~such as formal approval of state plan or waiver amendments, that~~  
36 ~~are set forth in the conditional approval.~~

37 (4)

38 (2) The director, after consultation with the hospital community,  
39 has determined, in the exercise of his or her sole discretion, that  
40 the ~~conditional federal approval~~ *letter* provides a sufficient level



1 of assurance to justify advanced implementation of the fee and  
2 payment provisions.

3 (c) Nothing in this section shall be construed as modifying the  
4 requirement under Section 14167.14 that payments shall be made  
5 only to the extent a sufficient amount of funds collected as the  
6 quality assurance fee are available to cover the nonfederal share  
7 of those payments.

8 (d) (1) Upon notice from the federal government that final  
9 federal approval for the fee model under this article or for any  
10 payment method under Article 5.21 (commencing with Section  
11 14167.1) has been denied, any fees collected pursuant to this  
12 section shall be refunded and any payments made pursuant to this  
13 article or Article 5.21 (commencing with Section 14167.1) shall  
14 be recouped, including, but not limited to, supplemental payments,  
15 increased capitation payments, payments to hospitals by health  
16 care plans resulting from the increased capitation payments, grants,  
17 increased payments, and payments for the health care coverage of  
18 children. To the extent fees were paid by a hospital that also  
19 received payments under this section, the payments may first be  
20 recouped from fees that would otherwise be refunded to the hospital  
21 prior to the use of any other recoupment method allowed under  
22 law.

23 (e) Any payment made pursuant to this section shall be a  
24 conditional payment until all final federal approvals necessary to  
25 fully implement this article and Article 5.21 (commencing with  
26 Section 14167.1) have been received.

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

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

33 (2) The dates on which payments of the quality assurance fee  
34 are due.

35 (g) The department may draw against the Hospital Quality  
36 Assurance Revenue Fund for all administrative costs associated  
37 with implementation under this article or Article 5.21 (commencing  
38 with Section 14167.1).

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

4 SEC. 24. Section 14167.353 is added to the Welfare and  
5 Institutions Code, to read:

6 14167.353. (a) Notwithstanding any other provision of law,  
7 the director shall have discretion to modify any timeline or  
8 timelines in this article or Article 5.21 (commencing with Section  
9 14167.1) ~~if all federal approvals required by the applicable articles~~  
10 ~~are the letter that indicates likely federal approval, as described~~  
11 ~~in Section 14167.352, is not secured on a conditional or final basis~~  
12 by September 1, 2010, and the director determines that it is  
13 impossible from an operational perspective to implement a timeline  
14 or timelines without the modification.

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

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

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

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

26 14167.354. (a) (1) Upon receipt of ~~conditional~~ *a letter that*  
27 *indicates likely* federal approval that the director determines is  
28 sufficient for implementation under Section 14167.352, or upon  
29 the receipt of all final federal approvals necessary for the  
30 implementation of this article and Article 5.21 (commencing with  
31 Section 14167.1) ~~if sufficient conditional approval is not received~~  
32 ~~by the department,~~, the following shall occur:

33 (A) To the maximum extent possible, and consistent with the  
34 availability of funds in the Hospital Quality Assurance Revenue  
35 Fund, the department shall make all of the payments under Sections  
36 14167.2, 14167.3, 14167.4, ~~and 14167.6~~ 14167.6, and 14167.11,  
37 and subdivision (d) of Section 14167.5, including, but not limited  
38 to, supplemental payments and increased capitation payments,  
39 prior to January 1, 2011.

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

5 (2) (A) In determining the amount available for the nonfederal  
6 share of payments in a particular payment cycle, the department  
7 shall deduct no more than the following amounts to account for  
8 the priority payments to the state under paragraph (2) of subdivision  
9 (c) of Section 14167.35:

10 (i) Eighty million dollars (\$80,000,000) for children’s health  
11 coverage for each quarter for which some or all supplemental  
12 payments to hospitals have already been made.

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

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

23 (B) Notwithstanding any other provision of law, in determining  
24 the amount available for the nonfederal share of payments in a  
25 payment cycle described in subparagraph (A), the department shall  
26 not consider any payments for children’s health care coverage  
27 previously made under paragraph (2) of subdivision (c) of Section  
28 14167.35.

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

33 (i) Seventy-three million seven hundred fifty thousand dollars  
34 (\$73,750,000) for each quarter for which some or all supplemental  
35 payments to hospitals have already been made.

36 (ii) Seventy-three million seven hundred fifty thousand dollars  
37 (\$73,750,000) for each quarter for which supplemental payments  
38 are being calculated to be paid to hospitals, subject to the  
39 availability of funding, in the current payment cycle.

1 (iii) Seventy-three million seven hundred fifty thousand dollars  
2 (\$73,750,000) for each quarter for which room under the upper  
3 payment limit for private hospitals for hospital inpatient services  
4 was used or will be used in calculating payments in the current  
5 payment cycles where the quarters were not already accounted for  
6 in clause (i) or (ii).

7 (B) Notwithstanding any other provision of law, in determining  
8 the amount available for a payment cycle described in subparagraph  
9 (A), the department shall not consider any payments of direct  
10 grants previously made to the designated public hospitals or  
11 transferred to the state from the Quality Assurance Revenue Fund  
12 under Section 14167.5 to account for the direct grants described  
13 in Section 14167.5.

14 (b) Notwithstanding any other provision of this article or Article  
15 5.21 (commencing with Section 14167.1), if the director  
16 determines, on or after December 15, 2010, that there are  
17 insufficient funds available in the Hospital Quality Assurance  
18 Revenue Fund to make all scheduled payments under Article 5.21  
19 (commencing with Section 14167.1) by the end of the 2010  
20 calendar year, he or she shall consult with representatives of the  
21 hospital community to develop an acceptable plan for making  
22 additional payments to providers in the first two quarters of 2011  
23 to maximize the use of delinquent fee payments or other deposits  
24 or interest projected to become available in the fund after December  
25 15, 2010, but before June 30, 2011.

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

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

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

39 (f) Nothing in this section shall be read as affecting the  
40 department's ongoing authority to continue, after December 31,

1 2010, to collect quality assurance fees imposed on or before  
2 December 31, 2010.

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

5 14167.355. Notwithstanding any other provision of law, if  
6 ~~conditional~~ *the letter that indicates likely* federal approval ~~under~~  
7 *in accordance with* Section 14167.352 has not been ~~obtained~~  
8 *received* on or before December 1, 2010, then this article shall  
9 become inoperative, and as of December 1, 2010, ~~are is~~ repealed,  
10 unless a later enacted statute, that is enacted before December 1,  
11 2010, deletes or extends that date.

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

14 14167.36. (a) This article shall only be implemented so long  
15 as the following conditions are met:

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

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

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

25 (b) No hospital shall be required to pay the quality assurance  
26 fee to the department unless and until the state receives and  
27 maintains federal approval of the quality assurance fee and Article  
28 5.21 (commencing with Section 14167.1) from the federal Centers  
29 for Medicare and Medicaid Services.

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

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

35 (2) Article 5.21 (commencing with Section 14167.1) is enacted  
36 and remains in effect and hospitals are reimbursed the increased  
37 rates beginning on the implementation date, as defined in Section  
38 14167.1.

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

4 (d) This article shall become inoperative if either of the  
5 following occurs:

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

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

12 (A) The federal Centers for Medicare and Medicaid Services  
13 denies approval for, or does not approve before January 1, 2012,  
14 the implementation of Article 5.21 (commencing with Section  
15 14167.1) or this article.

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

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

25 (f) This article and Article 5.21 (commencing with Section  
26 14167.1) shall not be implemented with respect to the 2009–10  
27 and 2010–11 federal fiscal years until the earlier of April 30, 2010,  
28 or the date the federal government approves a federal waiver for  
29 a demonstration that will replace the Current Section 1115 Waiver,  
30 as defined in subdivision (c) of Section 14167.1.

31 (g) (1) In the event that all necessary final federal approvals  
32 are not received as described and anticipated under this article or  
33 under Article 5.21 (commencing with Section 14167.1), the director  
34 shall have the discretion and authority to develop procedures for  
35 recoupment from managed health care plans, and from hospitals  
36 under contract with managed health care plans, of any amounts  
37 received pursuant to this article or Article 5.21 (commencing with  
38 Section 14167.1).

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

4 (3) Any procedure instituted pursuant to this subdivision shall  
5 be in addition to all other remedies made available under the law,  
6 pursuant to contracts between the department and the managed  
7 health care plans, or pursuant to contracts between the managed  
8 health care plans and the hospitals.

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

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

16

17

18 **CORRECTIONS:**

19 **Text—Pages 11, 22, 56, and 58.**

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