Assembly Bill No. 1653

Passed the Assembly August 30, 2010

Chief Clerk of the Assembly

Passed the Senate August 27, 2010

Secretary of the Senate

This bill was received by the Governor this _____ day of _____, 2010, at _____ o'clock ___M.

Private Secretary of the Governor

Corrected 9-7-10

CHAPTER _____

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, 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Existing law provides that these provisions shall remain in effect only until January 1, 2013, and as of that date are repealed.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 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 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 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 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 letter indicating likely federal approval is not 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, subject to certain conditions, 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 provisions shall be allocated to the designated public hospitals.

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

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

SECTION 1. Section 14158.1 is added to the Welfare and Institutions Code, to read:

14158.1. Effective for expenditures incurred after enactment of any new demonstration project under Article 5.4 (commencing with Section 14180), any federal financial participation that is available under the federal Medicaid Program, or any related waiver or demonstration project, based on the certified public expenditures of designated public hospitals, as defined in subdivision (d) of Section 14166.1, or the governmental entities with which they are affiliated, shall be paid to designated public hospitals or the governmental entities with which they are affiliated.

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

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

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

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

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

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

(3) To the extent not included in paragraph (1) or (2), the amount of the increase in state General Fund expenditures for Medi-Cal inpatient hospital services for the project year for project year private DSH hospitals and nondesignated public hospitals, including amounts expended in accordance with paragraph (1) of subdivision (c) of Section 14166.23, that exceeds the expenditure amount for the same purpose and the same hospitals necessary to provide the aggregate baseline funding amounts applicable to the project determined pursuant to Sections 14166.13 and 14166.18,

and any direct grants to designated public hospitals for services under the demonstration project.

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

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

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

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

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

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

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

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

(D) In the event that stabilization funding is less than one hundred forty-seven million dollars ($147,000,000), the amounts allocated to designated public hospitals, private DSH hospitals,

and nondesignated public hospitals under this paragraph shall be reduced proportionately.

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

(B) Notwithstanding subparagraph (A) and solely for the 2006–07 fiscal year, if the amount that otherwise would be made available for additional payments to distressed hospitals under subparagraph (A) is equal to or greater than eighteen million three hundred thousand dollars ($18,300,000), that amount shall be reduced by eighteen million three hundred thousand dollars ($18,300,000) and the state's obligation to make these payments shall be reduced by this amount. In the event the amount that otherwise would be made available under subparagraph (A) is less than eighteen million three hundred thousand dollars ($18,300,000), but greater than or equal to the minimum amount of fifteen million three hundred thousand dollars ($15,300,000), then the amount available under this paragraph shall be zero and the state's obligation to make these payments shall be zero.

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

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

(5) The amount remaining after subtracting the amount determined in paragraphs (1) and (2), subparagraph (A) of paragraph (3), and paragraph (4), without taking into account

subparagraphs (B) and (C) of paragraph (3), shall be allocated as follows:

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

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

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

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

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

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

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

(C) In addition to adjustments required in subparagraphs (A) and (B), the department shall adjust amounts paid or payable to designated public hospitals by any applicable deferrals or disallowances identified by the federal Centers for Medicare and Medicaid Services as of the date the determination is made under

subdivision (c) not otherwise reflected in subparagraphs (A) and (B).

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

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

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

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

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

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

14166.221. (a) It is the intent of the Legislature for the department to maximize the receipt of federal funds for California's Medi-Cal program, including this demonstration project, by identifying state resources which will enable the state to obtain additional federal reimbursement during this unprecedented fiscal crisis. It is further the intent of the Legislature that any program

identified by the department for the purposes specified in this section shall not be modified or altered in any manner unless subsequent statutory authority is expressly provided by the Legislature.

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

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

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

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

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

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

(d) Any amounts received in the 2008–09, 2009–10, and 2010–11 fiscal years from the federal government pursuant to additional demonstration project funding as specified in this section shall be deposited in the Federal Trust Fund. Notwithstanding Section 28.00 of the Budget Act of 2009, the Department of Finance may authorize expenditure of these funds in a manner

consistent with federal law and that offsets General Fund expenditures otherwise authorized in the Budget Act of 2009 for the Medi-Cal program, and as appropriated in Item 4260-101-0001, or for the Health Care Support Fund. For any adjustments made under the authority provided for by this section, the Department of Finance shall provide notification in writing to the Chairperson of the Joint Legislative Budget Committee not less than 30 days prior to the effective date of the adjustment, or not sooner than whatever lesser time the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may in each instance determine. The notification to the chairperson of the joint committee shall include, at a minimum, the amounts of the proposed appropriation adjustments, a description of any assumptions used in making the adjustments, the relevant federal authority, and any other clarifying description as relevant.

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

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

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

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

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

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

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

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

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

(4) The department is satisfied that the expenditures claimed under paragraph (3) of subdivision (g) represent valid expenditures for the purposes of federal financial participation under the Special Terms and Conditions for the demonstration project based on

federal law and guidance provided by the federal Centers for Medicare and Medicaid Services.

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

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

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

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

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

(c) The department shall promptly consult with the affected governmental entity regarding a dispute between a designated public hospital and the department regarding the validity of the hospital's certified public expenditures. If the department determines that the hospital's certification is valid, the department

shall submit the claim to obtain federal reimbursement for the certified expenditure in question.

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

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

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

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

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

(B) If the hospitals have additional certified public expenditures for which federal funds have not been received but for which federal funds could have been received under the demonstration project had additional federal funds been available, including federal funds made available under an extension of the demonstration project, the state shall first be allowed to respond to a deferral or disallowance based on the certified public expenditures of designated public hospitals, or the governmental

entities with which they are affiliated, by substituting the additional certified public expenditures for those deferred or disallowed.

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

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

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

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

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

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

(2) For each of the 2005–06 and 2006–07 project years, in the event that the one hundred eighty million dollars ($180,000,000) identified in paragraph 41 of the Special Terms and Conditions for the demonstration project is available in the safety net care pool for the project year, the lower of twenty-three million dollars ($23,000,000) or 7.67 percent of the amount identified in subdivision (a) to the County of Los Angeles, Department of Health

Services, hospitals. If an amount less than the one hundred eighty million dollars ($180,000,000) is available during the project year, the amount determined under this paragraph shall be reduced proportionately.

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

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

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

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

(C) The amount of federal financial participation received by each designated public hospital, and by the governmental entity, nonhospital clinics, and other provider types with which it is affiliated, based on certified public expenditures from the federal disproportionate share hospital allotment pursuant to paragraph (1) of subdivision (b) of Section 14166.6, and from the safety net care pool payments pursuant to subdivision (a) of Section 14166.7 shall be identified. With respect to this identification, if a payment adjustment for a hospital has been made pursuant to paragraph (2) of subdivision (f) of Section 14166.6, or paragraph (2) of subdivision (b) of Section 14166.7, the amount of federal financial participation received by the hospital based on certified public expenditures shall be determined as though no such payment adjustment had been made. The resulting amount shall be increased

by amounts distributed to the hospital pursuant to subdivision (c) of this section, paragraph (1) of subdivision (b) of Section 14166.20, and the initial allocation determined for the hospitals in subparagraph (A).

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

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

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

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

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

(2) Each designated public hospital for which, during the project year, the sum of the allowable costs incurred in rendering inpatient hospital services to Medi-Cal beneficiaries and the allowable costs incurred with respect to supplemental reimbursement for physician and nonphysician practitioner services rendered to Medi-Cal hospital inpatients, as specified in Section 14166.4, exceeds the

allowable costs incurred for those services rendered in the prior year, shall be allocated an amount equal to 60 percent of the difference in the allowable costs, multiplied by the applicable federal medical assistance percentage. The allocations under this paragraph, however, shall be reduced pro rata as necessary to ensure that the total of those allocations does not exceed 80 percent of the amount subject to this subdivision after the allocations in paragraph (1). For purposes of this paragraph, the most recent cost data that are available at the time of the department's determinations for the project year pursuant to Section 14166.20 shall be used.

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

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

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

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

(iii) The amount of federal financial participation received by each designated public hospital, and by the governmental entity, nonhospital clinics, and other provider types with which it is affiliated, based on certified public expenditures from the federal disproportionate share hospital allotment pursuant to paragraph (1) of subdivision (b) of Section 14166.6, and from the safety net

care pool payments pursuant to subdivision (a) of Section 14166.7 shall be identified. With respect to this identification, if a payment adjustment for a hospital has been made pursuant to paragraph (2) of subdivision (f) of Section 14166.6, or paragraph (2) of subdivision (b) of Section 14166.7, the amount of federal financial participation received by the hospital based on certified public expenditures shall be determined as though no payment adjustment had been made. The resulting amount shall be increased by amounts distributed to the hospital pursuant to subdivision (c), paragraphs (1) and (2) of this subdivision, paragraph (1) of subdivision (b) of Section 14166.20, and the initial allocation determined for the hospitals in clause (i).

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

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

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

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

(f) The department shall consult with designated public hospital representatives regarding the appropriate distribution of stabilization funding before stabilization funds are allocated and paid to hospitals. No later than 30 days after this consultation, the department shall issue a final allocation of stabilization funding under this section that shall not be modified for any reason other

than mathematical errors or mathematical omissions on the part of the department.

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

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

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

(b) "Converted hospital" means a private hospital that becomes a designated public hospital or a nondesignated public hospital after the implementation date, a nondesignated public hospital that becomes a private hospital or a designated public hospital after the implementation date, or a designated public hospital that becomes a private hospital or a nondesignated public hospital after the implementation date.

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

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

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

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

(g) "Hospital inpatient services" means all services covered under Medi-Cal and furnished by hospitals to patients who are admitted as hospital inpatients and reimbursed on a fee-for-service basis by the department directly or through its fiscal intermediary. Hospital inpatient services include outpatient services furnished by a hospital to a patient who is admitted to that hospital within

24 hours of the provision of the outpatient services that are related to the condition for which the patient is admitted. Hospital inpatient services do not include services for which a managed health care plan is financially responsible.

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

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

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

(j) "Individual hospital acute psychiatric supplemental payment" means the total amount of acute psychiatric hospital supplemental payments to a subject hospital for a quarter for which the supplemental payments are made. The "individual hospital acute psychiatric supplemental payment" shall be calculated for subject hospitals by multiplying the number of acute psychiatric days for

the individual hospital for which a mental health plan was financially responsible by four hundred eighty-five dollars ($485) and dividing the result by 4.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(p) "Nondesignated public hospital" means either of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

federal fiscal year and shall result in payments to hospitals that equal the applicable federal upper payment limit.

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

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

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

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

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

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

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

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

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

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

(2) Four hundred eighty-five dollars ($485) multiplied by the hospital's acute psychiatric days that were paid directly by the

department and were not the financial responsibility of a mental health plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Four hundred eighty-five dollars ($485) multiplied by the hospital's acute psychiatric days that were paid directly by the

department and were not the financial responsibility of a mental health plan.

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

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

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

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

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

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

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

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

(A) Federal approval shall be sought after all final federal approvals necessary to implement this article and Article 5.22

(commencing with Section 14167.31) are received by the department.

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

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

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

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

(b) The director shall allocate the amount specified in subdivision (a) among the designated public hospitals in accordance with this subdivision. In determining the allocation, the director shall rely on data from the Interim Hospital Payment Rate Workbooks. For purposes of this section, “Interim Hospital Payment Rate Workbook” means the Interim Hospital Payment Rate Workbook, developed by the department and approved by the federal Centers for Medicare and Medicaid Services for use in connection with the Medi-Cal Hospital/Uninsured Care 1115 Waiver Demonstration, as submitted by each designated public

hospital, or the governmental entity with which the hospital is affiliated, on or around June 2009 for the period of July 1, 2007, to June 30, 2008, inclusive.

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

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

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

(d) Designated public hospitals shall be paid supplemental Medi-Cal amounts for acute inpatient psychiatric services that are paid directly by the department and are not the financial responsibility of a mental health plan, as set forth in this subdivision. The supplemental amounts shall be in addition to any

other amounts payable to designated public hospitals, or a governmental entity with which the hospital is affiliated, with respect to those services and shall not affect any other payments to hospitals or to any governmental entity with which the hospital is affiliated.

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

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

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

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

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

(e) Notwithstanding subdivision (a) and subject to subdivisions (g) and (h) of Section 14166.221, the state may retain for the state's use the funds described in subdivision (a) that would otherwise be payable pursuant to subdivision (c) of Section 14167.9 in an aggregate amount not to exceed four hundred twenty million dollars ($420,000,000) for the period in which this article and Article 5.22 (commencing with Section 14167.31) are in effect, provided that the state allocates to the designated public hospitals an equal amount of federal funds available under the Medi-Cal

Hospital/Uninsured Care Demonstration Project pursuant to subdivision (c) of Section 14166.221, and the state has determined, after consultation with the designated public hospitals, that the designated public hospitals, or the governmental entities with which they are affiliated, have incurred sufficient expenditures so that the full amount allocated can be received as federal matching funds. Federal funds allocated to the designated public hospitals under this subdivision and claimed under subdivision (g) of Section 14166.221 shall be distributed among the designated public hospitals in accordance with subdivision (b).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) The amount of each payment made pursuant to this subdivision shall be one-seventh of the amount of payments

calculated for each hospital under Sections 14167.2, 14167.3, 14167.4, and subdivision (d) of Section 14167.5.

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

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

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

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

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

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

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

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

(b) For each subject federal fiscal year, the sum of all expenditures made by a managed health care plan for hospital services pursuant to this section shall equal, or approximately equal, all increased capitation payments received by the managed

health care plan, consistent with actuarial certification, enrollment, and utilization, from the department pursuant to Section 14167.6.

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

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

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

(b) For each fiscal quarter that begins on or after the implementation date, the state shall make increased payments to each mental health plan. The department shall consider the composition of Medi-Cal enrollees in the mental health plan, the anticipated utilization of hospital services by the mental health plan's Medi-Cal enrollees, and other factors that the department determines are reasonable and appropriate to ensure access to high-quality hospital services by the mental health plan's enrollees.

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

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

(2) The increased payments made for the first quarter for which increased payments are made under this section shall include the

sum of increased payments for all prior quarters for which payments are due under subdivision (b).

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

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

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

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

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

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

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

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

14167.12. (a) At the same time that the state makes an increased payment to a mental health plan under Section 14167.11, the state shall notify the mental health plan that the plan shall make payments to each subject hospital located in each county in which

the mental health plan operates as a consequence of receiving the increased payment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) (1) The director shall negotiate the federal approvals required to implement this article and Article 5.22 (commencing with Section 14167.31) for the 2009–10 and 2010–11 federal fiscal years concurrently with the negotiation of a federal waiver that will replace the Current Section 1115 Waiver, with a goal of obtaining federal approvals that do not adversely impact the federal funds that would otherwise be available for services to Medi-Cal beneficiaries and the uninsured. The director may initiate the

concurrent negotiations required by this subdivision by submitting a concept paper to the federal Centers for Medicare and Medicaid Services outlining the key elements of the replacement waiver consistent with the goals set forth in this subdivision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) "Aggregate quality assurance fee after the application of the fee percentage" shall be determined separately for each subject

federal fiscal year and means the aggregate annual quality assurance fee multiplied by the fee percentage for the subject federal fiscal year.

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

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

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

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

(e) "Converted hospital" shall mean a hospital described in subdivision (b) of Section 14167.1.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(k) "Fee-for-service days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "chemical dependency care and rehabilitation care," and the payer category is reported as "Medicare traditional," "county indigent programs–traditional," "other third parties–traditional," "other indigent," and "other payers," for purposes of the Annual Financial

Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

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

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

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

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

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

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

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

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

(t) "Medi-Cal per diem quality assurance fee rate" means a fixed fee on Medi-Cal days of two hundred thirty-two dollars ($232) per day.

(u) "Nondesignated public hospital" means either of the following:

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

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

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

(w) "Prepaid health plan hospital managed care per diem quality assurance fee rate" means a fixed fee on non-Medi-Cal managed

care days for prepaid health plan hospitals of twelve dollars and sixty cents ($12.60) per day.

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

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

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

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

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

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

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

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

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

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

14167.32. (a) There shall be imposed on each general acute care hospital that is not an exempt facility a quality assurance fee,

as a condition of participation in state-funded health insurance programs, other than the Medi-Cal program, provided that a quality assurance fee under this article shall not be imposed on a converted hospital for a subject federal fiscal year in which the hospital becomes a converted hospital or for subsequent federal fiscal years.

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

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

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

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

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

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

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

(B) The aggregate quality assurance fee.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(k) This subdivision creates a contractually enforceable promise on behalf of the state to use the proceeds of the quality assurance fee, including any federal matching funds, solely and exclusively for the purposes set forth in this article as they existed on the effective date of this article, to limit the amount of the proceeds of the quality assurance fee to be used to pay for the health care coverage of children to the amounts specified in this article and to make any payments for the department's costs of administration to the amounts set forth in this article on the effective date of this article to maintain and continue prior reimbursement levels as set forth in Article 5.21 (commencing with Section 14167.1) on the effective date of that article, and to otherwise comply with all its obligations set forth in Article 5.21 (commencing with Section 14167.1) and this article provided that the following amendments to this article or Article 5.21 (commencing with Section 14167.1) made during the 2010 portion of the 2009–10 Regular Session shall control for purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code,

the department may implement this article or Article 5.21 (commencing with Section 14167.1) by means of provider bulletins, all plan letters, or other similar instruction, without taking regulatory action. The department shall also provide notification to the Joint Legislative Budget Committee and to the appropriate policy and fiscal committees of the Legislature within five working days when the above-described action is taken in order to inform the Legislature that the action is being implemented.

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

14167.352. (a) Notwithstanding any other provision of this article or Article 5.21 (commencing with Section 14167.1) requiring federal approvals, the department may impose and collect the quality assurance fee and may make payments under this article and Article 5.21 (commencing with Section 14167.1), including increased capitation payments, based upon 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 letter is sufficient as set forth in subdivision (b).

(b) In order for the letter to be sufficient under this section, the director shall find that the letter meets all of the following requirements:

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

(2) The director, after consultation with the hospital community, has determined, in the exercise of his or her sole discretion, that the letter provides a sufficient level of assurance to justify advanced implementation of the fee and payment provisions.

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

(d) (1) Upon notice from the federal government that final federal approval for the fee model under this article or for any payment method under Article 5.21 (commencing with Section 14167.1) has been denied, any fees collected pursuant to this section shall be refunded and any payments made pursuant to this

article or Article 5.21 (commencing with Section 14167.1) shall be recouped, including, but not limited to, supplemental payments, increased capitation payments, payments to hospitals by health care plans resulting from the increased capitation payments, grants, increased payments, and payments for the health care coverage of children. To the extent fees were paid by a hospital that also received payments under this section, the payments may first be recouped from fees that would otherwise be refunded to the hospital prior to the use of any other recoupment method allowed under law.

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

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

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

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

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

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

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

14167.353. (a) Notwithstanding any other provision of law, the director shall have discretion to modify any timeline or timelines in this article or Article 5.21 (commencing with Section 14167.1) if the letter that indicates likely federal approval, as described in Section 14167.352, is not secured by September 1, 2010, and the director determines that it is impossible from an operational perspective to implement a timeline or timelines without the modification.

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

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

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

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

14167.354. (a) (1) Upon receipt of a letter that indicates likely federal approval that the director determines is sufficient for implementation under Section 14167.352, or upon the receipt of all final federal approvals necessary for the implementation of this article and Article 5.21 (commencing with Section 14167.1), the following shall occur:

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

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

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

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

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

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

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

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

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

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

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

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

(b) Notwithstanding any other provision of this article or Article 5.21 (commencing with Section 14167.1), if the director determines, on or after December 15, 2010, that there are insufficient funds available in the Hospital Quality Assurance

Revenue Fund to make all scheduled payments under Article 5.21 (commencing with Section 14167.1) by the end of the 2010 calendar year, he or she shall consult with representatives of the hospital community to develop an acceptable plan for making additional payments to providers in the first two quarters of 2011 to maximize the use of delinquent fee payments or other deposits or interest projected to become available in the fund after December 15, 2010, but before June 30, 2011.

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

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

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

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

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

14167.355. Notwithstanding any other provision of law, if the letter that indicates likely federal approval in accordance with Section 14167.352 has not been received on or before December 1, 2010, then this article shall become inoperative, and as of December 1, 2010, is repealed, unless a later enacted statute, that is enacted before December 1, 2010, deletes or extends that date.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) If this article becomes inoperative pursuant to paragraph (1) of subdivision (d) and the determination applies to any period or

periods of time prior to the effective date of the determination, the department may recoup all payments made pursuant to Article 5.21 (commencing with Section 14167.1) during that period or those periods of time.

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

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

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

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

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

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

Approved _____, 2010

_____

Governor