

AMENDED IN ASSEMBLY SEPTEMBER 6, 2013

AMENDED IN ASSEMBLY AUGUST 27, 2013

AMENDED IN ASSEMBLY AUGUST 14, 2013

AMENDED IN SENATE APRIL 17, 2013

SENATE BILL

No. 239

Introduced by Senators Hernandez and Steinberg

February 12, 2013

An act to amend 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.

(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.

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 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 and increased capitation payments to Medi-Cal managed care plans. The bill would also ~~authorize~~ *require* 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. 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 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 returned to the private hospitals pro rata, as specified. The bill would make other conforming changes.

(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.

(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.

(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.

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

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

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

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

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

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

27 (3) No hospital shall be required to pay the quality assurance
28 fee to the department unless and until the state receives and
29 maintains federal approval of the quality assurance fee and related
30 supplemental payments to hospitals.

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

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

36 14164. (a) In addition to the required intergovernmental
37 transfers set forth in Section 14163, any county, other political
38 subdivision of the state, or governmental entity in the state may
39 elect to transfer funds, subject to subdivision (m) of Section 14163,
40 to the department in support of the Medi-Cal program. Those

1 transfers may consist of cash or loans to the state. The department
2 shall have the discretion to accept or not accept any elective transfer
3 from a county, political subdivision, or other governmental entity,
4 as well as the discretion of whether to deposit the transfer in the
5 Medi-Cal Inpatient Payment Adjustment Fund established pursuant
6 to Section 14163. If the department accepts a transfer pursuant to
7 this section, the department shall obtain federal matching funds to
8 the full extent permitted by federal law.

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

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

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

30 14165. (a) There is hereby created in the Governor's office
31 the California Medical Assistance Commission, for the purpose
32 of contracting with health care delivery systems for the provision
33 of health care services to recipients under the California Medical
34 Assistance Program.

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

39 (1) Upon dissolution of the commission, all powers, duties, and
40 responsibilities of the commission shall be transferred to the

1 Director of Health Care Services. These powers, duties, and
2 responsibilities shall include, but are not limited to, those exercised
3 in the operation of the selective provider contracting program
4 pursuant to Article 2.6 (commencing with Section 14081).

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

9 (B) Employees who transfer pursuant to subparagraph (A) shall
10 be subject to the same conditions of employment under the
11 department as they were under the California Medical Assistance
12 Commission, including retention of their exempt status, until the
13 diagnosis-related groups payment system described in Section
14 14105.28 replaces the contract-based payment system described
15 in this article.

16 (C) (i) Notwithstanding any other law or rule, persons employed
17 by the department who transferred to the department pursuant to
18 subparagraph (A) shall be eligible to apply for civil service
19 examinations. Persons receiving passing scores shall have their
20 names placed on lists resulting from these examinations, or
21 otherwise gain eligibility for appointment. In evaluating minimum
22 qualifications, related California Medical Assistance Commission
23 experience shall be considered state civil service experience in a
24 class deemed comparable by the State Personnel Board, based on
25 the duties and responsibilities assigned.

26 (ii) On the date the diagnosis-related groups payment system
27 described in Section 14105.28 replaces the contract-based system
28 described in this article, employees who transferred to the
29 department pursuant to subparagraph (A) shall transfer to civil
30 service classifications within the department for which they are
31 eligible.

32 (3) Upon a determination by the Director of Health Care
33 Services that a payment system based on diagnosis-related groups
34 as described in Section 14105.28 that is sufficient to replace the
35 contract-based payment system described in this article has been
36 developed and implemented, the powers, duties, and responsibilities
37 conferred on the commission and transferred to the Director of
38 Health Care Services shall no longer be exercised, excluding all
39 of the following:

1 (A) Stabilization payments made or committed from Sections
2 14166.14 and 14166.19 for services rendered prior to the director's
3 determination pursuant to this paragraph.

4 (B) The ability to negotiate and make payments from the Private
5 Hospital Supplemental Fund, established pursuant to Section
6 14166.12, and the Nondesignated Public Hospital Supplemental
7 Fund, established pursuant to Section 14166.17.

8 (C) The ability to continue to administer and distribute payments
9 for the Construction Renovation Reimbursement Program, in
10 accordance with Sections 14085 to 14085.57, inclusive.
11 Notwithstanding any other law, maintaining or negotiating a
12 selective provider contract pursuant to Article 2.6 (commencing
13 with Section 14081) or a contract with a county organized health
14 system shall cease to be a requirement for a hospital's participation
15 in the Construction Renovation Reimbursement Program.

16 (4) Protections afforded to the negotiations and contracts of the
17 commission by the California Public Records Act (Chapter 3.5
18 (commencing with Section 6250) of Division 7 of Title 1 of the
19 Government Code) shall be applicable to the negotiations and
20 contracts conducted or entered into pursuant to this section by the
21 State Department of Health Care Services.

22 (c) Notwithstanding the rulemaking provisions of Chapter 3.5
23 (commencing with Section 11340) of Part 1 of Division 3 of Title
24 2 of the Government Code, or any other provision of law, the State
25 Department of Health Care Services may implement and administer
26 this section by means of provider bulletins or other similar
27 instructions, without taking regulatory action. The authority to
28 implement this section as set forth in this subdivision shall include
29 the authority to give notice by provider bulletin or other similar
30 instruction of a determination made pursuant to paragraph (3) of
31 subdivision (b) and to modify or supersede existing regulations in
32 Title 22 of the California Code of Regulations that conflict with
33 implementation of this section.

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

36 14167.35. (a) The Hospital Quality Assurance Revenue Fund
37 is hereby created in the State Treasury.

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

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

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

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

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

27 (3) To make increased capitation payments to managed health
28 care plans pursuant to Article 5.21 (commencing with Section
29 14167.1).

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

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

38 (d) Any amounts of the quality assurance fee collected in excess
39 of the funds required to implement subdivision (c), including any
40 funds recovered under subdivision (d) of Section 14167.14 or

1 subdivision (e) of Section 14167.36, shall be refunded to general
2 acute care hospitals, pro rata with the amount of quality assurance
3 fee paid by the hospital, subject to the limitations of federal law.
4 If federal rules prohibit the refund described in this subdivision,
5 the excess funds shall be deposited in the Distressed Hospital Fund
6 to be used for the purposes described in Section 14166.23, and
7 shall be supplemental to and not supplant existing funds.

8 (e) Any methodology or other provision specified in Article
9 5.21 (commencing with Section 14167.1) and this article may be
10 modified by the department, in consultation with the hospital
11 community, to the extent necessary to meet the requirements of
12 federal law or regulations to obtain federal approval or to enhance
13 the probability that federal approval can be obtained, provided the
14 modifications do not violate the spirit and intent of Article 5.21
15 (commencing with Section 14167.1) or this article and are not
16 inconsistent with the conditions of implementation set forth in
17 Section 14167.36.

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

23 (g) The department shall request approval from the federal
24 Centers for Medicare and Medicaid Services for the implementation
25 of this article. In making this request, the department shall seek
26 specific approval from the federal Centers for Medicare and
27 Medicaid Services to exempt providers identified in this article as
28 exempt from the fees specified, including the submission, as may
29 be necessary, of a request for waiver of the broad based
30 requirement, waiver of the uniform fee requirement, or both,
31 pursuant to paragraphs (e)(1) and (e)(2) of Section 433.68 of Title
32 42 of the Code of Federal Regulations.

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

36 (A) Reduces or increases the supplemental payments or grants
37 made under Article 5.21 (commencing with Section 14167.1) in
38 the aggregate for the 2008–09, 2009–10, and 2010–11 federal
39 fiscal years to a hospital by more than 2 percent of the amount that

1 would be determined under this article without any change or
2 adjustment.

3 (B) Reduces or increases the amount of the fee payable by a
4 hospital in total under this article for the 2008–09, 2009–10, and
5 2010–11 federal fiscal years by more than 2 percent of the amount
6 that would be determined under this article without any change or
7 adjustment.

8 (2) The department shall provide the Joint Legislative Budget
9 Committee and the fiscal and appropriate policy committees of
10 the Legislature a status update of the implementation of Article
11 5.21 (commencing with Section 14167.1) and this article on
12 January 1, 2010, and quarterly thereafter. Information on any
13 adjustments or modifications to the provisions of this article or
14 Article 5.21 (commencing with Section 14167.1) that may be
15 required for federal approval shall be provided coincident with the
16 consultation required under subdivisions (f) and (g).

17 (i) Notwithstanding Chapter 3.5 (commencing with Section
18 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
19 the department may implement this article or Article 5.21
20 (commencing with Section 14167.1) by means of provider
21 bulletins, all plan letters, or other similar instruction, without taking
22 regulatory action. The department shall also provide notification
23 to the Joint Legislative Budget Committee and to the appropriate
24 policy and fiscal committees of the Legislature within five working
25 days when the above-described action is taken in order to inform
26 the Legislature that the action is being implemented.

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

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

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

38 14167.37. (a) (1) The department shall make available all
39 public documentation it uses to administer and audit the program
40 authorized under Article 5.230 (commencing with Section

1 14169.51) and Article 5.231 (commencing with Section 14169.71)
2 pursuant to the Public Records Act (Chapter 3.5 (commencing
3 with Section 6250) of Division 7 of Title 1 of the Government
4 Code).

5 (2) In addition, upon request from a hospital, the department
6 shall require Medi-Cal managed care plans to furnish hospitals
7 with the amounts the plan intends to pay to the hospital pursuant
8 to Article 5.230 (commencing with Section 14169.51). Nothing
9 in this paragraph shall require the department to reconcile payments
10 made to individual hospitals from Medi-Cal managed care plans.

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

13 (1) Within 10 business days after receipt of approval of the
14 hospital quality assurance fee program under Article 5.230
15 (commencing with Section 14169.51) and Article 5.231
16 (commencing with Section 14169.71) from the federal Centers for
17 Medicare and Medicaid Services (CMS), the hospital quality
18 assurance fee final model and upper payment limit calculations.

19 (2) Quarterly updates on payments, fee schedules, and model
20 updates when applicable.

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

23 (c) For purposes of this section, the following definitions shall
24 apply:

25 (1) "Fee schedules" mean the dates on which the hospital quality
26 assurance fee will be due from the hospitals and the dates on which
27 the department will submit fee-for-service payments to the
28 hospitals. "Fee schedules" also include the dates on which the
29 department is expected to submit payments to managed care plans.

30 (2) "Hospital quality assurance fee final model" means the
31 spreadsheet calculating the supplemental amounts based on the
32 upper payment limit calculation from claims and hospital data
33 sources of days and hospital services once CMS approves the
34 program under Article 5.230 (commencing with Section 14169.51)
35 and Article 5.231 (commencing with Section 14169.71).

36 (3) "Upper payment limit calculation" means the determination
37 of the federal upper payment limit on the amount of the Medicaid
38 payment for which federal financial participation is available for
39 a class of service and a class of health care providers, as specified

1 in Part 447 of Title 42 of the Code of Federal Regulations and that
2 has been approved by CMS.

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

6
7 Article 5.230. Medi-Cal Hospital Reimbursement Improvement
8 Act of 2013
9

10 14169.51. For purposes of this article, the following definitions
11 shall apply:

12 (a) “Acute psychiatric days” means the total number of Medi-Cal
13 specialty mental health service administrative days, Medi-Cal
14 specialty mental health service acute care days, acute psychiatric
15 administrative days, and acute psychiatric acute days identified in
16 the Final Medi-Cal Utilization Statistics for the 2012–13 state
17 fiscal year as calculated by the department as of December 17,
18 2012.

19 (b) “Converted hospital” means a private hospital that becomes
20 a designated public hospital or a nondesignated public hospital on
21 or after January 1, 2014.

22 (c) “Days data source” means the hospital’s Annual Financial
23 Disclosure Report filed with the Office of Statewide Health
24 Planning and Development as of June 6, 2013, for its fiscal year
25 ending during 2010.

26 (d) “Department” means the State Department of Health Care
27 Services.

28 (e) “Designated public hospital” shall have the meaning given
29 in subdivision (d) of Section 14166.1.

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

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

36 (h) “High acuity days” means Medi-Cal coronary care unit days,
37 pediatric intensive care unit days, intensive care unit days, neonatal
38 intensive care unit days, and burn unit days paid by the department
39 during the 2010 calendar year, as reflected in the state paid claims
40 file prepared by the department on April 26, 2013.

1 (i) “Hospital community” means any general acute care hospital
2 and any hospital industry organization that represents general acute
3 care hospitals.

4 (j) “Hospital inpatient services” means all services covered
5 under Medi-Cal and furnished by hospitals to patients who are
6 admitted as hospital inpatients and reimbursed on a fee-for-service
7 basis by the department directly or through its fiscal intermediary.
8 Hospital inpatient services include outpatient services furnished
9 by a hospital to a patient who is admitted to that hospital within
10 24 hours of the provision of the outpatient services that are related
11 to the condition for which the patient is admitted. Hospital inpatient
12 services do not include services for which a managed health care
13 plan is financially responsible.

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

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

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

- 31 (i) Article 2.7 (commencing with Section 14087.3).
- 32 (ii) Article 2.8 (commencing with Section 14087.5).
- 33 (iii) Article 2.81 (commencing with Section 14087.96).
- 34 (iv) Article 2.82 (commencing with Section 14087.98).
- 35 (v) Article 2.91 (commencing with Section 14089).

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

38 (i) Mental health plans contracting to provide mental health care
39 for Medi-Cal beneficiaries pursuant to Chapter 8.9 (commencing
40 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 (m) “Medi-Cal managed care days” means the total number of
8 general acute care days, including well baby days, listed for the
9 county organized health system and prepaid health plans identified
10 in the Final Medi-Cal Utilization Statistics for the 2012–13 fiscal
11 year, as calculated by the department as of December 17, 2012.

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

17 (o) “New hospital” means a hospital operation, business, or
18 facility functioning under current or prior ownership as a private
19 hospital that does not have a days data source or a hospital that
20 has a days data source in whole, or in part, from a previous operator
21 where there is an outstanding monetary obligation owed to the
22 state in connection with the Medi-Cal program and the hospital is
23 not, or does not agree to become, financially responsible to the
24 department for the outstanding monetary obligation in accordance
25 with subdivision (d) of Section 14169.58.

26 (p) “Nondesignated public hospital” means either of the
27 following:

28 (1) A public hospital that is licensed under subdivision (a) of
29 Section 1250 of the Health and Safety Code, is not designated as
30 a specialty hospital in the hospital’s most recently filed Annual
31 Financial Disclosure Report as of January 1, 2014, and satisfies
32 the definition in paragraph (25) of subdivision (a) of Section
33 14105.98, excluding designated public hospitals.

34 (2) A tax-exempt nonprofit hospital that is licensed under
35 subdivision (a) of Section 1250 of the Health and Safety Code, is
36 not designated as a specialty hospital in the hospital’s most recently
37 filed Annual Financial Disclosure Report as of January 1, 2014,
38 is operating a hospital owned by a local health care district, and
39 is affiliated with the health care district hospital owner by means

1 of the district’s status as the nonprofit corporation’s sole corporate
2 member.

3 (q) “Outpatient base amount” means the total amount of
4 payments for hospital outpatient services made to a hospital in the
5 2010 calendar year, as reflected in the state paid claims file
6 prepared by the department on April 26, 2013.

7 (r) “Private hospital” means a hospital that meets all of the
8 following conditions:

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

11 (2) Is in the Charitable Research Hospital peer group, as set
12 forth in the 1991 Hospital Peer Grouping Report published by the
13 department, or is not designated as a specialty hospital in the
14 hospital’s most recently filed Office of Statewide Health Planning
15 and Development Annual Financial Disclosure Report as of January
16 1, 2014.

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

19 (4) Is a nonpublic hospital, nonpublic converted hospital, or
20 converted hospital as those terms are defined in paragraphs (26)
21 to (28), inclusive, respectively, of subdivision (a) of Section
22 14105.98.

23 (5) Is not a nondesignated public hospital or a designated public
24 hospital.

25 (s) “Program period” means the period from January 1, 2014,
26 to December 31, 2015, inclusive.

27 (t) “Subject fiscal quarter” means a state fiscal quarter beginning
28 on or after January 1, 2014, and ending before January 1, 2016.

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

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

33 (w) “Transplant days” means the number of Medi-Cal days, as
34 defined in subdivision (q) of Section 14169.71, for MS-DRGs 1,
35 2, 5 to 10, inclusive, 14, 15, and 652, according to the 2010 Patient
36 Discharge file from the Office of Statewide Health Planning and
37 Development accessed on June 28, 2011.

38 (x) “Upper payment limit” means a federal upper payment limit
39 on the amount of the Medicaid payment for which federal financial
40 participation is available for a class of service and a class of health

1 care providers, as specified in Part 447 of Title 42 of the Code of
2 Federal Regulations. The applicable upper payment limit shall be
3 separately calculated for inpatient and outpatient hospital services.

4 14169.52. (a) Private hospitals shall be paid supplemental
5 amounts for the provision of hospital outpatient services for each
6 subject fiscal quarter as set forth in this section. The supplemental
7 amounts shall be in addition to any other amounts payable to
8 hospitals with respect to those services and shall not affect any
9 other payments to hospitals. The supplemental amounts shall result
10 in payments equal to the statewide aggregate upper payment limit
11 for private hospitals for each subject fiscal year, except that with
12 respect to a subject fiscal year that begins before the start of the
13 program period or that ends after the end of the program period,
14 the outpatient supplemental amounts shall result in payments to
15 hospitals that equal a percentage of the applicable upper payment
16 limit where the percentage equals the percentage of the subject
17 fiscal year that occurs during the program period.

18 (b) Except as set forth in subdivisions (e) and (f), each private
19 hospital shall be paid an amount for each subject fiscal year equal
20 to a percentage of the hospital's outpatient base amount, which
21 payments shall be made on a quarterly basis. The percentage shall
22 be the same for each hospital for a subject fiscal year, or portion
23 thereof in the program period. The percentage shall result in
24 payments to hospitals that equal the applicable federal upper
25 payment limit as it may be modified pursuant to Section 14169.68
26 for a subject fiscal year, or any portion thereof in the program
27 period. For purposes of this subdivision the applicable federal
28 upper payment limit shall be the federal upper payment limit for
29 hospital outpatient services furnished by private hospitals for each
30 subject fiscal year, or portion thereof.

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

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

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

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

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

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

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

15 14169.53. (a) Except as provided in Section 14169.68, private
16 hospitals shall be paid supplemental amounts for the provision of
17 hospital inpatient services for each subject fiscal quarter as set
18 forth in this section. The supplemental amounts shall be in addition
19 to any other amounts payable to hospitals with respect to those
20 services and shall not affect any other payments to hospitals. The
21 supplemental amounts shall result in payments equal to the
22 statewide aggregate upper payment limit for private hospitals for
23 each subject fiscal year as it may be modified pursuant to Section
24 14169.68, except that with respect to a subject fiscal year that
25 begins before the start of the program period or that ends after the
26 end of the program period, the inpatient supplemental amounts
27 shall result in payments to hospitals that equal a percentage of the
28 applicable upper payment limit where the percentage equals the
29 percentage of the subject fiscal year that occurs during the program
30 period.

31 (b) Except as set forth in subdivisions (f) and (g), each private
32 hospital shall be paid the sum of all of the following amounts as
33 applicable for the provision of hospital inpatient services for each
34 subject fiscal quarter:

35 (1) One thousand two dollars (\$1,002) multiplied by the
36 hospital's general acute care days for supplemental payments for
37 the 2014 calendar year, divided by four, and one thousand two
38 hundred five dollars (\$1,205) multiplied by the hospital's general
39 acute care days for supplemental payments for the 2015 calendar
40 year, divided by four.

1 (2) Nine hundred seventy dollars (\$970) multiplied by the
2 hospital's acute psychiatric days for supplemental payments for
3 the 2014 calendar year, divided by four, and nine hundred
4 seventy-five dollars (\$975) multiplied by the hospital's acute
5 psychiatric days for supplemental payments for the 2015 calendar
6 year, divided by four.

7 (3) Two thousand five hundred dollars (\$2,500) multiplied by
8 the number of the hospital's high acuity days for the respective
9 calendar year for 2014 or 2015, divided by four, if the hospital's
10 Medicaid inpatient utilization rate is less than 43 percent and
11 greater than 5 percent and at least 5 percent of the hospital's general
12 acute care days are high acuity days.

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

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

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

38 (c) If federal financial participation for a subject fiscal year is
39 not available for all of the supplemental amounts payable to private
40 hospitals under subdivision (b) due to the application of a federal

1 upper payment limit or for any other reason, both of the following
2 shall apply:

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

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

11 (d) If the amount otherwise payable to a hospital under this
12 section for a subject fiscal year exceeds the amount for which
13 federal financial participation is available for that hospital, the
14 amount due to the hospital for that subject fiscal year shall be
15 reduced to the amount for which federal financial participation is
16 available.

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

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

21 (g) Payments shall be made to a converted hospital that converts
22 during a subject fiscal quarter by multiplying the hospital's
23 inpatient supplemental payment as calculated in subdivision (b)
24 by the number of days that the hospital was a private hospital in
25 the subject fiscal quarter, divided by the number of days in the
26 subject fiscal quarter. Payments shall not be made to a converted
27 hospital in any subsequent subject fiscal quarter.

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

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

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

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

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

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

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

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

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

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

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

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

14 (2) The determination under this subdivision for any subject
15 month shall be made after accounting for all federal financial
16 participation necessary for full implementation of Section 14182.15
17 for that month.

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

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

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

1 to subcontractors of the managed health care plan's obligation of
2 the duty to expend the capitation rate increases.

3 (d) The supplemental hospital payments made by managed
4 health care plans pursuant to this section shall reflect the overall
5 purpose of this article and Article 5.231 (commencing with Section
6 14169.71).

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

11 14169.56. (a) Designated public hospitals 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 designated public
17 hospitals shall be forty-five million dollars (\$45,000,000) in the
18 aggregate for the subject fiscal quarters in subject fiscal year
19 2013–14, ninety-three million dollars (\$93,000,000) for subject
20 fiscal year 2014–15, and forty-eight million dollars (\$48,000,000)
21 in the aggregate for the subject fiscal quarters in the subject fiscal
22 year 2015–16. For each subject fiscal year, the director shall
23 allocate the aggregate grant amounts in accordance with paragraph
24 (2).

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

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

1 thousand dollars (\$6,500,000) for each subject fiscal quarter in
2 subject fiscal year 2015–16 in accordance with the timeframes
3 specified in subdivision (a) of Section 14169.59.

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

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

1 among plans pursuant to a methodology developed in consultation
2 with the hospital 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 described
6 in subparagraph (B) of paragraph (2), shall not be considered
7 hospital fee direct grants as defined under subdivision (k) of
8 Section 17612.2 and shall not be included in the determination
9 under paragraph (1) of subdivision (a) of Section 17612.3.

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

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

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

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

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

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

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

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

35 14169.58. (a) (1) Except as provided in this section, all data
36 and other information relating to a hospital that are used for the
37 purposes of this article, including, without limitation, the days data
38 source, shall continue to be used to determine the payments to that
39 hospital pursuant to this article, regardless of whether the hospital
40 has undergone one or more changes of ownership.

1 (2) All supplemental payments to a hospital under this article
2 shall be made to the licensee of a hospital on the date the
3 supplemental payment is made.

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

23 (c) The payments to a hospital under this article shall not be
24 made for any period during which the hospital is closed. A hospital
25 shall be deemed to be closed on the first day of any period during
26 which the hospital has no general acute, psychiatric, or
27 rehabilitation inpatients for at least 30 consecutive days. A hospital
28 that has been deemed to be closed under this subdivision shall no
29 longer be deemed to be closed on the first subsequent day on which
30 it has general acute, psychiatric, or rehabilitation inpatients.
31 Payments under this article to a hospital that is closed during any
32 portion of a subject fiscal quarter shall be reduced by applying a
33 fraction, expressed as a percentage, the numerator of which shall
34 be the number of days during the applicable subject fiscal quarter
35 that the hospital is closed during the subject fiscal year and the
36 denominator of which shall be the number of days in the subject
37 fiscal quarter.

38 (d) The following provisions shall apply only for purposes of
39 this article and Article 5.231 (commencing with Section 14169.71),
40 and shall have no application outside of this article and Article

1 5.231 (commencing with Section 14169.71) nor shall they affect
2 the assumption of any outstanding monetary obligation to the
3 Medi-Cal program:

4 (1) The director shall develop and describe in provider bulletins
5 and on the department's Internet Web site a process by which the
6 new operator of a hospital that has a days data source in whole or
7 in part from a previous operator may enter into an agreement with
8 the department to confirm that it is financially responsible or to
9 become financially responsible to the department for the
10 outstanding monetary obligation to the Medi-Cal program of the
11 previous operator in order to avoid being classified as a new
12 hospital for purposes of this article. This process shall be available
13 for changes of ownership that occur before, on, or after January
14 1, 2014.

15 (2) The outstanding monetary obligation referred to in
16 subdivision (o) of Section 14169.51 and subdivision (u) of Section
17 14169.71 shall include liabilities for all of the following:

18 (A) Payment of the quality assurance fee established pursuant
19 to Article 5.231 (commencing with Section 14169.71).

20 (B) Known overpayments that have been asserted by the
21 department or its fiscal intermediary by sending a written
22 communication that is received by the hospital prior to the date
23 that the new operator becomes the licensee of the hospital.

24 (C) Overpayments that are asserted after that date and arise from
25 customary reconciliations of payments, such as cost report
26 settlements, and, with the exception of overpayments described in
27 subparagraph (B), shall exclude liabilities arising from the
28 fraudulent or intentionally criminal act of a prior operator if the
29 new operator did not knowingly participate in or continue that
30 fraudulent or criminal act after becoming the licensee.

31 (3) The department shall have the discretion to determine
32 whether the new owner properly and fully agreed to be financially
33 responsible for the outstanding monetary obligation in connection
34 with the Medi-Cal program and seek additional assurances as the
35 department deems necessary. However, a new owner that executes
36 an agreement with the department as described in paragraph (1)
37 shall be conclusively deemed to have agreed to be financially
38 responsible for the outstanding monetary obligation in connection
39 with the Medi-Cal program. The department may establish the
40 terms for satisfying the outstanding monetary obligation in

1 connection with the Medi-Cal program, including, but not limited
2 to, recoupment from amounts payable to the hospital under this
3 section.

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

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

10 (b) The funds shall be disbursed in accordance with the order
11 of priority set forth in subdivision (b) of Section 14169.73, except
12 that funds may be set aside for increased capitation payments to
13 managed care health plans pursuant to subdivision (f) of Section
14 14169.54.

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

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

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

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

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

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

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

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

1 Sections 14166.12 and 14166.17 are not included in the payments
2 under the diagnosis-related group methodology and continue to
3 be paid separately to hospitals, exclusive of those amounts,
4 calculated on an aggregate basis for the six months ending
5 December 31, 2013, adjusted, in consultation with the hospital
6 community, to reflect the movement of populations into managed
7 care under Article 5.4 (commencing with Section 14180).

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

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

20 14169.61. (a) The director shall do all of the following:

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

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

27 (3) Amend the contracts between the managed health care plans
28 and the department as necessary to incorporate the provisions of
29 Sections 14169.54 and 14169.55 and promptly seek all necessary
30 federal approvals of those amendments. The department shall
31 pursue amendments to the contracts as soon as possible after the
32 effective date of this article and Article 5.231 (commencing with
33 Section 14169.71), and shall not wait for federal approval of this
34 article or Article 5.231 (commencing with Section 14169.71) prior
35 to pursuing amendments to the contracts. The amendments to the
36 contracts shall, among other provisions, set forth an agreement to
37 increase capitation payments to managed health care plans under
38 Section 14169.54 and increase payments to hospitals under Section
39 14169.55 in a manner that relates back to January 1, 2014, or as
40 soon thereafter as possible, conditioned on obtaining all federal

1 approvals necessary for federal financial participation for the
2 increased capitation payments to the managed health care plans.

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

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

13 (1) In the event, and on the effective date, of a final judicial
14 determination made by any court of appellate jurisdiction or a final
15 determination by the federal Department of Health and Human
16 Services or the federal Centers for Medicare and Medicaid Services
17 that Section 14169.52 or ~~Section~~ 14169.53 cannot be implemented.
18 This paragraph shall not apply to a final judicial determination
19 made by any court of appellate jurisdiction in a case brought by
20 hospitals located outside the State of California.

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

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

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

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

37 (e) In the event any hospital, or any party on behalf of a hospital,
38 initiates a case or proceeding in any state or federal court in which
39 the hospital seeks any relief of any sort whatsoever, including, but
40 not limited to, monetary relief, injunctive relief, declaratory relief,

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

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

8 (2) Any amount computed to be payable to the hospital pursuant
9 to this article shall be withheld by the department and shall be paid
10 to the hospital only after the case or proceeding is finally resolved,
11 including the final disposition of all appeals.

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

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

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

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

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

33 (i) In order to ensure access to care for hospital services, the
34 director shall seek federal approval for supplemental payments for
35 hospital services provided to all Medi-Cal populations, including
36 the optional and expansion populations.

37 14169.62. Notwithstanding any other provision of this article
38 or Article 5.231 (commencing with Section 14169.71), the director
39 may proportionately reduce the amount of any supplemental
40 payments or increased capitation payments under this article to

1 the extent that the payment would result in the reduction of other
2 amounts payable to a hospital or managed health care plan due to
3 the application of federal law.

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

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

11 (1) January 1, 2017.

12 (2) The date of the last payment of the quality assurance fee
13 payments pursuant to Article 5.231 (commencing Section
14 14169.71).

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

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

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

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

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

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

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

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

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

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

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

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

1 14169.69. To the extent permitted by federal law and other
2 federal requirements, the director shall develop and describe in
3 provider bulletins and on the department's Internet Web site a
4 process by which a private general acute care hospital located
5 outside the state that serves Medi-Cal beneficiaries may opt in to
6 pay the quality assurance fee pursuant to Article 5.231
7 (commencing with Section 14169.71) and receive supplemental
8 payments pursuant to this article, in the same manner that the
9 hospital could participate if it were located in the state.
10 Notwithstanding Section 14169.51 and Section 14169.71, the
11 department shall rely on reliable data to make reasonable estimates
12 or projections made with respect to the hospital as to the data,
13 including, but not limited to, the days data source, used to calculate
14 the fees due under Article 5.231 (commencing with Section
15 14169.71) and the supplemental payments under this article.
16 Hospitals located outside the state that would meet the definition
17 of a small and rural hospital if they were located in the state shall
18 be deemed a small and rural hospital for the purposes of Article
19 5.231 (commencing with Section 14169.71) and this article.

20 14169.70. (a) Notwithstanding any provision of this article or
21 Article 5.231 (commencing with Section 14169.71), the director
22 may correct any identified material and egregious errors in the
23 data, including, but not limited to, the days data source, used in
24 this article or Article 5.231 (commencing with Section 14169.71).
25 An error is material and egregious if the error is clear to the
26 director, based on information the director finds to be reliable, and
27 results in an increase or decrease to a hospital's supplemental
28 payment under Sections 14169.52 and 14169.53, or an increase
29 or decrease to a hospital's quality assurance fee payments under
30 Article 5.231 (commencing with Section 14169.71), of at least one
31 million dollars (\$1,000,000) for any subject fiscal year. The
32 director's determination whether to exercise his or her discretion
33 under this section and any determination made by the director
34 under this section shall not be subject to judicial review, except
35 that a hospital may bring a writ of mandate under Section 1085 of
36 the Code of Civil Procedure to rectify an abuse of discretion by
37 the department in correcting that hospital's data when that
38 correction results in lower supplemental payments under Sections
39 14169.52 and 14169.53 in the aggregate or higher quality assurance

1 fees for that hospital pursuant to Article 5.231 (commencing with
2 Section 14169.71).

3 (b) Notwithstanding any other law, with respect to a hospital
4 described in subdivision (f) of Section 14165.50, both of the
5 following shall apply:

6 (1) The hospital shall not be considered a new hospital, as
7 defined in subdivision (o) of Section 14169.51 for purposes of this
8 article and subdivision (u) of Section 14169.71 for purposes of
9 Article 5.231 (commencing with Section 14169.71).

10 (2) To the extent permitted by federal law and other federal
11 requirements, the department shall use the best available and
12 reasonable estimates or projections made with respect to the
13 hospital for an annual period as the data, including, but not limited
14 to, the days data source, used in this article or Article 5.231
15 (commencing with Section 14169.71).

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

19
20 Article 5.231. Private Hospital Quality Assurance Fee Act of
21 2013

22
23 14169.71. For purposes of this article, the following definitions
24 shall apply:

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

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

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

34 (d) “Converted hospital” means a hospital described in
35 subdivision (b) of Section 14169.51.

36 (e) “Days data source” means the hospital’s Annual Financial
37 Disclosure Report filed with the Office of Statewide Health
38 Planning and Development as of June 6, 2013, for its fiscal year
39 ending during 2010.

1 (f) “Department” means the State Department of Health Care
2 Services.

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

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

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

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

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

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

16 (2) With the exception of a hospital that is in the Charitable
17 Research Hospital peer group, as set forth in the 1991 Hospital
18 Peer Grouping Report published by the department, a hospital that
19 is a hospital designated as a specialty hospital in the hospital’s
20 most recently filed Office of Statewide Health Planning and
21 Development Hospital Annual Financial Disclosure Report as of
22 January 1, 2014.

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

25 (4) A small and rural hospital as specified in Section 124840
26 of the Health and Safety Code designated as that in the hospital’s
27 most recently filed Office of Statewide Health Planning and
28 Development Hospital Annual Financial Disclosure Report as of
29 January 1, 2014.

30 (j) “Federal approval” means the approval by the federal
31 government of both the quality assurance fee established pursuant
32 to this article and the payments to private hospitals described in
33 Article 5.230 (commencing with Section 14169.51).

34 (k) (1) “Fee-for-service per diem quality assurance fee rate”
35 means a fixed daily fee on fee-for-service days.

36 (2) The fee-for-service per diem quality assurance fee rate shall
37 be three hundred ninety-nine dollars and thirty-six cents (\$399.36)
38 per day for the 2014 calendar year and four hundred fifty-four
39 dollars and seventy-nine cents (\$454.79) per day for the 2015
40 calendar year.

1 (3) Upon federal approval or conditional federal approval
2 described in Section 14169.74, the director shall determine the
3 fee-for-service per diem quality assurance fee rate based on the
4 funds required to make the payments specified in Article 5.230
5 (commencing with Section 14169.51), in consultation with the
6 hospital community.

7 (l) “Fee-for-service days” means inpatient hospital days where
8 the service type is reported as “acute care,” “psychiatric care,” and
9 “rehabilitation care,” and the payer category is reported as
10 “Medicare traditional,” “county indigent programs-traditional,”
11 “other third parties-traditional,” “other indigent,” and “other
12 payers,” for purposes of the Annual Financial Disclosure Report
13 submitted by hospitals to the Office of Statewide Health Planning
14 and Development.

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

18 (n) “Hospital community” means any general acute care hospital
19 and any hospital industry organization that represents general acute
20 care hospitals.

21 (o) “Managed care days” means inpatient hospital days where
22 the service type is reported as “acute care,” “psychiatric care,” and
23 “rehabilitation care,” and the payer category is reported as
24 “Medicare managed care,” “county indigent programs-managed
25 care,” and “other third parties-managed care,” for purposes of the
26 Annual Financial Disclosure Report submitted by hospitals to the
27 Office of Statewide Health Planning and Development.

28 (p) “Managed care per diem quality assurance fee rate” means
29 a fixed fee on managed care days of one hundred forty-five dollars
30 (\$145) per day for the 2014 calendar year and one hundred seventy
31 dollars (\$170) per day for the 2015 calendar year.

32 (q) “Medi-Cal days” means inpatient hospital days where the
33 service type is reported as “acute care,” “psychiatric care,” and
34 “rehabilitation care,” and the payer category is reported as
35 “Medi-Cal traditional” and “Medi-Cal managed care,” for purposes
36 of the Annual Financial Disclosure Report submitted by hospitals
37 to the Office of Statewide Health Planning and Development.

38 (r) “Medi-Cal fee-for-service days” means inpatient hospital
39 days where the service type is reported as “acute care,” “psychiatric
40 care,” and “rehabilitation care,” and the payer category is reported

1 as “Medi-Cal traditional” for purposes of the Annual Financial
2 Disclosure Report submitted by hospitals to the Office of Statewide
3 Health Planning and Development.

4 (s) “Medi-Cal managed care days” means inpatient hospital
5 days as reported on the days data source when the service type is
6 reported as “acute care,” “psychiatric care,” and “rehabilitation
7 care,” and the payer category is reported as “Medi-Cal managed
8 care” for purposes of the Annual Financial Disclosure Report
9 submitted by hospitals to the Office of Statewide Health Planning
10 and Development.

11 (t) “Medi-Cal per diem quality assurance fee rate” means a fixed
12 fee on Medi-Cal days of four hundred seventy-six dollars and
13 twenty-three cents (\$476.23) per day for the 2014 calendar year
14 and five hundred forty-seven dollars and sixty-eight cents (\$547.68)
15 for the 2015 calendar year.

16 (u) “New hospital” means a hospital operation, business, or
17 facility functioning under current or prior ownership as a private
18 hospital that does not have a days data source or a hospital that
19 has a days data source in whole, or in part, from a previous operator
20 where there is an outstanding monetary obligation owed to the
21 state in connection with the Medi-Cal program and the hospital is
22 not, or does not agree to become, financially responsible to the
23 department for the outstanding monetary obligation in accordance
24 with subdivision (d) of Section 14169.58.

25 (v) “Nondesignated public hospital” means either of the
26 following:

27 (1) A public hospital that is licensed under subdivision (a) of
28 Section 1250 of the Health and Safety Code, is not designated as
29 a specialty hospital in the hospital’s most recently filed Annual
30 Financial Disclosure Report as of January 1, 2014, and satisfies
31 the definition in paragraph (25) of subdivision (a) of Section
32 14105.98, excluding designated public hospitals.

33 (2) A tax-exempt nonprofit hospital that is licensed under
34 subdivision (a) of Section 1250 of the Health and Safety Code, is
35 not designated as a specialty hospital in the hospital’s most recently
36 filed Annual Financial Disclosure Report as of January 1, 2014,
37 is operating a hospital owned by a local health care district, and
38 is affiliated with the health care district hospital owner by means
39 of the district’s status as the nonprofit corporation’s sole corporate
40 member.

1 (w) “Prepaid health plan hospital” means a hospital owned by
2 a nonprofit public benefit corporation that shares a common board
3 of directors with a nonprofit health care service plan, which
4 exclusively contracts with no more than two medical groups in the
5 state to provide or arrange for professional medical services for
6 the enrollees of the plan.

7 (x) “Prepaid health plan hospital managed care per diem quality
8 assurance fee rate” means a fixed fee on non-Medi-Cal managed
9 care days for prepaid health plan hospitals of eighty-one dollars
10 and twenty cents (\$81.20) per day for the 2014 calendar year and
11 ninety-five dollars and twenty cents (\$95.20) per day for the 2015
12 calendar year.

13 (y) “Prepaid health plan hospital Medi-Cal managed care per
14 diem quality assurance fee rate” means a fixed fee on Medi-Cal
15 managed care days for prepaid health plan hospitals of two hundred
16 sixty-six dollars and sixty-nine cents (\$266.69) per day for the
17 2014 calendar year and three hundred six dollars and seventy cents
18 (\$306.70) per day for the 2015 calendar year.

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

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

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

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

31 (4) Is a nonpublic hospital, nonpublic converted hospital, or
32 converted hospital as those terms are defined in paragraphs (26)
33 to (28), inclusive, respectively, of subdivision (a) of Section
34 14105.98.

35 (5) Is not a nondesignated public hospital or a designated
36 hospital.

37 (aa) “Program period” means the period from January 1, 2014,
38 to December 31, 2015, inclusive.

1 (ab) “Quality assurance fee” means the quality assurance fee
2 assessed pursuant to Section 14169.72 and collected on the basis
3 of the quarterly quality assurance fee.

4 (ac) (1) “Quarterly quality assurance fee” means, with respect
5 to a hospital that is not a prepaid health plan hospital, the sum of
6 all of the following:

7 (A) The annual fee-for-service days for an individual hospital
8 multiplied by the fee-for-service per diem quality assurance fee
9 rate, divided by four.

10 (B) The annual managed care days for an individual hospital
11 multiplied by the managed care per diem quality assurance fee
12 rate, divided by four.

13 (C) The annual Medi-Cal days for an individual hospital
14 multiplied by the Medi-Cal per diem quality assurance fee rate,
15 divided by four.

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

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

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

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

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

31 (ad) “Subject fiscal quarter” means a state fiscal quarter during
32 the program period.

33 (ae) “Subject fiscal year” means a state fiscal year that ends
34 after July 1, 2013, and begins before January 1, 2016.

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

1 14169.72. (a) There shall be imposed on each general acute
2 care hospital that is not an exempt facility a quality assurance fee,
3 provided that a quality assurance fee under this article shall not be
4 imposed on a converted hospital for the periods when the hospital
5 is a public hospital or a new hospital.

6 (b) The department shall compute the quarterly quality assurance
7 fee for each subject fiscal quarter starting on January 1, 2014, and
8 through and including December 31, 2015.

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

11 (1) Within 10 business days following receipt of the notice of
12 federal approval from the federal government, the department shall
13 send notice to each hospital subject to the quality assurance fee
14 the following information:

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

16 (B) The quarterly quality assurance fee for each subject fiscal
17 year.

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

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

26 (3) Notwithstanding any other provision of this section, the
27 amount of each hospital's quarterly quality assurance fees for the
28 program period that have not been paid by the hospital before
29 December 15, 2015, shall be paid by the hospital no later than
30 December 15, 2015.

31 (4) Each hospital described in subdivision (a) shall pay the
32 quarterly quality assurance fees that are due, if any, in the amounts
33 and at the times set forth in the notice unless superseded by a
34 subsequent notice from the department.

35 (d) The quality assurance fee, as paid pursuant to this section,
36 shall be paid by each hospital subject to the fee to the department
37 for deposit in the Hospital Quality Assurance Revenue Fund
38 established pursuant to Section 14167.35. Deposits may be
39 accepted at any time and will be credited toward the program
40 period.

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

6 (f) In no case shall the aggregate fees collected in a federal fiscal
7 year pursuant to this section, former Section 14167.32, and Sections
8 14168.32 and 14169.32 exceed the maximum percentage of the
9 annual aggregate net patient revenue for hospitals subject to the
10 fee that is prescribed pursuant to federal law and regulations as
11 necessary to preclude a finding that an indirect guarantee has been
12 created.

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

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

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

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

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

1 (k) This subdivision creates a contractually enforceable promise
2 on behalf of the state to use the proceeds of the quality assurance
3 fee, including any federal matching funds, solely and exclusively
4 for the purposes set forth in this article as they existed on the
5 effective date of this article, to limit the amount of the proceeds
6 of the quality assurance fee to be used to pay for the health care
7 coverage of children to the amounts specified in this article, to
8 limit any payments for the department's costs of administration
9 to the amounts set forth in this article on the effective date of this
10 article, to maintain and continue prior reimbursement levels as set
11 forth in Section 14169.60 on the effective date of that section, and
12 to otherwise comply with all its obligations set forth in Article
13 5.230 (commencing with Section 14169.51) and this article
14 provided that amendments that arise from, or have as a basis for,
15 a decision, advice, or determination by the federal Centers for
16 Medicare and Medicaid Services relating to federal approval of
17 the quality assurance fee or the payments set forth in this article
18 or Article 5.230 (commencing with Section 14169.51) shall control
19 for the purposes of this subdivision.

20 (l) (1) Effective January 1, 2016, the rates payable to hospitals
21 and managed health care plans under Medi-Cal shall be the rates
22 then payable without the supplemental and increased capitation
23 payments set forth in Article 5.230 (commencing with Section
24 14169.51).

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

30 (m) (1) Subject to paragraph (2), the director may waive any
31 or all interest and penalties assessed under this article in the event
32 that the director determines, in his or her sole discretion, that the
33 hospital has demonstrated that imposition of the full quality
34 assurance fee on the timelines applicable under this article has a
35 high likelihood of creating a financial hardship for the hospital or
36 a significant danger of reducing the provision of needed health
37 care services.

38 (2) Waiver of some or all of the interest or penalties under this
39 subdivision shall be conditioned on the hospital's agreement to
40 make fee payments, or to have the payments withheld from

1 payments otherwise due from the Medi-Cal program to the hospital,
2 on a schedule developed by the department that takes into account
3 the financial situation of the hospital and the potential impact on
4 services.

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

7 (4) If fee payments are remitted to the department after the date
8 determined by the department to be the final date for calculating
9 the final supplemental payments under this article and Article
10 5.230 (commencing with Section 14169.51), the fee payments
11 shall be retained in the fund for purposes of funding supplemental
12 payments supported by a hospital quality assurance fee program
13 implemented under subsequent legislation. However, if
14 supplemental payments are not implemented under subsequent
15 legislation, then those fee payments shall be returned to the private
16 hospitals pro rata based on each hospital's total fee payments under
17 this article to the extent consistent with federal law.

18 (5) If during the implementation of this article, fee payments
19 that were due under former Article 5.21 (commencing with Section
20 14167.1) and former Article 5.22 (commencing with Section
21 14167.31), or former Article 5.226 (commencing with Section
22 14168.1) and Article 5.227 (commencing with Section 14168.31),
23 or Article 5.228 (commencing with Section 14169.1) and Article
24 5.229 (commencing with Section 14169.31) are remitted to the
25 department under a payment plan or for any other reason, and the
26 final date for calculating the final supplemental payments under
27 those articles has passed, then those fee payments shall be
28 deposited in the fund to support the uses established by this article.

29 14169.73. (a) (1) All fees required to be paid to the state
30 pursuant to this article shall be paid in the form of remittances
31 payable to the department.

32 (2) The department shall directly transmit the fee payments to
33 the Treasurer to be deposited in the Hospital Quality Assurance
34 Revenue Fund, created pursuant to Section 14167.35.
35 Notwithstanding Section 16305.7 of the Government Code, any
36 interest and dividends earned on deposits in the fund from the
37 proceeds of the fee assessed pursuant to this article shall be retained
38 in the fund for purposes specified in subdivision (b).

39 (b) (1) Notwithstanding subdivision (c) of Section 14167.35,
40 subdivision (b) of Section 14168.33, and subdivision (b) of Section

1 14169.33, all funds from the proceeds of the fee assessed pursuant
2 to this article in the Hospital Quality Assurance Revenue Fund,
3 together with any interest and dividends earned on money in the
4 fund, shall continue to be used exclusively to enhance federal
5 financial participation for hospital services under the Medi-Cal
6 program, to provide additional reimbursement to, and to support
7 quality improvement efforts of, hospitals, and to minimize
8 uncompensated care provided by hospitals to uninsured patients,
9 as well as to pay for the state's administrative costs and to provide
10 funding for children's health coverage, in the following order of
11 priority:

12 (A) To pay for the department's staffing and administrative
13 costs directly attributable to implementing Article 5.230
14 (commencing with Section 14169.51) and this article, not to exceed
15 ~~two million dollars (\$2,000,000)~~ *three million dollars (\$3,000,000)*
16 for the program period.

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

21 (C) To make increased capitation payments to managed health
22 care plans pursuant to Article 5.230 (commencing with Section
23 14169.51).

24 (D) To make increased payments and direct grants to hospitals
25 pursuant to Article 5.230 (commencing with Section 14169.51).

26 (2) Notwithstanding subdivision (c) of Section 14167.35,
27 subdivision (b) of Section 14168.33, and subdivision (b) of Section
28 14169.33, and notwithstanding Section 13340 of the Government
29 Code, the moneys in the Hospital Quality Assurance Revenue
30 Fund shall be continuously appropriated without regard to fiscal
31 year for the purposes of this article, Article 5.230 (commencing
32 with Section 14169.51), Article 5.229 (commencing with Section
33 14169.31), Article 5.228 (commencing with Section 14169.1),
34 Article 5.227 (commencing with Section 14168.31), former Article
35 5.226 (commencing with Section 14168.1), former Article 5.22
36 (commencing with Section 14167.31) and former Article 5.21
37 (commencing with Section 14167.1).

38 (c) Any amounts of the quality assurance fee collected in excess
39 of the funds required to implement subdivision (b), including any
40 funds recovered under subdivision (d) of Section 14169.61 or

1 subdivision (e) of Section 14169.78, shall be refunded to general
2 acute care hospitals, pro rata with the amount of quality assurance
3 fee paid by the hospital, subject to the limitations of federal law.
4 If federal rules prohibit the refund described in this subdivision,
5 the excess funds shall be returned to the private hospitals pro rata
6 based on each hospital's total fee payments under this article to
7 the extent consistent with federal law.

8 (d) Any methodology or other provision specified in Article
9 5.230 (commencing with Section 14169.51) or this article may be
10 modified by the department, in consultation with the hospital
11 community, to the extent necessary to meet the requirements of
12 federal law or regulations to obtain federal approval or to enhance
13 the probability that federal approval can be obtained, provided the
14 modifications do not violate the spirit and intent of Article 5.230
15 (commencing with Section 14169.51) or this article and are not
16 inconsistent with the conditions of implementation set forth in
17 Section 14169.80.

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

23 (f) The department shall request approval from the federal
24 Centers for Medicare and Medicaid Services for the implementation
25 of this article. In making this request, the department shall seek
26 specific approval from the federal Centers for Medicare and
27 Medicaid Services to exempt providers identified in this article as
28 exempt from the fees specified, including the submission, as may
29 be necessary, of a request for waiver of the broad-based
30 requirement, waiver of the uniform fee requirement, or both,
31 pursuant to paragraphs (1) and (2) of subdivision (e) of Section
32 433.68 of Title 42 of the Code of Federal Regulations.

33 (g) Notwithstanding Chapter 3.5 (commencing with Section
34 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
35 the department may implement this article or Article 5.230
36 (commencing with Section 14169.51) by means of provider
37 bulletins, all plan letters, or other similar instruction, without taking
38 regulatory action. The department shall also provide notification
39 to the Joint Legislative Budget Committee and to the appropriate
40 policy and fiscal committees of the Legislature within five working

1 days when the above-described action is taken in order to inform
2 the Legislature that the action is being implemented.

3 14169.74. (a) Notwithstanding any other provision of this
4 article or Article 5.230 (commencing with Section 14169.51)
5 requiring federal approvals, the department may impose and collect
6 the quality assurance fee and may make payments under this article
7 and Article 5.230 (commencing with Section 14169.51), including
8 increased capitation payments, based upon receiving a letter from
9 the federal Centers for Medicare and Medicaid Services or the
10 United States Department of Health and Human Services that
11 indicates likely federal approval, but only if and to the extent that
12 the letter is sufficient as set forth in subdivision (b).

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

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

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

23 (c) Nothing in this section shall be construed as modifying the
24 requirement under Section 14169.61 that payments shall be made
25 only to the extent a sufficient amount of funds collected as the
26 quality assurance fee are available to cover the nonfederal share
27 of those payments.

28 (d) Upon notice from the federal government that final federal
29 approval for the fee model under this article or for the supplemental
30 payments to private hospitals under Section 14169.52 or 14169.53
31 has been denied, any fees collected pursuant to this section shall
32 be refunded and any payments made pursuant to this article or
33 Article 5.230 (commencing with Section 14169.51) shall be
34 recouped, including, but not limited to, supplemental payments
35 and grants, increased capitation payments, payments to hospitals
36 by health care plans resulting from the increased capitation
37 payments, and payments for the health care coverage of children.
38 To the extent fees were paid by a hospital that also received
39 payments under this section, the payments may first be recouped

1 from fees that would otherwise be refunded to the hospital prior
2 to the use of any other recoupment method allowed under law.

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

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

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

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

14 (g) The department may draw against the Hospital Quality
15 Assurance Revenue Fund for all administrative costs associated
16 with implementation under this article or Article 5.230
17 (commencing with Section 14169.51).

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

21 14169.75. (a) Notwithstanding any other law, the director shall
22 have discretion to modify any timeline or timelines in this article
23 or Article 5.230 (commencing with Section 14169.51) if the letter
24 that indicates likely federal approval, as described in Section
25 14169.74, is not secured by December 15, 2015, and the director
26 determines that it is impossible from an operational perspective
27 to implement a timeline or timelines without the modification.

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

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

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

37 14169.76. (a) Upon receipt of a letter that indicates likely
38 federal approval that the director determines is sufficient for
39 implementation under Section 14169.74, or upon the receipt of
40 federal approval, the following shall occur:

1 (1) To the maximum extent possible, and consistent with the
2 availability of funds in the Hospital Quality Assurance Revenue
3 Fund, the department shall make all of the payments under Sections
4 14169.52, 14169.53, and 14169.54, including, but not limited to,
5 supplemental payments and increased capitation payments, prior
6 to January 1, 2016, except that the increased capitation payments
7 under Section 14169.54 shall not be made until federal approval
8 is obtained for these payments.

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

13 (b) Notwithstanding any other provision of this article or Article
14 5.230 (commencing with Section 14169.51), if the director
15 determines, on or after December 15, 2015, that there are
16 insufficient funds available in the Hospital Quality Assurance
17 Revenue Fund to make all scheduled payments under Article 5.230
18 (commencing with Section 14169.51) before January 1, 2016, he
19 or she shall consult with representatives of the hospital community
20 to develop an acceptable plan for making additional payments to
21 hospitals and managed health care plans to maximize the use of
22 delinquent fee payments or other deposits or interest projected to
23 become available in the fund after December 15, 2015, but before
24 June 15, 2016.

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

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

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

39 (f) Nothing in this section shall be read as affecting the
40 department's ongoing authority to continue, after December 31,

1 2015, to collect quality assurance fees imposed on or before
2 December 31, 2015.

3 14169.77. Notwithstanding any other law, if actual federal
4 approval or a letter that indicates likely federal approval in
5 accordance with Section 14169.74 has not been received on or
6 before December 1, 2015, then this article shall become
7 inoperative, and as of December 1, 2015, is repealed, unless a later
8 enacted statute, that is enacted before December 1, 2015, deletes
9 or extends that date.

10 14169.78. (a) This article shall be implemented only as long
11 as all of the following conditions are met:

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

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

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

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

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

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

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

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

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

39 (1) In the event, and on the effective date, of a final judicial
40 determination made by any court of appellate jurisdiction or a final

1 determination by the United States Department of Health and
2 Human Services or the federal Centers for Medicare and Medicaid
3 Services that the quality assurance fee established pursuant to this
4 article cannot be implemented. This paragraph shall not apply to
5 a final judicial determination made by any court of appellate
6 jurisdiction in a case brought by hospitals located outside the state.

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

8 (A) The federal Centers for Medicare and Medicaid Services
9 denies approval for, or does not approve before January 1, 2016,
10 the implementation of Sections 14169.52 and 14169.53 or this
11 article.

12 (B) Section 14169.52, Section 14169.53, or this article cannot
13 be modified by the department pursuant to subdivision (d) of
14 Section 14169.73 in order to meet the requirements of federal law
15 or to obtain federal approval.

16 (e) If this article becomes inoperative pursuant to paragraph (1)
17 of subdivision (d) and the determination applies to any period or
18 periods of time prior to the effective date of the determination, the
19 department may recoup all payments made pursuant to Article
20 5.230 (commencing with Section 14169.51) during that period or
21 those periods of time.

22 (f) (1) If all necessary final federal approvals are not received
23 as described and anticipated under this article or Article 5.230
24 (commencing with Section 14169.51), the director shall have the
25 discretion and authority to develop procedures for recoupment
26 from managed health care plans, and from hospitals under contract
27 with managed health care plans, of any amounts received pursuant
28 to this article or Article 5.230 (commencing with Section
29 14169.51).

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

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

38 14169.79. Notwithstanding any other provision of this article
39 or Article 5.230 (commencing with Section 14169.51),
40 supplemental payments or other payments under Article 5.230

1 (commencing with Section 14169.51) shall only be required and
2 payable in any quarter for which a fee payment obligation exists.

3 14169.80. (a) This article and Article 5.230 (commencing with
4 Section 14169.51) shall become inoperative and the requirements
5 for supplemental payments or other payments under Article 5.230
6 (commencing with Section 14169.51) shall be retroactively
7 invalidated, on the first day of the first month of the calendar
8 quarter following notification to the Joint Legislative Budget
9 Committee by the Department of Finance, that any of the following
10 have occurred:

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

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

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

20 (2) The department has sought but has not received federal
21 financial participation for the supplemental payments and other
22 costs required by this article for which federal financial
23 participation has been sought.

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

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

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

34 (1) A loss of federal financial participation.

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

38 (c) (1) The director shall have the authority to recoup any
39 payments made under Article 5.230 (commencing with Section
40 14169.51) if any of the following apply:

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

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

6 (C) Recoupment of payments made under Article 5.230
7 (commencing with Section 14169.51) is necessary to prevent a
8 General Fund cost that is estimated to be equal to or greater than
9 one-quarter of 1 percent of the General Fund expenditures
10 authorized in the most recent annual Budget Act and that results
11 from implementation of a court order or the unavailability of
12 federal financial participation.

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

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

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

24 (d) In the event the department determines that recoupment of
25 supplemental payments is necessary to implement any provision
26 of this section, the department may recoup payments made pursuant
27 to Article 5.230 (commencing with Section 14169.51) from fees
28 paid by the hospital pursuant to this article.

29 (e) Concurrent with invoking any provision of this section, the
30 director shall notify the fiscal and appropriate policy committees
31 of the Legislature of the intended action and the specific reason
32 or reasons for the proposed action.

33 14169.81. Notwithstanding Chapter 3.5 (commencing with
34 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
35 Code, the department shall implement this article by means of
36 policy letters or similar instructions, without taking further
37 regulatory action.

38 14169.82. (a) This article shall remain operative only until the
39 later of the following:

40 (1) January 1, 2017.

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

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

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

9 (c) If this article becomes inoperative under paragraph (2) or
10 (3) of subdivision (a), this article shall be repealed on January 1
11 of the year following the date this article becomes inoperative,
12 unless a later enacted statute enacted before that date, deletes or
13 extends that date.

14 14169.83. If the director determines that this article has become
15 inoperative pursuant to Section 14169.77, 14169.78, 14169.80, or
16 14169.82, or that Section 14169.72 has become inoperative
17 pursuant to subdivision (e) of that section, the director shall execute
18 a declaration stating that this determination has been made and
19 stating the basis for this determination. The director shall retain
20 the declaration and provide a copy, within five working days of
21 the execution of the declaration, to the fiscal and appropriate policy
22 committees of the Legislature. In addition, the director shall post
23 the declaration on the department's Internet Web site and the
24 director shall send the declaration to the Secretary of State, the
25 Secretary of the Senate, the Chief Clerk of the Assembly, and the
26 Legislative Counsel.

27 14169.84. (a) (1) Except as provided in this section, all data
28 and other information relating to a hospital that are used for the
29 purposes of this article, including, without limitation, the days data
30 source, shall continue to be used to determine the quality assurance
31 fees due from that hospital pursuant to this article, regardless of
32 whether the hospital has undergone one or more changes of
33 ownership.

34 (2) All quality assurance fee payments under this article shall
35 be paid by the licensee of a hospital on the date the quarterly
36 quality assurance fee payment is due.

37 (b) The data of separate facilities prior to a consolidation shall
38 be aggregated for the purposes of this article if: (1) a private
39 hospital consolidates with another private hospital, (2) the facilities
40 operate under a consolidated hospital license, (3) data for a period

1 prior to the consolidation is used for purposes of this article, and
2 (4) neither hospital has had a change of ownership on or after the
3 effective date of this article unless paragraph (2) of subdivision
4 (d) has been satisfied by the new owner. Data of a facility that was
5 a separately licensed hospital prior to the consolidation shall not
6 be included in the data, including the days data source, for the
7 purpose of determining the quality assurance fees due from the
8 facility under the article for any time period during which such
9 facility is closed. A facility shall be deemed to be closed for
10 purposes of this subdivision on the first day of any period during
11 which the facility has no general acute, psychiatric, or rehabilitation
12 inpatients for at least 30 consecutive days. A facility that has been
13 deemed to be closed under this subdivision shall no longer be
14 deemed to be closed on the first subsequent day on which it has
15 general acute, psychiatric, or rehabilitation inpatients.

16 (c) The quality assurance fees under this article shall not be due,
17 for any period during which the hospital is closed. A hospital shall
18 be deemed to be closed on the first day of any period during which
19 the hospital has no general acute, psychiatric, or rehabilitation
20 inpatients for at least 30 consecutive days. A hospital that has been
21 deemed to be closed under this subdivision shall no longer be
22 deemed to be closed on the first subsequent day on which it has
23 general acute, psychiatric, or rehabilitation inpatients. Payments
24 of the quality assurance fee under this article due from a hospital
25 that is closed during any portion of a subject fiscal quarter shall
26 be reduced by applying a fraction, expressed as a percentage, the
27 numerator of which shall be the number of days during the
28 applicable subject fiscal quarter that the hospital is closed during
29 the subject fiscal year and the denominator of which shall be the
30 number of days in the subject fiscal quarter.

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

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

37 In order to make the necessary changes to increase Medi-Cal
38 payments to hospitals and improve access at the earliest time, so
39 as to allow this act to be operative as soon as approval from the
40 federal Centers for Medicare and Medicaid Services is obtained

- 1 by the State Department of Health Care Services, it is necessary
- 2 that this act takes effect immediately.

O