

Assembly Bill No. 498

Passed the Assembly September 12, 2013

Chief Clerk of the Assembly

Passed the Senate September 12, 2013

Secretary of the Senate

This bill was received by the Governor this _____ day
of _____, 2013, at _____ o'clock ____M.

Private Secretary of the Governor

CHAPTER _____

An act to amend Sections 14105.27 and 14166.151 of, and to repeal Sections 14166.152, 14166.153, 14166.154, and 14166.155 of, the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 498, Chávez. Medi-Cal.

(1) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. Existing law provides that a health facility is eligible to receive supplemental reimbursement under the Medi-Cal program if the facility has specified characteristics, including that the facility is owned or operated by the state, a county, a city, a city and county, or a health care district. Existing law prohibits claimed expenditures for specified nursing facility services, when combined with the amount received from all other sources of reimbursement from the Medi-Cal program, from exceeding 100% of projected costs, as determined pursuant to the Medi-Cal State Plan, for skilled nursing services at each facility.

This bill would, instead, prohibit those claimed expenditures from exceeding 100% of allowable costs. The bill would require that supplemental reimbursement be subject to a reconciliation process established in the state plan to ensure that supplemental reimbursement is not made in excess of allowable costs, and to ensure that it is made up to allowable costs.

(2) The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law, subject to federal approval, modifies the inpatient fee-for-service reimbursement methodology for nondesignated public hospitals, as defined, under a specified demonstration project for services on or after July 1, 2012. Existing law provides that beginning with the 2012–13 fiscal year, and if specified conditions are met, nondesignated public hospitals, or governmental entities with which the hospitals are affiliated, shall be eligible to receive safety net care pool payments for uncompensated care from the Health Care Support Fund. Existing law provides that these provisions

shall become operative on the date that all necessary federal approvals have been obtained to implement these and other related provisions. Existing law requires designated public hospitals to report and certify specified information for each successor demonstration year beginning with the 2012–13 fiscal year.

This bill would revise and recast those provisions. This bill would instead authorize the department to seek necessary federal approvals or waivers to separately implement the safety net care pool payments for uncompensated care provisions for the 2013–14 and 2014–15 fiscal years. The bill would require the state, if the state receives federal safety net care pool funds for uncompensated care under these provisions, to retain $\frac{1}{2}$ of the funds for Medi-Cal related expenditures.

(3) Under existing law, nondesignated public hospitals may receive fee-for-service payments for inpatient services, as specified. Under existing law, beginning with the 2012–13 fiscal year, subject to federal approval and if specified conditions are met, nondesignated public hospitals may receive delivery system reform incentive pool funding, as specified.

This bill would eliminate those provisions.

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

SECTION 1. Section 14105.27 of the Welfare and Institutions Code is amended to read:

14105.27. (a) Each eligible facility, as described in subdivision (b) may, in addition to the rate of payment that the facility would otherwise receive for skilled nursing services, receive supplemental Medi-Cal reimbursement to the extent provided in this section.

(b) A facility shall be eligible for supplemental reimbursement only if the facility has all of the following characteristics continuously during the department’s rate year:

- (1) Provides services to Medi-Cal beneficiaries.
- (2) Is either of the following:

(A) For the department’s rate year beginning August 1, 2001, and for subsequent rate years, a distinct part of an acute care hospital providing skilled nursing services. For purposes of this section, “acute care hospital” means a facility described by subdivision (a) or (b), or both, of Section 1250 of the Health and Safety Code.

(B) For the department's rate year beginning August 1, 2006, and for subsequent rate years, a state home, as defined in Section 101 (19) of Title 38 of the United States Code.

(3) Is owned or operated by the state, or by a county, city, city and county, or health care district organized pursuant to Chapter 1 (commencing with Section 32000) of Division 23 of the Health and Safety Code.

(c) An eligible facility's supplemental reimbursement pursuant to this section shall be calculated and paid as follows:

(1) The supplemental reimbursement to an eligible facility, as described in paragraph (4), shall be equal to the amount of federal financial participation received as a result of the claims submitted pursuant to paragraph (2) of subdivision (g).

(2) In no instance shall the amount certified pursuant to paragraph (1) of subdivision (e), when combined with the amount received from all other sources of reimbursement from the Medi-Cal program, exceed 100 percent of allowable costs, as determined pursuant to the Medi-Cal State Plan, for distinct part skilled nursing services at each facility.

(3) Costs associated with the provision of subacute services pursuant to Section 14132.25 shall not be certified for supplemental reimbursement pursuant to this section.

(4) The supplemental Medi-Cal reimbursement provided by this section shall be distributed under a payment methodology based on skilled nursing services provided to Medi-Cal patients at the eligible facility, either on a per diem basis, a per discharge basis, or any other federally permissible basis. The department shall seek approval from the federal Centers for Medicare and Medicaid Services for the payment methodology to be utilized, and shall not make any payment pursuant to this section prior to obtaining that approval.

(d) (1) It is the Legislature's intent in enacting this section to provide the supplemental reimbursement described in this section without any expenditure from the General Fund. An eligible facility, as a condition of receiving supplemental reimbursement pursuant to this section, shall enter into, and maintain, an agreement with the department for the purposes of implementing this section and reimbursing the department for the costs of administering this section.

(2) The state share of the supplemental reimbursement submitted to the federal Centers for Medicare and Medicaid Services for purposes of claiming federal financial participation shall be paid only with funds from the governmental entities described in paragraph (3) of subdivision (b) and certified to the state as provided in subdivision (e).

(e) The particular governmental entity, described in paragraph (3) of subdivision (b), on behalf of any eligible facility shall do all of the following:

(1) Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for distinct part nursing facility services are eligible for federal financial participation.

(2) Provide evidence supporting the certification as specified by the department.

(3) Submit data as specified by the department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation.

(4) Keep, maintain, and have readily retrievable, any records specified by the department to fully disclose reimbursement amounts to which the eligible facility is entitled, and any other records required by the federal Centers for Medicare and Medicaid Services.

(f) The department may require that any governmental entity, described in paragraph (3) of subdivision (b), seeking supplemental reimbursement under this section enter into an interagency agreement with the department for the purpose of implementing this section.

(g) (1) The department shall promptly seek any necessary federal approvals, including a federal medicaid waiver, for the implementation of this section. If necessary to obtain federal approval, the department may limit the program to those costs that are allowable expenditures under Title XIX of the federal Social Security Act (Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code). If federal approval is not obtained for implementation of this section, this section shall become inoperative.

(2) The department shall submit claims for federal financial participation for the expenditures for the services described in subdivision (e) that are allowable expenditures under federal law.

(3) The department shall, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.

(h) In the event there is a final judicial determination by any court of appellate jurisdiction or a final determination by the administrator of the federal Centers for Medicare and Medicaid Services that the supplemental reimbursement provided in this section must be made to any facility not described in this section, this section shall become immediately inoperative.

(i) All funds expended pursuant to this section are subject to review and audit by the department.

(j) Supplemental reimbursement made pursuant to this section shall be subject to a reconciliation process established in the Medi-Cal State Plan to ensure that it is not made in excess of allowable costs, and to ensure that it is made up to allowable costs.

SEC. 2. Section 14166.151 of the Welfare and Institutions Code is amended to read:

14166.151. (a) It is the intent of the Legislature to allow for a voluntary process for nondesignated public hospitals to claim reimbursement from the safety net care pool in the successor demonstration project based on their public structure, to the extent that there is funding available for nondesignated public hospitals in that pool, as allowed by the federal government, which shall be allocated equally between the state and the nondesignated public hospital, so that for every dollar of certified public expenditure used by the nondesignated public hospital, the nondesignated public hospital shall voluntarily allow the state to use a corresponding certified public expenditure amount for claiming purposes.

(b) (1) Beginning with services provided on or after July 1, 2013, nondesignated public hospitals shall be eligible to receive safety net care pool payments for uncompensated care costs to the extent that additional federal funding is made available pursuant to the Special Terms and Conditions for the safety net care pool uncompensated care limit of the successor demonstration project and if they comply with the requirements set forth in this section.

(2) The amount of funds that may be claimed pursuant to paragraph (1) shall not exceed the additional federal funding made available under the safety net care pool for nondesignated public hospital uncompensated care costs, and shall not reduce the

amounts of federal funding for safety net care pool uncompensated care costs that would otherwise be made available to designated public hospitals in the absence of this paragraph, including the amounts available under the Special Terms and Conditions in effect as of July 1, 2013, and amounts available pursuant to Section 15916.

(3) (A) Notwithstanding paragraph (2), if the designated public hospitals do not have sufficient certified public expenditures to claim the full amount of federal funding made available to the designated public hospitals as referenced in paragraph (2), including consideration of the potential for the designated public hospitals to have sufficient certified public expenditures in a subsequent year, the department may authorize the funding to be claimed by the nondesignated public hospitals.

(B) The department may determine whether designated public hospitals do not have sufficient certified public expenditures to claim the full amount of federal funding pursuant to subparagraph (B) no sooner than after the submission of the cost reporting information required pursuant to Section 14166.8 for the applicable successor demonstration year.

(C) If the department makes the determination identified in subparagraph (B) based on as-filed cost reporting information submitted prior to a final audit, the department shall make the determination in consultation with the designated public hospitals and shall apply an audit cushion of at least 5 percent to the as-filed cost information. If the department makes the determination identified in subparagraph (B) based on audited cost reporting information, no audit cushion shall be applied.

(c) Beginning in the 2013–14 fiscal year, within five months after the end of a successor demonstration year, nondesignated public hospitals shall submit to the department all of the following reports:

(1) The hospital’s Medicare or Medicaid cost report for the successor demonstration year.

(2) Other cost reporting and statistical data necessary for the determination of amounts due to the hospital under the successor demonstration project, as requested by the department.

(d) For each successor demonstration year, the reports shall identify all of the costs incurred in providing hospital services to uninsured individuals.

(e) A nondesignated public hospital, or the governmental entity with which it is affiliated, that operates nonhospital clinics or provides physician, nonphysician practitioner, or other health care services that are not identified as hospital services under the Special Terms and Conditions for the successor demonstration project, shall report and certify all of the uncompensated uninsured costs of the services furnished.

(f) Reports submitted under this section shall include all allowable costs.

(g) The appropriate public official shall certify to all of the following:

(1) The accuracy of the reports required under this section.

(2) That the expenditures to meet the reported costs comply with Section 433.51 of Title 42 of the Code of Federal Regulations.

(3) That the sources of funds used to make the expenditures certified under this section do not include impermissible provider taxes or donations, as defined under Section 1396b(w) of Title 42 of the United States Code, or other federal funds. For this purpose, federal funds do not include delivery system reform incentive pool payments or patient care revenue received as payment for services rendered under programs such as nondesignated state health programs, the Low Income Health Program, Medicare, or Medicaid.

(h) The certification of public expenditures made pursuant to this section shall be based on a schedule established by the department in accordance with federal requirements.

(1) The director may require nondesignated public hospitals to submit quarterly estimates of anticipated expenditures, if these estimates are necessary to obtain interim payments of federal Medicaid funds.

(2) All reported expenditures shall be subject to reconciliation to allowable costs, as determined in accordance with applicable implementing documents for the successor demonstration project.

(i) The timeframes for data submission and reporting periods may be adjusted as necessary in accordance with federal requirements.

(j) (1) Beginning in the 2013–14 fiscal year, safety net care pool payments for uncompensated care shall be allocated to nondesignated public hospitals as follows:

(A) The department shall determine the maximum amount of safety net care pool payments for uncompensated care that is available to nondesignated public hospitals for the successor demonstration year pursuant to this section. This determination shall be made solely with respect to allowable uncompensated care costs incurred by nondesignated public hospitals and reported pursuant to subdivisions (c) to (i), inclusive.

(B) The department shall establish, in consultation with the nondesignated public hospitals, an allocation methodology to determine the amount of safety net care pool payments to be made to the nondesignated public hospitals. The allocation methodology shall be implemented when the director issues a declaration stating that the methodology complies with all applicable federal requirements for federal financial participation.

(2) A safety net care pool payment amount may be paid to a nondesignated public hospital, or governmental entity with which it is affiliated, pursuant to this section independent of the amount of uncompensated uninsured costs that is certified as public expenditures pursuant to subdivisions (c) to (i), inclusive, provided that, in accordance with the Special Terms and Conditions for the successor demonstration project, the recipient hospital shall not return any portion of the funds received to any unit of government, excluding amounts recovered by the state or federal government.

(3) Nondesignated public hospitals, or governmental entities with which they are affiliated, shall receive the amount established pursuant to this subdivision, less the 50 percent retained by the state pursuant to subdivision (l), in quarterly interim payments during the successor demonstration year. The determination of the interim payments shall be made on an interim basis prior to the start of each successor demonstration year. The department shall use the cost and statistical data that is in subdivisions (c) to (i), inclusive.

(k) (1) No later than April 1 following the end of the relevant reporting period for the successor demonstration year, the department shall undertake an interim reconciliation of the payment amount established pursuant to subdivision (j) for nondesignated public hospitals using Medicare and other cost, payment, and statistical data submitted by the hospitals for the successor demonstration year, and shall adjust payments to the hospitals accordingly.

(2) All payments to nondesignated public hospitals are subject to a final reconciliation that is subject to final audits of all applicable Medicare and other cost, payment, discharge, and statistical data for the successor demonstration year.

(l) The process for supplemental payments made in subdivisions (j) and (k) is a voluntary process the implementation of which is limited by this subdivision. The department may submit for federal approval a proposed amendment to the successor demonstration project to implement this section.

(1) If a nondesignated public hospital voluntarily agrees to participate in a process that, up to the amount of safety net care pool funds available, allows the certified public expenditures for uncompensated care under this section to be allocated equally between the state and the nondesignated public hospital, so that for every dollar of certified public expenditure used by the nondesignated public hospital, the nondesignated public hospital shall voluntarily allow the state to use a corresponding certified public expenditure amount for claiming purposes. Participation in the safety net care pool under this section is voluntary on the part of the nondesignated public hospital for the purposes of all applicable federal laws. If a nondesignated public hospital does not voluntarily agree to participate in this process, it shall not be eligible to receive safety net care pool funds.

(2) If the budget neutrality requirements established under Section XI of the Special Terms and Conditions of the successor demonstration project are exceeded, payments made under this section shall be reduced or refunded to achieve budget neutrality before any other payments under the successor demonstration project are made. The state's share of the federal financial participation shall be reduced after the provider's share has been exhausted.

(3) Notwithstanding any other provision of law, upon the receipt of a notice of disallowance or deferral from the federal government related to any certified public expenditures for uncompensated care incurred by the nondesignated public hospital that are used for federal claiming under the safety net care pool pursuant to the successor demonstration project after this section is implemented, and subject to the processes set forth in this section, the department and the nondesignated public hospitals shall each be responsible for one-half of the repayment of the federal portion of any federal

disallowance or deferral for the applicable successor demonstration year, up to the amount claimed and allocated pursuant to this section for that particular year beginning with the 2013–14 fiscal year.

(4) This section shall be implemented only to the extent other federal financial participation is not jeopardized.

(m) Eligible providers, as a condition of receiving supplemental reimbursement pursuant to this section, shall enter into, and maintain, an agreement with the department for the purposes of implementing this section and reimbursing the department for the costs of administering this section, including, but not limited to, the state personnel costs. No General Fund moneys shall be expended for the implementation and administration of this section.

SEC. 3. Section 14166.152 of the Welfare and Institutions Code is repealed.

SEC. 4. Section 14166.153 of the Welfare and Institutions Code is repealed.

SEC. 5. Section 14166.154 of the Welfare and Institutions Code is repealed.

SEC. 6. Section 14166.155 of the Welfare and Institutions Code is repealed.

Approved _____, 2013

Governor