

AMENDED IN ASSEMBLY AUGUST 14, 2013

AMENDED IN SENATE APRIL 17, 2013

SENATE BILL

No. 239

Introduced by Senators Hernandez and Steinberg

February 12, 2013

An act to amend ~~Section~~ *Sections 14164, 14165, and 14167.35* of, to add *Section 14167.37* to, and to add and repeal Article 5.230 (commencing with Section 14169.51) and Article 5.231 (commencing with Section 14169.71) ~~to~~ of Chapter 7 of Part 3 of Division 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

SB 239, as amended, Hernandez. Medi-Cal: ~~hospital~~ *hospitals*: 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. *Existing law also establishes the continuously appropriated Distressed Hospital Fund, which consists of moneys transferred to the fund or appropriated by the Legislature and used as the nonfederal share of payments to distressed hospitals.*

~~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 31, 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, subject to federal approval, provide that moneys in the Hospital Quality Assurance Revenue Fund shall, upon appropriation by the Legislature, be available only for certain purposes, including paying for health care coverage for children, as specified, 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. The bill would also authorize the payment of direct grants to designated and nondesignated public hospitals in support of health care expenditures funded by the quality assurance fee. The bill would require the department to make available all public documentation it uses to administer and audit these provisions and would require the department to, upon request, assist hospitals in reconciling payments due and received from Medi-Cal managed care plans. The bill would require the department to post specified documents on its Internet Web site relating to these provisions.~~

The bill would provide that if quality assurance fee payments are remitted to the department after the date determined by the department to be the final date for calculating the final supplemental payments, the fee payments shall be retained in the fund for purposes of funding supplemental payments supported by a hospital quality assurance fee program under subsequent legislation, but if supplemental payments are not implemented under subsequent legislation, then those quality assurance fee payments shall be deposited into the Distressed Hospital Fund. The bill would also provide that if amounts of the quality assurance fees are collected in excess of the funds required to make the payments above and federal rules prohibit the department from refunding the fee payments to the general acute care hospitals, the excess funds shall be deposited into the Distressed Hospital Fund. By increasing the amount of moneys that may be deposited into the Distressed Hospital Fund, this bill would make an appropriation. The bill would make other conforming changes.

Existing law provides that any county, other political subdivision of the state, or governmental entity in the state may elect to transfer funds in the form of cash or loans to the department in support of the Medi-Cal program. Existing law provides the department discretion to accept or not accept any elective transfer from a county, political subdivision, or other governmental entity for purposes of obtaining federal financial participation.

This bill would authorize the Director of Health Care Services to maximize federal financial participation to provide access to services provided by hospitals that are not reimbursed by certified public expenditure, as specified, by authorizing the use of intergovernmental transfers to fund the nonfederal share of supplemental payments as permitted under federal law.

Existing law requires that the California Medical Assistance Commission be dissolved after June 30, 2012, and requires that, upon dissolution of the commission, all powers, duties, and responsibilities of the commission be transferred to the Director of Health Care Services. Existing law provides that upon a determination by the director that a payment system based on diagnosis-related groups, as described, has been developed and implemented, the powers, duties, and responsibilities conferred on the commission and transferred to the director shall no longer be exercised, except as specified.

This bill would add to those exceptions by authorizing the director to continue to administer and distribute payments for the Construction

and Renovation Reimbursement Program, which provides supplemental reimbursement to hospitals that contract under the selective provider contracting program or with a county organized health system, as specified. The bill would provide that maintaining or negotiating a selective provider contract shall cease to be a requirement for a hospital's participation in the Construction and Renovation Reimbursement Program.

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

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

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

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

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

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

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

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

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

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

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

9 (3) No hospital shall be required to pay the quality assurance
10 fee to the department unless and until the state receives and
11 maintains federal approval of the quality assurance fee and related
12 supplemental payments to hospitals.

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

16 *SEC. 3. Section 14164 of the Welfare and Institutions Code is*
17 *amended to read:*

18 14164. (a) In addition to the required intergovernmental
19 transfers set forth in Section 14163, any county, other political
20 subdivision of the state, or governmental entity in the state may
21 elect to transfer funds, subject to subdivision (m) of Section 14163,
22 to the department in support of the Medi-Cal program. Those
23 transfers may consist of cash or loans to the state. The department
24 shall have the discretion to accept or not accept any elective transfer
25 from a county, political subdivision, or other governmental entity,
26 as well as the discretion of whether to deposit the transfer in the
27 Medi-Cal Inpatient Payment Adjustment Fund established pursuant
28 to Section 14163. If the department accepts a transfer pursuant to
29 this section, the department shall obtain federal matching funds to
30 the full extent permitted by federal law.

31 (b) (1) *The director may maximize available federal financial*
32 *participation to provide access to services provided by hospitals*
33 *that are not reimbursed by certified public expenditure pursuant*
34 *to Article 5.2 (commencing with Section 14166) by authorizing*
35 *the use of intergovernmental transfers to fund the nonfederal share*
36 *of supplemental payments as permitted under Section 433.51 of*
37 *Title 42 of the Code of Federal Regulations or any other applicable*
38 *federal Medicaid laws. The transferring entity shall certify to the*
39 *department that the funds are in compliance with all federal rules*
40 *and regulations. Any payments funded by intergovernmental*

1 *transfers shall remain with the hospital and shall not be transferred*
2 *back to any county, other political subdivision of the state, or*
3 *governmental entity in the state, except for federal disallowance*
4 *or withhold recovery efforts by the department. Participation in*
5 *intergovernmental transfers under this subdivision is voluntary*
6 *on the part of the transferring entity for purposes of all applicable*
7 *federal laws.*

8 *(2) This subdivision shall be implemented only to the extent*
9 *federal financial participation is not jeopardized.*

10 *SEC. 4. Section 14165 of the Welfare and Institutions Code is*
11 *amended to read:*

12 14165. (a) There is hereby created in the Governor's office
13 the California Medical Assistance Commission, for the purpose
14 of contracting with health care delivery systems for the provision
15 of health care services to recipients under the California Medical
16 Assistance program.

17 (b) Notwithstanding any other ~~provision of law~~, the commission
18 created pursuant to subdivision (a) shall continue through June 30,
19 2012, after which, it shall be dissolved and the term of any
20 commissioner serving at that time shall end.

21 (1) Upon dissolution of the commission, all powers, duties, and
22 responsibilities of the commission shall be transferred to the
23 Director of Health Care Services. These powers, duties, and
24 responsibilities shall include, but are not limited to, those exercised
25 in the operation of the selective provider contracting program
26 pursuant to Article 2.6 (commencing with Section 14081).

27 (2) (A) On July 1, 2012, notwithstanding any other law,
28 employees of the California Medical Assistance Commission as
29 of June 30, 2012, excluding commissioners, shall transfer to the
30 State Department of Health Care Services.

31 (B) Employees who transfer pursuant to subparagraph (A) shall
32 be subject to the same conditions of employment under the
33 department as they were under the California Medical Assistance
34 Commission, including retention of their exempt status, until the
35 diagnosis-related groups payment system described in Section
36 14105.28 replaces the contract-based payment system described
37 in this article.

38 (C) (i) Notwithstanding any other law or rule, persons employed
39 by the department who transferred to the department pursuant to
40 subparagraph (A) shall be eligible to apply for civil service

1 examinations. Persons receiving passing scores shall have their
2 names placed on lists resulting from these examinations, or
3 otherwise gain eligibility for appointment. In evaluating minimum
4 qualifications, related California Medical Assistance Commission
5 experience shall be considered state civil service experience in a
6 class deemed comparable by the State Personnel Board, based on
7 the duties and responsibilities assigned.

8 (ii) On the date the diagnosis-related groups payment system
9 described in Section 14105.28 replaces the contract-based system
10 described in this article, employees who transferred to the
11 department pursuant to subparagraph (A) shall transfer to civil
12 service classifications within the department for which they are
13 eligible.

14 (3) Upon a determination by the Director of Health Care
15 Services that a payment system based on diagnosis-related groups
16 as described in Section 14105.28 that is sufficient to replace the
17 contract-based payment system described in this article has been
18 developed and implemented, the powers, duties, and responsibilities
19 conferred on the commission and transferred to the Director of
20 Health Care Services shall no longer be exercised, excluding both
21 *all of the following:*

22 (A) Stabilization payments made or committed from Sections
23 14166.14 and 14166.19 for services rendered prior to the director's
24 determination pursuant to this paragraph.

25 (B) The ability to negotiate and make payments from the Private
26 Hospital Supplemental Fund, established pursuant to Section
27 14166.12, and the Nondesignated Public Hospital Supplemental
28 Fund, established pursuant to Section 14166.17.

29 (C) *The ability to continue to administer and distribute payments*
30 *for the Construction Renovation Reimbursement Program, in*
31 *accordance with Sections 14085 to 14085.57, inclusive.*
32 *Notwithstanding any other law, maintaining or negotiating a*
33 *selective provider contract pursuant to Article 2.6 (commencing*
34 *with Section 14081) shall cease to be a requirement for a hospital's*
35 *participation in the Construction Renovation Reimbursement*
36 *Program.*

37 (4) Protections afforded to the negotiations and contracts of the
38 commission by the California Public Records Act (Chapter 3.5
39 (commencing with Section 6250) of Division 7 of Title 1 of the
40 Government Code) shall be applicable to the negotiations and

1 contracts conducted or entered into pursuant to this section by the
2 State Department of Health Care Services.

3 (c) Notwithstanding the rulemaking provisions of Chapter 3.5
4 (commencing with Section 11340) of Part 1 of Division 3 of Title
5 2 of the Government Code, or any other provision of law, the State
6 Department of Health Care Services may implement and administer
7 this section by means of provider bulletins or other similar
8 instructions, without taking regulatory action. The authority to
9 implement this section as set forth in this subdivision shall include
10 the authority to give notice by provider bulletin or other similar
11 instruction of a determination made pursuant to paragraph (3) of
12 subdivision (b) and to modify or supersede existing regulations in
13 Title 22 of the California Code of Regulations that conflict with
14 implementation of this section.

15 ~~SEC. 3.~~

16 *SEC. 5.* Section 14167.35 of the Welfare and Institutions Code
17 is amended to read:

18 14167.35. (a) The Hospital Quality Assurance Revenue Fund
19 is hereby created in the State Treasury.

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

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

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

37 (1) To pay for the department's staffing and administrative costs
38 directly attributable to implementing Article 5.21 (commencing
39 with Section 14167.1) and this article, including any administrative
40 fees that the director determines shall be paid to mental health

1 plans pursuant to subdivision (d) of Section 14167.11 and
2 repayment of the loan made to the department from the Private
3 Hospital Supplemental Fund pursuant to the act that added this
4 section.

5 (2) To pay for the health care coverage for children in the
6 amount of eighty million dollars (\$80,000,000) for each subject
7 fiscal quarter for which payments are made under Article 5.21
8 (commencing with Section 14167.1).

9 (3) To make increased capitation payments to managed health
10 care plans pursuant to Article 5.21 (commencing with Section
11 14167.1).

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

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

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

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

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

6 (g) The department shall request approval from the federal
7 Centers for Medicare and Medicaid Services for the implementation
8 of this article. In making this request, the department shall seek
9 specific approval from the federal Centers for Medicare and
10 Medicaid Services to exempt providers identified in this article as
11 exempt from the fees specified, including the submission, as may
12 be necessary, of a request for waiver of the broad based
13 requirement, waiver of the uniform fee requirement, or both,
14 pursuant to paragraphs (e)(1) and (e)(2) of Section 433.68 of Title
15 42 of the Code of Federal Regulations.

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

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

25 (B) Reduces or increases the amount of the fee payable by a
26 hospital in total under this article for the 2008–09, 2009–10, and
27 2010–11 federal fiscal years by more than 2 percent of the amount
28 that would be determined under this article without any change or
29 adjustment.

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

39 (i) Notwithstanding Chapter 3.5 (commencing with Section
40 11340) of Part 1 of Division 3 of Title 2 of the Government Code,

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

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

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

18 *SEC. 6. Section 14167.37 is added to the Welfare and*
19 *Institutions Code, to read:*

20 *14167.37. (a) The department shall make available all public*
21 *documentation it uses to administer and audit the program*
22 *authorized under Article 5.230 (commencing with Section*
23 *14169.51) and Article 5.231 (commencing with Section 14169.71)*
24 *pursuant to the Public Records Act (Chapter 3.5 (commencing*
25 *with Section 6250) of Division 7 of Title 1 of the Government*
26 *Code). In addition, upon request, the department shall assist*
27 *hospitals in reconciling payments due and received from Medi-Cal*
28 *managed care plans under Article 5.230 (commencing with Section*
29 *14169.51).*

30 *(b) Notwithstanding subdivision (a), the department shall post*
31 *all of the following on the department's Internet Web site:*

32 *(1) Within 10 business days after receipt of approval of the*
33 *hospital quality assurance fee program under Article 5.230*
34 *(commencing with Section 14169.51) and Article 5.231*
35 *(commencing with Section 14169.71) from the federal Centers for*
36 *Medicare and Medicaid Services (CMS), the hospital quality*
37 *assurance fee final model and upper payment limit calculations.*

38 *(2) Quarterly updates on payments, fee schedules, and model*
39 *updates when applicable.*

1 (3) Within 10 business days after receipt, information on
2 managed care rate approvals.

3 (c) For purposes of this section, the following definitions shall
4 apply:

5 (1) “Fee schedules” mean the dates on which the hospital
6 quality assurance fee will be due from the hospitals and the dates
7 on which the department will submit fee-for-service payments to
8 the hospitals. “Fee schedules” also include the dates on which
9 the department is expected to submit payments to managed care
10 plans.

11 (2) “Hospital quality assurance fee final model” means the
12 spreadsheet calculating the supplemental amounts based on the
13 upper payment limit calculation from claims and hospital data
14 sources of days and hospital services once CMS approves the
15 program under Article 5.230 (commencing with Section 14169.51)
16 and Article 5.231 (commencing with Section 14169.71).

17 (3) “Upper payment limit calculation” means the determination
18 of the federal upper payment limit on the amount of the Medicaid
19 payment for which federal financial participation is available for
20 a class of service and a class of health care providers, as specified
21 in Part 447 of Title 42 of the Code of Federal Regulations and
22 that has been approved by CMS.

23 ~~SEC. 4.~~

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

27
28 Article 5.230. Medi-Cal Hospital Reimbursement Improvement
29 Act of ~~2014~~ 2013

30
31 ~~14169.51. For the purposes of this article, the following~~
32 ~~definitions shall apply:~~

33 (a) ~~“General acute care days” means the total number of~~
34 ~~Medi-Cal general acute care days paid by the department to a~~
35 ~~hospital for services in the ___ calendar year, as reflected in the~~
36 ~~state paid claims file on ___.~~

37 (b) ~~“Hospital inpatient services” means all services covered~~
38 ~~under Medi-Cal and furnished by hospitals to patients who are~~
39 ~~admitted as hospital inpatients and reimbursed on a fee-for-service~~
40 ~~basis by the department directly or through its fiscal intermediary.~~

1 Hospital inpatient services include outpatient services furnished
2 by a hospital to a patient who is admitted to that hospital within
3 24 hours of the provision of the outpatient services that are related
4 to the condition for which the patient is admitted. Hospital inpatient
5 services do not include services for which a managed health care
6 plan is financially responsible.

7 (e) “Hospital outpatient services” means all services covered
8 under Medi-Cal furnished by hospitals to patients who are
9 registered as hospital outpatients and reimbursed by the department
10 on a fee-for-service basis directly or through its fiscal intermediary.
11 Hospital outpatient services do not include services for which a
12 managed health care plan is financially responsible, or services
13 rendered by a hospital-based federally qualified health center for
14 which reimbursement is received pursuant to Section 14132.100.

15 (d) (1) “Managed health care plan” means a health care delivery
16 system that manages the provision of health care and receives
17 prepaid capitated payments from the state in return for providing
18 services to Medi-Cal beneficiaries.

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

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

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

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

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

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

30 (i) Mental health plans contracting to provide mental health care
31 for Medi-Cal beneficiaries pursuant to Chapter 8.9 (commencing
32 with Section 14700).

33 (ii) Health plans not covering inpatient services such as primary
34 care case management plans operating pursuant to Section
35 14088.85.

36 (iii) Program for All-Inclusive Care for the Elderly organizations
37 operating pursuant to Chapter 8.75 (commencing with Section
38 14591).

39 (e) “New hospital” means a hospital operation, business, or
40 facility functioning under current or prior ownership as a private

1 hospital that does not have a days data source or a hospital that
2 has a days data source in whole, or in part, from a previous operator
3 where there is an outstanding monetary liability owed to the state
4 in connection with the Medi-Cal program and the new operator
5 did not assume liability for the outstanding monetary obligation.

6 (f) ~~“Private hospital” means a hospital that meets all of the~~
7 ~~following conditions:~~

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

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

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

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

22 (g) ~~“Program period” means the period from January 1, 2014,~~
23 ~~to December 31, 2015, inclusive.~~

24 (h) ~~“Upper payment limit” means a federal upper payment limit~~
25 ~~on the amount of the Medicaid payment for which federal financial~~
26 ~~participation is available for a class of service and a class of health~~
27 ~~care providers, as specified in Part 447 of Title 42 of the Code of~~
28 ~~Federal Regulations. The applicable upper payment limit shall be~~
29 ~~separately calculated for inpatient and outpatient hospital services.~~

30 *14169.51. (a) “Acute psychiatric days” means the total number*
31 *of Medi-Cal specialty mental health service administrative days,*
32 *Medi-Cal specialty mental health service acute care days, acute*
33 *psychiatric administrative days, and acute psychiatric acute days*
34 *identified in the Final Medi-Cal Utilization Statistics for the*
35 *2012–13 state fiscal year as calculated by the department as of*
36 *December 17, 2012.*

37 (b) ~~“Converted hospital” means a private hospital that becomes~~
38 ~~a designated public hospital or a nondesignated public hospital~~
39 ~~on or after January 1, 2014.~~

1 (c) “Days data source” means the hospital’s Annual Financial
2 Disclosure Report filed with the Office of Statewide Health
3 Planning and Development as of June 6, 2013, for its fiscal year
4 ending during 2010, except for Downey Regional Medical Center
5 which shall be the Annual Financial Disclosure Report for the
6 fiscal year ending during 2011 retrieved from the Office of
7 Statewide Health Planning and Development as of July 23, 2013.

8 (d) “Designated public hospital” shall have the meaning given
9 in subdivision (d) of Section 14166.1 as of January 1, 2014.

10 (e) “General acute care days” means the total number of
11 Medi-Cal general acute care days paid by the department to a
12 hospital for services in the 2010 calendar year, as reflected in the
13 state paid claims file on April 26, 2013.

14 (f) “High acuity days” means Medi-Cal coronary care unit
15 days, pediatric intensive care unit days, intensive care unit days,
16 neonatal intensive care unit days, and burn unit days paid by the
17 department during the 2010 calendar year, as reflected in the state
18 paid claims file prepared by the department on April 26, 2013.

19 (g) “Hospital inpatient services” means all services covered
20 under Medi-Cal and furnished by hospitals to patients who are
21 admitted as hospital inpatients and reimbursed on a fee-for-service
22 basis by the department directly or through its fiscal intermediary.
23 Hospital inpatient services include outpatient services furnished
24 by a hospital to a patient who is admitted to that hospital within
25 24 hours of the provision of the outpatient services that are related
26 to the condition for which the patient is admitted. Hospital inpatient
27 services do not include services for which a managed health care
28 plan is financially responsible.

29 (h) “Hospital outpatient services” means all services covered
30 under Medi-Cal furnished by hospitals to patients who are
31 registered as hospital outpatients and reimbursed by the
32 department on a fee-for-service basis directly or through its fiscal
33 intermediary. Hospital outpatient services do not include services
34 for which a managed health care plan is financially responsible,
35 or services rendered by a hospital-based federally qualified health
36 center for which reimbursement is received pursuant to Section
37 14132.100.

38 (i) “Individual hospital acute psychiatric supplemental
39 payment” means the total amount of acute psychiatric hospital
40 supplemental payments to a subject hospital for a quarter for which

1 *the supplemental payments are made. The “individual hospital*
2 *acute psychiatric supplemental payment” shall be calculated for*
3 *subject hospitals by multiplying the number of acute psychiatric*
4 *days for the individual hospital for which a mental health plan*
5 *was financially responsible by the amount calculated in accordance*
6 *with paragraph (2) of subdivision (b) of Section 14169.53 and*
7 *dividing the result by four.*

8 (j) (1) *“Managed health care plan” means a health care*
9 *delivery system that manages the provision of health care and*
10 *receives prepaid capitated payments from the state in return for*
11 *providing services to Medi-Cal beneficiaries.*

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

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

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

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

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

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

23 (i) *Mental health plans contracting to provide mental health*
24 *care for Medi-Cal beneficiaries pursuant to Chapter 8.9*
25 *(commencing with Section 14700).*

26 (ii) *Health plans not covering inpatient services such as primary*
27 *care case management plans operating pursuant to Section*
28 *14088.85.*

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

32 (k) *“Medi-Cal managed care days” means the total number of*
33 *general acute care days, including well baby days, listed for the*
34 *county organized health system and prepaid health plans identified*
35 *in the Final Medi-Cal Utilization Statistics for the 2012–13 fiscal*
36 *year, as calculated by the department as of December 17, 2012.*

37 (l) *“Medicaid inpatient utilization rate” means Medicaid*
38 *inpatient utilization rate as defined in Section 1396r-4 of Title 42*
39 *of the United States Code and as set forth in the Final Medi-Cal*

1 *Utilization Statistics for the 2012–13 fiscal year, as calculated by*
2 *the department as of December 17, 2012.*

3 (m) *“Mental health plan” means a mental health plan that*
4 *contracts with the state to furnish or arrange for the provision of*
5 *mental health services to Medi-Cal beneficiaries pursuant to*
6 *Chapter 8.9 (commencing with Section 14700).*

7 (n) *“New hospital” means a hospital operation, business, or*
8 *facility functioning under current or prior ownership as a private*
9 *hospital that does not have a days data source or a hospital that*
10 *has a days data source in whole, or in part, from a previous*
11 *operator when there is an outstanding monetary liability owed to*
12 *the state in connection with the Medi-Cal program and the new*
13 *operator did not assume liability for the outstanding monetary*
14 *obligation.*

15 (o) *“Nondesignated public hospital” means either of the*
16 *following:*

17 (1) *A public hospital that is licensed under subdivision (a) of*
18 *Section 1250 of the Health and Safety Code, is not designated as*
19 *a specialty hospital in the hospital’s most recent publicly available*
20 *Annual Financial Disclosure Report, and satisfies the definition*
21 *in paragraph (25) of subdivision (a) of Section 14105.98, excluding*
22 *designated public hospitals.*

23 (2) *A tax-exempt nonprofit hospital that is licensed under*
24 *subdivision (a) of Section 1250 of the Health and Safety Code, is*
25 *not designated as a specialty hospital in the hospital’s most recent*
26 *publicly available Annual Financial Disclosure Report, is*
27 *operating a hospital owned by a local health care district, and is*
28 *affiliated with the health care district hospital owner by means of*
29 *the district’s status as the nonprofit corporation’s sole corporate*
30 *member.*

31 (p) *“Outpatient base amount” means the total amount of*
32 *payments for hospital outpatient services made to a hospital in*
33 *the 2010 calendar year, as reflected in the state paid claims file*
34 *prepared by the department on April 26, 2013.*

35 (q) *“Private hospital” means a hospital that meets all of the*
36 *following conditions:*

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

39 (2) *Is in the Charitable Research Hospital peer group, as set*
40 *forth in the 1991 Hospital Peer Grouping Report published by the*

1 department, or is not designated as a specialty hospital in the
2 hospital's most recent publicly available Office of Statewide Health
3 Planning and Development Annual Financial Disclosure Report.

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

6 (4) Is a nonpublic hospital, nonpublic converted hospital, or
7 converted hospital as those terms are defined in paragraphs (26)
8 to (28), inclusive, respectively, of subdivision (a) of Section
9 14105.98.

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

12 (s) "Subject fiscal quarter" means a state fiscal quarter
13 beginning on or after January 1, 2014, and ending before January
14 1, 2016.

15 (t) "Subject fiscal year" means a state fiscal year that ends after
16 January 1, 2014, and begins before January 1, 2016.

17 (u) "Subject hospital" means a hospital that meets all of the
18 following conditions:

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

21 (2) Is in the Charitable Research Hospital peer group, as set
22 forth in the 1991 Hospital Peer Grouping Report published by the
23 department, or is not designated as a specialty hospital in the
24 hospital's most recent publicly available Office of Statewide Health
25 Planning and Development Annual Financial Disclosure Report.

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

28 (v) "Subject month" means a calendar month beginning on or
29 after January 1, 2014, and ending before January 1, 2016.

30 (w) "Transplant days" means the number of Medi-Cal days for
31 MS-DRGs 1, 2, 5 to 10, inclusive, 14, 15 and 652, according to
32 the 2010 Patient Discharge file from the Office of Statewide Health
33 Planning and Development accessed on June 28, 2011.

34 (x) "Upper payment limit" means a federal upper payment limit
35 on the amount of the Medicaid payment for which federal financial
36 participation is available for a class of service and a class of health
37 care providers, as specified in Part 447 of Title 42 of the Code of
38 Federal Regulations. The applicable upper payment limit shall be
39 separately calculated for inpatient and outpatient hospital services.

1 14169.52. (a) Private hospitals shall be paid supplemental
2 amounts for the provision of hospital outpatient services as set
3 forth in this section. The supplemental amounts shall be in addition
4 to any other amounts payable to hospitals with respect to those
5 services and shall not affect any other payments to hospitals. The
6 supplemental amounts shall result in payments equal to the
7 statewide aggregate upper payment limit for private hospitals for
8 each subject fiscal year.

9 (b) *Except as set forth in subdivisions (e) and (f), each private*
10 *hospital shall be paid an amount for each subject fiscal year equal*
11 *to a percentage of the hospital's outpatient base amount. The*
12 *percentage shall be the same for each hospital for a subject fiscal*
13 *year. The percentage shall result in payments to hospitals that*
14 *equal the applicable federal upper payment limit as it may be*
15 *modified pursuant to Section 14169.68 for a subject fiscal year.*
16 *For purposes of this subdivision the applicable federal upper*
17 *payment limit shall be the federal upper payment limit for hospital*
18 *outpatient services furnished by private hospitals for each subject*
19 *fiscal year.*

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

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

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

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

35 (e) *Payments shall not be made under this section to a new*
36 *hospital.*

37 (f) *No payments shall be made under this section to a converted*
38 *hospital.*

39 14169.53. ~~Private~~ (a) *Except as provided in Section 14169.68,*
40 *private hospitals shall be paid supplemental amounts for the*

1 provision of hospital inpatient services for the program period as
2 set forth in this section. The supplemental amounts shall be in
3 addition to any other amounts payable to hospitals with respect to
4 those services and shall not affect any other payments to hospitals.
5 The supplemental amounts shall result in payments equal to the
6 statewide aggregate upper payment limit for private hospitals for
7 each subject fiscal year *as it may be modified pursuant to Section*
8 *14169.68.*

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

12 *(1) Eight hundred ninety-six dollars and forty eight cents*
13 *(\$896.48) multiplied by the hospital's general acute care days for*
14 *supplemental payments for the 2014 calendar year, and one*
15 *thousand eighty-one dollars and eighty-four cents (\$1,081.84)*
16 *multiplied by the hospital's general acute care days for*
17 *supplemental payments for the 2015 calendar year.*

18 *(2) For the hospital's acute psychiatric days that were paid*
19 *directly by the department and were not the financial responsibility*
20 *of a mental health plan, nine hundred sixty-five dollars (\$965)*
21 *multiplied by the hospital's acute psychiatric days for supplemental*
22 *payments for the 2014 calendar year, and nine hundred seventy-five*
23 *dollars (\$975) multiplied by the hospital's acute psychiatric days*
24 *for supplemental payments for the 2015 calendar year.*

25 *(3) (A) For the 2014 and 2015 calendar years, two thousand*
26 *five hundred dollars (\$2,500) multiplied by the number of the*
27 *hospital's high acuity days if the hospital's Medicaid inpatient*
28 *utilization rate is less than 43 percent and greater than 5 percent*
29 *and at least 5 percent of the hospital's general acute care days*
30 *are high acuity days.*

31 *(B) The amount under this paragraph shall be in addition to*
32 *the amounts specified in paragraphs (1) and (2).*

33 *(4) (A) For the 2014 and 2015 calendar years, two thousand*
34 *five hundred dollars (\$2,500) multiplied by the number of the*
35 *hospital's high acuity days if the hospital qualifies to receive the*
36 *amount set forth in paragraph (3) and has been designated as a*
37 *Level I, Level II, Adult/Ped Level I, or Adult/Ped Level II trauma*
38 *center by the Emergency Medical Services Authority established*
39 *pursuant to Section 1797.1 of the Health and Safety Code.*

1 (B) *The amount under this paragraph shall be in addition to*
2 *the amounts specified in paragraphs (1), (2), and (3).*

3 (5) (A) *For the 2014 and 2015 calendar years, two thousand*
4 *five hundred dollars (\$2,500) multiplied by the number of the*
5 *hospital's transplant days if the hospital's Medicaid inpatient*
6 *utilization rate is less than 43 percent and greater than 5 percent.*

7 (B) *The amount under this paragraph shall be in addition to*
8 *the amounts specified in paragraphs (1), (2), (3), and (4).*

9 (c) *A private hospital that provided Medi-Cal subacute services*
10 *during the 2010 calendar year and has a Medicaid inpatient*
11 *utilization rate that is greater than 5 percent and less than 43*
12 *percent shall be paid a supplemental amount equal to 50 percent*
13 *for the 2014 calendar year and 60 percent for the 2015 calendar*
14 *year of the Medi-Cal subacute payments paid by the department*
15 *to the hospital during the 2010 calendar year, as reflected in the*
16 *state paid claims file prepared by the department on April 26,*
17 *2013.*

18 (d) (1) *If federal financial participation for a subject fiscal year*
19 *is not available for all of the supplemental amounts payable to*
20 *private hospitals under subdivision (b) due to the application of*
21 *a federal upper payment limit or for any other reason, both of the*
22 *following shall apply:*

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

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

31 (2) *If federal financial participation for a subject fiscal year is*
32 *not available for all of the supplemental amounts payable to private*
33 *hospitals under subdivision (c) due to the application of a federal*
34 *upper payment limit or for any other reason, both of the following*
35 *shall apply:*

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

39 (B) *The amount payable under subdivision (c) to each private*
40 *hospital for the subject fiscal year shall be equal to the amount*

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

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

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

12 *(g) Payments shall not be made under this section to a new*
13 *hospital.*

14 *(h) Payments shall not be made under this section to a converted*
15 *hospital.*

16 *(i) (1) The department shall increase payments to mental health*
17 *plans for the program period exclusively for the purpose of making*
18 *payments to private hospitals. The aggregate amount of the*
19 *increased payments for a subject fiscal quarter shall be the total*
20 *of the individual hospital acute psychiatric supplemental payment*
21 *amounts for all hospitals for which federal financial participation*
22 *is available.*

23 *(2) The payments described in paragraph (1) may be made*
24 *directly by the department to hospitals when federal law does not*
25 *require that the payments be transmitted to hospitals via mental*
26 *health plans.*

27 14169.54. (a) The department shall increase capitation
28 payments to Medi-Cal managed health care plans for each subject
29 fiscal year as set forth in this section.

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

33 (c) The aggregate amount of increased capitation payments to
34 all Medi-Cal managed health care plans for each subject fiscal
35 year shall be the maximum amount for which federal financial
36 participation is available on an aggregate statewide basis for the
37 applicable subject fiscal year.

38 (d) The department shall determine the amount of the increased
39 capitation payments for each managed health care plan. The
40 department shall consider the composition of Medi-Cal enrollees

1 in the plan, the anticipated utilization of hospital services by the
2 plan's Medi-Cal enrollees, and other factors that the department
3 determines are reasonable and appropriate to ensure access to
4 high-quality hospital services by the plan's enrollees.

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

13 (f) (1) The increased capitation payments to managed health
14 care plans under this section shall be made to support the
15 availability of hospital services and ensure access to hospital
16 services for Medi-Cal beneficiaries. The increased capitation
17 payments to managed health care plans shall commence within 90
18 days of the date on which all necessary federal approvals have
19 been received, and shall include, but not be limited to, the sum of
20 the increased payments for all prior months for which payments
21 are due.

22 (2) To secure the necessary funding for the payment or payments
23 made pursuant to paragraph (1), the department may accumulate
24 funds in the Hospital Quality Assurance Revenue Fund, established
25 pursuant to Section 14167.35, for the purpose of funding managed
26 health care capitation payments under this article regardless of the
27 date on which capitation payments are scheduled to be paid in
28 order to secure the necessary total funding for managed health care
29 payments by December 31, 2015.

30 (g) Payments to managed health care plans that would be paid
31 consistent with actuarial certification and enrollment in the absence
32 of the payments made pursuant to this section, including, but not
33 limited to, payments described in Section 14182.15, shall not be
34 reduced as a consequence of payments under this section.

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

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

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

6 (i) ~~In the event~~ (1) If federal financial participation is not
7 available for all of the increased capitation payments determined
8 for a month pursuant to this section for any reason, the increased
9 capitation payments mandated by this section for that month shall
10 be reduced proportionately to the amount for which federal
11 financial participation is available.

12 (2) *The determination under this subdivision for any month in*
13 *the program period shall be made after accounting for all federal*
14 *financial participation necessary for full implementation of Section*
15 *14182.15 for that month.*

16 14169.55. (a) Each managed health care plan receiving
17 increased capitation payments under Section 14169.54 shall expend
18 the capitation rate increases in a manner consistent with actuarial
19 certification, enrollment, and utilization on hospital services. Each
20 managed health care plan shall expend increased capitation
21 payments on hospital services within 30 days of receiving the
22 increased capitation payments to the extent they are made for a
23 subject month that is prior to the date on which the payments are
24 received by the managed health care plan.

25 (b) The sum of all expenditures made by a managed health care
26 plan for hospital services pursuant to this section shall equal, or
27 approximately equal, all increased capitation payments received
28 by the managed health care plan, consistent with actuarial
29 certification, enrollment, and utilization, from the department
30 pursuant to Section 14169.54.

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

1 (d) The supplemental hospital payments made by managed
2 health care plans pursuant to this section shall reflect the overall
3 purpose of this article and Article 5.231 (commencing with Section
4 14169.71).

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

9 *14169.56. (a) Designated public hospitals may be paid direct*
10 *grants in support of health care expenditures, which shall not*
11 *constitute Medi-Cal payments, and which shall be funded by the*
12 *quality assurance fee set forth in Article 5.231 (commencing with*
13 *Section 14169.71).*

14 *(b) Nondesignated public hospitals may be paid direct grants*
15 *in support of health care expenditures, which shall not constitute*
16 *Medi-Cal payments, and which shall be funded by the quality*
17 *assurance fee set forth in Article 5.231 (commencing with Section*
18 *14169.71).*

19 *14169.57. (a) The amount of any payments made under this*
20 *article to private hospitals, including the amount of payments made*
21 *under Sections 14169.52 and 14169.53 and additional payments*
22 *to private hospitals by managed health care plans pursuant to*
23 *Section 14169.54, shall not be included in the calculation of the*
24 *low-income percent or the OBRA 1993 payment limitation, as*
25 *defined in paragraph (24) of subdivision (a) of Section 14105.98,*
26 *for purposes of determining payments to private hospitals.*

27 *(b) The amount of any payments made to a hospital under this*
28 *article shall not be included in the calculation of stabilization*
29 *funding under Article 5.2 (commencing with Section 14166) or*
30 *any successor legislation, including legislation implementing*
31 *California's Bridge to Reform Section 1115(a) Medicaid*
32 *Demonstration (11-W-00193/9).*

33 *14169.58. The payments to a hospital under this article shall*
34 *not be made for any portion of a subject fiscal year during which*
35 *the hospital is closed. A hospital shall be deemed to be closed on*
36 *the first day of any period during which the hospital has no acute*
37 *inpatients for at least 30 consecutive days. Payments under this*
38 *article to a hospital that is closed during any portion of a subject*
39 *fiscal year shall be reduced by applying a fraction, expressed as*
40 *a percentage, the numerator of which shall be the number of days*

1 during the applicable subject fiscal year that the hospital is closed
2 and the denominator of which shall be 365.

3 14169.59. The department shall make disbursements from the
4 Hospital Quality Assurance Revenue Fund consistent with all of
5 the following:

6 (a) Fund disbursements shall be made periodically within 15
7 days of each date on which quality assurance fees are due from
8 hospitals.

9 (b) The funds shall be disbursed in accordance with the order
10 of priority set forth in subdivision (b) of Section 14169.73, except
11 that funds may be set aside for increased capitation payments to
12 managed care health plans pursuant to subdivision (f) of Section
13 14169.54.

14 (c) The funds shall be disbursed in each payment cycle in
15 accordance with the order of priority set forth in subdivision (b)
16 of Section 14169.73 as modified by subdivision (b) so that the
17 supplemental payments, direct grants to hospitals, and increased
18 capitation payments to managed health care plans are made to
19 the maximum extent for which funds are available.

20 (d) To the maximum extent possible, consistent with the
21 availability of funds in the Hospital Quality Assurance Revenue
22 Fund and the timing of federal approvals, the supplemental
23 payments, direct grants to hospitals, and increased capitation
24 payments to managed health care plans under this article shall be
25 made before December 31, 2015.

26 (e) The aggregate amount of funds to be disbursed to private
27 hospitals shall be determined under Sections 14169.52 and
28 14169.53. The aggregate amount of funds to be disbursed to
29 managed health care plans shall be determined under Section
30 14169.54. The aggregate amount of direct grants to designated
31 and nondesignated public hospitals shall be determined under
32 Section 14169.56.

33 ~~14169.56.~~

34 14169.60. (a) Exclusive of payments made under Article _____
35 (commencing with Section _____) and Article _____ (commencing
36 with Section _____) former Article 5.21 (commencing with Section
37 14167.1), former Article 5.226 (commencing with Section 14168.1),
38 and Article 5.228 (commencing with Section 14169.1), payment
39 rates for hospital outpatient services, furnished by private hospitals,
40 nondesignated public hospitals, and designated public hospitals

1 before December 31, 2015, exclusive of amounts payable under
2 this article, shall not be reduced below the rates in effect on January
3 1, 2014.

4 (b) Rates payable to hospitals for hospital inpatient services
5 furnished before December 31, 2015, under contracts negotiated
6 pursuant to the selective provider contracting program under Article
7 2.6 (commencing with Section 14081), shall not be reduced below
8 the contract rates in effect on January 1, 2014. This subdivision
9 shall not prohibit changes to the supplemental payments paid to
10 individual hospitals under Sections 14166.12, 14166.17, and
11 14166.23, provided that the aggregate amount of the payments for
12 each subject fiscal year is not less than the minimum amount
13 permitted under former Section 14167.13.

14 (c) Notwithstanding Section 14105.281, exclusive of payments
15 made under former Article 5.21 (commencing with Section
16 14167.1) ~~and, former Article 5.226 (commencing with Section~~
17 ~~14168.1), and Article 5.228 (commencing with Section 14169.1),~~
18 payments to private hospitals for hospital inpatient services
19 furnished before January 1, 2014, that are not reimbursed under a
20 contract negotiated pursuant to the selective provider contracting
21 program under Article 2.6 (commencing with Section 14081),
22 exclusive of amounts payable under this article, shall not be less
23 than the amount of payments that would have been made under
24 the payment methodology in effect on the effective date of this
25 article.

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

1 amounts payable under Sections 14166.11 and 14166.23, and if
2 amounts payable under Sections 14166.12 and 14166.17 are not
3 included in the payments under the diagnosis-related group
4 methodology and continue to be paid separately to hospitals,
5 exclusive of those amounts, calculated on an aggregate basis for
6 the fiscal year ending June 30, 2012, adjusted, in consultation with
7 the hospital community, to reflect the movement of populations
8 into managed care under Article 5.4 (commencing with Section
9 14180).

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

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

22 *14169.61. (a) The director shall do all of the following:*

23 *(1) Promptly submit any state plan amendment or waiver request*
24 *that may be necessary to implement this article.*

25 *(2) Promptly seek federal approvals or waivers as may be*
26 *necessary to implement this article and to obtain federal financial*
27 *participation to the maximum extent possible for the payments*
28 *under this article.*

29 *(3) Amend the contracts between the managed health care plans*
30 *and the department as necessary to incorporate the provisions of*
31 *Sections 14169.54 and 14169.55 and promptly seek all necessary*
32 *federal approvals of those amendments. The department shall*
33 *pursue amendments to the contracts as soon as possible after the*
34 *effective date of this article and Article 5.231 (commencing with*
35 *Section 14169.71), and shall not wait for federal approval of this*
36 *article or Article 5.231 (commencing with Section 14169.71) prior*
37 *to pursuing amendments to the contracts. The amendments to the*
38 *contracts shall, among other provisions, set forth an agreement*
39 *to increase capitation payments to managed health care plans*
40 *under Section 14169.54 and increase payments to hospitals under*

1 Section 14169.55 in a manner that relates back to January 1, 2014,
2 or as soon thereafter as possible, conditioned on obtaining all
3 federal approvals necessary for federal financial participation for
4 the increased capitation payments to the managed health care
5 plans.

6 (b) In implementing this article, the department may utilize the
7 services of the Medi-Cal fiscal intermediary through a change
8 order to the fiscal intermediary contract to administer this
9 program, consistent with the requirements of Sections 14104.6,
10 14104.7, 14104.8, and 14104.9. Contracts entered into for purposes
11 of implementing this article or Article 5.231 (commencing with
12 Section 14169.71) shall not be subject to Part 2 (commencing with
13 Section 10100) of Division 2 of the Public Contract Code.

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

16 (1) In the event, and on the effective date, of a final judicial
17 determination made by any court of appellate jurisdiction or a
18 final determination by the federal Department of Health and
19 Human Services or the federal Centers for Medicare and Medicaid
20 Services that Section 14169.52 or Section 14169.53 cannot be
21 implemented.

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

23 (A) The federal Centers for Medicare and Medicaid Services
24 denies approval for, or does not approve before January 1, 2016,
25 the implementation of Section 14169.52, Section 14169.53, or the
26 quality assurance fee established pursuant to Article 5.231
27 (commencing with Section 14169.71).

28 (B) Section 14169.52, Section 14169.53, or Article 5.231
29 (commencing with Section 14169.71) cannot be modified by the
30 department pursuant to subdivision (e) of Section 14169.73 in
31 order to meet the requirements of federal law or to obtain federal
32 approval.

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

38 (e) If any hospital, or any party on behalf of a hospital, shall
39 initiate a case or proceeding in any state or federal court in which
40 the hospital seeks any relief of any sort whatsoever, including, but

1 *not limited to, monetary relief, injunctive relief, declaratory relief,*
2 *or a writ, based in whole or in part on a contention that any or all*
3 *of this article or Article 5.231 (commencing with Section 14169.71)*
4 *is unlawful and may not be lawfully implemented, both of the*
5 *following shall apply:*

6 *(1) Payments shall not be made to the hospital pursuant to this*
7 *article until the case or proceeding is finally resolved, including*
8 *the final disposition of all appeals.*

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

14 *(f) Subject to Section 14169.74, no payment shall be made under*
15 *this article until all necessary federal approvals for the payment*
16 *and for the fee provisions in Article 5.231 (commencing with*
17 *Section 14169.71) have been obtained and the fee has been*
18 *imposed and collected. Notwithstanding any other law, payments*
19 *under this article shall be made only to the extent that the fee*
20 *established in Article 5.231 (commencing with Section 14169.71)*
21 *is collected and available to cover the nonfederal share of the*
22 *payments.*

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

27 *(h) All payments made by the department to hospitals and*
28 *managed health care plans under this article shall be made only*
29 *from the following:*

30 *(1) The quality assurance fee set forth in Article 5.231*
31 *(commencing with Section 14169.71) and due and payable on or*
32 *before December 31, 2015, along with any interest or other*
33 *investment income thereon.*

34 *(2) Federal reimbursement and any other related federal funds.*
35 *14169.62. Notwithstanding any other provision of this article*
36 *or Article 5.231 (commencing with Section 14169.71), the director*
37 *may proportionately reduce the amount of any supplemental*
38 *payments or increased capitation payments under this article to*
39 *the extent that the payment would result in the reduction of other*

1 amounts payable to a hospital or managed health care plan due
2 to the application of federal law.

3 14169.63. The director may, pursuant to Section 14169.80,
4 decide not to implement or to discontinue implementation of this
5 article and Article 5.231 (commencing with Section 14169.71),
6 and to retroactively invalidate the requirements for supplemental
7 payments or other payments under this article.

8 14169.64. (a) This article shall remain operative only until
9 the later of the following:

10 (1) January 1, 2017.

11 (2) The date of the last payment of the quality assurance fee
12 payments pursuant to Article 5.231 (commencing Section
13 14169.71).

14 (3) The date of the last payment from the department pursuant
15 to this article.

16 (b) If this article becomes inoperative under paragraph (1) of
17 subdivision (a), this article shall be repealed on January 1, 2017,
18 unless a later enacted statute enacted before that date, deletes or
19 extends that date.

20 (c) If this article becomes inoperative under paragraph (2) or
21 (3) of subdivision (a), this article shall be repealed on January 1
22 of the year following the date this article becomes inoperative,
23 unless a later enacted statute enacted before that date, deletes or
24 extends that date.

25 14169.65. Notwithstanding any other law, if federal approval
26 or a letter that indicates likely federal approval in accordance
27 with Section 14169.74 has not been received on or before
28 December 1, 2015, then this article shall become inoperative, and
29 as of December 1, 2015, is repealed, unless a later enacted statute,
30 that is enacted before December 1, 2015, deletes or extends that
31 date.

32 14169.66. Notwithstanding Chapter 3.5 (commencing with
33 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
34 Code, the department shall implement this article by means of
35 policy letters or similar instructions, without taking further
36 regulatory action.

37 14169.67. If the director determines that this article has become
38 inoperative pursuant to Section 14169.61, 14169.64, 14169.65,
39 or 14169.80, the director shall execute a declaration stating that
40 this determination has been made and stating the basis for this

1 *determination. The director shall retain the declaration and*
2 *provide a copy, within five working days of the execution of the*
3 *declaration, to the fiscal and appropriate policy committees of the*
4 *Legislature. In addition, the director shall post the declaration on*
5 *the department's Internet Web site and the director shall send the*
6 *declaration to the Secretary of State, the Secretary of the Senate,*
7 *the Chief Clerk of the Assembly, and the Legislative Counsel.*

8 *14169.68. (a) It is the intent of the Legislature to consider*
9 *legislation requiring the director to seek approval to increase*
10 *payments to hospitals in accordance with subdivision (b) of Section*
11 *14169.52, subdivision (a) of Section 14169.53, and subdivision*
12 *(c) of Section 14169.54, and to adopt a corresponding increase in*
13 *the fee imposed pursuant to Article 5.231 (commencing with*
14 *Section 14169.71), consistent with federal law and regulations, if*
15 *the director determines that the maximum available upper payment*
16 *limits in subdivision (b) of Section 14169.52 or subdivision (a) of*
17 *Section 14169.53, or the amount of federal financial participation*
18 *for increased capitation payments to managed care health plans*
19 *in subdivision (c) of Section 14169.54, have increased during the*
20 *program period.*

21 *(b) The legislation described in subdivision (a) shall do both of*
22 *the following:*

23 *(1) Require the director to work in consultation with the hospital*
24 *community in seeking any necessary approvals from the federal*
25 *Centers for Medicare and Medicaid Services to increase payments*
26 *to hospitals and to impose corresponding fee increases.*

27 *(2) Require that, in the event that the director determines that*
28 *the maximum available upper payment limits in subdivision (b) of*
29 *Section 14169.52 or subdivision (a) of Section 14169.53, or the*
30 *amount of federal financial participation for increased capitation*
31 *payments to managed care health plans in subdivision (c) of*
32 *Section 14169.54, have increased during the program period, the*
33 *increases shall first be made available for the purposes of this*
34 *section prior to being used for other purposes.*

35 *(c) Notwithstanding any other provision of this article or Article*
36 *5.231 (commencing with Section 14169.71), failure to secure, or*
37 *denial of, any necessary federal approvals required by the*
38 *legislation described in subdivision (a) shall not affect*
39 *implementation of this article or Article 5.231 (commencing with*
40 *Section 14169.71).*

1 ~~SEC. 5.~~

2 *SEC. 8.* Article 5.231 (commencing with Section 14169.71) is
3 added to Chapter 3 of Part 7 of ~~Division 9~~ Part 3 of Division 9 of
4 the Welfare and Institutions Code, to read:

5
6 Article 5.231. Private Hospital Quality Assurance Fee Act of
7 2014 2013

8
9 *14169.71. For the purposes of this article, the following*
10 *definitions shall apply:*

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

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

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

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

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

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

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

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

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

37 (3) “Aggregate quality assurance fee after the application of
38 the fee percentage” means the aggregate quality assurance fee
39 multiplied by the fee percentage for each subject fiscal year.

1 (b) “Annual fee-for-service days” means the number of
2 fee-for-service days of each hospital subject to the quality
3 assurance fee, as reported on the days data source.

4 (c) “Annual managed care days” means the number of managed
5 care days of each hospital subject to the quality assurance fee, as
6 reported on the days data source.

7 (d) “Annual Medi-Cal days” means the number of Medi-Cal
8 days of each hospital subject to the quality assurance fee, as
9 reported on the days data source.

10 (e) “Converted hospital” shall mean a hospital described in
11 subdivision (b) of Section 14169.51.

12 (f) “Days data source” means the hospital’s Annual Financial
13 Disclosure Report filed with the Office of Statewide Health
14 Planning and Development as of June 6, 2013, for its fiscal year
15 ending during 2010.

16 (g) “Designated public hospital” shall have the meaning given
17 in subdivision (d) of Section 14166.1 as of January 1, 2014.

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

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

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

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

28 (2) With the exception of a hospital that is in the Charitable
29 Research Hospital peer group, as set forth in the 1991 Hospital
30 Peer Grouping Report published by the department, a hospital
31 that is a hospital designated as a specialty hospital in the hospital’s
32 most recent publicly available Office of Statewide Health Planning
33 and Development Hospital Annual Financial Disclosure Report.

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

36 (4) A small and rural hospital as specified in Section 124840
37 of the Health and Safety Code designated as that in the hospital’s
38 Office of Statewide Health Planning and Development Hospital
39 Annual Financial Disclosure Report for the hospital’s fiscal year
40 ending in the 2010 calendar year.

1 (i) “Federal approval” means the approval by the federal
2 government of both the quality assurance fee established pursuant
3 to this article and the supplemental payments to private hospitals
4 described in Sections 14169.52 and 14169.53.

5 (j) (1) “Fee-for-service per diem quality assurance fee rate”
6 means a fixed daily fee on fee-for-service days.

7 (2) The fee-for-service per diem quality assurance fee rate shall
8 be four hundred one dollars and forty-one cents (\$401.41) per day
9 for the 2014 calendar year and four hundred fifty-two dollars and
10 seventy three cents (\$452.73) per day for the 2015 calendar year.

11 (3) Upon federal approval or conditional federal approval
12 described in Section 14169.74, the director shall determine the
13 fee-for-service per diem quality assurance fee rate based on the
14 funds required to make the payments specified in Article 5.230
15 (commencing with Section 14169.51), in consultation with the
16 hospital community.

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

25 (l) “Fee percentage” means a fraction, expressed as a
26 percentage, the numerator of which is the amount of payments for
27 each subject fiscal year under Sections 14169.52, 14169.53, and
28 14169.54, for which federal financial participation is available
29 and the denominator of which is ____.

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

33 (n) “Hospital community” means any hospital industry
34 organization or system that represents hospitals.

35 (o) “Managed care days” means inpatient hospital days when
36 the service type is reported as “acute care,” “psychiatric care,”
37 and “rehabilitation care,” and the payer category is reported as
38 “Medicare managed care,” “county indigent programs-managed
39 care,” and “other third parties-managed care,” for purposes of

1 *the Annual Financial Disclosure Report submitted by hospitals to*
2 *the Office of Statewide Health Planning and Development.*

3 (p) *“Managed care per diem quality assurance fee rate” means*
4 *a fixed fee on managed care days of one hundred forty dollars*
5 *(\$140) per day for the 2014 calendar year and one hundred*
6 *sixty-five dollars (\$165) per day for the 2015 calendar year.*

7 (q) *“Medi-Cal days” means inpatient hospital days when the*
8 *service type is reported as “acute care,” “psychiatric care,” and*
9 *“rehabilitation care,” and the payer category is reported as*
10 *“Medi-Cal traditional” and “Medi-Cal managed care,” for*
11 *purposes of the Annual Financial Disclosure Report submitted by*
12 *hospitals to the Office of Statewide Health Planning and*
13 *Development.*

14 (r) *“Medi-Cal fee-for-service days” means inpatient hospital*
15 *days when the service type is reported as “acute care,”*
16 *“psychiatric care,” and “rehabilitation care,” and the payer*
17 *category is reported as “Medi-Cal traditional” for purposes of*
18 *the Annual Financial Disclosure Report submitted by hospitals to*
19 *the Office of Statewide Health Planning and Development.*

20 (s) *“Medi-Cal managed care days” means inpatient hospital*
21 *days as reported on the days data source when the service type is*
22 *reported as “acute care,” “psychiatric care,” and “rehabilitation*
23 *care,” and the payer category is reported as “Medi-Cal managed*
24 *care” for purposes of the Annual Financial Disclosure Report*
25 *submitted by hospitals to the Office of Statewide Health Planning*
26 *and Development.*

27 (t) *“Medi-Cal per diem quality assurance fee rate” means a*
28 *fixed fee on Medi-Cal days of four hundred seventy-four dollars*
29 *and sixty-four cents (\$474.64) per day for the 2014 calendar year*
30 *and five hundred forty-two dollars and thirty-six cents (\$542.36)*
31 *for the 2015 calendar year.*

32 (u) *“New hospital” means a hospital operation, business, or*
33 *facility functioning under current or prior ownership as a private*
34 *hospital that does not have a days data source or a hospital that*
35 *has a days data source in whole, or in part, from a previous*
36 *operator when there is an outstanding monetary liability owed to*
37 *the state in connection with the Medi-Cal program and the new*
38 *operator did not assume liability for the outstanding monetary*
39 *obligation.*

1 (v) “Nondesignated public hospital” means either of the
2 following:

3 (1) A public hospital that is licensed under subdivision (a) of
4 Section 1250 of the Health and Safety Code, is not designated as
5 a specialty hospital in the hospital’s Annual Financial Disclosure
6 Report for the hospital’s latest fiscal year, and satisfies the
7 definition in paragraph (25) of subdivision (a) of Section 14105.98,
8 excluding designated public hospitals.

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

17 (w) “Prepaid health plan hospital” means a hospital owned by
18 a nonprofit public benefit corporation that shares a common board
19 of directors with a nonprofit health care service plan.

20 (x) “Prepaid health plan hospital managed care per diem quality
21 assurance fee rate” means a fixed fee on non-Medi-Cal managed
22 care days for prepaid health plan hospitals of seventy-eight dollars
23 and forty cents (\$78.40) per day for the 2014 calendar year and
24 ninety-two dollars and forty cents (\$92.40) for the 2015 calendar
25 year.

26 (y) “Prepaid health plan hospital Medi-Cal managed care per
27 diem quality assurance fee rate” means a fixed fee on Medi-Cal
28 managed care days for prepaid health plan hospitals of two
29 hundred sixty-five dollars and eighty cents (\$265.80) per day for
30 the 2014 calendar year and three hundred three dollars and
31 seventy-two cents (\$303.72) per day for the 2015 calendar year.

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

38 (aa) “Private hospital” means a hospital that meets all of the
39 following conditions:

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

3 (2) *Is in the Charitable Research Hospital peer group, as set*
4 *forth in the 1991 Hospital Peer Grouping Report published by the*
5 *department, or is not designated as a specialty hospital in the*
6 *hospital's most recent publicly available Office of Statewide Health*
7 *Planning and Development Annual Financial Disclosure Report.*

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

10 (4) *Is a nonpublic hospital, nonpublic converted hospital, or*
11 *converted hospital as those terms are defined in paragraphs (26)*
12 *to (28), inclusive, respectively, of subdivision (a) of Section*
13 *14105.98.*

14 (ab) *“Program period” means the period from January 1, 2014,*
15 *to December 31, 2015, inclusive.*

16 (ac) *“Subject fiscal quarter” means a state fiscal quarter during*
17 *the program period.*

18 (ad) *“Subject fiscal year” means a state fiscal year that ends*
19 *after July 1, 2013, and begins before January 1, 2016.*

20 (ae) *“Upper payment limit” means a federal upper payment*
21 *limit on the amount of the Medicaid payment for which federal*
22 *financial participation is available for a class of service and a*
23 *class of health care providers, as specified in Part 447 of Title 42*
24 *of the Code of Federal Regulations. The applicable upper payment*
25 *limit shall be separately calculated for inpatient and outpatient*
26 *hospital services.*

27 ~~14169.71.~~

28 14169.72. (a) *There shall be imposed on each general acute*
29 *care hospital that is not an exempt facility a quality assurance fee,*
30 *provided that a quality assurance fee under this article shall not be*
31 *imposed on a converted hospital.*

32 (b) *The quality assurance fee shall be computed starting on*
33 *January 1, 2014, and continue through and including December*
34 *31, 2015.*

35 (c) *Subject to Section 14169.74, upon receipt of federal*
36 *approval, the following shall become operative:*

37 (1) *Within 10 business days following receipt of the notice of*
38 *federal approval from the federal government, the department*
39 *shall send notice to each hospital subject to the quality assurance*
40 *fee, and publish on its Internet Web site, the following information:*

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

2 (B) *The fee percentage for each subject fiscal year.*

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

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

7 (B) *The aggregate quality assurance fee.*

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

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

11 (3) *The hospitals shall pay the aggregate quality assurance fee*
12 *after application of the fee percentage for all subject fiscal years*
13 *in eight installments. The department shall establish the date that*
14 *each installment is due, provided that the first installment shall*
15 *be due no earlier than 20 days following the department sending*
16 *the notice pursuant to paragraph (1), and the installments shall*
17 *be paid at least one month apart, but if possible, the installments*
18 *shall be paid on a quarterly basis.*

19 (4) *Notwithstanding any other provision of this section, the*
20 *amount of each hospital's aggregate quality assurance fee after*
21 *the application of the fee percentage for each subject fiscal year*
22 *that has not been paid by the hospital before December 15, 2015,*
23 *pursuant to paragraphs (3) and (8), shall be paid by the hospital*
24 *no later than December 15, 2015.*

25 (5) (A) *Notwithstanding subdivision (1) of Section 14169.71, for*
26 *the purpose of determining the installments under paragraph (3),*
27 *the department shall use an interim fee percentage as follows:*

28 (i) *One hundred percent for the 2014 calendar year until the*
29 *federal government has approved or disapproved additional*
30 *capitation payments described in Section 14169.54 for that subject*
31 *fiscal year.*

32 (ii) *One hundred percent for the 2015 calendar year until the*
33 *federal government has approved or disapproved additional*
34 *capitation payments described in Section 14169.54 for that subject*
35 *fiscal year.*

36 (B) *The director may use a lower interim fee percentage for*
37 *each subject fiscal year under this paragraph as the director, in*
38 *his or her discretion, determines is reasonable in order to generate*
39 *sufficient but not excessive installment payments to make the*
40 *payments described in subdivision (b) of Section 14169.73.*

1 (6) The director shall determine the final fee percentage for
2 each subject fiscal year within 15 days of the approval or
3 disapproval, in whole or in part, by the federal government of all
4 changes to the capitation rates of managed health care plans
5 requested by the department to implement Section 14169.54 for
6 that subject fiscal year, but in no event later than December 1,
7 2015. At the time the director determines the final fee percentage
8 for a subject fiscal year, the director shall also determine the
9 amount of future installment payments of the quality assurance
10 fee for each hospital subject to the fee, if any are due. The amount
11 of each future installment payment shall be established by the
12 director with the objective that the total of the installment payments
13 of the quality assurance fee due from a hospital shall equal the
14 director's estimate for each subject fiscal year for the hospital of
15 the aggregate quality assurance fee after the application of the
16 fee percentage.

17 (7) The director, within 15 days of determining the final fee
18 percentage for a subject fiscal year pursuant to paragraph (6),
19 shall send notice to each hospital subject to the quality assurance
20 fee of the following information:

21 (A) The final fee percentage for each subject fiscal year for
22 which the final fee percentage has been determined.

23 (B) The fee percentage determined under paragraph (5) for
24 each subject fiscal year for which the final fee percentage has not
25 been determined.

26 (C) The aggregate quality assurance fee after application of
27 the fee percentage for each subject fiscal year.

28 (D) The director's estimate of total quality assurance fee
29 payments due from the hospital under this article whether or not
30 paid. This amount shall be the sum of the aggregate quality
31 assurance fee after application of the fee percentage for each
32 subject fiscal year using the fee percentages contained in the
33 notice.

34 (E) The total quality assurance fee payments that the hospital
35 has made under this article.

36 (F) The amount, if any, by which the total quality assurance fee
37 payments due from the hospital under this article as described in
38 subparagraph (D) exceed the total quality assurance fee payments
39 that the hospital has made under this article.

1 (G) *The amount of each remaining installment of the quality*
2 *assurance fee, if any, due from the hospital and the date each*
3 *installment is due. This amount shall be the amount described in*
4 *subparagraph (E) divided by the number of installment payments*
5 *remaining.*

6 (8) *Each hospital that is sent a notice under paragraph (7) shall*
7 *pay the additional installments of the quality assurance fee that*
8 *are due, if any, in the amounts and at the times set forth in the*
9 *notice unless superseded by a subsequent notice from the*
10 *department.*

11 (9) *The department shall refund to a hospital paying the quality*
12 *assurance fee the amount, if any, by which the total quality*
13 *assurance fee payments that the hospital has made under this*
14 *article for all subject fiscal years exceed the total quality assurance*
15 *fee payments due from the hospital under this article within 30*
16 *days of the date on which the notice is sent to the hospital under*
17 *paragraph (7).*

18 (e)

19 (d) *The quality assurance fee, as paid pursuant to this section,*
20 *shall be paid by each hospital subject to the fee to the department*
21 *for deposit in the Hospital Quality Assurance Revenue Fund*
22 *established pursuant to Section 14167.35. Deposits may be*
23 *accepted at any time and will be credited toward the program*
24 *period.*

25 (d)

26 (e) *This section shall become inoperative if the federal Centers*
27 *for Medicare and Medicaid Services denies approval for, or does*
28 *not approve before July 1, 2015, 2016, the implementation of the*
29 *quality assurance fee pursuant to this article or the supplemental*
30 *payments to private hospitals described in Sections 14169.52 and*
31 *14169.53.*

32 (e)

33 (f) *In no case shall the aggregate fees collected in a federal fiscal*
34 *year pursuant to this section, former Section 14167.32, ~~Section~~*
35 *~~14168.32, and Section and Sections 14168.32 and 14169.32~~ exceed*
36 *the maximum percentage of the annual aggregate net patient*
37 *revenue for hospitals subject to the fee that is prescribed pursuant*
38 *to federal law and regulations as necessary to preclude a finding*
39 *that an indirect guarantee has been created.*

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

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

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

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

26 ~~(f)~~

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

30 ~~(g)~~

31 (k) This subdivision creates a contractually enforceable promise
32 on behalf of the state to use the proceeds of the quality assurance
33 fee, including any federal matching funds, solely and exclusively
34 for the purposes set forth in this article as they existed on the
35 effective date of this article, to limit the amount of the proceeds
36 of the quality assurance fee to be used to pay for the health care
37 coverage of children to the amounts specified in this article, to
38 limit any payments for the department's costs of administration
39 to the amounts set forth in this article on the effective date of this
40 article, to maintain and continue prior reimbursement levels as set

1 forth in Section ~~_____~~ 14169.60 on the effective date of that ~~article~~
2 *section*, and to otherwise comply with all its obligations set forth
3 in Article 5.230 (commencing with Section 14169.51) and this
4 article provided that amendments that arise from, or have as a basis
5 for, a decision, advice, or determination by the federal Centers for
6 Medicare and Medicaid Services relating to federal approval of
7 the quality assurance fee or the payments set forth in this article
8 or Article 5.230 (commencing with Section 14169.51) shall control
9 for the purposes of this subdivision.

10 ~~(h)~~

11 *(l)* (1) Effective January 1, ~~2014~~ 2016, the rates payable to
12 hospitals and managed health care plans under Medi-Cal shall be
13 the rates then payable without the supplemental and increased
14 capitation payments set forth in Article 5.230 (commencing with
15 Section 14169.51).

16 (2) The supplemental payments and other payments under
17 Article 5.230 (commencing with Section 14169.51) shall be
18 regarded as quality assurance payments, the implementation or
19 suspension of which does not affect a determination of the
20 adequacy of any rates under federal law.

21 *(m)* (1) *Subject to paragraph (2), the director may waive any*
22 *or all interest and penalties assessed under this article in the event*
23 *that the director determines, in his or her sole discretion, that the*
24 *hospital has demonstrated that imposition of the full quality*
25 *assurance fee on the timelines applicable under this article has a*
26 *high likelihood of creating a financial hardship for the hospital*
27 *or a significant danger of reducing the provision of needed health*
28 *care services.*

29 (2) *Waiver of some or all of the interest or penalties under this*
30 *subdivision shall be conditioned on the hospital's agreement to*
31 *make fee payments, or to have the payments withheld from*
32 *payments otherwise due from the Medi-Cal program to the hospital,*
33 *on a schedule developed by the department that takes into account*
34 *the financial situation of the hospital and the potential impact on*
35 *services.*

36 (3) *A decision by the director under this subdivision shall not*
37 *be subject to judicial review.*

38 (4) *If fee payments are remitted to the department after the date*
39 *determined by the department to be the final date for calculating*
40 *the final supplemental payments under this article and Article*

1 5.230 (commencing with Section 14169.51), the fee payments shall
 2 be retained in the fund for purposes of funding supplemental
 3 payments supported by a hospital quality assurance fee program
 4 implemented under subsequent legislation. However, if
 5 supplemental payments are not implemented under subsequent
 6 legislation, then those fee payments shall be deposited in the
 7 Distressed Hospital Fund.

8 (5) If during the implementation of this article, fee payments
 9 that were due under former Article 5.21 (commencing with Section
 10 14167.1) and former Article 5.22 (commencing with Section
 11 14167.31), or former Article 5.226 (commencing with Section
 12 14168.1) and Article 5.227 (commencing with Section 14168.31),
 13 or Article 5.228 (commencing with Section 14169.1) and Article
 14 5.229 (commencing with Section 14169.31) are remitted to the
 15 department under a payment plan or for any other reason, and the
 16 final date for calculating the final supplemental payments under
 17 those articles has passed, then those fee payments shall be
 18 deposited in the fund to support the uses established by this article.

19 ~~14169.72.~~

20 14169.73. (a) (1) All fees required to be paid to the state
 21 pursuant to this article shall be paid in the form of remittances
 22 payable to the department.

23 (2) The department shall directly transmit the fee payments to
 24 the Treasurer to be deposited in the Hospital Quality Assurance
 25 Revenue Fund, created pursuant to Section 14167.35.
 26 Notwithstanding Section 16305.7 of the Government Code, any
 27 interest and dividends earned on deposits in the fund from the
 28 proceeds of the fee assessed pursuant to this article shall be retained
 29 in the fund for purposes specified in subdivision (b).

30 (b) Notwithstanding subdivision (c) of Section 14167.35,
 31 subdivision (b) of Section 14168.33, and subdivision (b) of Section
 32 14169.33, all funds from the proceeds of the fee assessed pursuant
 33 to this article in the Hospital Quality Assurance Revenue Fund,
 34 together with any interest and dividends earned on money in the
 35 fund, shall, upon appropriation by the Legislature, continue to be
 36 used exclusively to enhance federal financial participation for
 37 hospital services under the Medi-Cal program, to provide additional
 38 reimbursement to, and to support quality improvement efforts of,
 39 hospitals, and to minimize uncompensated care provided by
 40 hospitals to uninsured ~~patients~~: patients, as well as to pay for the

1 state's administrative costs and to provide funding for children's
2 health coverage, in the following order of priority:

3 (1) To pay for the department's staffing and administrative costs
4 directly attributable to implementing Article 5.230 (commencing
5 with Section 14169.51) and this article, not to exceed two million
6 dollars (\$2,000,000) for the program period.

7 (2) To pay for the health care coverage for children in the
8 amount of one hundred fifty-five million dollars (\$155,000,000)
9 for each subject fiscal quarter during the 2014 and 2015 calendar
10 years.

11 (3) To make increased capitation payments to managed health
12 care plans pursuant to Article 5.230 (commencing with Section
13 14169.51).

14 (4) To make increased payments or direct grants to hospitals
15 pursuant to Article 5.230 (commencing with Section 14169.51).

16 (c) Any amounts of the quality assurance fee collected in excess
17 of the funds required to implement subdivision (b), including any
18 funds recovered under subdivision (d) of Section 14169.61 or
19 subdivision (e) of Section 14169.78, shall be refunded to general
20 acute care hospitals, pro rata with the amount of quality assurance
21 fee paid by the hospital, subject to the limitations of federal law.
22 If federal rules prohibit the refund described in this subdivision,
23 the excess funds shall be deposited in the Distressed Hospital Fund
24 to be used for the purposes described in Section 14166.23, and
25 shall be supplemental to and not supplant existing funds.

26 (d) Any methodology or other provision specified in Article
27 5.230 (commencing with Section 14169.51) or this article may be
28 modified by the department, in consultation with the hospital
29 community, to the extent necessary to meet the requirements of
30 federal law or regulations to obtain federal approval or to enhance
31 the probability that federal approval can be obtained, provided
32 the modifications do not violate the spirit and intent of Article
33 5.230 (commencing with Section 14169.51) or this article and are
34 not inconsistent with the conditions of implementation set forth in
35 Section 14169.80.

36 (e) The department, in consultation with the hospital community,
37 shall make adjustments, as necessary, to the amounts calculated
38 pursuant to Section 14169.72 in order to ensure compliance with
39 the federal requirements set forth in Section 433.68 of Title 42 of
40 the Code of Federal Regulations or elsewhere in federal law.

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

11 (g) Notwithstanding Chapter 3.5 (commencing with Section
12 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
13 the department may implement this article or Article 5.230
14 (commencing with Section 14169.51) by means of provider
15 bulletins, all plan letters, or other similar instruction, without
16 taking regulatory action. The department shall also provide
17 notification to the Joint Legislative Budget Committee and to the
18 appropriate policy and fiscal committees of the Legislature within
19 five working days when the above-described action is taken in
20 order to inform the Legislature that the action is being
21 implemented.

22 14169.74. (a) Notwithstanding any other provision of this
23 article or Article 5.230 (commencing with Section 14169.51)
24 requiring federal approvals, the department may impose and
25 collect the quality assurance fee and may make payments under
26 this article and Article 5.230 (commencing with Section 14169.51),
27 including increased capitation payments, based upon receiving a
28 letter from the federal Centers for Medicare and Medicaid Services
29 or the United States Department of Health and Human Services
30 that indicates likely federal approval, but only if and to the extent
31 that the letter is sufficient as set forth in subdivision (b).

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

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

38 (2) The director, after consultation with the hospital community,
39 has determined, in the exercise of his or her sole discretion, that

1 *the letter provides a sufficient level of assurance to justify advanced*
2 *implementation of the fee and payment provisions.*

3 *(c) Nothing in this section shall be construed as modifying the*
4 *requirement under Section 14169.61 that payments shall be made*
5 *only to the extent a sufficient amount of funds collected as the*
6 *quality assurance fee are available to cover the nonfederal share*
7 *of those payments.*

8 *(d) Upon notice from the federal government that final federal*
9 *approval for the fee model under this article or for the*
10 *supplemental payments to private hospitals under Section 14169.52*
11 *or 14169.53 has been denied, any fees collected pursuant to this*
12 *section shall be refunded and any payments made pursuant to this*
13 *article or Article 5.230 (commencing with Section 14169.51) shall*
14 *be recouped, including, but not limited to, supplemental payments*
15 *and grants, increased capitation payments, payments to hospitals*
16 *by health care plans resulting from the increased capitation*
17 *payments, and payments for the health care coverage of children.*
18 *To the extent fees were paid by a hospital that also received*
19 *payments under this section, the payments may first be recouped*
20 *from fees that would otherwise be refunded to the hospital prior*
21 *to the use of any other recoupment method allowed under law.*

22 *(e) Any payment made pursuant to this section shall be a*
23 *conditional payment until final federal approval has been received.*

24 *(f) The director shall have broad authority under this section*
25 *to collect the quality assurance fee for an interim period after*
26 *receipt of the letter described in subdivision (a) pending receipt*
27 *of all necessary federal approvals. This authority shall include*
28 *discretion to determine both of the following:*

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

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

33 *(g) The department may draw against the Hospital Quality*
34 *Assurance Revenue Fund for all administrative costs associated*
35 *with implementation under this article or Article 5.230*
36 *(commencing with Section 14169.51).*

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

1 14169.75. (a) Notwithstanding any other law, the director
2 shall have discretion to modify any timeline or timelines in this
3 article or Article 5.230 (commencing with Section 14169.51) if
4 the letter that indicates likely federal approval, as described in
5 Section 14169.74, is not secured by December 15, 2015, and the
6 director determines that it is impossible from an operational
7 perspective to implement a timeline or timelines without the
8 modification.

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

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

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

18 14169.76. (a) Upon receipt of a letter that indicates likely
19 federal approval that the director determines is sufficient for
20 implementation under Section 14169.74, or upon the receipt of
21 federal approval, the following shall occur:

22 (1) To the maximum extent possible, and consistent with the
23 availability of funds in the Hospital Quality Assurance Revenue
24 Fund, the department shall make all of the payments under Sections
25 14169.52, 14169.53, and 14169.54, including, but not limited to,
26 supplemental payments and increased capitation payments, prior
27 to January 1, 2016, except that the increased capitation payments
28 under Section 14169.54 shall not be made until federal approval
29 is obtained for these payments.

30 (2) The department shall make supplemental payments to
31 hospitals under Article 5.230 (commencing with Section 14169.51)
32 consistent with the timeframe described in Section 14169.59 or a
33 modified timeline developed pursuant to Section 14169.75.

34 (b) Notwithstanding any other provision of this article or Article
35 5.230 (commencing with Section 14169.51), if the director
36 determines, on or after December 15, 2015, that there are
37 insufficient funds available in the Hospital Quality Assurance
38 Revenue Fund to make all scheduled payments under Article 5.230
39 (commencing with Section 14169.51) before January 1, 2016, he
40 or she shall consult with representatives of the hospital community

1 to develop an acceptable plan for making additional payments to
2 hospitals and managed health care plans to maximize the use of
3 delinquent fee payments or other deposits or interest projected to
4 become available in the fund after December 15, 2015, but before
5 June 15, 2016.

6 (c) Nothing in this section shall require the department to
7 continue to make payments under Article 5.230 (commencing with
8 Section 14169.51) if, after the consultation required under
9 subdivision (b), the director determines in the exercise of his or
10 her sole discretion that a workable plan for the continued payments
11 cannot be developed.

12 (d) Subdivisions (b) and (c) shall be implemented only if and to
13 the extent federal financial participation is available for continued
14 supplemental payments and to providers and continued increased
15 capitation payments to managed health care plans.

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

20 (f) Nothing in this section shall be read as affecting the
21 department's ongoing authority to continue, after December 31,
22 2015, to collect quality assurance fees imposed on or before
23 December 31, 2015.

24 14169.77. Notwithstanding any other law, if actual federal
25 approval or a letter that indicates likely federal approval in
26 accordance with Section 14169.74 has not been received on or
27 before December 1, 2015, then this article shall become
28 inoperative, and as of December 1, 2015, is repealed, unless a
29 later enacted statute, that is enacted before December 1, 2015,
30 deletes or extends that date.

31 ~~14169.73.~~

32 14169.78. (a) This article shall be implemented only as long
33 as all of the following conditions are met:

34 ~~(1) Subject to Section _____, the quality assurance fee is~~
35 ~~established in a manner that is fundamentally consistent with this~~
36 ~~article.~~

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

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

4 ~~(b) No hospital shall be required to pay the quality assurance~~
5 ~~fee to the department unless and until the state receives and~~
6 ~~maintains federal approval.~~

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

10 ~~(1) The federal Centers for Medicare and Medicaid Services~~
11 ~~allows the use of the quality assurance fee as set forth in this article~~
12 ~~in accordance with federal approval.~~

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

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

20 *(1) Subject to Section 14169.73, the quality assurance fee is*
21 *established in a manner that is fundamentally consistent with this*
22 *article.*

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

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

29 *(b) No hospital shall be required to pay the quality assurance*
30 *fee to the department unless and until the state receives and*
31 *maintains federal approval.*

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

35 *(1) The federal Centers for Medicare and Medicaid Services*
36 *allows the use of the quality assurance fee as set forth in this article*
37 *in accordance with federal approval.*

38 *(2) Article 5.230 (commencing with Section 14169.51) is enacted*
39 *and remains in effect and hospitals are reimbursed the increased*

1 rates for services during the program period, as defined in Section
2 14169.51.

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

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

8 (1) In the event, and on the effective date, of a final judicial
9 determination made by any court of appellate jurisdiction or a
10 final determination by the United States Department of Health and
11 Human Services or the federal Centers for Medicare and Medicaid
12 Services that the quality assurance fee established pursuant to this
13 article cannot be implemented.

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

15 (A) The federal Centers for Medicare and Medicaid Services
16 denies approval for, or does not approve before January 1, 2016,
17 the implementation of Sections 14169.52 and 14169.53 or this
18 article.

19 (B) Section 14169.52, Section 14169.53, or this article cannot
20 be modified by the department pursuant to subdivision (d) of
21 Section 14169.73 in order to meet the requirements of federal law
22 or to obtain federal approval.

23 (e) If this article becomes inoperative pursuant to paragraph
24 (1) of subdivision (d) and the determination applies to any period
25 or periods of time prior to the effective date of the determination,
26 the department may recoup all payments made pursuant to Article
27 5.230 (commencing with Section 14169.51) during that period or
28 those periods of time.

29 (f) (1) If all necessary final federal approvals are not received
30 as described and anticipated under this article or Article 5.230
31 (commencing with Section 14169.51), the director shall have the
32 discretion and authority to develop procedures for recoupment
33 from managed health care plans, and from hospitals under contract
34 with managed health care plans, of any amounts received pursuant
35 to this article or Article 5.230 (commencing with Section
36 14169.51).

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

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

6 14169.79. Notwithstanding any other provision of this article
7 or Article 5.230 (commencing with Section 14169.51),
8 supplemental payments or other payments under Article 5.230
9 (commencing with Section 14169.51) shall only be required and
10 payable in any quarter for which a fee payment obligation exists.

11 14169.80. (a) This article and Article 5.230 (commencing with
12 Section 14169.51) shall become inoperative and the requirements
13 for supplemental payments or other payments under Article 5.230
14 (commencing with Section 14169.51) shall be retroactively
15 invalidated, on the first day of the first month of the calendar
16 quarter following notification to the Joint Legislative Budget
17 Committee by the Department of Finance, that any of the following
18 have occurred:

19 (1) A final judicial determination by the California Supreme
20 Court or any California Court of Appeal that the revenues collected
21 pursuant to this article that are deposited in the Hospital Quality
22 Assurance Revenue Fund are either of the following:

23 (A) General Fund proceeds of taxes appropriated pursuant to
24 Article XIII B of the California Constitution, as used in subdivision
25 (b) of Section 8 of Article XVI of the California Constitution.

26 (B) Allocated local proceeds of taxes, as used in subdivision
27 (b) of Section 8 of Article XVI of the California Constitution.

28 (2) The department has sought but has not received federal
29 financial participation for the supplemental payments and other
30 costs required by this article for which federal financial
31 participation has been sought.

32 (3) A lawsuit related to this article or Article 5.230 (commencing
33 with Section 14169.51) is filed against the state and a preliminary
34 injunction or other order has been issued that results in a financial
35 disadvantage to the state.

36 (4) The director, in consultation with the Department of Finance,
37 determines that the implementation of this article or Article 5.230
38 (commencing with Section 14169.51) has resulted in a financial
39 disadvantage to the state.

1 (b) For purposes of this section, “financial disadvantage to the
2 state” means either of the following:

3 (1) A loss of federal financial participation.

4 (2) A cost to the General Fund, that is equal to or greater than
5 one-quarter of 1 percent of the General Fund expenditures
6 authorized in the most recent annual Budget Act.

7 (c) (1) The director shall have the authority to recoup any
8 payments made under Article 5.230 (commencing with Section
9 14169.51) if any of the following apply:

10 (A) Recoupment of payments made under Article 5.230
11 (commencing with Section 14169.51) is ordered by a court.

12 (B) Federal financial participation is not available for payments
13 made under Article 5.230 (commencing with Section 14169.51)
14 for which federal financial participation has been sought.

15 (C) Recoupment of payments made under Article 5.230
16 (commencing with Section 14169.51) is necessary to prevent a
17 General Fund cost that is estimated to be equal to or greater than
18 one-quarter of 1 percent of the General Fund expenditures
19 authorized in the most recent annual Budget Act and that results
20 from implementation of a court order or the unavailability of
21 federal financial participation.

22 (2) In the event payments are recouped for a particular quarter,
23 fees paid by a hospital for that quarter pursuant to this article
24 shall be refunded to the extent that the hospital meets both of the
25 following conditions:

26 (A) The hospital has actually paid the fee for the subject quarter
27 and for all prior quarters.

28 (B) The hospital has returned the payment received pursuant
29 to Article 5.230 (commencing with Section 14169.51) for that
30 quarter, or has had that payment recouped through a withholding
31 of funds owed by Medi-Cal or other state payments, or recouped
32 through other means.

33 (d) In the event the department determines that recoupment of
34 supplemental payments is necessary to implement any provision
35 of this section, the department may recoup payments made pursuant
36 to Article 5.230 (commencing with Section 14169.51) from fees
37 paid by the hospital pursuant to this article.

38 (e) Concurrent with invoking any provision of this section, the
39 director shall notify the fiscal and appropriate policy committees

1 of the Legislature of the intended action and the specific reason
2 or reasons for the proposed action.

3 14169.81. Notwithstanding Chapter 3.5 (commencing with
4 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
5 Code, the department shall implement this article by means of
6 policy letters or similar instructions, without taking further
7 regulatory action.

8 14169.82. (a) This article shall remain operative only until
9 the later of the following:

10 (1) January 1, 2017.

11 (2) The date of the last payment of the quality assurance fee
12 payments pursuant to this article.

13 (3) The date of the last payment from the department pursuant
14 to Article 5.230 (commencing with Section 14169.51).

15 (b) If this article becomes inoperative under paragraph (1) of
16 subdivision (a), this article shall be repealed on January 1, 2017,
17 unless a later enacted statute enacted before that date, deletes or
18 extends that date.

19 (c) If this article becomes inoperative under paragraph (2) or
20 (3) of subdivision (a), this article shall be repealed on January 1
21 of the year following the date this article becomes inoperative,
22 unless a later enacted statute enacted before that date, deletes or
23 extends that date.

24 14169.83. If the director determines that this article has become
25 inoperative pursuant to Section 14169.77, 14169.78, 14169.80,
26 or 14169.82, or that Section 14169.72 has become inoperative
27 pursuant to subdivision (e) of that section, the director shall
28 execute a declaration stating that this determination has been
29 made and stating the basis for this determination. The director
30 shall retain the declaration and provide a copy, within five working
31 days of the execution of the declaration, to the fiscal and
32 appropriate policy committees of the Legislature. In addition, the
33 director shall post the declaration on the department's Internet
34 Web site and the director shall send the declaration to the
35 Secretary of State, the Secretary of the Senate, the Chief Clerk of
36 the Assembly, and the Legislative Counsel.

37 ~~SEC. 6.~~

38 SEC. 9. This act is an urgency statute necessary for the
39 immediate preservation of the public peace, health, or safety within

1 the meaning of Article IV of the Constitution and shall go into
2 immediate effect. The facts constituting the necessity are:
3 In order to make the necessary changes to increase ~~medi-cal~~
4 *Medi-Cal* payments to hospitals and improve access at the earliest
5 time, so as to allow this act to be operative as soon as approval
6 from the federal ~~centers~~ *Centers* for Medicare and Medicaid
7 Services is obtained by the State Department of Health Care
8 Services, it is necessary that this act takes effect immediately.

O