

AMENDED IN ASSEMBLY AUGUST 27, 2013

AMENDED IN ASSEMBLY AUGUST 14, 2013

AMENDED IN SENATE APRIL 17, 2013

**SENATE BILL**

**No. 239**

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**Introduced by Senators Hernandez and Steinberg**

February 12, 2013

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An act to amend 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) 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: hospitals: quality assurance fee.

**Existing**

(1) *Existing* law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. 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, subject to federal approval, impose a hospital quality assurance fee, as specified, on certain general acute care hospitals from January 1, 2014, through December 31, 2015, to be deposited into the Hospital Quality Assurance Revenue Fund. This bill would, subject to federal approval, provide that moneys in the Hospital Quality Assurance Revenue Fund shall, upon appropriation by the Legislature, be *continuously appropriated and* 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, *hospitals and* 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 *and returned to the private hospitals pro rata, as specified.* 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 returned to the private hospitals pro rata, as specified.~~ The bill would make other conforming changes.

~~Existing~~

~~(2) 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~~

~~(3) 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 *or a contract with a county organized health system* shall cease to be a requirement for a hospital's participation in the Construction and Renovation Reimbursement Program.

~~This~~

~~(4) This bill would declare that it is to take effect immediately as an urgency statute.~~

Vote:  $\frac{2}{3}$ . Appropriation: 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:

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

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

34 (3) No hospital shall be required to pay the quality assurance  
35 fee to the department unless and until the state receives and

1 maintains federal approval of the quality assurance fee and related  
2 supplemental payments to hospitals.

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

6 SEC. 3. Section 14164 of the Welfare and Institutions Code is  
7 amended to read:

8 14164. (a) In addition to the required intergovernmental  
9 transfers set forth in Section 14163, any county, other political  
10 subdivision of the state, or governmental entity in the state may  
11 elect to transfer funds, subject to subdivision (m) of Section 14163,  
12 to the department in support of the Medi-Cal program. Those  
13 transfers may consist of cash or loans to the state. The department  
14 shall have the discretion to accept or not accept any elective transfer  
15 from a county, political subdivision, or other governmental entity,  
16 as well as the discretion of whether to deposit the transfer in the  
17 Medi-Cal Inpatient Payment Adjustment Fund established pursuant  
18 to Section 14163. If the department accepts a transfer pursuant to  
19 this section, the department shall obtain federal matching funds to  
20 the full extent permitted by federal law.

21 (b) (1) The director may maximize available federal financial  
22 participation to provide access to services provided by hospitals  
23 that are not reimbursed by certified public expenditure pursuant  
24 to Article 5.2 (commencing with Section 14166) by authorizing  
25 the use of intergovernmental transfers to fund the nonfederal share  
26 of supplemental payments as permitted under Section 433.51 of  
27 Title 42 of the Code of Federal Regulations or any other applicable  
28 federal Medicaid laws. The transferring entity shall certify to the  
29 department that the funds are in compliance with all federal rules  
30 and regulations. Any payments funded by intergovernmental  
31 transfers shall remain with the hospital and shall not be transferred  
32 back to any county, other political subdivision of the state, or  
33 governmental entity in the state, except for federal disallowance  
34 or withhold recovery efforts by the department. Participation in  
35 intergovernmental transfers under this subdivision is voluntary on  
36 the part of the transferring entity for purposes of all applicable  
37 federal laws.

38 (2) This subdivision shall be implemented only to the extent  
39 federal financial participation is not jeopardized.

1 SEC. 4. Section 14165 of the Welfare and Institutions Code is  
2 amended to read:

3 14165. (a) There is hereby created in the Governor's office  
4 the California Medical Assistance Commission, for the purpose  
5 of contracting with health care delivery systems for the provision  
6 of health care services to recipients under the California Medical  
7 Assistance Program.

8 (b) Notwithstanding any other law, the commission created  
9 pursuant to subdivision (a) shall continue through June 30, 2012,  
10 after which, it shall be dissolved and the term of any commissioner  
11 serving at that time shall end.

12 (1) Upon dissolution of the commission, all powers, duties, and  
13 responsibilities of the commission shall be transferred to the  
14 Director of Health Care Services. These powers, duties, and  
15 responsibilities shall include, but are not limited to, those exercised  
16 in the operation of the selective provider contracting program  
17 pursuant to Article 2.6 (commencing with Section 14081).

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

22 (B) Employees who transfer pursuant to subparagraph (A) shall  
23 be subject to the same conditions of employment under the  
24 department as they were under the California Medical Assistance  
25 Commission, including retention of their exempt status, until the  
26 diagnosis-related groups payment system described in Section  
27 14105.28 replaces the contract-based payment system described  
28 in this article.

29 (C) (i) Notwithstanding any other law or rule, persons employed  
30 by the department who transferred to the department pursuant to  
31 subparagraph (A) shall be eligible to apply for civil service  
32 examinations. Persons receiving passing scores shall have their  
33 names placed on lists resulting from these examinations, or  
34 otherwise gain eligibility for appointment. In evaluating minimum  
35 qualifications, related California Medical Assistance Commission  
36 experience shall be considered state civil service experience in a  
37 class deemed comparable by the State Personnel Board, based on  
38 the duties and responsibilities assigned.

39 (ii) On the date the diagnosis-related groups payment system  
40 described in Section 14105.28 replaces the contract-based system

1 described in this article, employees who transferred to the  
2 department pursuant to subparagraph (A) shall transfer to civil  
3 service classifications within the department for which they are  
4 eligible.

5 (3) Upon a determination by the Director of Health Care  
6 Services that a payment system based on diagnosis-related groups  
7 as described in Section 14105.28 that is sufficient to replace the  
8 contract-based payment system described in this article has been  
9 developed and implemented, the powers, duties, and responsibilities  
10 conferred on the commission and transferred to the Director of  
11 Health Care Services shall no longer be exercised, excluding all  
12 of the following:

13 (A) Stabilization payments made or committed from Sections  
14 14166.14 and 14166.19 for services rendered prior to the director's  
15 determination pursuant to this paragraph.

16 (B) The ability to negotiate and make payments from the Private  
17 Hospital Supplemental Fund, established pursuant to Section  
18 14166.12, and the Nondesignated Public Hospital Supplemental  
19 Fund, established pursuant to Section 14166.17.

20 (C) The ability to continue to administer and distribute payments  
21 for the Construction Renovation Reimbursement Program, in  
22 accordance with Sections 14085 to 14085.57, inclusive.  
23 Notwithstanding any other law, maintaining or negotiating a  
24 selective provider contract pursuant to Article 2.6 (commencing  
25 with Section 14081) *or a contract with a county organized health*  
26 *system* shall cease to be a requirement for a hospital's participation  
27 in the Construction Renovation Reimbursement Program.

28 (4) Protections afforded to the negotiations and contracts of the  
29 commission by the California Public Records Act (Chapter 3.5  
30 (commencing with Section 6250) of Division 7 of Title 1 of the  
31 Government Code) shall be applicable to the negotiations and  
32 contracts conducted or entered into pursuant to this section by the  
33 State Department of Health Care Services.

34 (c) Notwithstanding the rulemaking provisions of Chapter 3.5  
35 (commencing with Section 11340) of Part 1 of Division 3 of Title  
36 2 of the Government Code, or any other provision of law, the State  
37 Department of Health Care Services may implement and administer  
38 this section by means of provider bulletins or other similar  
39 instructions, without taking regulatory action. The authority to  
40 implement this section as set forth in this subdivision shall include

1 the authority to give notice by provider bulletin or other similar  
2 instruction of a determination made pursuant to paragraph (3) of  
3 subdivision (b) and to modify or supersede existing regulations in  
4 Title 22 of the California Code of Regulations that conflict with  
5 implementation of this section.

6 SEC. 5. Section 14167.35 of the Welfare and Institutions Code  
7 is amended to read:

8 14167.35. (a) The Hospital Quality Assurance Revenue Fund  
9 is hereby created in the State Treasury.

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

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

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

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

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



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

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

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

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

22 (e) Any methodology or other provision specified in Article  
23 5.21 (commencing with Section 14167.1) and this article may be  
24 modified by the department, in consultation with the hospital  
25 community, to the extent necessary to meet the requirements of  
26 federal law or regulations to obtain federal approval or to enhance  
27 the probability that federal approval can be obtained, provided the  
28 modifications do not violate the spirit and intent of Article 5.21  
29 (commencing with Section 14167.1) or this article and are not  
30 inconsistent with the conditions of implementation set forth in  
31 Section 14167.36.

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

37 (g) The department shall request approval from the federal  
38 Centers for Medicare and Medicaid Services for the implementation  
39 of this article. In making this request, the department shall seek  
40 specific approval from the federal Centers for Medicare and

1 Medicaid Services to exempt providers identified in this article as  
2 exempt from the fees specified, including the submission, as may  
3 be necessary, of a request for waiver of the broad based  
4 requirement, waiver of the uniform fee requirement, or both,  
5 pursuant to paragraphs (e)(1) and (e)(2) of Section 433.68 of Title  
6 42 of the Code of Federal Regulations.

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

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

16 (B) Reduces or increases the amount of the fee payable by a  
17 hospital in total under this article for the 2008–09, 2009–10, and  
18 2010–11 federal fiscal years by more than 2 percent of the amount  
19 that would be determined under this article without any change or  
20 adjustment.

21 (2) The department shall provide the Joint Legislative Budget  
22 Committee and the fiscal and appropriate policy committees of  
23 the Legislature a status update of the implementation of Article  
24 5.21 (commencing with Section 14167.1) and this article on  
25 January 1, 2010, and quarterly thereafter. Information on any  
26 adjustments or modifications to the provisions of this article or  
27 Article 5.21 (commencing with Section 14167.1) that may be  
28 required for federal approval shall be provided coincident with the  
29 consultation required under subdivisions (f) and (g).

30 (i) Notwithstanding Chapter 3.5 (commencing with Section  
31 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
32 the department may implement this article or Article 5.21  
33 (commencing with Section 14167.1) by means of provider  
34 bulletins, all plan letters, or other similar instruction, without taking  
35 regulatory action. The department shall also provide notification  
36 to the Joint Legislative Budget Committee and to the appropriate  
37 policy and fiscal committees of the Legislature within five working  
38 days when the above-described action is taken in order to inform  
39 the Legislature that the action is being implemented.

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

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

10 SEC. 6. Section 14167.37 is added to the Welfare and  
11 Institutions Code, to read:

12 14167.37. (a) *(1)* The department shall make available all  
13 public documentation it uses to administer and audit the program  
14 authorized under Article 5.230 (commencing with Section  
15 14169.51) and Article 5.231 (commencing with Section 14169.71)  
16 pursuant to the Public Records Act (Chapter 3.5 (commencing  
17 with Section 6250) of Division 7 of Title 1 of the Government  
18 Code). ~~In addition, upon request, the department shall assist~~  
19 ~~hospitals in reconciling payments due and received from Medi-Cal~~  
20 ~~managed care plans under Article 5.230 (commencing with Section~~  
21 ~~14169.51).~~

22 *(2)* ~~In addition, upon request from a hospital, the department~~  
23 ~~shall require Medi-Cal managed care plans to furnish hospitals~~  
24 ~~with the amounts the plan intends to pay to the hospital pursuant~~  
25 ~~to Article 5.230 (commencing with Section 14169.51). Nothing in~~  
26 ~~this paragraph shall require the department to reconcile payments~~  
27 ~~made to individual hospitals from Medi-Cal managed care plans.~~

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

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

36 (2) Quarterly updates on payments, fee schedules, and model  
37 updates when applicable.

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

1 (c) For purposes of this section, the following definitions shall  
2 apply:

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

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

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

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

23  
24 Article 5.230. Medi-Cal Hospital Reimbursement Improvement  
25 Act of 2013  
26

27 14169.51. ~~(a) “Acute~~ *For purposes of this article, the following*  
28 *definitions shall apply:*

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

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

39 (c) “Days data source” means the hospital’s Annual Financial  
40 Disclosure Report filed with the Office of Statewide Health

1 Planning and Development as of June 6, 2013, for its fiscal year  
2 ending during 2010, except for Downey Regional Medical Center  
3 which shall be the Annual Financial Disclosure Report for the  
4 fiscal year ending during 2011 retrieved from the Office of  
5 Statewide Health Planning and Development as of July 23, 2013.  
6 2010.

7 (d) *“Department” means the State Department of Health Care*  
8 *Services.*

9 ~~(e)~~

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

12 (f) *“Director” means the Director of Health Care Services.*

13 ~~(e)~~

14 (g) *“General acute care days” means the total number of*  
15 *Medi-Cal general acute care days, including well baby days, less*  
16 *any acute psychiatric inpatient days, paid by the department to a*  
17 *hospital for services in the 2010 calendar year, as reflected in the*  
18 *state paid claims file on April 26, 2013.*

19 ~~(f)~~

20 (h) *“High acuity days” means Medi-Cal coronary care unit days,*  
21 *pediatric intensive care unit days, intensive care unit days, neonatal*  
22 *intensive care unit days, and burn unit days paid by the department*  
23 *during the 2010 calendar year, as reflected in the state paid claims*  
24 *file prepared by the department on April 26, 2013.*

25 (i) *“Hospital community” means any general acute care hospital*  
26 *and any hospital industry organization that represents general*  
27 *acute care hospitals.*

28 ~~(g)~~

29 (j) *“Hospital inpatient services” means all services covered*  
30 *under Medi-Cal and furnished by hospitals to patients who are*  
31 *admitted as hospital inpatients and reimbursed on a fee-for-service*  
32 *basis by the department directly or through its fiscal intermediary.*  
33 *Hospital inpatient services include outpatient services furnished*  
34 *by a hospital to a patient who is admitted to that hospital within*  
35 *24 hours of the provision of the outpatient services that are related*  
36 *to the condition for which the patient is admitted. Hospital inpatient*  
37 *services do not include services for which a managed health care*  
38 *plan is financially responsible.*

39 ~~(h)~~

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

9 ~~(i) “Individual hospital acute psychiatric supplemental payment”~~  
 10 ~~means the total amount of acute psychiatric hospital supplemental~~  
 11 ~~payments to a subject hospital for a quarter for which the~~  
 12 ~~supplemental payments are made. The “individual hospital acute~~  
 13 ~~psychiatric supplemental payment” shall be calculated for subject~~  
 14 ~~hospitals by multiplying the number of acute psychiatric days for~~  
 15 ~~the individual hospital for which a mental health plan was~~  
 16 ~~financially responsible by the amount calculated in accordance~~  
 17 ~~with paragraph (2) of subdivision (b) of Section 14169.53 and~~  
 18 ~~dividing the result by four.~~

19 ~~(j)~~

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

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

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

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

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

32 (iv) *Article 2.82 (commencing with Section 14087.98).*

33 ~~(iv)~~

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

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

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

1 (ii) Health plans not covering inpatient services such as primary  
2 care case management plans operating pursuant to Section  
3 14088.85.

4 (iii) Program for All-Inclusive Care for the Elderly organizations  
5 operating pursuant to Chapter 8.75 (commencing with Section  
6 14591).

7 ~~(k)~~

8 (m) “Medi-Cal managed care days” means the total number of  
9 general acute care days, including well baby days, listed for the  
10 county organized health system and prepaid health plans identified  
11 in the Final Medi-Cal Utilization Statistics for the 2012–13 fiscal  
12 year, as calculated by the department as of December 17, 2012.

13 ~~(l)~~

14 (n) “Medicaid inpatient utilization rate” means Medicaid  
15 inpatient utilization rate as defined in Section 1396r-4 of Title 42  
16 of the United States Code and as set forth in the Final Medi-Cal  
17 Utilization Statistics for the 2012–13 fiscal year, as calculated by  
18 the department as of December 17, 2012.

19 ~~(m) “Mental health plan” means a mental health plan that~~  
20 ~~contracts with the state to furnish or arrange for the provision of~~  
21 ~~mental health services to Medi-Cal beneficiaries pursuant to~~  
22 ~~Chapter 8.9 (commencing with Section 14700).~~

23 ~~(n)~~

24 (o) “New hospital” means a hospital operation, business, or  
25 facility functioning under current or prior ownership as a private  
26 hospital that does not have a days data source or a hospital that  
27 has a days data source in whole, or in part, from a previous operator  
28 ~~when where~~ there is an outstanding monetary liability obligation  
29 owed to the state in connection with the Medi-Cal program and  
30 ~~the new operator did not assume liability~~ hospital is not, or does  
31 not agree to become, financially responsible to the department for  
32 the outstanding monetary obligation in accordance with subdivision  
33 (d) of Section 14169.58.

34 ~~(o)~~

35 (p) “Nondesignated public hospital” means either of the  
36 following:

37 (1) A public hospital that is licensed under subdivision (a) of  
38 Section 1250 of the Health and Safety Code, is not designated as  
39 a specialty hospital in the hospital’s most recent publicly available  
40 recently filed Annual Financial Disclosure Report as of January

1 *I, 2014*, and satisfies the definition in paragraph (25) of subdivision  
2 (a) of Section 14105.98, excluding designated public hospitals.

3 (2) A tax-exempt nonprofit hospital that is licensed under  
4 subdivision (a) of Section 1250 of the Health and Safety Code, is  
5 not designated as a specialty hospital in the hospital's most ~~recent~~  
6 ~~publicly available~~ *recently filed* Annual Financial Disclosure  
7 Report *as of January 1, 2014*, is operating a hospital owned by a  
8 local health care district, and is affiliated with the health care  
9 district hospital owner by means of the district's status as the  
10 nonprofit corporation's sole corporate member.

11 (p)

12 (q) "Outpatient base amount" means the total amount of  
13 payments for hospital outpatient services made to a hospital in the  
14 2010 calendar year, as reflected in the state paid claims file  
15 prepared by the department on April 26, 2013.

16 (q)

17 (r) "Private 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~~ *recently filed* Office of  
25 Statewide Health Planning and Development Annual Financial  
26 Disclosure Report *as of January 1, 2014*.

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

29 (4) Is a nonpublic hospital, nonpublic converted hospital, or  
30 converted hospital as those terms are defined in paragraphs (26)  
31 to (28), inclusive, respectively, of subdivision (a) of Section  
32 14105.98.

33 (5) *Is not a nondesignated public hospital or a designated public*  
34 *hospital.*

35 (r)

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

38 (s)

39 (t) "Subject fiscal quarter" means a state fiscal quarter beginning  
40 on or after January 1, 2014, and ending before January 1, 2016.



1 (t)

2 (u) “Subject fiscal year” means a state fiscal year that ends after  
3 January 1, 2014, and begins before January 1, 2016.

4 (u) ~~“Subject hospital” means a hospital that meets all of the~~  
5 ~~following conditions:~~

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

8 ~~(2) Is in the Charitable Research Hospital peer group, as set~~  
9 ~~forth in the 1991 Hospital Peer Grouping Report published by the~~  
10 ~~department, or is not designated as a specialty hospital in the~~  
11 ~~hospital’s most recent publicly available Office of Statewide Health~~  
12 ~~Planning and Development Annual Financial Disclosure Report.~~

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

15 (v) “Subject month” means a calendar month beginning on or  
16 after January 1, 2014, and ending before January 1, 2016.

17 (w) “Transplant days” means the number of Medi-Cal days, *as*  
18 *defined in subdivision (q) of Section 14169.71*, for MS-DRGs 1,  
19 2, 5 to 10, inclusive, 14, 15 and 652, according to the 2010 Patient  
20 Discharge file from the Office of Statewide Health Planning and  
21 Development accessed on June 28, 2011.

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

28 14169.52. (a) Private hospitals shall be paid supplemental  
29 amounts for the provision of hospital outpatient services *for each*  
30 *subject fiscal quarter* as set forth in this section. The supplemental  
31 amounts shall be in addition to any other amounts payable to  
32 hospitals with respect to those services and shall not affect any  
33 other payments to hospitals. The supplemental amounts shall result  
34 in payments equal to the statewide aggregate upper payment limit  
35 for private hospitals for each subject fiscal year, *except that with*  
36 *respect to a subject fiscal year that begins before the start of the*  
37 *program period or that ends after the end of the program period,*  
38 *the outpatient supplemental amounts shall result in payments to*  
39 *hospitals that equal a percentage of the applicable upper payment*

1 *limit where the percentage equals the percentage of the subject*  
2 *fiscal year that occurs during the program period.*

3 (b) Except as set forth in subdivisions (e) and (f), each private  
4 hospital shall be paid an amount for each subject fiscal year equal  
5 to a percentage of the hospital's outpatient base amount, *which*  
6 *payments shall be made on a quarterly basis.* The percentage shall  
7 be the same for each hospital for a subject fiscal year, *or portion*  
8 *thereof in the program period.* The percentage shall result in  
9 payments to hospitals that equal the applicable federal upper  
10 payment limit as it may be modified pursuant to Section 14169.68  
11 for a subject fiscal year, *or any portion thereof in the program*  
12 *period.* For purposes of this subdivision the applicable federal  
13 upper payment limit shall be the federal upper payment limit for  
14 hospital outpatient services furnished by private hospitals for each  
15 subject fiscal year, *or portion thereof.*

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

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

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

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

31 (e) Payments shall not be made under this section to a new  
32 hospital *for the periods when the hospital is a new hospital.*

33 ~~(f) No payments shall be made under this section to a converted~~  
34 ~~hospital.~~

35 (f) *Payments shall be made to a converted hospital that converts*  
36 *during a subject fiscal quarter by multiplying the hospital's*  
37 *outpatient supplemental payment as calculated in subdivision (b)*  
38 *by the number of days that the hospital was a private hospital in*  
39 *the subject fiscal quarter, divided by the number of days in the*

1 *subject fiscal quarter. Payments shall not be made to a converted*  
2 *hospital in any subsequent subject fiscal quarter.*

3 14169.53. (a) Except as provided in Section 14169.68, private  
4 hospitals shall be paid supplemental amounts for the provision of  
5 hospital inpatient services for ~~the program period~~ *each subject*  
6 *fiscal quarter* as set forth in this section. The supplemental amounts  
7 shall be in addition to any other amounts payable to hospitals with  
8 respect to those services and shall not affect any other payments  
9 to hospitals. The supplemental amounts shall result in payments  
10 equal to the statewide aggregate upper payment limit for private  
11 hospitals for each subject fiscal year as it may be modified pursuant  
12 to Section 14169.68, *except that with respect to a subject fiscal*  
13 *year that begins before the start of the program period or that*  
14 *ends after the end of the program period, the inpatient*  
15 *supplemental amounts shall result in payments to hospitals that*  
16 *equal a percentage of the applicable upper payment limit where*  
17 *the percentage equals the percentage of the subject fiscal year that*  
18 *occurs during the program period.*

19 (b) Except as set forth in subdivisions ~~(g) and (h)~~ *(f) and (g)*,  
20 each private hospital shall be paid the *sum of all of the* following  
21 amounts as applicable for the provision of hospital inpatient  
22 services for each subject fiscal ~~year~~ *quarter*:

23 (1) ~~Eight hundred ninety-six dollars and forty-eight cents~~  
24 ~~(\$896.48)~~ *One thousand two dollars (\$1,002)* multiplied by the  
25 hospital's general acute care days for supplemental payments for  
26 the 2014 calendar year, *divided by four*, and one thousand  
27 ~~eighty-one dollars and eighty-four cents (\$1,081.84)~~ *two hundred*  
28 *five dollars (\$1,205)* multiplied by the hospital's general acute  
29 care days for supplemental payments for the 2015 calendar year,  
30 *divided by four*.

31 (2) ~~For the hospital's acute psychiatric days that were paid~~  
32 ~~directly by the department and were not the financial responsibility~~  
33 ~~of a mental health plan, nine hundred sixty-five dollars (\$965)~~  
34 *Nine hundred seventy dollars (\$970)* multiplied by the hospital's  
35 acute psychiatric days for supplemental payments for the 2014  
36 calendar year, *divided by four*, and nine hundred seventy-five  
37 dollars (\$975) multiplied by the hospital's acute psychiatric days  
38 for supplemental payments for the 2015 calendar year, *divided by*  
39 *four*.

1 (3) (A) ~~For the 2014 and 2015 calendar years, two~~ *Two*  
 2 thousand five hundred dollars (\$2,500) multiplied by the number  
 3 of the hospital's high acuity days *for the respective calendar year*  
 4 *for 2014 or 2015, divided by four*, if the hospital's Medicaid  
 5 inpatient utilization rate is less than 43 percent and greater than 5  
 6 percent and at least 5 percent of the hospital's general acute care  
 7 days are high acuity days.

8 ~~(B) The amount under this paragraph shall be in addition to the~~  
 9 ~~amounts specified in paragraphs (1) and (2).~~

10 (4) (A) ~~For the 2014 and 2015 calendar years, two~~ *Two*  
 11 thousand five hundred dollars (\$2,500) multiplied by the number  
 12 of the hospital's high acuity days *for the respective calendar year*  
 13 *for 2014 and 2015, divided by four*, if the hospital qualifies to  
 14 receive the amount set forth in paragraph (3) and has been  
 15 designated as a Level I, Level II, Adult/Ped Level I, or Adult/Ped  
 16 Level II trauma center by the Emergency Medical Services  
 17 Authority established pursuant to Section 1797.1 of the Health and  
 18 Safety Code.

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

21 (5) (A) ~~For the 2014 and 2015 calendar years, two~~ *Two*  
 22 thousand five hundred dollars (\$2,500) multiplied by the number  
 23 of the hospital's transplant days *for the respective calendar year*  
 24 *for 2014 and 2015, divided by four*, if the hospital's Medicaid  
 25 inpatient utilization rate is less than 43 percent and greater than 5  
 26 percent.

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

29 (e)

30 (6) ~~A private hospital payment for hospital inpatient services~~  
 31 ~~for private hospitals that provided Medi-Cal subacute services~~  
 32 ~~during the 2010 calendar year and has have a Medicaid inpatient~~  
 33 ~~utilization rate that is greater than 5 percent and less than 43 percent~~  
 34 ~~shall be paid a supplemental amount equal to 50 equal to 55 percent~~  
 35 ~~for the 2014 calendar year of the Medi-Cal subacute payments~~  
 36 ~~paid by the department to the hospital during the 2010 calendar~~  
 37 ~~year, as reflected in the state paid claims file prepared by the~~  
 38 ~~department on April 26, 2013, divided by four, and 60 percent for~~  
 39 ~~the 2015 calendar year of the Medi-Cal subacute payments paid~~  
 40 ~~by the department to the hospital during the 2010 calendar year,~~

1 as reflected in the state paid claims file prepared by the department  
2 on April 26, 2013, *divided by four*.

3 ~~(d) (1)~~

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

9 (A)

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

13 ~~(B)~~

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

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

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

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

32 ~~(e)~~

33 (d) If the amount otherwise payable to a hospital under this  
34 section for a subject fiscal year exceeds the amount for which  
35 federal financial participation is available for that hospital, the  
36 amount due to the hospital for that subject fiscal year shall be  
37 reduced to the amount for which federal financial participation is  
38 available.

39 ~~(f)~~

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

3 ~~(g)~~

4 (f) Payments shall not be made under this section to a new  
5 hospital *for the periods when the hospital is a new hospital.*

6 (g) *Payments shall be made to a converted hospital that converts*  
7 *during a subject fiscal quarter by multiplying the hospital's*  
8 *inpatient supplemental payment as calculated in subdivision (b)*  
9 *by the number of days that the hospital was a private hospital in*  
10 *the subject fiscal quarter, divided by the number of days in the*  
11 *subject fiscal quarter. Payments shall not be made to a converted*  
12 *hospital in any subsequent subject fiscal quarter.*

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

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

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

26 14169.54. (a) The department shall increase capitation  
27 payments to Medi-Cal managed health care plans for each subject  
28 fiscal year *month* as set forth in this section.

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

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

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~~ *department*.

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

12 (2) The determination under this subdivision for any *subject*  
13 month ~~in the program period~~ shall be made after accounting for  
14 all federal financial participation necessary for full implementation  
15 of Section 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~~ *shall* be paid  
10 direct grants in support of health care expenditures, which shall  
11 not constitute Medi-Cal payments, and which shall be funded by  
12 the quality assurance fee set forth in Article 5.231 (commencing  
13 with Section 14169.71).

14 *(1) The aggregate amount of the grants to designated public*  
15 *hospitals shall be forty-five million dollars (\$45,000,000) in the*  
16 *aggregate for the subject fiscal quarters in subject fiscal year*  
17 *2013–14, ninety-three million dollars (\$93,000,000) for subject*  
18 *fiscal year 2014–15, and forty-eight million dollars (\$48,000,000)*  
19 *in the aggregate for the subject fiscal quarters in the subject fiscal*  
20 *year 2015–16. For each subject fiscal year, the director shall*  
21 *allocate the aggregate grant amounts in accordance with*  
22 *paragraph (2).*

23 *(2) (A) Of the direct grant amounts set forth in paragraph (1),*  
24 *the director shall allocate twenty-four million five hundred*  
25 *thousand dollars (\$24,500,000) in the aggregate for the subject*  
26 *fiscal quarters in subject fiscal year 2013–14, fifty million five*  
27 *hundred thousand dollars (\$50,500,000) for subject fiscal year*  
28 *2014–15, and twenty-six million dollars (\$26,000,000) in the*  
29 *aggregate for the subject fiscal quarters in subject fiscal year*  
30 *2015–16, among the designated public hospitals pursuant to a*  
31 *methodology developed in consultation with the designated public*  
32 *hospitals.*

33 *(i) Of the direct grant amounts set forth in this subparagraph,*  
34 *the director shall distribute six million one hundred twenty-five*  
35 *thousand dollars (\$6,125,000) for each subject fiscal quarter in*  
36 *subject fiscal year 2013–14, six million three hundred twelve*  
37 *thousand five hundred dollars (\$6,312,500) for each subject fiscal*  
38 *quarter in subject fiscal year 2014–15, and six million five hundred*  
39 *thousand dollars (\$6,500,000) for each subject fiscal quarter in*

1 *subject fiscal year 2015–16 in accordance with the timeframes*  
2 *specified in subdivision (a) of Section 14169.59.*

3 *(ii) Of the direct grant amounts set forth in this subparagraph,*  
4 *the director shall distribute six million one hundred twenty-five*  
5 *thousand dollars (\$6,125,000) for each subject fiscal quarter in*  
6 *subject fiscal year 2013–14, six million three hundred twelve*  
7 *thousand five hundred dollars (\$6,312,500) for each subject fiscal*  
8 *quarter in subject fiscal year 2014–15, and six million five hundred*  
9 *thousand dollars (\$6,500,000) for each subject fiscal quarter in*  
10 *subject fiscal year 2015–16 only upon 100 percent of the rate*  
11 *range increases under subparagraph (B) being distributed to*  
12 *managed health care plans pursuant to subparagraph (B) for the*  
13 *respective subject fiscal quarter. If the rate range increases under*  
14 *subparagraph (B) are distributed to managed health care plans,*  
15 *the direct grant amounts described in this clause shall be*  
16 *distributed to designated public hospitals no later than 30 days*  
17 *after the rate range increases have been distributed to managed*  
18 *health care plans pursuant to subparagraph (B).*

19 *(B) Of the direct grant amounts set forth in paragraph (1),*  
20 *twenty million five hundred thousand dollars (\$20,500,000) in the*  
21 *aggregate for the subject fiscal quarters in subject fiscal year*  
22 *2013–14, forty-two million five hundred thousand dollars*  
23 *(\$42,500,000) for subject fiscal year 2014–15, and twenty-two*  
24 *million dollars (\$22,000,000) in the aggregate for the subject fiscal*  
25 *quarters in subject fiscal year 2015–16 shall be withheld from*  
26 *payment to the designated public hospitals by the director, and*  
27 *shall be used as the nonfederal share for rate range increases, as*  
28 *defined in paragraph (4) of subdivision (b) of Section 14301.4, to*  
29 *risk-based payments to managed care health plans that contract*  
30 *with the department to serve counties where a designated public*  
31 *hospital is located. The rate range increases shall apply to*  
32 *managed care rates for beneficiaries other than newly eligible*  
33 *beneficiaries, as defined in subdivision (s) of Section 17612.2, and*  
34 *shall enable plans to compensate hospitals for Medi-Cal health*  
35 *services and to support the Medi-Cal program. Each managed*  
36 *health care plan shall expend 100 percent of the rate range*  
37 *increases on hospital services within 30 days of receiving the*  
38 *increased payments. Rate range increases funded under this*  
39 *subparagraph shall be allocated among plans pursuant to a*

1 methodology developed in consultation with the hospital  
2 community.

3 (3) Notwithstanding any other law, any amounts withheld from  
4 payment to the designated public hospitals by the director as the  
5 nonfederal share for rate range increases, including those  
6 described in subparagraph (B) of paragraph (2), shall not be  
7 considered hospital fee direct grants as defined under subdivision  
8 (k) of Section 17612.2 and shall not be included in the  
9 determination under paragraph (1) of subdivision (a) of Section  
10 17612.3.

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

16 (1) The aggregate amount of the grants to nondesignated public  
17 hospitals shall be twelve million five hundred thousand dollars  
18 (\$12,500,000) in the aggregate for the subject fiscal quarters in  
19 subject fiscal year 2013–14, twenty-five million dollars  
20 (\$25,000,000) for subject fiscal year 2014–15, and twelve million  
21 five hundred thousand dollars (\$12,500,000) in the aggregate for  
22 the subject fiscal quarters in subject fiscal year 2015–16. For each  
23 subject fiscal year, the director shall allocate the aggregate grant  
24 amounts in accordance with paragraph (2).

25 (2) (A) Of the direct grant amounts set forth in paragraph (1),  
26 the director shall allocate two million five hundred thousand  
27 dollars (\$2,500,000) in the aggregate for the subject fiscal quarters  
28 in subject fiscal year 2013–14, five million dollars (\$5,000,000)  
29 for subject fiscal year 2014–15, and two million five hundred  
30 thousand dollars (\$2,500,000) in the aggregate for the subject  
31 fiscal quarters in subject fiscal year 2015–16 among the  
32 nondesignated public hospitals pursuant to a methodology  
33 developed in consultation with the nondesignated public hospitals.

34 (B) Of the direct grant amounts set forth in paragraph (1), ten  
35 million dollars (\$10,000,000) in the aggregate for the subject fiscal  
36 quarters in subject fiscal year 2013–14, twenty million dollars  
37 (\$20,000,000) for subject fiscal year 2014–15, and ten million  
38 dollars (\$10,000,000) in the aggregate for the subject fiscal  
39 quarters in subject fiscal year 2015–16 shall be withheld from  
40 payment to the nondesignated public hospitals by the director, and

1 shall be used as the nonfederal share for rate range increases, as  
2 defined in paragraph (4) of subdivision (b) of Section 14301.4, to  
3 risk-based payments to managed care health plans that contract  
4 with the department. The rate range increases shall enable plans  
5 to compensate hospitals for Medi-Cal health services and to  
6 support the Medi-Cal program. Each managed health care plan  
7 shall expend 100 percent of the rate range increases on hospital  
8 services within 30 days of receiving the increased payments. Rate  
9 range increases funded under this subparagraph shall be allocated  
10 among plans pursuant to a methodology developed in consultation  
11 with the hospital community.

12 (c) If the amounts set forth in this section for rate range  
13 increases are not actually used for rate range increases as  
14 described in this section, the direct grant amounts set forth in this  
15 section that are withheld pursuant to clause (ii) of subparagraph  
16 (A) of paragraph (1) of subdivision (a) or as the nonfederal share  
17 for rate range increases for rate range increases pursuant to  
18 subparagraph (B) of paragraph (2) of subdivision (a) or  
19 subparagraph (B) of paragraph (2) of subdivision (b) shall be  
20 returned to the Hospital Quality Assurance Revenue Fund subject  
21 to subdivision (c) of Section 14169.73.

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

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

36 ~~14169.58. The payments to a hospital under this article shall~~  
37 ~~not be made for any portion of a subject fiscal year during which~~  
38 ~~the hospital is closed. A hospital shall be deemed to be closed on~~  
39 ~~the first day of any period during which the hospital has no acute~~  
40 ~~inpatients for at least 30 consecutive days. Payments under this~~

1 ~~article to a hospital that is closed during any portion of a subject~~  
2 ~~fiscal year shall be reduced by applying a fraction, expressed as a~~  
3 ~~percentage, the numerator of which shall be the number of days~~  
4 ~~during the applicable subject fiscal year that the hospital is closed~~  
5 ~~and the denominator of which shall be 365.~~

6 *14169.58. (a) (1) Except as provided in this section, all data*  
7 *and other information relating to a hospital that are used for the*  
8 *purposes of this article, including, without limitation, the days*  
9 *data source, shall continue to be used to determine the payments*  
10 *to that hospital pursuant to this article, regardless of whether the*  
11 *hospital has undergone one or more changes of ownership.*

12 *(2) All supplemental payments to a hospital under this article*  
13 *shall be made to the licensee of a hospital on the date the*  
14 *supplemental payment is made.*

15 *(b) The data of separate facilities prior to a consolidation shall*  
16 *be aggregated for the purposes of this article if: (1) a private*  
17 *hospital consolidates with another private hospital, (2) the facilities*  
18 *operate under a consolidated hospital license, (3) data for a period*  
19 *prior to the consolidation is used for purposes of this article, and*  
20 *(4) neither hospital has had a change of ownership on or after the*  
21 *effective date of this article unless paragraph (2) of subdivision*  
22 *(d) has been satisfied by the new owner. Data of a facility that was*  
23 *a separately licensed hospital prior to the consolidation shall not*  
24 *be included in the data, including the days data source, for the*  
25 *purpose of determining payments to the facility under this article*  
26 *for any time period during which the facility is closed. A facility*  
27 *shall be deemed to be closed for purposes of this subdivision on*  
28 *the first day of any period during which the facility has no general*  
29 *acute, psychiatric, or rehabilitation inpatients for at least 30*  
30 *consecutive days. A facility that has been deemed to be closed*  
31 *under this subdivision shall no longer be deemed to be closed on*  
32 *the first subsequent day on which it has general acute, psychiatric,*  
33 *or rehabilitation inpatients.*

34 *(c) The payments to a hospital under this article shall not be*  
35 *made for any period during which the hospital is closed. A hospital*  
36 *shall be deemed to be closed on the first day of any period during*  
37 *which the hospital has no general acute, psychiatric, or*  
38 *rehabilitation inpatients for at least 30 consecutive days. A hospital*  
39 *that has been deemed to be closed under this subdivision shall no*  
40 *longer be deemed to be closed on the first subsequent day on which*

1 *it has general acute, psychiatric, or rehabilitation inpatients.*  
2 *Payments under this article to a hospital that is closed during any*  
3 *portion of a subject fiscal quarter shall be reduced by applying a*  
4 *fraction, expressed as a percentage, the numerator of which shall*  
5 *be the number of days during the applicable subject fiscal quarter*  
6 *that the hospital is closed during the subject fiscal year and the*  
7 *denominator of which shall be the number of days in the subject*  
8 *fiscal quarter.*

9 *(d) The following provisions shall apply only for purposes of*  
10 *this article and Article 5.231 (commencing with Section 14169.71),*  
11 *and shall have no application outside of this article and Article*  
12 *5.231 (commencing with Section 14169.71) nor shall they affect*  
13 *the assumption of any outstanding monetary obligation to the*  
14 *Medi-Cal program:*

15 *(1) The director shall develop and describe in provider bulletins*  
16 *and on the department's Internet Web site a process by which the*  
17 *new operator of a hospital that has a days data source in whole*  
18 *or in part from a previous operator may enter into an agreement*  
19 *with the department to confirm that it is financially responsible*  
20 *or to become financially responsible to the department for the*  
21 *outstanding monetary obligation to the Medi-Cal program of the*  
22 *previous operator in order to avoid being classified as a new*  
23 *hospital for purposes of this article. This process shall be available*  
24 *for changes of ownership that occur before, on, or after January*  
25 *1, 2014.*

26 *(2) The outstanding monetary obligation referred to in*  
27 *subdivision (o) of Section 14169.51 and subdivision (u) of Section*  
28 *14169.71 shall include liabilities for all of the following:*

29 *(A) Payment of the quality assurance fee established pursuant*  
30 *to Article 5.231 (commencing with Section 14169.71).*

31 *(B) Known overpayments that have been asserted by the*  
32 *department or its fiscal intermediary by sending a written*  
33 *communication that is received by the hospital prior to the date*  
34 *that the new operator becomes the licensee of the hospital.*

35 *(C) Overpayments that are asserted after that date and arise*  
36 *from customary reconciliations of payments, such as cost report*  
37 *settlements, and, with the exception of overpayments described in*  
38 *subparagraph (B), shall exclude liabilities arising from the*  
39 *fraudulent or intentionally criminal act of a prior operator if the*

1 *new operator did not knowingly participate in or continue that*  
2 *fraudulent or criminal act after becoming the licensee.*

3 *(3) The department shall have the discretion to determine*  
4 *whether the new owner properly and fully agreed to be financially*  
5 *responsible for the outstanding monetary obligation in connection*  
6 *with the Medi-Cal program and seek additional assurances as the*  
7 *department deems necessary. However, a new owner that executes*  
8 *an agreement with the department as described in paragraph (1)*  
9 *shall be conclusively deemed to have agreed to be financially*  
10 *responsible for the outstanding monetary obligation in connection*  
11 *with the Medi-Cal program. The department may establish the*  
12 *terms for satisfying the outstanding monetary obligation in*  
13 *connection with the Medi-Cal program, including, but not limited*  
14 *to, recoupment from amounts payable to the hospital under this*  
15 *section.*

16 14169.59. The department shall make disbursements from the  
17 Hospital Quality Assurance Revenue Fund consistent with all of  
18 the following:

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

22 (b) The funds shall be disbursed in accordance with the order  
23 of priority set forth in subdivision (b) of Section 14169.73, except  
24 that funds may be set aside for increased capitation payments to  
25 managed care health plans pursuant to subdivision (f) of Section  
26 14169.54.

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

33 (d) To the maximum extent possible, consistent with the  
34 availability of funds in the Hospital Quality Assurance Revenue  
35 Fund and the timing of federal approvals, the supplemental  
36 payments, direct grants to hospitals, and increased capitation  
37 payments to managed health care plans under this article shall be  
38 made before December 31, 2015.

39 (e) The aggregate amount of funds to be disbursed to private  
40 hospitals shall be determined under Sections 14169.52 and

1 14169.53. The aggregate amount of funds to be disbursed to  
2 managed health care plans shall be determined under Section  
3 14169.54. The aggregate amount of direct grants to designated  
4 and nondesignated public hospitals shall be determined under  
5 Section 14169.56.

6 14169.60. (a) Exclusive of payments made under former  
7 Article 5.21 (commencing with Section 14167.1), former Article  
8 5.226 (commencing with Section 14168.1), and Article 5.228  
9 (commencing with Section 14169.1), payment rates for hospital  
10 outpatient services, furnished by private hospitals, nondesignated  
11 public hospitals, and designated public hospitals before December  
12 31, 2015, exclusive of amounts payable under this article, shall  
13 not be reduced below the rates in effect on January 1, 2014.

14 (b) Rates payable to hospitals for hospital inpatient services  
15 furnished before December 31, 2015, under contracts negotiated  
16 pursuant to the selective provider contracting program under Article  
17 2.6 (commencing with Section 14081), shall not be reduced below  
18 the contract rates in effect on January 1, 2014. This subdivision  
19 shall not prohibit changes to the supplemental payments paid to  
20 individual hospitals under Sections 14166.12, 14166.17, and  
21 14166.23, provided that the aggregate amount of the payments for  
22 each subject fiscal year is not less than the minimum amount  
23 permitted under former Section 14167.13.

24 (c) Notwithstanding Section 14105.281, exclusive of payments  
25 made under former Article 5.21 (commencing with Section  
26 14167.1), former Article 5.226 (commencing with Section  
27 14168.1), and Article 5.228 (commencing with Section 14169.1),  
28 payments to private hospitals for hospital inpatient services  
29 furnished before January 1, 2014, that are not reimbursed under a  
30 contract negotiated pursuant to the selective provider contracting  
31 program under Article 2.6 (commencing with Section 14081),  
32 exclusive of amounts payable under this article, shall not be less  
33 than the amount of payments that would have been made under  
34 the payment methodology in effect on the effective date of this  
35 article.

36 ~~(d) Upon the implementation of the new Medi-Cal inpatient~~  
37 ~~hospital reimbursement methodology based on diagnosis-related~~  
38 ~~groups pursuant to Section 14105.28, the requirements in~~  
39 ~~subdivisions (b) and (c) shall be met. *The requirements in*~~  
40 ~~*subdivisions (b) and (c) shall be met with respect to the inpatient*~~



1 *hospital reimbursement methodology based on diagnosis-related*  
2 *groups pursuant to Section 14105.28 if the rates paid under the*  
3 ~~new~~ *Medi-Cal inpatient hospital reimbursement methodology*  
4 *based on diagnosis-related groups result in an average payment*  
5 *per discharge to all hospitals subject to the new reimbursement*  
6 *methodology, calculated on an aggregate basis per subject fiscal*  
7 *year, exclusive of amounts payable under this article, amounts*  
8 *payable under Sections 14166.11 and 14166.23, and if amounts*  
9 *payable under Sections 14166.12 and 14166.17 are not included*  
10 *in the payments under the diagnosis-related group methodology*  
11 *and continue to be paid separately to hospitals, exclusive of those*  
12 *amounts, that is not less than the average payment per discharge*  
13 *to the hospitals, exclusive of amounts payable under this article,*  
14 *amounts payable under Sections 14166.11 and 14166.23, and if*  
15 *amounts payable under Sections 14166.12 and 14166.17 are not*  
16 *included in the payments under the diagnosis-related group*  
17 *methodology and continue to be paid separately to hospitals,*  
18 *exclusive of those amounts, calculated on an aggregate basis for*  
19 ~~the fiscal year ending June 30, 2012~~ *six months ending December*  
20 *31, 2013, adjusted, in consultation with the hospital community,*  
21 *to reflect the movement of populations into managed care under*  
22 *Article 5.4 (commencing with Section 14180).*

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

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

35 14169.61. (a) The director shall do all of the following:

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

38 (2) Promptly seek federal approvals or waivers as may be  
39 necessary to implement this article and to obtain federal financial

1 participation to the maximum extent possible for the payments  
2 under this article.

3 (3) Amend the contracts between the managed health care plans  
4 and the department as necessary to incorporate the provisions of  
5 Sections 14169.54 and 14169.55 and promptly seek all necessary  
6 federal approvals of those amendments. The department shall  
7 pursue amendments to the contracts as soon as possible after the  
8 effective date of this article and Article 5.231 (commencing with  
9 Section 14169.71), and shall not wait for federal approval of this  
10 article or Article 5.231 (commencing with Section 14169.71) prior  
11 to pursuing amendments to the contracts. The amendments to the  
12 contracts shall, among other provisions, set forth an agreement to  
13 increase capitation payments to managed health care plans under  
14 Section 14169.54 and increase payments to hospitals under Section  
15 14169.55 in a manner that relates back to January 1, 2014, or as  
16 soon thereafter as possible, conditioned on obtaining all federal  
17 approvals necessary for federal financial participation for the  
18 increased capitation payments to the managed health care plans.

19 (b) In implementing this article, the department may utilize the  
20 services of the Medi-Cal fiscal intermediary through a change  
21 order to the fiscal intermediary contract to administer this program,  
22 consistent with the requirements of Sections 14104.6, 14104.7,  
23 14104.8, and 14104.9. Contracts entered into for purposes of  
24 implementing this article or Article 5.231 (commencing with  
25 Section 14169.71) shall not be subject to Part 2 (commencing with  
26 Section 10100) of Division 2 of the Public Contract Code.

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

29 (1) In the event, and on the effective date, of a final judicial  
30 determination made by any court of appellate jurisdiction or a final  
31 determination by the federal Department of Health and Human  
32 Services or the federal Centers for Medicare and Medicaid Services  
33 that Section 14169.52 or Section 14169.53 cannot be implemented.  
34 *This paragraph shall not apply to a final judicial determination*  
35 *made by any court of appellate jurisdiction in a case brought by*  
36 *hospitals located outside the State of California.*

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

38 (A) The federal Centers for Medicare and Medicaid Services  
39 denies approval for, or does not approve before January 1, 2016,  
40 the implementation of Section 14169.52, Section 14169.53, or the

1 quality assurance fee established pursuant to Article 5.231  
2 (commencing with Section 14169.71).

3 (B) Section 14169.52, Section 14169.53, or Article 5.231  
4 (commencing with Section 14169.71) cannot be modified by the  
5 department pursuant to subdivision (e) of Section 14169.73 in  
6 order to meet the requirements of federal law or to obtain federal  
7 approval.

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

13 (e) ~~If~~ *In the event* any hospital, or any party on behalf of a  
14 hospital, ~~shall initiate~~ *initiates* a case or proceeding in any state or  
15 federal court in which the hospital seeks any relief of any sort  
16 whatsoever, including, but not limited to, monetary relief,  
17 injunctive relief, declaratory relief, or a writ, based in whole or in  
18 part on a contention that any or all of this article or Article 5.231  
19 (commencing with Section 14169.71) is unlawful and may not be  
20 lawfully implemented, both of the following shall apply:

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

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

29 (f) Subject to Section 14169.74, no payment shall be made under  
30 this article until all necessary federal approvals for the payment  
31 and for the fee provisions in Article 5.231 (commencing with  
32 Section 14169.71) have been obtained and the fee has been  
33 imposed and collected. Notwithstanding any other law, payments  
34 under this article shall be made only to the extent that the fee  
35 established in Article 5.231 (commencing with Section 14169.71)  
36 is collected and available to cover the nonfederal share of the  
37 payments.

38 (g) A hospital's receipt of payments under this article for  
39 services rendered prior to the effective date of this article is

1 conditioned on the hospital's continued participation in Medi-Cal  
2 for at least 30 days after the effective date of this article.

3 (h) All payments made by the department to hospitals and  
4 managed health care plans under this article shall be made only  
5 from the following:

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

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

11 (i) *In order to ensure access to care for hospital services, the*  
12 *director shall seek federal approval for supplemental payments*  
13 *for hospital services provided to all Medi-Cal populations,*  
14 *including the optional and expansion populations.*

15 14169.62. Notwithstanding any other provision of this article  
16 or Article 5.231 (commencing with Section 14169.71), the director  
17 may proportionately reduce the amount of any supplemental  
18 payments or increased capitation payments under this article to  
19 the extent that the payment would result in the reduction of other  
20 amounts payable to a hospital or managed health care plan due to  
21 the application of federal law.

22 14169.63. The director may, pursuant to Section 14169.80,  
23 decide not to implement or to discontinue implementation of this  
24 article and Article 5.231 (commencing with Section 14169.71),  
25 and to retroactively invalidate the requirements for supplemental  
26 payments or other payments under this article.

27 14169.64. (a) This article shall remain operative only until the  
28 later of the following:

29 (1) January 1, 2017.

30 (2) The date of the last payment of the quality assurance fee  
31 payments pursuant to Article 5.231 (commencing Section  
32 14169.71).

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

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

39 (c) If this article becomes inoperative under paragraph (2) or  
40 (3) of subdivision (a), this article shall be repealed on January 1

1 of the year following the date this article becomes inoperative,  
2 unless a later enacted statute enacted before that date, deletes or  
3 extends that date.

4 14169.65. Notwithstanding any other law, if federal approval  
5 or a letter that indicates likely federal approval in accordance with  
6 Section 14169.74 has not been received on or before December  
7 1, 2015, then this article shall become inoperative, and as of  
8 December 1, 2015, is repealed, unless a later enacted statute, that  
9 is enacted before December 1, 2015, deletes or extends that date.

10 14169.66. Notwithstanding Chapter 3.5 (commencing with  
11 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
12 Code, the department shall implement this article by means of  
13 policy letters or similar instructions, without taking further  
14 regulatory action.

15 14169.67. If the director determines that this article has become  
16 inoperative pursuant to Section 14169.61, 14169.64, 14169.65, or  
17 14169.80, the director shall execute a declaration stating that this  
18 determination has been made and stating the basis for this  
19 determination. The director shall retain the declaration and provide  
20 a copy, within five working days of the execution of the  
21 declaration, to the fiscal and appropriate policy committees of the  
22 Legislature. In addition, the director shall post the declaration on  
23 the department's Internet Web site and the director shall send the  
24 declaration to the Secretary of State, the Secretary of the Senate,  
25 the Chief Clerk of the Assembly, and the Legislative Counsel.

26 14169.68. (a) It is the intent of the Legislature to consider  
27 legislation requiring the director to seek approval to increase  
28 payments to hospitals in accordance with ~~subdivision (b)~~ of Section  
29 14169.52, ~~subdivision (a)~~ of Section 14169.53, and ~~subdivision~~  
30 ~~(e)~~ of Section 14169.54, and to adopt a corresponding increase in  
31 the fee imposed pursuant to Article 5.231 (commencing with  
32 Section 14169.71), consistent with federal law and regulations, if  
33 the director determines that the maximum available upper payment  
34 limits ~~in subdivision (b) described in subdivision (a)~~ of Section  
35 14169.52 or subdivision (a) of Section 14169.53, or the amount  
36 of federal financial participation for increased capitation payments  
37 to managed care health plans in subdivision (c) of Section  
38 14169.54, have increased during the program period.

39 (b) The legislation described in subdivision (a) shall do both of  
40 the following:

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

5 (2) Require that, in the event that the director determines that  
6 the maximum available upper payment limits in subdivision ~~(b)~~  
7 (a) of Section 14169.52 or subdivision (a) of Section 14169.53,  
8 or the amount of federal financial participation for increased  
9 capitation payments to managed care health plans in subdivision  
10 (c) of Section 14169.54, have increased during the program period,  
11 the increases shall first be made available for the purposes of this  
12 section prior to being used for other purposes.

13 (c) Notwithstanding any other provision of this article or Article  
14 5.231 (commencing with Section 14169.71), failure to secure, or  
15 denial of, any necessary federal approvals required by the  
16 legislation described in subdivision (a) shall not affect  
17 implementation of this article or Article 5.231 (commencing with  
18 Section 14169.71).

19 *14169.69. To the extent permitted by federal law and other*  
20 *federal requirements, the director shall develop and describe in*  
21 *provider bulletins and on the department's Internet Web site a*  
22 *process by which a private general acute care hospital located*  
23 *outside the state that serves Medi-Cal beneficiaries may opt in to*  
24 *pay the quality assurance fee pursuant to Article 5.231*  
25 *(commencing with Section 14169.71) and receive supplemental*  
26 *payments pursuant to this article, in the same manner that the*  
27 *hospital could participate if it were located in the state.*  
28 *Notwithstanding Section 14169.51 and Section 14169.71, the*  
29 *department shall rely on reliable data to make reasonable estimates*  
30 *or projections made with respect to the hospital as to the data,*  
31 *including, but not limited to, the days data source, used to calculate*  
32 *the fees due under Article 5.231 (commencing with Section*  
33 *14169.71) and the supplemental payments under this article.*  
34 *Hospitals located outside the state that would meet the definition*  
35 *of a small and rural hospital if they were located in the state shall*  
36 *be deemed a small and rural hospital for the purposes of Article*  
37 *5.231 (commencing with Section 14169.71) and this article.*

38 *14169.70. (a) Notwithstanding any provision of this article or*  
39 *Article 5.231 (commencing with Section 14169.71), the director*  
40 *may correct any identified material and egregious errors in the*

1 *data, including, but not limited to, the days data source, used in*  
2 *this article or Article 5.231 (commencing with Section 14169.71).*  
3 *An error is material and egregious if the error is clear to the*  
4 *director, based on information the director finds to be reliable,*  
5 *and results in an increase or decrease to a hospital's supplemental*  
6 *payment under Sections 14169.52 and 14169.53, or an increase*  
7 *or decrease to a hospital's quality assurance fee payments under*  
8 *Article 5.231 (commencing with Section 14169.71), of at least one*  
9 *million dollars (\$1,000,000) for any subject fiscal year. The*  
10 *director's determination whether to exercise his or her discretion*  
11 *under this section and any determination made by the director*  
12 *under this section shall not be subject to judicial review, except*  
13 *that a hospital may bring a writ of mandate under Section 1085*  
14 *of the Code of Civil Procedure to rectify an abuse of discretion by*  
15 *the department in correcting that hospital's data when that*  
16 *correction results in lower supplemental payments under Sections*  
17 *14169.52 and 14169.53 in the aggregate or higher quality*  
18 *assurance fees for that hospital pursuant to Article 5.231*  
19 *(commencing with Section 14169.71).*

20 *(b) Notwithstanding any other law, with respect to a hospital*  
21 *described in subdivision (f) of Section 14165.50, both of the*  
22 *following shall apply:*

23 *(1) The hospital shall not be considered a new hospital, as*  
24 *defined in subdivision (o) of Section 14169.51 for purposes of this*  
25 *article and subdivision (u) of Section 14169.71 for purposes of*  
26 *Article 5.231 (commencing with Section 14169.71).*

27 *(2) To the extent permitted by federal law and other federal*  
28 *requirements, the department shall use the best available and*  
29 *reasonable estimates or projections made with respect to the*  
30 *hospital for an annual period as the data, including, but not limited*  
31 *to, the days data source, used in this article or Article 5.231*  
32 *(commencing with Section 14169.71).*

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

1 Article 5.231. Private Hospital Quality Assurance Fee Act of  
2 2013

3  
4 14169.71. For the purposes of this article, the following  
5 definitions shall apply:

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

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

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

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

17 ~~(2) “Aggregate quality assurance fee” means, with respect to a~~  
18 ~~hospital that is a prepaid health plan hospital, the sum of all of the~~  
19 ~~following:~~

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

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

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

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

32 ~~(3) “Aggregate quality assurance fee after the application of the~~  
33 ~~fee percentage” means the aggregate quality assurance fee~~  
34 ~~multiplied by the fee percentage for each subject fiscal year.~~

35 ~~(b)~~

36 ~~(a) “Annual fee-for-service days” means the number of~~  
37 ~~fee-for-service days of each hospital subject to the quality assurance~~  
38 ~~fee, as reported on the days data source.~~

39 ~~(e)~~



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

4 ~~(d)~~

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

8 ~~(e)~~

9 (d) “Converted hospital” ~~shall mean~~ *means* a hospital described  
10 in subdivision (b) of Section 14169.51.

11 ~~(f)~~

12 (e) “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 (f) “*Department*” *means the State Department of Health Care*  
17 *Services.*

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

20 (h) “*Director*” *means the Director of Health Care Services.*

21 ~~(i)~~

22 (i) “Exempt facility” means any of the following:

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

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

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

32 (2) With the exception of a hospital that is in the Charitable  
33 Research Hospital peer group, as set forth in the 1991 Hospital  
34 Peer Grouping Report published by the department, a hospital that  
35 is a hospital designated as a specialty hospital in the hospital’s  
36 ~~most recent publicly available~~ *recently filed* Office of Statewide  
37 Health Planning and Development Hospital Annual Financial  
38 Disclosure Report *as of January 1, 2014.*

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

1 (4) A small and rural hospital as specified in Section 124840  
2 of the Health and Safety Code designated as that in the hospital's  
3 *most recently filed* Office of Statewide Health Planning and  
4 Development Hospital Annual Financial Disclosure Report ~~for the~~  
5 ~~hospital's fiscal year ending in the 2010 calendar year as of~~  
6 *January 1, 2014.*

7 ~~(i)~~

8 (j) "Federal approval" means the approval by the federal  
9 government of both the quality assurance fee established pursuant  
10 to this article and the ~~supplemental~~ payments to private hospitals  
11 described in ~~Sections 14169.52 and 14169.53~~ *Article 5.230*  
12 *(commencing with Section 14169.51).*

13 ~~(j)~~

14 (k) (1) "Fee-for-service per diem quality assurance fee rate"  
15 means a fixed daily fee on fee-for-service days.

16 (2) The fee-for-service per diem quality assurance fee rate shall  
17 ~~be four hundred one dollars and forty one cents (\$401.41)~~ *three*  
18 *hundred ninety-nine dollars and thirty-six cents (\$399.36)* per day  
19 for the 2014 calendar year and ~~four hundred fifty-two dollars and~~  
20 ~~seventy three cents (\$452.73)~~ *fifty-four dollars and seventy-nine*  
21 *cents (\$454.79)* per day for the 2015 calendar year.

22 (3) Upon federal approval or conditional federal approval  
23 described in Section 14169.74, the director shall determine the  
24 fee-for-service per diem quality assurance fee rate based on the  
25 funds required to make the payments specified in Article 5.230  
26 (commencing with Section 14169.51), in consultation with the  
27 hospital community.

28 ~~(k)~~

29 (l) "Fee-for-service days" means inpatient hospital days ~~when~~  
30 *where* the service type is reported as "acute care," "psychiatric  
31 care," and "rehabilitation care," and the payer category is reported  
32 as "Medicare traditional," "county indigent programs-traditional,"  
33 "other third parties-traditional," "other indigent," and "other  
34 payers," for purposes of the Annual Financial Disclosure Report  
35 submitted by hospitals to the Office of Statewide Health Planning  
36 and Development.

37 (t) "Fee percentage" means a fraction, expressed as a percentage,  
38 ~~the numerator of which is the amount of payments for each subject~~  
39 ~~fiscal year under Sections 14169.52, 14169.53, and 14169.54, for~~

1 ~~which federal financial participation is available and the~~  
2 ~~denominator of which is \_\_\_\_\_.~~

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

6 (n) “Hospital community” means any ~~hospital industry~~  
7 ~~organization or system that represents~~ *general acute care hospital*  
8 *and any hospital industry organization that represents general*  
9 *acute care hospitals.*

10 (o) “Managed care days” means inpatient hospital days ~~when~~  
11 *where* the service type is reported as “acute care,” “psychiatric  
12 care,” and “rehabilitation care,” and the payer category is reported  
13 as “Medicare managed care,” “county indigent programs-managed  
14 care,” and “other third parties-managed care,” for purposes of the  
15 Annual Financial Disclosure Report submitted by hospitals to the  
16 Office of Statewide Health Planning and Development.

17 (p) “Managed care per diem quality assurance fee rate” means  
18 a fixed fee on managed care days of one hundred ~~forty dollars~~  
19 ~~(\$140)~~ *forty-five dollars (\$145)* per day for the 2014 calendar year  
20 and one hundred ~~sixty-five dollars (\$165)~~ *seventy dollars (\$170)*  
21 per day for the 2015 calendar year.

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

28 (r) “Medi-Cal fee-for-service days” means inpatient hospital  
29 days ~~when~~ *where* the service type is reported as “acute care,”  
30 “psychiatric care,” and “rehabilitation care,” and the payer category  
31 is reported as “Medi-Cal traditional” for purposes of the Annual  
32 Financial Disclosure Report submitted by hospitals to the Office  
33 of Statewide Health Planning and Development.

34 (s) “Medi-Cal managed care days” means inpatient hospital  
35 days as reported on the days data source when the service type is  
36 reported as “acute care,” “psychiatric care,” and “rehabilitation  
37 care,” and the payer category is reported as “Medi-Cal managed  
38 care” for purposes of the Annual Financial Disclosure Report  
39 submitted by hospitals to the Office of Statewide Health Planning  
40 and Development.

1 (t) “Medi-Cal per diem quality assurance fee rate” means a fixed  
 2 fee on Medi-Cal days of four hundred ~~seventy-four dollars and~~  
 3 ~~sixty-four cents (\$474.64)~~ *seventy-six dollars and twenty-three*  
 4 *cents (\$476.23)* per day for the 2014 calendar year and five hundred  
 5 ~~forty-two dollars and thirty-six cents (\$542.36)~~ *forty-seven dollars*  
 6 *and sixty-eight cents (\$547.68)* for the 2015 calendar year.

7 (u) “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 operator  
 11 ~~when~~ *where* there is an outstanding monetary ~~liability obligation~~  
 12 owed to the state in connection with the Medi-Cal program and  
 13 ~~the new operator did not assume liability~~ *hospital is not, or does*  
 14 *not agree to become, financially responsible to the department for*  
 15 *the outstanding monetary obligation in accordance with subdivision*  
 16 *(d) of Section 14169.58.*

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

19 (1) A public hospital that is licensed under subdivision (a) of  
 20 Section 1250 of the Health and Safety Code, is not designated as  
 21 a specialty hospital in the hospital’s *most recently filed* Annual  
 22 Financial Disclosure Report ~~for the hospital’s latest fiscal year as~~  
 23 *of January 1, 2014*, and satisfies the definition in paragraph (25)  
 24 of subdivision (a) of Section 14105.98, excluding designated public  
 25 hospitals.

26 (2) A tax-exempt nonprofit hospital that is licensed under  
 27 subdivision (a) of Section 1250 of the Health and Safety Code, is  
 28 not designated as a specialty hospital in the hospital’s *most recently*  
 29 *filed* Annual Financial Disclosure Report ~~for the hospital’s latest~~  
 30 ~~fiscal year as of January 1, 2014~~, is operating a hospital owned  
 31 by a local health care district, and is affiliated with the health care  
 32 district hospital owner by means of the district’s status as the  
 33 nonprofit corporation’s sole corporate member.

34 (w) “Prepaid health plan hospital” means a hospital owned by  
 35 a nonprofit public benefit corporation that shares a common board  
 36 of directors with a nonprofit health care service plan, *which*  
 37 *exclusively contracts with no more than two medical groups in the*  
 38 *state to provide or arrange for professional medical services for*  
 39 *the enrollees of the plan.*

1 (x) “Prepaid health plan hospital managed care per diem quality  
2 assurance fee rate” means a fixed fee on non-Medi-Cal managed  
3 care days for prepaid health plan hospitals of ~~seventy-eight dollars~~  
4 ~~and forty cents (\$78.40)~~ *eighty-one dollars and twenty cents*  
5 *(\$81.20)* per day for the 2014 calendar year and ~~ninety-two dollars~~  
6 ~~and forty cents (\$92.40)~~ *ninety-five dollars and twenty cents*  
7 *(\$95.20) per day* for the 2015 calendar year.

8 (y) “Prepaid health plan hospital Medi-Cal managed care per  
9 diem quality assurance fee rate” means a fixed fee on Medi-Cal  
10 managed care days for prepaid health plan hospitals of two hundred  
11 ~~sixty-five dollars and eighty cents (\$265.80)~~ *sixty-six dollars and*  
12 *sixty-nine cents (\$266.69)* per day for the 2014 calendar year and  
13 ~~three hundred three dollars and seventy-two cents (\$303.72)~~ *six*  
14 *dollars and seventy cents (\$306.70)* per day for the 2015 calendar  
15 year.

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

22 (aa)

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

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

27 (2) Is in the Charitable Research Hospital peer group, as set  
28 forth in the 1991 Hospital Peer Grouping Report published by the  
29 department, or is not designated as a specialty hospital in the  
30 hospital’s most recent publicly available *recently filed* Office of  
31 Statewide Health Planning and Development Annual Financial  
32 Disclosure Report *as of January 1, 2014*.

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

35 (4) Is a nonpublic hospital, nonpublic converted hospital, or  
36 converted hospital as those terms are defined in paragraphs (26)  
37 to (28), inclusive, respectively, of subdivision (a) of Section  
38 14105.98.

39 (5) *Is not a nondesignated public hospital or a designated*  
40 *hospital.*

- 1     ~~(ab)~~
- 2     (aa) “Program period” means the period from January 1, 2014,
- 3     to December 31, 2015, inclusive.
- 4     (ab) “Quality assurance fee” means the quality assurance fee
- 5     assessed pursuant to Section 14169.72 and collected on the basis
- 6     of the quarterly quality assurance fee.
- 7     (ac) (1) “Quarterly quality assurance fee” means, with respect
- 8     to a hospital that is not a prepaid health plan hospital, the sum of
- 9     all of the following:
- 10    (A) The annual fee-for-service days for an individual hospital
- 11    multiplied by the fee-for-service per diem quality assurance fee
- 12    rate, divided by four.
- 13    (B) The annual managed care days for an individual hospital
- 14    multiplied by the managed care per diem quality assurance fee
- 15    rate, divided by four.
- 16    (C) The annual Medi-Cal days for an individual hospital
- 17    multiplied by the Medi-Cal per diem quality assurance fee rate,
- 18    divided by four.
- 19    (2) “Quarterly quality assurance fee” means, with respect to a
- 20    hospital that is a prepaid health plan hospital, the sum of all of
- 21    the following:
- 22    (A) The annual fee-for-service days for an individual hospital
- 23    multiplied by the fee-for-service per diem quality assurance fee
- 24    rate, divided by four.
- 25    (B) The annual managed care days for an individual hospital
- 26    multiplied by the prepaid health plan hospital managed care per
- 27    diem quality assurance fee rate, divided by four.
- 28    (C) The annual Medi-Cal managed care days for an individual
- 29    hospital multiplied by the prepaid health plan hospital Medi-Cal
- 30    managed care per diem quality assurance fee rate, divided by four.
- 31    (D) The annual Medi-Cal fee-for-service days for an individual
- 32    hospital multiplied by the Medi-Cal per diem quality assurance
- 33    fee rate, divided by four.
- 34    ~~(ae)~~
- 35    (ad) “Subject fiscal quarter” means a state fiscal quarter during
- 36    the program period.
- 37    ~~(ad)~~
- 38    (ae) “Subject fiscal year” means a state fiscal year that ends
- 39    after July 1, 2013, and begins before January 1, 2016.
- 40    ~~(ae)~~

1 (af) “Upper payment limit” means a federal upper payment limit  
2 on the amount of the Medicaid payment for which federal financial  
3 participation is available for a class of service and a class of health  
4 care providers, as specified in Part 447 of Title 42 of the Code of  
5 Federal Regulations. The applicable upper payment limit shall be  
6 separately calculated for inpatient and outpatient hospital services.

7 14169.72. (a) There shall be imposed on each general acute  
8 care hospital that is not an exempt facility a quality assurance fee,  
9 provided that a quality assurance fee under this article shall not be  
10 imposed on a converted hospital *for the periods when the hospital*  
11 *is a public hospital or a new hospital.*

12 (b) *The department shall compute the quarterly quality*  
13 *assurance fee shall be computed for each subject fiscal quarter*  
14 *starting on January 1, 2014, and continue through and including*  
15 *December 31, 2015.*

16 (c) Subject to Section 14169.74, upon receipt of federal  
17 approval, the following shall become operative:

18 (1) Within 10 business days following receipt of the notice of  
19 federal approval from the federal government, the department shall  
20 send notice to each hospital subject to the quality assurance fee;  
21 ~~and publish on its Internet Web site,~~ the following information:

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

23 (B) ~~The fee percentage~~ *quarterly quality assurance fee* for each  
24 subject fiscal year.

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

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

29 ~~(B) The aggregate quality assurance fee.~~

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

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

33 ~~(3) The hospitals shall pay the aggregate quality assurance fee~~  
34 ~~after application of the fee percentage for all subject fiscal years~~  
35 ~~in eight installments. The department shall establish the date that~~  
36 ~~each installment is due, provided that the first installment shall be~~  
37 ~~due no earlier than 20 days following the department sending the~~  
38 ~~notice pursuant to paragraph (1), and the installments shall be paid~~  
39 ~~at least one month apart, but if possible, the installments shall be~~  
40 ~~paid on a quarterly basis.~~

1 (C) *The date on which each payment is due.*

2 (2) *The hospitals shall pay the quarterly quality assurance fees,*  
3 *based on a schedule developed by the department. The department*  
4 *shall establish the date that each payment is due, provided that*  
5 *the first payment shall be due no earlier than 20 days following*  
6 *the date the department sends the notice pursuant to paragraph*  
7 *(1), and the payments shall be paid at least one month apart, but*  
8 *if possible, the payments shall be paid on a quarterly basis.*

9 (4)

10 (3) ~~Notwithstanding any other provision of this section, the~~  
11 ~~amount of each hospital's aggregate quarterly quality assurance~~  
12 ~~fee after the application of the fee percentage for each subject fiscal~~  
13 ~~year fees for the program period that has have not been paid by~~  
14 ~~the hospital before December 15, 2015, pursuant to paragraphs (3)~~  
15 ~~and (8), shall be paid by the hospital no later than December 15,~~  
16 ~~2015.~~

17 (5) (A) ~~Notwithstanding subdivision (l) of Section 14169.71,~~  
18 ~~for the purpose of determining the installments under paragraph~~  
19 ~~(3), the department shall use an interim fee percentage as follows:~~

20 (i) ~~One hundred percent for the 2014 calendar year until the~~  
21 ~~federal government has approved or disapproved additional~~  
22 ~~capitation payments described in Section 14169.54 for that subject~~  
23 ~~fiscal year.~~

24 (ii) ~~One hundred percent for the 2015 calendar year until the~~  
25 ~~federal government has approved or disapproved additional~~  
26 ~~capitation payments described in Section 14169.54 for that subject~~  
27 ~~fiscal year.~~

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

33 (6) ~~The director shall determine the final fee percentage for each~~  
34 ~~subject fiscal year within 15 days of the approval or disapproval,~~  
35 ~~in whole or in part, by the federal government of all changes to~~  
36 ~~the capitation rates of managed health care plans requested by the~~  
37 ~~department to implement Section 14169.54 for that subject fiscal~~  
38 ~~year, but in no event later than December 1, 2015. At the time the~~  
39 ~~director determines the final fee percentage for a subject fiscal~~  
40 ~~year, the director shall also determine the amount of future~~



1 installment payments of the quality assurance fee for each hospital  
2 subject to the fee, if any are due. The amount of each future  
3 installment payment shall be established by the director with the  
4 objective that the total of the installment payments of the quality  
5 assurance fee due from a hospital shall equal the director's estimate  
6 for each subject fiscal year for the hospital of the aggregate quality  
7 assurance fee after the application of the fee percentage.

8 ~~(7) The director, within 15 days of determining the final fee~~  
9 ~~percentage for a subject fiscal year pursuant to paragraph (6), shall~~  
10 ~~send notice to each hospital subject to the quality assurance fee of~~  
11 ~~the following information:~~

12 ~~(A) The final fee percentage for each subject fiscal year for~~  
13 ~~which the final fee percentage has been determined.~~

14 ~~(B) The fee percentage determined under paragraph (5) for each~~  
15 ~~subject fiscal year for which the final fee percentage has not been~~  
16 ~~determined.~~

17 ~~(C) The aggregate quality assurance fee after application of the~~  
18 ~~fee percentage for each subject fiscal year.~~

19 ~~(D) The director's estimate of total quality assurance fee~~  
20 ~~payments due from the hospital under this article whether or not~~  
21 ~~paid. This amount shall be the sum of the aggregate quality~~  
22 ~~assurance fee after application of the fee percentage for each~~  
23 ~~subject fiscal year using the fee percentages contained in the notice.~~

24 ~~(E) The total quality assurance fee payments that the hospital~~  
25 ~~has made under this article.~~

26 ~~(F) The amount, if any, by which the total quality assurance fee~~  
27 ~~payments due from the hospital under this article as described in~~  
28 ~~subparagraph (D) exceed the total quality assurance fee payments~~  
29 ~~that the hospital has made under this article.~~

30 ~~(G) The amount of each remaining installment of the quality~~  
31 ~~assurance fee, if any, due from the hospital and the date each~~  
32 ~~installment is due. This amount shall be the amount described in~~  
33 ~~subparagraph (E) divided by the number of installment payments~~  
34 ~~remaining.~~

35 (8)

36 (4) Each hospital that is sent a notice under paragraph (7)  
37 described in subdivision (a) shall pay the additional installments  
38 of the quality assurance fee *quarterly quality assurance fees* that  
39 are due, if any, in the amounts and at the times set forth in the

1 notice unless superseded by a subsequent notice from the  
2 department.

3 ~~(9) The department shall refund to a hospital paying the quality  
4 assurance fee the amount, if any, by which the total quality  
5 assurance fee payments that the hospital has made under this article  
6 for all subject fiscal years exceed the total quality assurance fee  
7 payments due from the hospital under this article within 30 days  
8 of the date on which the notice is sent to the hospital under  
9 paragraph (7).~~

10 (d) The quality assurance fee, as paid pursuant to this section,  
11 shall be paid by each hospital subject to the fee to the department  
12 for deposit in the Hospital Quality Assurance Revenue Fund  
13 established pursuant to Section 14167.35. Deposits may be  
14 accepted at any time and will be credited toward the program  
15 period.

16 (e) This section shall become inoperative if the federal Centers  
17 for Medicare and Medicaid Services denies approval for, or does  
18 not approve before July 1, 2016, the implementation of the quality  
19 assurance fee pursuant to this article or the supplemental payments  
20 to private hospitals described in Sections 14169.52 and 14169.53.

21 (f) In no case shall the aggregate fees collected in a federal fiscal  
22 year pursuant to this section, former Section 14167.32, and Sections  
23 14168.32 and 14169.32 exceed the maximum percentage of the  
24 annual aggregate net patient revenue for hospitals subject to the  
25 fee that is prescribed pursuant to federal law and regulations as  
26 necessary to preclude a finding that an indirect guarantee has been  
27 created.

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

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

39 (h) When a hospital fails to pay all or part of the quality  
40 assurance fee on or before the date that payment is due, the

1 department may immediately begin to deduct the unpaid assessment  
2 and interest from any Medi-Cal payments owed to the hospital,  
3 or, in accordance with Section 12419.5 of the Government Code,  
4 from any other state payments owed to the hospital until the full  
5 amount is recovered. All amounts, except penalties, deducted by  
6 the department under this subdivision shall be deposited in the  
7 Hospital Quality Assurance Revenue Fund. The remedy provided  
8 to the department by this section is in addition to other remedies  
9 available under law.

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

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

16 (k) This subdivision creates a contractually enforceable promise  
17 on behalf of the state to use the proceeds of the quality assurance  
18 fee, including any federal matching funds, solely and exclusively  
19 for the purposes set forth in this article as they existed on the  
20 effective date of this article, to limit the amount of the proceeds  
21 of the quality assurance fee to be used to pay for the health care  
22 coverage of children to the amounts specified in this article, to  
23 limit any payments for the department's costs of administration  
24 to the amounts set forth in this article on the effective date of this  
25 article, to maintain and continue prior reimbursement levels as set  
26 forth in Section 14169.60 on the effective date of that section, and  
27 to otherwise comply with all its obligations set forth in Article  
28 5.230 (commencing with Section 14169.51) and this article  
29 provided that amendments that arise from, or have as a basis for,  
30 a decision, advice, or determination by the federal Centers for  
31 Medicare and Medicaid Services relating to federal approval of  
32 the quality assurance fee or the payments set forth in this article  
33 or Article 5.230 (commencing with Section 14169.51) shall control  
34 for the purposes of this subdivision.

35 (l) (1) Effective January 1, 2016, the rates payable to hospitals  
36 and managed health care plans under Medi-Cal shall be the rates  
37 then payable without the supplemental and increased capitation  
38 payments set forth in Article 5.230 (commencing with Section  
39 14169.51).

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

6 (m) (1) Subject to paragraph (2), the director may waive any  
7 or all interest and penalties assessed under this article in the event  
8 that the director determines, in his or her sole discretion, that the  
9 hospital has demonstrated that imposition of the full quality  
10 assurance fee on the timelines applicable under this article has a  
11 high likelihood of creating a financial hardship for the hospital or  
12 a significant danger of reducing the provision of needed health  
13 care services.

14 (2) Waiver of some or all of the interest or penalties under this  
15 subdivision shall be conditioned on the hospital's agreement to  
16 make fee payments, or to have the payments withheld from  
17 payments otherwise due from the Medi-Cal program to the hospital,  
18 on a schedule developed by the department that takes into account  
19 the financial situation of the hospital and the potential impact on  
20 services.

21 (3) A decision by the director under this subdivision shall not  
22 be subject to judicial review.

23 (4) If fee payments are remitted to the department after the date  
24 determined by the department to be the final date for calculating  
25 the final supplemental payments under this article and Article  
26 5.230 (commencing with Section 14169.51), the fee payments  
27 shall be retained in the fund for purposes of funding supplemental  
28 payments supported by a hospital quality assurance fee program  
29 implemented under subsequent legislation. However, if  
30 supplemental payments are not implemented under subsequent  
31 legislation, then those fee payments shall be ~~deposited in the~~  
32 ~~Distressed Hospital Fund~~ *returned to the private hospitals pro rata*  
33 *based on each hospital's total fee payments under this article to*  
34 *the extent consistent with federal law.*

35 (5) If during the implementation of this article, fee payments  
36 that were due under former Article 5.21 (commencing with Section  
37 14167.1) and former Article 5.22 (commencing with Section  
38 14167.31), or former Article 5.226 (commencing with Section  
39 14168.1) and Article 5.227 (commencing with Section 14168.31),  
40 or Article 5.228 (commencing with Section 14169.1) and Article

1 5.229 (commencing with Section 14169.31) are remitted to the  
2 department under a payment plan or for any other reason, and the  
3 final date for calculating the final supplemental payments under  
4 those articles has passed, then those fee payments shall be  
5 deposited in the fund to support the uses established by this article.

6 14169.73. (a) (1) All fees required to be paid to the state  
7 pursuant to this article shall be paid in the form of remittances  
8 payable to the department.

9 (2) The department shall directly transmit the fee payments to  
10 the Treasurer to be deposited in the Hospital Quality Assurance  
11 Revenue Fund, created pursuant to Section 14167.35.  
12 Notwithstanding Section 16305.7 of the Government Code, any  
13 interest and dividends earned on deposits in the fund from the  
14 proceeds of the fee assessed pursuant to this article shall be retained  
15 in the fund for purposes specified in subdivision (b).

16 (b) (1) Notwithstanding subdivision (c) of Section 14167.35,  
17 subdivision (b) of Section 14168.33, and subdivision (b) of Section  
18 14169.33, all funds from the proceeds of the fee assessed pursuant  
19 to this article in the Hospital Quality Assurance Revenue Fund,  
20 together with any interest and dividends earned on money in the  
21 fund, shall, ~~upon appropriation by the Legislature,~~ continue to be  
22 used exclusively to enhance federal financial participation for  
23 hospital services under the Medi-Cal program, to provide additional  
24 reimbursement to, and to support quality improvement efforts of,  
25 hospitals, and to minimize uncompensated care provided by  
26 hospitals to uninsured patients, as well as to pay for the state's  
27 administrative costs and to provide funding for children's health  
28 coverage, in the following order of priority:

29 (1)

30 (A) To pay for the department's staffing and administrative costs  
31 directly attributable to implementing Article 5.230 (commencing  
32 with Section 14169.51) and this article, not to exceed two million  
33 dollars (\$2,000,000) for the program period.

34 (2)

35 (B) To pay for the health care coverage for children in the  
36 amount of one hundred fifty-five million dollars (\$155,000,000)  
37 for each subject fiscal quarter during the 2014 and 2015 calendar  
38 years.

39 (3)

1 (C) To make increased capitation payments to managed health  
2 care plans pursuant to Article 5.230 (commencing with Section  
3 14169.51).

4 ~~(4)~~

5 (D) To make increased payments ~~or~~ *and* direct grants to hospitals  
6 pursuant to Article 5.230 (commencing with Section 14169.51).

7 (2) *Notwithstanding subdivision (c) of Section 14167.35,*  
8 *subdivision (b) of Section 14168.33, and subdivision (b) of Section*  
9 *14169.33, and notwithstanding Section 13340 of the Government*  
10 *Code, the moneys in the Hospital Quality Assurance Revenue Fund*  
11 *shall be continuously appropriated without regard to fiscal year*  
12 *for the purposes of this article, Article 5.230 (commencing with*  
13 *Section 14169.51), Article 5.229 (commencing with Section*  
14 *14169.31), Article 5.228 (commencing with Section 14169.1),*  
15 *Article 5.227 (commencing with Section 14168.31), former Article*  
16 *5.226 (commencing with Section 14168.1), former Article 5.22*  
17 *(commencing with Section 14167.31) and former Article 5.21*  
18 *(commencing with Section 14167.1).*

19 (c) Any amounts of the quality assurance fee collected in excess  
20 of the funds required to implement subdivision (b), including any  
21 funds recovered under subdivision (d) of Section 14169.61 or  
22 subdivision (e) of Section 14169.78, shall be refunded to general  
23 acute care hospitals, pro rata with the amount of quality assurance  
24 fee paid by the hospital, subject to the limitations of federal law.  
25 If federal rules prohibit the refund described in this subdivision,  
26 the excess funds shall be ~~deposited in the Distressed Hospital Fund~~  
27 ~~to be used for the purposes described in Section 14166.23, and~~  
28 ~~shall be supplemental to and not supplant existing funds; returned~~  
29 ~~to the private hospitals pro rata based on each hospital's total fee~~  
30 ~~payments under this article to the extent consistent with federal~~  
31 ~~law.~~

32 (d) Any methodology or other provision specified in Article  
33 5.230 (commencing with Section 14169.51) or this article may be  
34 modified by the department, in consultation with the hospital  
35 community, to the extent necessary to meet the requirements of  
36 federal law or regulations to obtain federal approval or to enhance  
37 the probability that federal approval can be obtained, provided the  
38 modifications do not violate the spirit and intent of Article 5.230  
39 (commencing with Section 14169.51) or this article and are not

1 inconsistent with the conditions of implementation set forth in  
2 Section 14169.80.

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

8 (f) The department shall request approval from the federal  
9 Centers for Medicare and Medicaid Services for the implementation  
10 of this article. In making this request, the department shall seek  
11 specific approval from the federal Centers for Medicare and  
12 Medicaid Services to exempt providers identified in this article as  
13 exempt from the fees specified, including the submission, as may  
14 be necessary, of a request for waiver of the broad-based  
15 requirement, waiver of the uniform fee requirement, or both,  
16 pursuant to paragraphs (1) and (2) of subdivision (e) of Section  
17 433.68 of Title 42 of the Code of Federal Regulations.

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

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

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

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

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

8 (c) Nothing in this section shall be construed as modifying the  
9 requirement under Section 14169.61 that payments shall be made  
10 only to the extent a sufficient amount of funds collected as the  
11 quality assurance fee are available to cover the nonfederal share  
12 of those payments.

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

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

29 (f) The director shall have broad authority under this section to  
30 collect the quality assurance fee for an interim period after receipt  
31 of the letter described in subdivision (a) pending receipt of all  
32 necessary federal approvals. This authority shall include discretion  
33 to determine both of the following:

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

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

38 (g) The department may draw against the Hospital Quality  
39 Assurance Revenue Fund for all administrative costs associated



1 with implementation under this article or Article 5.230  
2 (commencing with Section 14169.51).

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

6 14169.75. (a) Notwithstanding any other law, the director shall  
7 have discretion to modify any timeline or timelines in this article  
8 or Article 5.230 (commencing with Section 14169.51) if the letter  
9 that indicates likely federal approval, as described in Section  
10 14169.74, is not secured by December 15, 2015, and the director  
11 determines that it is impossible from an operational perspective  
12 to implement a timeline or timelines without the modification.

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

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

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

22 14169.76. (a) Upon receipt of a letter that indicates likely  
23 federal approval that the director determines is sufficient for  
24 implementation under Section 14169.74, or upon the receipt of  
25 federal approval, the following shall occur:

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

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

38 (b) Notwithstanding any other provision of this article or Article  
39 5.230 (commencing with Section 14169.51), if the director  
40 determines, on or after December 15, 2015, that there are

1 insufficient funds available in the Hospital Quality Assurance  
2 Revenue Fund to make all scheduled payments under Article 5.230  
3 (commencing with Section 14169.51) before January 1, 2016, he  
4 or she shall consult with representatives of the hospital community  
5 to develop an acceptable plan for making additional payments to  
6 hospitals and managed health care plans to maximize the use of  
7 delinquent fee payments or other deposits or interest projected to  
8 become available in the fund after December 15, 2015, but before  
9 June 15, 2016.

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

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

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

24 (f) Nothing in this section shall be read as affecting the  
25 department's ongoing authority to continue, after December 31,  
26 2015, to collect quality assurance fees imposed on or before  
27 December 31, 2015.

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

35 14169.78. (a) This article shall be implemented only as long  
36 as all of the following conditions are met:

37 (1) Subject to Section 14169.73, the quality assurance fee is  
38 established in a manner that is fundamentally consistent with this  
39 article.

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

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

7 (b) No hospital shall be required to pay the quality assurance  
8 fee to the department unless and until the state receives and  
9 maintains federal approval.

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

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

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

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

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

25 (1) In the event, and on the effective date, of a final judicial  
26 determination made by any court of appellate jurisdiction or a final  
27 determination by the United States Department of Health and  
28 Human Services or the federal Centers for Medicare and Medicaid  
29 Services that the quality assurance fee established pursuant to this  
30 article cannot be implemented. *This paragraph shall not apply to*  
31 *a final judicial determination made by any court of appellate*  
32 *jurisdiction in a case brought by hospitals located outside the*  
33 *state.*

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

35 (A) The federal Centers for Medicare and Medicaid Services  
36 denies approval for, or does not approve before January 1, 2016,  
37 the implementation of Sections 14169.52 and 14169.53 or this  
38 article.

39 (B) Section 14169.52, Section 14169.53, or this article cannot  
40 be modified by the department pursuant to subdivision (d) of

1 Section 14169.73 in order to meet the requirements of federal law  
2 or to obtain federal approval.

3 (e) If this article becomes inoperative pursuant to paragraph (1)  
4 of subdivision (d) and the determination applies to any period or  
5 periods of time prior to the effective date of the determination, the  
6 department may recoup all payments made pursuant to Article  
7 5.230 (commencing with Section 14169.51) during that period or  
8 those periods of time.

9 (f) (1) If all necessary final federal approvals are not received  
10 as described and anticipated under this article or Article 5.230  
11 (commencing with Section 14169.51), the director shall have the  
12 discretion and authority to develop procedures for recoupment  
13 from managed health care plans, and from hospitals under contract  
14 with managed health care plans, of any amounts received pursuant  
15 to this article or Article 5.230 (commencing with Section  
16 14169.51).

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

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

25 14169.79. Notwithstanding any other provision of this article  
26 or Article 5.230 (commencing with Section 14169.51),  
27 supplemental payments or other payments under Article 5.230  
28 (commencing with Section 14169.51) shall only be required and  
29 payable in any quarter for which a fee payment obligation exists.

30 14169.80. (a) This article and Article 5.230 (commencing with  
31 Section 14169.51) shall become inoperative and the requirements  
32 for supplemental payments or other payments under Article 5.230  
33 (commencing with Section 14169.51) shall be retroactively  
34 invalidated, on the first day of the first month of the calendar  
35 quarter following notification to the Joint Legislative Budget  
36 Committee by the Department of Finance, that any of the following  
37 have occurred:

38 (1) A final judicial determination by the California Supreme  
39 Court or any California Court of Appeal that the revenues collected

1 pursuant to this article that are deposited in the Hospital Quality  
2 Assurance Revenue Fund are either of the following:

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

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

8 (2) The department has sought but has not received federal  
9 financial participation for the supplemental payments and other  
10 costs required by this article for which federal financial  
11 participation has been sought.

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

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

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

22 (1) A loss of federal financial participation.

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

26 (c) (1) The director shall have the authority to recoup any  
27 payments made under Article 5.230 (commencing with Section  
28 14169.51) if any of the following apply:

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

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

34 (C) Recoupment of payments made under Article 5.230  
35 (commencing with Section 14169.51) is necessary to prevent a  
36 General Fund cost that is estimated to be equal to or greater than  
37 one-quarter of 1 percent of the General Fund expenditures  
38 authorized in the most recent annual Budget Act and that results  
39 from implementation of a court order or the unavailability of  
40 federal financial participation.

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

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

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

12 (d) In the event the department determines that recoupment of  
13 supplemental payments is necessary to implement any provision  
14 of this section, the department may recoup payments made pursuant  
15 to Article 5.230 (commencing with Section 14169.51) from fees  
16 paid by the hospital pursuant to this article.

17 (e) Concurrent with invoking any provision of this section, the  
18 director shall notify the fiscal and appropriate policy committees  
19 of the Legislature of the intended action and the specific reason  
20 or reasons for the proposed action.

21 14169.81. Notwithstanding Chapter 3.5 (commencing with  
22 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
23 Code, the department shall implement this article by means of  
24 policy letters or similar instructions, without taking further  
25 regulatory action.

26 14169.82. (a) This article shall remain operative only until the  
27 later of the following:

28 (1) January 1, 2017.

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

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

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

37 (c) If this article becomes inoperative under paragraph (2) or  
38 (3) of subdivision (a), this article shall be repealed on January 1  
39 of the year following the date this article becomes inoperative,

1 unless a later enacted statute enacted before that date, deletes or  
2 extends that date.

3 14169.83. If the director determines that this article has become  
4 inoperative pursuant to Section 14169.77, 14169.78, 14169.80, or  
5 14169.82, or that Section 14169.72 has become inoperative  
6 pursuant to subdivision (e) of that section, the director shall execute  
7 a declaration stating that this determination has been made and  
8 stating the basis for this determination. The director shall retain  
9 the declaration and provide a copy, within five working days of  
10 the execution of the declaration, to the fiscal and appropriate policy  
11 committees of the Legislature. In addition, the director shall post  
12 the declaration on the department's Internet Web site and the  
13 director shall send the declaration to the Secretary of State, the  
14 Secretary of the Senate, the Chief Clerk of the Assembly, and the  
15 Legislative Counsel.

16 14169.84. (a) (1) *Except as provided in this section, all data*  
17 *and other information relating to a hospital that are used for the*  
18 *purposes of this article, including, without limitation, the days*  
19 *data source, shall continue to be used to determine the quality*  
20 *assurance fees due from that hospital pursuant to this article,*  
21 *regardless of whether the hospital has undergone one or more*  
22 *changes of ownership.*

23 (2) *All quality assurance fee payments under this article shall*  
24 *be paid by the licensee of a hospital on the date the quarterly*  
25 *quality assurance fee payment is due.*

26 (b) *The data of separate facilities prior to a consolidation shall*  
27 *be aggregated for the purposes of this article if: (1) a private*  
28 *hospital consolidates with another private hospital, (2) the facilities*  
29 *operate under a consolidated hospital license, (3) data for a period*  
30 *prior to the consolidation is used for purposes of this article, and*  
31 *(4) neither hospital has had a change of ownership on or after the*  
32 *effective date of this article unless paragraph (2) of subdivision*  
33 *(d) has been satisfied by the new owner. Data of a facility that was*  
34 *a separately licensed hospital prior to the consolidation shall not*  
35 *be included in the data, including the days data source, for the*  
36 *purpose of determining the quality assurance fees due from the*  
37 *facility under the article for any time period during which such*  
38 *facility is closed. A facility shall be deemed to be closed for*  
39 *purposes of this subdivision on the first day of any period during*  
40 *which the facility has no general acute, psychiatric, or*

1 *rehabilitation inpatients for at least 30 consecutive days. A facility*  
2 *that has been deemed to be closed under this subdivision shall no*  
3 *longer be deemed to be closed on the first subsequent day on which*  
4 *it has general acute, psychiatric, or rehabilitation inpatients.*

5 *(c) The quality assurance fees under this article shall not be*  
6 *due, for any period during which the hospital is closed. A hospital*  
7 *shall be deemed to be closed on the first day of any period during*  
8 *which the hospital has no general acute, psychiatric, or*  
9 *rehabilitation inpatients for at least 30 consecutive days. A hospital*  
10 *that has been deemed to be closed under this subdivision shall no*  
11 *longer be deemed to be closed on the first subsequent day on which*  
12 *it has general acute, psychiatric, or rehabilitation inpatients.*  
13 *Payments of the quality assurance fee under this article due from*  
14 *a hospital that is closed during any portion of a subject fiscal*  
15 *quarter shall be reduced by applying a fraction, expressed as a*  
16 *percentage, the numerator of which shall be the number of days*  
17 *during the applicable subject fiscal quarter that the hospital is*  
18 *closed during the subject fiscal year and the denominator of which*  
19 *shall be the number of days in the subject fiscal quarter.*

20 *(d) The procedure established by the director pursuant to*  
21 *subdivision (d) of Section 14169.58 shall apply to this article.*

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

26 In order to make the necessary changes to increase Medi-Cal  
27 payments to hospitals and improve access at the earliest time, so  
28 as to allow this act to be operative as soon as approval from the  
29 federal Centers for Medicare and Medicaid Services is obtained  
30 by the State Department of Health Care Services, it is necessary  
31 that this act takes effect immediately.