AMENDED IN SENATE APRIL 17, 2013

SENATE BILL No. 239

Introduced by Senators Hernandez and Steinberg

February 12, 2013

An act *to amend Section 14167.35 of, and to add Article 5.230 (commencing with Section 14169.51) and Article 5.231 (commencing with Section 14169.71) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code,* relating to Medi-Cal, *and declaring the urgency thereof, to take effect immediately*.

LEGISLATIVE COUNSEL'S DIGEST

SB 239, as amended, Hernandez. Medi-Cal: hospital quality assurance fee.

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. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law, subject to federal approval, imposes a quality assurance fee, as specified, on certain general acute care hospitals from July 1, 2011, through December 31, 2013. Existing law, subject to federal approval, requires the fee to be deposited into the Hospital Quality Assurance Revenue Fund, and requires that the moneys in the fund be used, upon appropriation by the Legislature, only for certain purposes, including, among other things, paying for health care coverage for children and making supplemental payments for certain services to private hospitals, increased capitation payments to Medi-Cal managed care plans, and increased payments to mental health plans.

This bill would state the intent of the Legislature to impose a quality assurance fee to be paid by hospitals, which would be used to increase federal financial participation in order to make supplemental Medi-Cal payments to hospitals for the period of January 1, 2014, through December 31, 2015, and to help pay for health care coverage for low-income children. This bill would require the department to make every effort to obtain the necessary federal approvals to implement the quality assurance fee as described.

This bill would, subject to federal approval, impose a hospital quality assurance fee, as specified, on certain general acute care hospitals from January 1, 2014, through December 30, 2015, to be deposited into the Hospital Quality Assurance Revenue Fund. This bill would, subject to federal approval, impose a hospital quality assurance fee, as specified, on certain general acute care hospitals from January 1, 2014, through December 30, 2015, to be deposited into the Hospital Quality Assurance Revenue Fund. The bill would, subject to federal approval, require supplemental payments to be made to private hospitals for certain services and increased capitation payments to be made to Medi-Cal managed care plans, as specified. The bill would also make conforming changes.

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

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

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

SECTION 1. The Legislature finds and declares both of the following:

(a) The Legislature continues to recognize the essential role that hospitals play in serving the state's Medi-Cal beneficiaries. To that end, it has been, and remains, the intent of the Legislature to improve funding for hospitals and obtain all available federal funds to make supplemental Medi-Cal payments to hospitals.

(b) It is the intent of the Legislature that funding provided to hospitals through a hospital quality assurance fee be explored with the goal of increasing access to care and improving hospital reimbursement through supplemental Medi-Cal payments to hospitals.

SEC. 2. (a) It is the intent of the Legislature to impose a quality assurance fee to be paid by hospitals, which would be used to increase federal financial participation in order to make supplemental Medi-Cal payments to hospitals for the period of January 1, 2014, through December 31, 2015, and to help pay for health care coverage for low-income children.

(b) The State Department of Health Care Services shall make every effort to obtain the necessary federal approvals to implement the quality assurance fee described in subdivision (a) in order to make supplemental Medi-Cal payments to hospitals for the period of January 1, 2014, through December 31, 2015.

(c) It is the intent of the Legislature that the quality assurance fee be implemented only if all of the following conditions are met:

(1) The quality assurance fee is established in consultation with the hospital community.

(2) The quality assurance fee, including any interest earned after collection by the department, is deposited into segregated funds apart from the General Fund and used exclusively for supplemental Medi-Cal payments to hospitals, health care coverage for low-income children, and for the direct costs of administering the program by the department.

(3) 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 related supplemental payments to hospitals.

(4) The full amount of the quality assurance fee assessed and collected remains available only for the purposes specified by the Legislature in this act.

SEC. 3. 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 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 subject fiscal quarter for which payments are made under Article 5.21 (commencing with Section 14167.1).

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

(4) To pay funds from the Hospital Quality Assurance Revenue 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.

(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 (e)(1) and (e)(2) 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.

(j) Notwithstanding any law, the Controller may use the funds in the Hospital Quality Assurance Revenue Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

(k) Notwithstanding Sections 14167.17 and 14167.40, subdivisions (b) to (h), inclusive, shall become inoperative on January 1, 2013, subdivisions (a), (i), and (j) shall remain operative until January 1, ~~2015,~~ *2017,* and as of January 1, ~~2015,~~ *2017,* this section is repealed.

SEC. 4. Article 5.230 (commencing with Section 14169.51) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.230. Medi-Cal Hospital Reimbursement Improvement Act of 2014

14169.51. For the purposes of this article, the following definitions shall apply:

(a) "General acute care days" means the total number of Medi-Cal general acute care days paid by the department to a hospital for services in the __ calendar year, as reflected in the state paid claims file on ___.

(b) "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.

(c) "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 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.

(d) (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 plans contracting to provide mental health care for Medi-Cal beneficiaries pursuant to Chapter 8.9 (commencing with Section 14700).

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

(iii) Program for All-Inclusive Care for the Elderly organizations operating pursuant to Chapter 8.75 (commencing with Section 14591).

(e) "New hospital" means a hospital operation, business, or facility functioning under current or prior ownership as a private hospital that does not have a days data source or a hospital that has a days data source in whole, or in part, from a previous operator where there is an outstanding monetary liability owed to the state in connection with the Medi-Cal program and the new operator did not assume liability for the outstanding monetary obligation.

(f) "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 __.

(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.

(g) "Program period" means the period from January 1, 2014, to December 31, 2015, inclusive.

(h) "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. The applicable upper payment limit shall be separately calculated for inpatient and outpatient hospital services.

14169.52. 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. The supplemental amounts shall result in payments equal to the statewide aggregate upper payment limit for private hospitals for each subject fiscal year.

14169.53. Private hospitals shall be paid supplemental amounts for the provision of hospital inpatient services for the program period 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. The supplemental amounts shall result in payments equal to the statewide aggregate upper payment limit for private hospitals for each subject fiscal year.

14169.54. (a) The department shall increase capitation payments to Medi-Cal managed health care plans for each subject fiscal year 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 each subject fiscal year shall be the maximum amount for which federal financial participation is available on an aggregate statewide basis for the applicable subject fiscal year.

(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 ensure access to high-quality hospital services by the plan's enrollees.

(e) The amount of increased capitation payments to each Medi-Cal managed health care 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 within 90 days of the date on which all necessary federal approvals have been received, 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 may accumulate funds in the Hospital Quality Assurance Revenue Fund, established pursuant to Section 14167.35, for the purpose of funding managed health 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 health care payments by December 31, 2015.

(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, including, but not limited to, payments described in Section 14182.15, shall not be reduced as a consequence of payments 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.

14169.55. (a) Each managed health care plan receiving increased capitation payments under Section 14169.54 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) 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 14169.54.

(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 that 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.

(d) The supplemental hospital payments made by managed health care plans pursuant to this section shall reflect the overall purpose of this article and Article 5.231 (commencing with Section 14169.71).

(e) This article is not intended to create a private right of action by a hospital against a managed care plan provided that the managed health care plan expends all increased capitation payments for hospital services.

14169.56. (a) Exclusive of payments made under Article ____ (commencing with Section ____) and Article ____ (commencing with Section ____), payment rates for hospital outpatient services, furnished by private hospitals, nondesignated public hospitals,

and designated public hospitals before December 31, 2015, exclusive of amounts payable under this article, shall not be reduced below the rates in effect on January 1, 2014.

(b) Rates payable to hospitals for hospital inpatient services furnished before December 31, 2015, under contracts negotiated pursuant to the selective provider contracting program under Article 2.6 (commencing with Section 14081), shall not be reduced below the contract rates in effect on January 1, 2014. This subdivision shall not prohibit changes to the supplemental payments paid to individual hospitals under Sections 14166.12, 14166.17, and 14166.23, provided that the aggregate amount of the payments for each subject fiscal year is not less than the minimum amount permitted under former Section 14167.13.

(c) Notwithstanding Section 14105.281, exclusive of payments made under former Article 5.21 (commencing with Section 14167.1) and Article 5.226 (commencing with Section 14168.1), payments to private hospitals for hospital inpatient services furnished before January 1, 2014, that are not reimbursed under a contract negotiated pursuant to the selective provider contracting program under Article 2.6 (commencing with Section 14081), exclusive of amounts payable under this article, shall not be less than the amount of payments that would have been made under the payment methodology in effect on the effective date of this article.

(d) Upon the implementation of the new Medi-Cal inpatient hospital reimbursement methodology based on diagnosis-related groups pursuant to Section 14105.28, the requirements in subdivisions (b) and (c) shall be met if the rates paid under the new Medi-Cal inpatient hospital reimbursement methodology based on diagnosis-related groups result in an average payment per discharge to all hospitals subject to the new reimbursement methodology, calculated on an aggregate basis per subject fiscal year, exclusive of amounts payable under this article, amounts payable under Sections 14166.11 and 14166.23, and if amounts payable under Sections 14166.12 and 14166.17 are not included in the payments under the diagnosis-related group methodology and continue to be paid separately to hospitals, exclusive of those amounts, that is not less than the average payment per discharge to the hospitals, exclusive of amounts payable under this article, amounts payable under Sections 14166.11 and 14166.23, and if

amounts payable under Sections 14166.12 and 14166.17 are not included in the payments under the diagnosis-related group methodology and continue to be paid separately to hospitals, exclusive of those amounts, calculated on an aggregate basis for the fiscal year ending June 30, 2012, adjusted, in consultation with the hospital community, to reflect the movement of populations into managed care under Article 5.4 (commencing with Section 14180).

(e) Solely for purposes of this article, a rate reduction or a change in a rate methodology that is enjoined by a court shall be included in the determination of a rate or a rate methodology until all appeals or judicial reviews have been exhausted and the rate reduction or change in rate methodology has been permanently enjoined, denied by the federal government, or otherwise permanently prevented from being implemented.

(f) Disproportionate share replacement payments to private hospitals shall be not less than the amount determined pursuant to Section 14166.11. For purposes of this subdivision, references to Section 14166.11 are to the version of Section 14166.11 in effect on the effective date of the act that added this subdivision.

SEC. 5. Article 5.231 (commencing with Section 14169.71) is added to Chapter 3 of Part 7 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.231. Private Hospital Quality Assurance Fee Act of 2014

14169.71. (a) There shall be imposed on each general acute care hospital that is not an exempt facility a quality assurance fee, provided that a quality assurance fee under this article shall not be imposed on a converted hospital.

(b) The quality assurance fee shall be computed starting on January 1, 2014, and continue through and including December 31, 2015.

(c) The quality assurance fee, as paid pursuant to this section, 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 program period.

(d) This section shall become inoperative if the federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before July 1, 2015, the implementation of the quality assurance fee pursuant to this article or the supplemental payments to private hospitals described in Sections 14169.52 and 14169.53.

(e) In no case shall the aggregate fees collected in a federal fiscal year pursuant to this section, former Section 14167.32, Section 14168.32, and Section 14169.32 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.

(f) The department shall work in consultation with the hospital community to implement this article and Article 5.230 (commencing with Section 14169.51).

(g) 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, to limit 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 Section ____ on the effective date of that article, and to otherwise comply with all its obligations set forth in Article 5.230 (commencing with Section 14169.51) and this article provided that amendments that arise from, or have as a basis for, 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 5.230 (commencing with Section 14169.51) shall control for the purposes of this subdivision.

(h) (1) Effective January 1, 2014, 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 5.230 (commencing with Section 14169.51).

(2) The supplemental payments and other payments under Article 5.230 (commencing with Section 14169.51) 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.

14169.72. (a) (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 to the Treasurer to be deposited in the Hospital Quality Assurance Revenue Fund, created pursuant to Section 14167.35. Notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on deposits in the fund from the proceeds of the fee assessed pursuant to this article shall be retained in the fund for purposes specified in subdivision (b).

(b) Notwithstanding subdivision (c) of Section 14167.35, subdivision (b) of Section 14168.33, and subdivision (b) of Section 14169.33, all funds from the proceeds of the fee assessed pursuant to this article 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, continue to 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.

14169.73. (a) This article shall be implemented only as long as all of the following conditions are met:

(1) Subject to Section ____, 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.

(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 in accordance with federal approval.

(2) Article 5.230 (commencing with Section 14169.51) is enacted and remains in effect and hospitals are reimbursed the increased rates for services during the program period, as defined in Section 14169.51.

(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.

SEC. 6. 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 changes to increase medi-cal payments to hospitals and improve access at the earliest time, so as to allow this act to be operative as soon as approval from the federal centers for Medicare and Medicaid Services is obtained by the State Department of Health Care Services, it is necessary that this act takes effect immediately.

O