Senate Bill No. 239

CHAPTER 657

An act to amend Sections 14164, 14165, and 14167.35 of, to add Sections 14165.58 and 14167.37 to, to add Article 5.231 (commencing with Section 14169.81) to, and to add and repeal Article 5.230 (commencing with Section 14169.50) 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.

[Approved by Governor October 8, 2013. Filed with Secretary of State October 8, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 239, Hernandez. Medi-Cal: hospitals: quality assurance fees: distinct part skilled nursing facilities.

(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, to December 31, 2013, inclusive. 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 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 during the first program period of January 1, 2014, to December 31, 2016, inclusive, 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 require the payment of direct grants to designated and nondesignated public hospitals in support of health care expenditures funded by the quality assurance fee for the first program period. The bill would, for subsequent program periods, authorize the payment of direct grants for designated and nondesignated public

hospitals and require that the moneys in the Hospital Quality Assurance Revenue Fund be used for the above-described purposes upon appropriation by the Legislature in the annual Budget Act. 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.

(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) Existing law requires, except as otherwise provided, Medi-Cal provider payments to be reduced by 1% or 5%, and provider payments for specified non-Medi-Cal programs to be reduced by 1%, for dates of service on and after March 1, 2009, and until June 1, 2011. Existing law requires, except as otherwise provided, Medi-Cal provider payments and payments for specified non-Medi-Cal programs to be reduced by 10% for dates of service on and after June 1, 2011.

This bill would require that reimbursement for services provided by skilled nursing facilities that are distinct parts of general acute care hospitals be determined, for dates of service on or after October 1, 2013, without application of the reductions and limitations set forth in those provisions. The bill would also require the department to develop, in consultation with

the hospital community, proposed modifications to the quality assurance fee provisions to collect additional fees for increasing managed care plan rate range increases for the purpose of increasing payments to private hospitals and nondesignated public hospitals in counties that do not have designated public hospitals. The bill would also require the department to develop a process by which a private general acute care hospital located outside the state that serves Medi-Cal beneficiaries may opt in to pay the quality assurance fee and receive supplemental payments, as specified.

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

Appropriation: yes.

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

SECTION 1. Section 14164 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) The ability to continue to administer and distribute payments for the Construction and Renovation Reimbursement Program, in accordance with Sections 14085 to 14085.57, inclusive. Notwithstanding any other law, maintaining or negotiating a selective provider contract pursuant to Article 2.6 (commencing with Section 14081) 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) Protections afforded to the negotiations and contracts of the commission by the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) shall be applicable to the negotiations and contracts conducted or entered into pursuant to this section by the State Department of Health Care Services.

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

SEC. 3. Section 14165.58 is added to the Welfare and Institutions Code, to read:

14165.58. (a) The department shall design and implement, in consultation with nondesignated public hospitals, an intergovernmental transfer program relating to Medi-Cal managed care services provided by nondesignated public hospitals in order to increase capitation payments for the purpose of increasing their reimbursement.

(b) The increased capitation payments under this section shall be actuarially equivalent to the increased fee-for-service payments made pursuant to Section 14165.57 to the extent permissible under federal law.

(c) This section shall be implemented on the later of January 1, 2014, or the date on which all necessary federal approvals have been received, and only to the extent intergovernmental transfers from nondesignated public hospitals are provided for this purpose.

(d) Participation in the intergovernmental transfers under this section is voluntary on the part of the transferring entities for the purposes of all applicable federal laws.

(e) This section shall be implemented only to the extent federal financial participation is available for the reimbursement specified in subdivision (b).

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

(g) To the extent that the director determines that the payments do not comply with the federal Medicaid requirements, the director retains the discretion not to implement an intergovernmental transfer and may adjust the payment as necessary to comply with federal Medicaid requirements.

(h) To the extent federal approval is secured, the increased capitation payments under this section may cover dates of service on or after January 1, 2014.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of policy letters or similar instructions, without taking further regulatory action. Notwithstanding Section 10231.5 of the Government Code, the department shall provide the Joint Legislative Budget Committee and the fiscal and appropriate policy committees of the Legislature a status update of the implementation of this section on January 1, 2014, and annually thereafter.

SEC. 4. Section 14167.35 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Reduces or increases the supplemental payments or grants made under Article 5.21 (commencing with Section 14167.1) in the aggregate for the 2008–09, 2009–10, and 2010–11 federal fiscal years to a hospital by

more than 2 percent of the amount that would be determined under this article without any change or adjustment.

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

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

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

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

(k) Notwithstanding Sections 14167.17 and 14167.40, subdivisions (b) to (h), inclusive, shall become inoperative on January 1, 2013, subdivisions (a), (i), and (j) shall remain operative until January 1, 2018, and as of January 1, 2018, this section is repealed.

SEC. 5. Section 14167.37 is added to the Welfare and Institutions Code, to read:

14167.37. (a) (1) The department shall make available all public documentation it uses to administer and audit the program authorized under Article 5.230 (commencing with Section 14169.50) pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(2) In addition, upon request from a hospital, the department shall require Medi-Cal managed care plans to furnish hospitals with the amounts the plan intends to pay to the hospital pursuant to Article 5.230 (commencing with Section 14169.50). Nothing in this paragraph shall require the department to reconcile payments made to individual hospitals from Medi-Cal managed care plans.

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

(1) Within 10 business days after receipt of approval of the hospital quality assurance fee program under Article 5.230 (commencing with Section

14169.50) from the federal Centers for Medicare and Medicaid Services (CMS), the hospital quality assurance fee final model and upper payment limit calculations.

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

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

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

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

(2) "Hospital quality assurance fee final model" means the spreadsheet calculating the supplemental amounts based on the upper payment limit calculation from claims and hospital data sources of days and hospital services once CMS approves the program under Article 5.230 (commencing with Section 14169.50).

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

SEC. 6. Article 5.230 (commencing with Section 14169.50) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.230. Medi-Cal Hospital Reimbursement Improvement Act of 2013

14169.50. The Legislature finds and declares all of the following:

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

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

(c) It is the intent of the Legislature to recognize the fundamental structure of the components used to develop a successful hospital quality assurance fee program.

(d) It is the intent of the Legislature to impose a quality assurance fee to be paid by hospitals, which would be used to increase federal financial

participation in order to make supplemental Medi-Cal payments to hospitals, and to help pay for health care coverage for low-income children.

(e) The State Department of Health Care Services shall make every effort to obtain the necessary federal approvals to implement the quality assurance fee described in subdivision (d) in order to make supplemental Medi-Cal payments to hospitals.

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

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

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

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

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

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

(a) "Acute psychiatric days" means the total number of Medi-Cal specialty mental health service administrative days, Medi-Cal specialty mental health service acute care days, acute psychiatric administrative days, and acute psychiatric acute days identified in the Final Medi-Cal Utilization Statistics for the state fiscal year preceding the rebase calculation year as calculated by the department as of the retrieval date.

(b) "Acute psychiatric per diem supplemental rate" means a fixed per diem supplemental payment for acute psychiatric days.

(c) "Annual fee-for-service days" means the number of fee-for-service days of each hospital subject to the quality assurance fee, as reported on the days data source.

(d) "Annual managed care days" means the number of managed care days of each hospital subject to the quality assurance fee, as reported on the days data source.

(e) "Annual Medi-Cal days" means the number of Medi-Cal days of each hospital subject to the quality assurance fee, as reported on the days data source.

(f) "Base calendar year" means a calendar year that ends before a subject fiscal year begins, but no more than six years before a subject fiscal year begins. Beginning with the third program period, the department shall establish the base calendar year during the rebase calculation year as the calendar year for which the most recent data is available that the department determines is reliable.

(g) "Converted hospital" means a private hospital that becomes a designated public hospital or a nondesignated public hospital on or after the first day of a program period.

(h) "Days data source" means either: (1) if a hospital's Annual Financial Disclosure Report for its fiscal year ending in the base calendar year includes data for a full fiscal year of operation, the hospital's Annual Financial Disclosure Report retrieved from the Office of Statewide Health Planning and Development as retrieved by the department on the retrieval date pursuant to Section 14169.59, for its fiscal year ending in the base calendar year; or (2) if a hospital's Annual Financial Disclosure Report for its fiscal year ending in the base calendar year includes data for more than one day, but less than a full year of operation, the department's best and reasonable estimates of the hospital's Annual Financial Disclosure Report if the hospital had operated for a full year.

(i) "Department" means the State Department of Health Care Services.

(j) "Designated public hospital" shall have the meaning given in subdivision (d) of Section 14166.1.

(k) "Director" means the Director of Health Care Services.

(*l*) "Exempt facility" means any of the following:

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

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

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

(2) With the exception of a hospital that is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, a hospital that is designated as a specialty hospital in the hospital's most recently filed Office of Statewide Health Planning and Development Hospital Annual Financial Disclosure Report, as of the first day of a program period.

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

(4) A small and rural hospital as specified in Section 124840 of the Health and Safety Code designated as that in the hospital's most recently filed Office of Statewide Health Planning and Development Hospital Annual Financial Disclosure Report, as of the first day of a program period.

(m) "Federal approval" means the approval by the federal government of both the quality assurance fee established pursuant to this article and the supplemental payments to private hospitals described pursuant to this article.

(n) "Fee-for-service per diem quality assurance fee rate" means a fixed fee on fee-for-service days.

(o) "Fee-for-service days" means inpatient hospital days as reported on the days data source where the service type is reported as "acute care," "psychiatric care," or "rehabilitation care," and the payer category is reported

as "Medicare traditional," "county indigent programs-traditional," "other third parties-traditional," "other indigent," or "other payers," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(p) "General acute care days" means the total number of Medi-Cal general acute care days, including well baby days, less any acute psychiatric inpatient days, paid by the department to a hospital for services in the base calendar year, as reflected in the state paid claims file on the retrieval date.

(q) "General acute care hospital" means any hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

(r) "General acute care per diem supplemental rate" means a fixed per diem supplemental payment for general acute care days.

(s) "High acuity days" means Medi-Cal coronary care unit days, pediatric intensive care unit days, intensive care unit days, neonatal intensive care unit days, and burn unit days paid by the department to a hospital for services in the base calendar year, as reflected in the state paid claims file prepared by the department on the retrieval date.

(t) "High acuity per diem supplemental rate" means a fixed per diem supplemental payment for high acuity days for specified hospitals in Section 14169.55.

(u) "High acuity trauma per diem supplemental rate" means a fixed per diem supplemental payment for high acuity days for specified hospitals in Section 14169.55 that have been designated as specified types of trauma hospitals.

(v) "Hospital community" includes, but is not limited to, the statewide hospital industry organization and systems representing general acute care hospitals.

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

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

(y) "Managed care days" means inpatient hospital days as reported on the days data source where the service type is reported as "acute care," "psychiatric care," or "rehabilitation care," and the payer category is reported

as “Medicare managed care,” “county indigent programs-managed care,” or “other third parties-managed care,” for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(z) “Managed care per diem quality assurance fee rate” means a fixed fee on managed care days.

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

(2) (A) Managed health care plans include county organized health systems and entities contracting with the department to provide or arrange services for Medi-Cal beneficiaries pursuant to the two-plan model, geographic managed care, or regional managed care for the rural expansion. Entities providing these services contract with the department pursuant to any of the following:

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

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

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

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

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

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

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

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

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

(ab) “Medi-Cal days” means inpatient hospital days as reported on the days data source where the service type is reported as “acute care,” “psychiatric care,” or “rehabilitation care,” and the payer category is reported as “Medi-Cal traditional” or “Medi-Cal managed care,” for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(ac) “Medi-Cal fee-for-service days” means inpatient hospital days as reported on the days data source where the service type is reported as “acute care,” “psychiatric care,” or “rehabilitation care,” and the payer category is reported as “Medi-Cal traditional” for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(ad) “Medi-Cal managed care days” means the total number of general acute care days, including well baby days, listed for the county organized health system and prepaid health plans identified in the Final Medi-Cal Utilization Statistics for the state fiscal year preceding the rebase calculation year, as calculated by the department as of the retrieval date.

(ae) "Medi-Cal managed care fee days" means inpatient hospital days as reported on the days data source where the service type is reported as "acute care," "psychiatric care," or "rehabilitation care," and the payer category is reported as "Medi-Cal managed care" for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(af) "Medi-Cal per diem quality assurance fee rate" means a fixed fee on Medi-Cal days.

(ag) "Medicaid inpatient utilization rate" means Medicaid inpatient utilization rate as defined in Section 1396r-4 of Title 42 of the United States Code and as set forth in the Final Medi-Cal Utilization Statistics for the state fiscal year preceding the rebase calculation year, as calculated by the department as of the retrieval date.

(ah) "New hospital" means a hospital operation, business, or facility functioning under current or prior ownership as a private hospital that does not have a days data source or a hospital that has a days data source in whole, or in part, from a previous operator where there is an outstanding monetary obligation owed to the state in connection with the Medi-Cal program and the hospital is not, or does not agree to become, financially responsible to the department for the outstanding monetary obligation in accordance with subdivision (d) of Section 14169.61.

(ai) "Nondesignated public hospital" means either of the following:

(1) A public hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's most recently filed Annual Financial Disclosure Report, as of the first day of a program period, and satisfies the definition in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(2) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's most recently filed Annual Financial Disclosure Report, as of the first day of a program period, is operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(aj) "Outpatient base amount" means the total amount of payments for hospital outpatient services made to a hospital in the base calendar year, as reflected in the state paid claims files prepared by the department as of the retrieval date.

(ak) "Outpatient supplemental rate" means a fixed proportional supplemental payment for Medi-Cal outpatient services.

(al) "Prepaid health plan hospital" means a hospital owned by a nonprofit public benefit corporation that shares a common board of directors with a nonprofit health care service plan, which exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan, as of the effective date of this article.

(am) "Prepaid health plan hospital managed care per diem quality assurance fee rate" means a fixed fee on non-Medi-Cal managed care fee days for prepaid health plan hospitals.

(an) "Prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate" means a fixed fee on Medi-Cal managed care fee days for prepaid health plan hospitals.

(ao) "Private hospital" means a hospital that meets all of the following conditions:

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

(2) Is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, or is not designated as a specialty hospital in the hospital's most recently filed Office of Statewide Health Planning and Development Annual Financial Disclosure Report, as of the first day of a program period.

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

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

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

(ap) "Program period" means a period not to exceed three years during which a fee model and a supplemental payment model developed under this article shall be effective. The first program period shall be the period beginning January 1, 2014, and ending December 31, 2016, inclusive. The second program period shall be the period beginning on January 1, 2017, and ending June 30, 2019. Each subsequent program period shall begin on the day immediately following the last day of the immediately preceding program period and shall end on the last day of a state fiscal year, as determined by the department.

(aq) "Quality assurance fee" means the quality assurance fee assessed pursuant to Section 14169.52 and collected on the basis of the quarterly quality assurance fee.

(ar) (1) "Quarterly quality assurance fee" means, with respect to a hospital that is not a prepaid health plan hospital, the sum of all of the following:

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

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

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

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

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

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

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

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

(as) "Rebase calculation year" means a state fiscal year during which the department shall rebase the data, including, but not limited to, the days data source, used for the following: acute psychiatric days, annual fee-for-service days, annual managed care days, annual Medi-Cal days, fee-for-service days, general acute care days, high acuity days, managed care days, Medi-Cal days, Medi-Cal fee-for-service days, Medi-Cal managed care days, Medi-Cal managed care fee days, outpatient base amount, and transplant days, pursuant to Section 14169.59. Beginning with the third program period, the rebase calculation year for a program period shall be the last subject fiscal year of the immediately preceding program period.

(at) "Rebase year" means the first state fiscal year of a program period and shall immediately follow a rebase calculation year.

(au) "Retrieval date" means a day for each data element during the last quarter of the rebase calculation year upon which the department retrieves the data, including, but not limited to, the days data source, used for the following: acute psychiatric days, annual fee-for-service days, annual managed care days, annual Medi-Cal days, fee-for-service days, general acute care days, high acuity days, managed care days, Medi-Cal days, Medi-Cal fee-for-service days, Medi-Cal managed care days, Medi-Cal managed care fee days, outpatient base amount, and transplant days, pursuant to Section 14169.59. The retrieval date for each data element may be a different date within the quarter as determined to be necessary and appropriate by the department.

(av) "Subacute supplemental rate" means a fixed proportional supplemental payment for acute inpatient services based on a hospital's prior provision of Medi-Cal subacute services.

(aw) "Subject fiscal quarter" means a state fiscal quarter beginning on or after the first day of a program period and ending on or before the last day of a program period.

(ax) "Subject fiscal year" means a state fiscal year beginning on or after the first day of a program period and ending on or before the last day of a program period.

(ay) "Subject month" means a calendar month beginning on or after the first day of a program period and ending on or before the last day of a program period.

(az) "Transplant days" means the number of Medi-Cal days for Medicare Severity-Diagnosis Related Groups (MS-DRGs) 1, 2, 5 to 10, inclusive, 14, 15, or 652, according to the Patient Discharge file from the Office of

Statewide Health Planning and Development for the base calendar year accessed on the retrieval date.

(ba) "Transplant per diem supplemental rate" means a fixed per diem supplemental payment for transplant days.

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

14169.52. (a) There shall be imposed on each general acute care hospital that is not an exempt facility a quality assurance fee, except that a quality assurance fee under this article shall not be imposed on a converted hospital for the periods when the hospital is a public hospital or a new hospital with respect to a program period.

(b) The department shall compute the quarterly quality assurance fee for each subject fiscal year during a program period pursuant to Section 14169.59.

(c) Subject to Section 14169.63, on the later of the date of the department's receipt of federal approval or the first day of each program period, the following shall commence:

(1) Within 10 business days following receipt of the notice of federal approval, the department shall send notice to each hospital subject to the quality assurance fee, which shall contain the following information:

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

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

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

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

(3) Notwithstanding any other provision of this section, the amount of each hospital's quarterly quality assurance fee for a program period that has not been paid by the hospital before 15 days prior to the end of a program period shall be paid by the hospital no later than 15 days prior to the end of a program period.

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

(d) The quality assurance fee, as assessed pursuant to this section, shall be paid by each hospital subject to the fee to the department for deposit in the Hospital Quality Assurance Revenue Fund. Deposits may be accepted at any time and shall be credited toward the program period for which the

fees were assessed. This article shall not affect the ability of a hospital to pay fees assessed for a program period after the end of that program period.

(e) This section shall become inoperative if the federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before December 1, 2016, the implementation of the quality assurance fee pursuant to this article or the supplemental payments to private hospitals pursuant to this article for the first program period.

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

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

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

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

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

(j) The department shall work in consultation with the hospital community to implement this article.

(k) This subdivision creates a contractually enforceable promise on behalf of the state to use the proceeds of the quality assurance fee, including any federal matching funds, solely and exclusively for the purposes set forth in this article, to limit the amount of the proceeds of the quality assurance fee to be used to pay for the health care coverage of children as provided in Section 14169.53, to limit any payments for the department's costs of administration to the amounts set forth in this article, to maintain and continue prior reimbursement levels as set forth in Section 14169.68 on the effective date of that section, and to otherwise comply with all its obligations set forth in this article, provided that amendments that arise from, or have as a basis for, a decision, advice, or determination by the federal Centers

for Medicare and Medicaid Services relating to federal approval of the quality assurance fee or the payments set forth in this article shall control for the purposes of this subdivision.

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

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

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

(4) If 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 for a program period under this article, the fee payments shall be refunded to general acute care hospitals, pro rata with the amount of quality assurance fee paid by the hospital in the program period, subject to the limitations of federal law. If federal rules prohibit the refund described in this paragraph, the excess funds shall be used as quality assurance fees for the next program period for general acute care hospitals, pro rata with the quality assurance fees paid by the hospital for the program period.

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

14169.53. (a) (1) All fees required to be paid to the state pursuant to this article shall be paid in the form of remittances payable to the department.

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

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

(A) To pay for the department's staffing and administrative costs directly attributable to implementing this article, not to exceed two hundred fifty thousand dollars ($250,000) for each subject fiscal quarter, exclusive of any federal matching funds.

(B) To pay for the health care coverage, as described in subdivision (g), except that for the two subject fiscal quarters in the 2013–14 fiscal year, the amount for children's health care coverage shall be one hundred fifty-five million dollars ($155,000,000) for each subject fiscal quarter, exclusive of any federal matching funds.

(C) To make increased capitation payments to managed health care plans pursuant to this article and Section 14169.82, including the nonfederal share of capitation payments to managed health care plans pursuant to this article and Section 14169.82 for services provided to individuals who meet the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)).

(D) To make increased payments and direct grants to hospitals pursuant to this article and Section 14169.83, including the nonfederal share of payments to hospitals under this article and Section 14169.83 for services provided to individuals who meet the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)).

(2) Notwithstanding subdivision (c) of Section 14167.35, subdivision (b) of Section 14168.33, and subdivision (b) of Section 14169.33, and notwithstanding Section 13340 of the Government Code, the moneys in the Hospital Quality Assurance Revenue Fund shall be continuously appropriated during the first program period only, without regard to fiscal year, for the purposes of this article, Article 5.229 (commencing with Section 14169.31), Article 5.228 (commencing with Section 14169.1), Article 5.227 (commencing with Section 14168.31), former Article 5.226 (commencing with Section 14168.1), former Article 5.22 (commencing with Section 14167.31), and former Article 5.21 (commencing with Section 14167.1).

(3) For subsequent program periods, the moneys in the Hospital Quality Assurance Revenue Fund shall be used, upon appropriation by the Legislature in the annual Budget Act, for the purposes of this article and Sections 14169.82 and 14169.83.

(c) Any amounts of the quality assurance fee collected in excess of the funds required to implement subdivision (b), including any funds recovered under subdivision (d) of Section 14169.61, shall be refunded to general acute care hospitals, pro rata with the amount of quality assurance fee paid by the hospital, subject to the limitations of federal law. If federal rules prohibit the refund described in this subdivision, the excess funds shall be used as quality assurance fees for the next program period for general acute care hospitals, pro rata with the amount of quality assurance fees paid by the hospital for the program period.

(d) Any methodology or other provision specified in this article may be modified by the department, in consultation with the hospital community, to the extent necessary to meet the requirements of federal law or regulations to obtain federal approval or to enhance the probability that federal approval can be obtained, provided the modifications do not violate the spirit, purposes, and intent of this article and are not inconsistent with the conditions of implementation set forth in Section 14169.72. The department shall notify the Joint Legislative Budget Committee and the fiscal and appropriate policy committees of the Legislature 30 days prior to implementation of a modification pursuant to this subdivision.

(e) The department, in consultation with the hospital community, shall make adjustments, as necessary, to the amounts calculated pursuant to Section 14169.52 in order to ensure compliance with the federal requirements set forth in Section 433.68 of Title 42 of the Code of Federal Regulations or elsewhere in federal law.

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

(g) (1) For purposes of this subdivision, the following definitions shall apply:

(A) “Actual net benefit” means the net benefit determined by the department for a net benefit period after the conclusion of the net benefit period using payments and grants actually made, and fees actually collected, for the net benefit period.

(B) “Aggregate fees” means the aggregate fees collected from hospitals under this article.

(C) “Aggregate payments” means the aggregate payments and grants made directly or indirectly to hospitals under this article, including payments

and grants described in Sections 14169.54, 14169.55, 14169.57, and 14169.58, and subdivision (b) of Section 14169.82.

(D) "Fund" means the Hospital Quality Assurance Revenue Fund established pursuant to Section 14167.35.

(E) "Net benefit" means the aggregate payments for a net benefit period minus the aggregate fees for the net benefit period.

(F) "Net benefit period" means a subject fiscal year or portion thereof that is in a program period and begins on or after July 1, 2014.

(G) "Preliminary net benefit" means the net benefit determined by the department for a net benefit period prior to the beginning of that net benefit period using estimated or projected data.

(2) The amount of funding provided for children's health care coverage under subdivision (b) for a net benefit period shall be equal to 24 percent of the net benefit for that net benefit period.

(3) The department shall determine the preliminary net benefit for all net benefit periods in the first program period before July 1, 2014. The department shall determine the preliminary net benefit for all net benefit periods in a subsequent program period before the beginning of the program period.

(4) The department shall determine the actual net benefit and make the reconciliation described in paragraph (5) for each net benefit period within six months after the date determined by the department pursuant to subdivision (h).

(5) For each net benefit period, the department shall reconcile the amount of moneys in the fund used for children's health coverage based on the preliminary net benefit with the amount of the fund that may be used for children's health coverage under this subdivision based on the actual net benefit. For each net benefit period, any amounts that were in the fund and used for children's health coverage in excess of the 24 percent of the actual net benefit shall be returned to the fund, and the amount, if any, by which 24 percent of the actual net benefit exceeds 24 percent of the preliminary net benefit shall be available from the fund to the department for children's health coverage. The department shall notify the Joint Legislative Budget Committee and the fiscal and appropriate policy committees of the Legislature of the results of the reconciliation for each net benefit period pursuant to this paragraph within five working days of performing the reconciliation.

(6) The department shall make all calculations and reconciliations required by this subdivision in consultation with the hospital community using data that the department determines is the best data reasonably available.

(h) After consultation with the hospital community, the department shall determine a date upon which substantially all fees have been paid and substantially all supplemental payments, grants, and rate range increases have been made for a program period, which date shall be no later than two years after the end of a program period. After the date determined by the department pursuant to this subdivision, no further supplemental payments

shall be made under the program period, and any fees collected with respect to the program period shall be used for a subsequent program period consistent with this section. Nothing in this subdivision shall affect the department's authority to collect quality assurance fees for a program period after the end of the program period or after the date determined by the department pursuant to this subdivision. The department shall notify the Joint Legislative Budget Committee and fiscal and appropriate policy committees of that date within five working days of the determination.

(i) Use of the fee proceeds to enhance federal financial participation pursuant to subdivision (b) shall include use of the proceeds to supply the nonfederal share, if any, of payments to hospitals under this article for services provided to individuals who meet the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)) such that expenditures for services provided to the individual are eligible for the enhanced federal medical assistance percentage described in that section.

14169.54. (a) Private hospitals shall be paid supplemental amounts for each subject fiscal quarter in a program period for the provision of hospital outpatient services as set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services and shall not affect any other payments to hospitals. The supplemental amounts shall result in payments equal to the statewide aggregate upper payment limit for private hospitals for each subject fiscal year.

(b) Except as set forth in subdivisions (d) and (e), each private hospital shall be paid an amount for each subject fiscal year equal to the outpatient supplemental rate multiplied by the hospital's outpatient base amount, which payments shall be made on a quarterly basis. The outpatient supplemental rate shall result in payments to hospitals that equal the applicable federal upper payment limit for the subject fiscal year, except that with respect to a subject fiscal year that begins before the start of a program period or that ends after the end of the program period for which the payments are made, the outpatient supplemental rate shall result in payments to hospitals that equal a percentage of the applicable upper payment limit where the percentage equals the percentage of the subject fiscal year that occurs during the program period. For purposes of this subdivision, the applicable federal upper payment limit shall be the federal upper payment limit for hospital outpatient services furnished by private hospitals for each subject fiscal year.

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

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

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

(d) Payments shall not be made under this section for the periods when a hospital is a new hospital during a program period.

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

14169.55. (a) Private hospitals shall be paid supplemental amounts for the provision of hospital inpatient services for each subject fiscal quarter in a program period as set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services and shall not affect any other payments to hospitals. The inpatient supplemental amounts shall result in payments to hospitals that equal the applicable federal upper payment limit for the subject fiscal year, except that with respect to a subject fiscal year that begins before the start of a program period or that ends after the end of the program period for which the payments are made, the inpatient supplemental amounts shall result in payments to hospitals that equal a percentage of the applicable upper payment limit where the percentage equals the percentage of the subject fiscal year that occurs during the program period.

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

(1) A general acute care per diem supplemental rate multiplied by the hospital's general acute care days.

(2) An acute psychiatric per diem supplemental rate multiplied by the hospital's acute psychiatric days.

(3) A high acuity per diem supplemental rate multiplied by the number of the hospital's high acuity days if the hospital's Medicaid inpatient utilization rate is less than the percent required to be eligible to receive disproportionate share replacement funds for the state fiscal year ending in the base calendar year and greater than 5 percent and at least 5 percent of the hospital's general acute care days are high acuity days.

(4) A high acuity trauma per diem supplemental rate multiplied by the number of the hospital's high acuity days if the hospital qualifies to receive the amount set forth in paragraph (3) and has been designated as a Level I, Level II, Adult/Ped Level I, or Adult/Ped Level II trauma center by the

Emergency Medical Services Authority established pursuant to Section 1797.1 of the Health and Safety Code.

(5) A transplant per diem supplemental rate multiplied by the number of the hospital's transplant days if the hospital's Medicaid inpatient utilization rate is less than the percent required to be eligible to receive disproportionate share replacement funds for the state fiscal year ending in the base calendar year and greater than 5 percent.

(6) A payment for hospital inpatient services equal to the subacute supplemental rate multiplied by the Medi-Cal subacute payments as reflected in the state paid claims file prepared by the department as of the retrieval date for the base calendar year if the private hospital provided Medi-Cal subacute services during the base calendar year.

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

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

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

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

(e) Payments shall not be made under this section for the periods when a hospital is a new hospital during a program period.

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

14169.56. (a) The department shall increase capitation payments to Medi-Cal managed health care plans for each subject fiscal year as set forth in this section.

(b) (1) Subject to the limitation in paragraph (2), the increased capitation payments shall be made as part of the monthly capitated payments made by the department to managed health care plans. The aggregate amount of increased capitation payments to all Medi-Cal managed health care plans for each subject fiscal year, or portion thereof, shall be the maximum amount for which federal financial participation is available on an aggregate

statewide basis for the applicable subject fiscal year within a program period, or portion thereof.

(2) (A) The limitation in subparagraph (B) shall be applied with respect to a subject fiscal year or portion thereof for which the federal matching assistance percentage is less than 90 percentage for expenditures for services furnished to individuals who meet the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)).

(B) During a subject fiscal year or portion thereof described in subparagraph (A), the aggregate amount of the increased capitation payments under this section shall not exceed the aggregate amount of the increased capitation payments that would be made if the nonfederal share of the increased capitation payments were the amount that the nonfederal share would have been if the federal matching assistance percentage were 90 percent for expenditures for services furnished to individuals who meet the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)).

(c) The department shall determine the amount of the increased capitation payments for each managed health care plan for each subject fiscal year or portion thereof during a program period. The department shall consider the composition of Medi-Cal enrollees in the plan, the anticipated utilization of hospital services by the plan's Medi-Cal enrollees, and other factors that the department determines are reasonable and appropriate to ensure access to high-quality hospital services by the plan's enrollees.

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

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

(2) To secure the necessary funding for the payment or payments made pursuant to paragraph (1), the department may accumulate funds in the Hospital Quality Assurance Revenue Fund, established pursuant to Section 14167.35, for the purpose of funding managed health care capitation

payments under this article regardless of the date on which capitation payments are scheduled to be paid in order to secure the necessary total funding for managed health care payments by the end of a program period.

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

(g) (1) Each managed health care plan shall expend 100 percent of any increased capitation payments it receives under this section on hospital services as provided in Section 14169.57.

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

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

(h) (1) In the event federal financial participation is not available for all of the increased capitation payments determined for a month pursuant to this section for any reason, the increased capitation payments mandated by this section for that month shall be reduced proportionately to the amount for which federal financial participation is available.

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

14169.57. (a) Each managed health care plan receiving increased capitation payments under Section 14169.56 shall expend the capitation rate increases in a manner consistent with actuarial certification, enrollment, and utilization on hospital services. Each managed health care plan shall expend increased capitation payments on hospital services within 30 days of receiving the increased capitation payments to the extent they are made for a subject month that is prior to the date on which the payments are received by the managed health care plan.

(b) The sum of all expenditures made by a managed health care plan for hospital services pursuant to this section shall equal, or approximately equal, all increased capitation payments received by the managed health care plan, consistent with actuarial certification, enrollment, and utilization, from the department pursuant to Section 14169.56.

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

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

(d) The supplemental hospital payments made by managed health care plans pursuant to this section shall reflect the overall purpose of this article.

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

14169.58. (a) (1) For the first program period, designated public hospitals shall be paid direct grants in support of health care expenditures, which shall not constitute Medi-Cal payments, and which shall be funded by the quality assurance fee set forth in this article. For the first program period, the aggregate amount of the grants to designated public hospitals funded by the quality assurance fee set forth in this article shall be forty-five million dollars ($45,000,000) in the aggregate for the two subject fiscal quarters in the 2013–14 subject fiscal year, ninety-three million dollars ($93,000,000) for the 2014–15 subject fiscal year, one hundred ten million five hundred thousand dollars ($110,500,000) for the 2015–16 subject fiscal year, and sixty-two million five hundred thousand dollars ($62,500,000) in the aggregate for the two subject fiscal quarters in the 2016–17 subject fiscal year.

(2) (A) Of the direct grant amounts set forth in paragraph (1), the director shall allocate twenty-four million five hundred thousand dollars ($24,500,000) in the aggregate for the two subject fiscal quarters in the 2013–14 subject fiscal year, fifty million five hundred thousand dollars ($50,500,000) for the 2014–15 subject fiscal year, sixty million five hundred thousand dollars ($60,500,000) for the 2015–16 subject fiscal year, and thirty-four million five hundred thousand dollars ($34,500,000) in the aggregate for the two subject fiscal quarters in the 2016–17 subject fiscal year among the designated public hospitals pursuant to a methodology developed in consultation with the designated public hospitals.

(B) Of the direct grant amounts set forth in subparagraph (A), the director shall distribute six million one hundred twenty-five thousand dollars ($6,125,000) for each subject fiscal quarter in the 2013–14 subject fiscal year, six million three hundred twelve thousand five hundred dollars ($6,312,500) for each subject fiscal quarter in the 2014–15 subject fiscal year, seven million five hundred sixty-two thousand five hundred dollars ($7,562,500) for each subject fiscal quarter in the 2015–16 subject fiscal year, and eight million six hundred twenty-five thousand dollars ($8,625,000) for each subject fiscal quarter in the 2016–17 subject fiscal year in accordance with the timeframes specified in subdivision (a) of Section 14169.66.

(C) Of the direct grant amounts set forth in subparagraph (A), the director shall distribute six million one hundred twenty-five thousand dollars ($6,125,000) for each subject fiscal quarter in the 2013–14 subject fiscal year, six million three hundred twelve thousand five hundred dollars ($6,312,500) for each subject fiscal quarter in the 2014–15 subject fiscal year, seven million five hundred sixty-two thousand five hundred dollars

($7,562,500) for each subject fiscal quarter in the 2015–16 subject fiscal year, and eight million six hundred twenty-five thousand dollars ($8,625,000) for each subject fiscal quarter in the 2016–17 subject fiscal year only upon 100 percent of the rate range increases being distributed to managed health care plans pursuant to subparagraph (D) for the respective subject fiscal quarter. If the rate range increases pursuant to subparagraph (D) are distributed to managed health care plans, the direct grant amounts described in this subparagraph shall be distributed to designated public hospitals no later than 30 days after the rate range increases have been distributed to managed health care plans pursuant to subparagraph (D).

(D) Of the direct grant amounts set forth in paragraph (1), twenty million five hundred thousand dollars ($20,500,000) in the aggregate for the two subject fiscal quarters in the 2013–14 subject fiscal year, forty-two million five hundred thousand dollars ($42,500,000) for the 2014–15 subject fiscal year, fifty million dollars ($50,000,000) for the 2015–16 subject fiscal year, and twenty-eight million dollars ($28,000,000) in the aggregate for the two subject fiscal quarters in the 2016–17 subject fiscal year shall be withheld from payment to the designated public hospitals by the director, and shall be used as the nonfederal share for rate range increases, as defined in paragraph (4) of subdivision (b) of Section 14301.4, to risk-based payments to managed care health plans that contract with the department to serve counties where a designated public hospital is located. The rate range increases shall apply to managed care rates for beneficiaries other than newly eligible beneficiaries, as defined in subdivision (s) of Section 17612.2, and shall enable plans to compensate hospitals for Medi-Cal health services and to support the Medi-Cal program. Each managed health care plan shall expend 100 percent of the rate range increases on hospital services within 30 days of receiving the increased payments. Rate range increases funded under this subparagraph shall be allocated among plans pursuant to a methodology developed in consultation with the hospital community.

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

(b) (1) For the first program period, nondesignated public hospitals shall be paid direct grants in support of health care expenditures, which shall not constitute Medi-Cal payments, and which shall be funded by the quality assurance fee set forth in this article. For the first program period, the aggregate amount of the grants funded by the quality assurance fee set forth in this article to nondesignated public hospitals shall be twelve million five hundred thousand dollars ($12,500,000) in the aggregate for two subject fiscal quarters in the 2013–14 subject fiscal year, twenty-five million dollars ($25,000,000) for the 2014–15 subject fiscal year, thirty million dollars ($30,000,000) for the 2015–16 subject fiscal year, and seventeen million

five hundred thousand dollars ($17,500,000) in the aggregate for the two subject fiscal quarters in the 2016–17 subject fiscal year.

(2) (A) Of the direct grant amounts set forth in paragraph (1), the director shall allocate two million five hundred thousand dollars ($2,500,000) in the aggregate for the two subject fiscal quarters in the 2013–14 subject fiscal year, five million dollars ($5,000,000) for the 2014–15 subject fiscal year, six million dollars ($6,000,000) for the 2015–16 subject fiscal year, and three million five hundred thousand dollars ($3,500,000) in the aggregate for the two subject fiscal quarters in the 2016–17 subject fiscal year among the nondesignated public hospitals pursuant to a methodology developed in consultation with the nondesignated public hospitals.

(B) Of the direct grant amounts set forth in paragraph (1), ten million dollars ($10,000,000) in the aggregate for the two subject fiscal quarters in the 2013–14 subject fiscal year, twenty million dollars ($20,000,000) for the 2014–15 subject fiscal year, twenty-four million dollars ($24,000,000) for the 2015–16 subject fiscal year, and fourteen million dollars ($14,000,000) in the aggregate for the two subject fiscal quarters in the 2016–17 subject fiscal year shall be withheld from payment to the nondesignated public hospitals by the director, and shall be used as the nonfederal share for rate range increases, as defined in paragraph (4) of subdivision (b) of Section 14301.4, to risk-based payments to managed care health plans that contract with the department. The rate range increases shall enable plans to compensate hospitals for Medi-Cal health services and to support the Medi-Cal program. Each managed health care plan shall expend 100 percent of the rate range increases on hospital services within 30 days of receiving the increased payments. Rate range increases funded under this subparagraph shall be allocated among plans pursuant to a methodology developed in consultation with the hospital community.

(c) If the amounts set forth in this section for rate range increases are not actually used for rate range increases as described in this section, the direct grant amounts set forth in this section that are withheld pursuant to subparagraph (D) of paragraph (2) of subdivision (a) and subparagraph (B) of paragraph (2) of subdivision (b) shall be returned the Hospital Quality Assurance Revenue Fund subject to paragraph (4) of subdivision (*l*) of Section 14169.52.

(d) For subsequent program periods, designated public hospitals and nondesignated public hospitals may be paid direct grants pursuant to subdivision (e) of Section 14169.59 upon appropriation in the annual Budget Act.

14169.59. (a) The department shall determine during each rebase calculation year the number of subject fiscal years in the next program period.

(b) During each rebase calculation year, the department shall retrieve the data, including, but not limited to, the days data source, used to determine the following for the subsequent program period: acute psychiatric days, annual fee-for-service days, annual managed care days, annual Medi-Cal days, fee-for-service days, general acute care days, high acuity days,

managed care days, Medi-Cal days, Medi-Cal fee-for-service days, Medi-Cal managed care days, Medi-Cal managed care fee days, outpatient base amount, and transplant days. The department shall pull data from the most recent base calendar year for which the department determines reliable data is available for all hospitals.

(c) During each rebase calculation year, the department shall determine all of the following rates for the subsequent program period, which rates shall be specified in provisional language in the annual Budget Act:

(1) The acute psychiatric per diem supplemental rate for each subject fiscal year during the program period.

(2) The fee-for-service per diem quality assurance fee rate for each subject fiscal year during the program period.

(3) The general acute care per diem supplemental rate for each subject fiscal year during the program period.

(4) The high acuity per diem supplemental rate for each subject fiscal year during the program period.

(5) The high acuity trauma per diem supplemental rate for each subject fiscal year during the program period.

(6) The managed care per diem quality assurance fee rate for each subject fiscal year during the program period.

(7) The Medi-Cal per diem quality assurance fee rate for each subject fiscal year during the program period.

(8) The outpatient supplemental rate for each subject fiscal year during the program period.

(9) The prepaid health plan hospital managed care per diem quality assurance fee rate for each subject fiscal year during the program period.

(10) The prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate for each subject fiscal year during the program period.

(11) The subacute supplemental rate for each subject fiscal year during the program period.

(12) The transplant per diem supplemental rate for each subject fiscal year during the program period.

(d) The department shall determine the rates set forth in paragraphs (1) to (12), inclusive, of subdivision (c) based on the data retrieved pursuant to subdivision (b). Each rate determined by the department shall be the same for all hospitals to which the rate applies. These rates shall be specified in provisional language in the annual Budget Act. The department shall determine the rates in accordance with all of the following:

(1) The rates shall meet the requirements of federal law and be established in a manner to obtain federal approval.

(2) The department shall consult with the hospital community in determining the rates.

(3) The supplemental payments and other Medi-Cal payments for hospital outpatient services furnished by private hospitals for each fiscal year shall equal as close as possible the applicable federal upper payment limit.

(4) The supplemental payments and other Medi-Cal payments for hospital inpatient services furnished by private hospitals for each fiscal year shall equal as close as possible the applicable federal upper payment limit.

(5) The increased capitation payments to managed health care plans shall result in the maximum payments to the plans permitted by federal law.

(6) The quality assurance fee proceeds shall be adequate to make the expenditures described in this article, but shall not be more than necessary to make the expenditures.

(7) The relative values of per diem supplemental payment rates to one another for the various categories of patient days shall be generally consistent with the relative values during the first program period under this article.

(8) The relative values of per diem fee rates to one another for the various categories of patient days shall be generally consistent with the relative values during the first program period under this article.

(9) The rates shall result in supplemental payments and quality assurance fees that are consistent with the purposes of this article.

(e) During each rebase calculation year, the director shall determine the amounts and allocation methodology, if any, of direct grants to designated public hospitals and nondesignated public hospitals for each subject fiscal year in a program period, in consultation with the hospital community. The amounts and allocation methodology may include a withhold of direct grants to be used as the nonfederal share for rate range increases. These amounts shall be specified in provisional language in the annual Budget Act.

(f) Notwithstanding any other provision in this article, the following shall apply to the first program period under this article:

(1) The first program period under this article shall be the period from January 1, 2014, to December 31, 2016, inclusive.

(2) The acute psychiatric days shall be those identified in the Final Medi-Cal Utilization Statistics for the 2012–13 state fiscal year as calculated by the department as of December 17, 2012.

(3) The acute psychiatric per diem supplemental rate shall be nine hundred sixty-five dollars ($965) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, nine hundred seventy dollars ($970) for the subject fiscal quarters in the 2014–15 subject fiscal year, nine hundred seventy-five dollars ($975) for the subject fiscal quarters in the 2015–16 subject fiscal year and nine hundred seventy-five dollars ($975) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(4) The days data source shall be the hospital's Annual Financial Disclosure Report filed with the Office of Statewide Health Planning and Development as of June 6, 2013, for its fiscal year ending during the 2010 calendar year.

(5) The fee-for-service per diem quality assurance fee rate shall be three hundred seventy-four dollars and ninety-one cents ($374.91) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, four hundred twenty-five dollars and twenty-two cents ($425.22) for the subject fiscal quarters in the 2014–15 subject fiscal year, four hundred eighty dollars and eleven cents ($480.11) for the subject fiscal quarters in the 2015–16

subject fiscal year, and five hundred forty-two dollars and ten cents ($542.10) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(6) The general acute care days shall be those identified in the 2010 calendar year, as reflected in the state paid claims file on April 26, 2013.

(7) The general acute care per diem supplemental rate shall be eight hundred twenty-four dollars and forty cents ($824.40) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, one thousand one hundred ten dollars and sixty-seven cents ($1,110.67) for the subject fiscal quarters in the 2014–15 subject fiscal year, one thousand three hundred thirty-five dollars and forty-two cents ($1,335.42) for the subject fiscal quarters in the 2015–16 subject fiscal year, and one thousand four hundred forty-one dollars and twenty cents ($1,441.20) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(8) The high acuity days shall be those paid during the 2010 calendar year, as reflected in the state paid claims file prepared by the department on April 26, 2013.

(9) The high acuity per diem supplemental rate shall be two thousand five hundred dollars ($2,500) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, two thousand five hundred dollars ($2,500) for the subject fiscal quarters in the 2014–15 subject fiscal year, two thousand five hundred dollars ($2,500) for the subject fiscal quarters in the 2015–16 subject fiscal year, and two thousand five hundred dollars ($2,500) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(10) The high acuity trauma per diem supplemental rate shall be two thousand five hundred dollars ($2,500) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, two thousand five hundred dollars ($2,500) for the subject fiscal quarters in the 2014–15 subject fiscal year, two thousand five hundred dollars ($2,500) for the subject fiscal quarters in the 2015–16 subject fiscal year, and two thousand five hundred dollars ($2,500) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(11) The managed care per diem quality assurance fee rate shall be one hundred forty-five dollars ($145) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, one hundred forty-five dollars ($145) for the subject fiscal quarters in the 2014–15 subject fiscal year, one hundred seventy dollars ($170) for the subject fiscal quarters in the 2015-16 subject fiscal year, and one hundred seventy dollars ($170) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(12) The Medi-Cal managed care days shall be those identified in the Final Medi-Cal Utilization Statistics for the 2012–13 fiscal year, as calculated by the department as of December 17, 2012.

(13) The Medi-Cal per diem quality assurance fee rate shall be four hundred fifty-seven dollars and ten cents ($457.10) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, four hundred ninety-seven dollars and eight cents ($497.08) for the subject fiscal quarters in the 2014–15 subject fiscal year, five hundred sixty-eight dollars and

fifteen cents ($568.15) for the subject fiscal quarters in the 2015–16 subject fiscal year, and six hundred eighteen dollars and fourteen cents ($618.14) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(14) The outpatient base amount shall be those payments for outpatient services made to a hospital in the 2010 calendar year, as reflected in the state paid claims files prepared by the department on April 26, 2013.

(15) The outpatient supplemental rate shall be 119 percent of the outpatient base amount for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, 268 percent of the outpatient base amount for the subject fiscal quarters in the 2014–15 subject fiscal year, 292 percent of the outpatient base amount for the subject fiscal quarters in the 2015–16 subject fiscal year, and 151 percent of the outpatient base amount for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(16) The prepaid health plan hospital managed care per diem quality assurance fee rate shall be eighty-one dollars and twenty cents ($81.20) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, eighty-one dollars and twenty cents ($81.20) for the subject fiscal quarters in the 2014–15 subject fiscal year, ninety-five dollars and twenty cents ($95.20) for the subject fiscal quarters in the 2015–16 subject fiscal year, and ninety-five dollars and twenty cents ($95.20) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(17) The prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate shall be two hundred fifty-five dollars and ninety-seven cents ($255.97) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, two hundred seventy-eight dollars and thirty-seven cents ($278.37) for the subject fiscal quarters in the 2014–15 subject fiscal year, three hundred eighteen dollars and sixteen cents ($318.16) for the subject fiscal quarters in the 2015–16 subject fiscal year, and three hundred forty-six dollars and sixteen cents ($346.16) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(18) The subacute supplemental rate shall be 50 percent for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, 55 percent for the subject fiscal quarters in the 2014–15 subject fiscal year, 60 percent for the subject fiscal quarters in the 2015–16 subject fiscal year, and 60 percent for the first two subject fiscal quarters in the 2016–17 subject fiscal year of the Medi-Cal subacute payments paid by the department to the hospital during the 2010 calendar year, as reflected in the state paid claims file prepared by the department on April 26, 2013.

(19) The transplant days shall be those identified in the 2010 Patient Discharge file from the Office of Statewide Health Planning and Development accessed on June 28, 2011.

(20) The transplant per diem supplemental rate shall be two thousand five hundred dollars ($2,500) for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, two thousand five hundred dollars ($2,500) for the subject fiscal quarters in the 2014–15 subject fiscal year, two thousand five hundred dollars ($2,500) for the subject fiscal quarters in the 2015–16 subject fiscal year, and two thousand five hundred dollars

($2,500) for the first two subject fiscal quarters in the 2016–17 subject fiscal year.

(21) Upon federal approval or conditional federal approval described in Section 14169.63, the director shall have the discretion to revise the fee-for-service per diem quality assurance fee rate, the managed care per diem quality assurance fee rate, the Medi-Cal per diem quality assurance fee rate, the prepaid health plan hospital managed care per diem quality assurance fee rate, or the prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate, based on the funds required to make the payments specified in this article, in consultation with the hospital community.

(22) With respect to a hospital described in subdivision (f) of Section 14165.50, both of the following shall apply:

(A) The hospital shall not be considered a new hospital as defined in subdivision (ah) of Section 14169.51 for the purposes of this article.

(B) To the extent permitted by federal law and other federal requirements, the department shall use the best available and reasonable current estimates or projections made with respect to the hospital for an annual period as the data, including, but not limited to, the days data source and data described as being derived from a state paid claims file, used for all purposes, including, but not limited to, the calculation of supplemental payments and the quality assurance fee. The estimates and projections shall be deemed to reflect paid claims and shall be used for each data element regardless of the time period otherwise applicable to the data element. The data elements include, but are not limited to, acute psychiatric days, annual fee-for-service days, annual managed care days, annual Medi-Cal days, fee-for-service days, general acute care days, high acuity days, managed care days, Medi-Cal days, Medi-Cal fee-for-service days, Medi-Cal managed care days, Medi-Cal managed care fee days, outpatient base amount, and transplant days.

(g) Notwithstanding any other provision in this article, the following shall apply to the second program period under this article:

(1) The second program period under this article shall begin on January 1, 2017, and shall end on June 30, 2019.

(2) The retrieval date shall occur between October 1, 2016, and December 31, 2016.

(3) The base calendar year shall be the 2013 calendar year, or a more recent calendar year for which the department determines reliable data is available.

(4) The rebase calculation year shall be the 2015–16 state fiscal year.

(5) With respect to a hospital described in subdivision (f) of Section 14165.50, both of the following shall apply:

(A) The hospital shall not be considered a new hospital as defined in subdivision (ah) of Section 14169.51 for the purposes of this article.

(B) To the extent permitted by federal law or other federal requirements, the department shall use the best available and reasonable current estimates or projections made with respect to the hospital for an annual period as to the data, including, but not limited to, the days data source and data described

as being derived from a state paid claims file, used for all purposes, including, but not limited to, the calculation of supplemental payments and the quality assurance fee. The estimates and projections shall be deemed to reflect paid claims and shall be used for each data element regardless of the time period otherwise applicable to the data element. The data elements include, but are not limited to, acute psychiatric days, annual fee-for-service days, annual managed care days, annual Medi-Cal days, fee-for-service days, general acute care days, high acuity days, managed care days, Medi-Cal days, Medi-Cal fee-for-service days, Medi-Cal managed care days, Medi-Cal managed care fee days, outpatient base amount, and transplant days.

(i) Commencing January 2016, the department shall provide a clear narrative description along with fiscal detail in the Medi-Cal estimate package, submitted to the Legislature in January and May of each year, of all of the calculations made by the department pursuant to this section for the second program period and every program period thereafter.

14169.60. (a) The amount of any payments made under this article to private hospitals, including the amount of payments made under Sections 14169.54 and 14169.55 and additional payments to private hospitals by managed health care plans pursuant to Section 14169.57, shall not be included in the calculation of the low-income percent or the OBRA 1993 payment limitation, as defined in paragraph (24) of subdivision (a) of Section 14105.98, for purposes of determining payments to private hospitals.

(b) The supplemental payments and other payments under this article shall be regarded as quality assurance payments, the implementation or suspension of which does not affect a determination of the adequacy of any rates under federal law.

14169.61. (a) (1) Except as provided in this section, all data and other information relating to a hospital that are used for the purposes of this article, including, without limitation, the days data source, shall continue to be used to determine the payments to that hospital, regardless of whether the hospital has undergone one or more changes of ownership.

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

(b) The data of separate facilities prior to a consolidation shall be aggregated for the purposes of this article if: (1) a private hospital consolidates with another private hospital, (2) the facilities operate under a consolidated hospital license, (3) data for a period prior to the consolidation is used for purposes of this article, and (4) neither hospital has had a change of ownership on or after the effective date of this article unless paragraph (2) of subdivision (d) has been satisfied by the new owner. Data of a facility that was a separately licensed hospital prior to the consolidation shall not be included in the data, including the days data source, for the purpose of determining payments to the facility or the quality assurance fees due from the facility under the article for any time period during which the facility is

closed. A facility shall be deemed to be closed for purposes of this subdivision on the first day of any period during which the facility has no general acute, psychiatric, or rehabilitation inpatients for at least 30 consecutive days. A facility that has been deemed to be closed under this subdivision shall no longer be deemed to be closed on the first subsequent day on which it has general acute, psychiatric, or rehabilitation inpatients.

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

(d) The following provisions shall apply only for purposes of this article, and shall have no application outside of this article nor shall they affect the assumption of any outstanding monetary obligation to the Medi-Cal program:

(1) The director shall develop and describe in provider bulletins and on the department's Internet Web site a process by which the new operator of a hospital that has a days data source in whole or in part from a previous operator may enter into an agreement with the department to confirm that it is financially responsible or to become financially responsible to the department for the outstanding monetary obligation to the Medi-Cal program of the previous operator in order to avoid being classified as a new hospital for purposes of this article. This process shall be available for changes of ownership that occur before, on, or after January 1, 2014, but only in regard to payments under this article and otherwise shall have no retroactive effect.

(2) The outstanding monetary obligation referred to in subdivision (ah) of Section 14169.51 shall include responsibility for all of the following:

(A) Payment of the quality assurance fee established pursuant to this article.

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

(C) Overpayments that are asserted after such date and arise from customary reconciliations of payments, such as cost report settlements, and, with the exception of overpayments described in subparagraph (B), shall exclude liabilities arising from the fraudulent or intentionally criminal act

of a prior operator if the new operator did not knowingly participate in or continue the fraudulent or criminal act after becoming the licensee.

(3) The department shall have the discretion to determine whether the new owner properly and fully agreed to be financially responsible for the outstanding monetary obligation in connection with the Medi-Cal program and seek additional assurances as the department deems necessary, except that a new owner that executes an agreement with the department to be financially responsible for the monetary obligations as described in paragraph (1) shall be conclusively deemed to have agreed to be financially responsible for the outstanding monetary obligation in connection with the Medi-Cal program. The department shall have the discretion to establish the terms for satisfying the outstanding monetary obligation in connection with the Medi-Cal program, including, but not limited to, recoupment from amounts payable to the hospital under this section.

14169.62. Notwithstanding any provision in this article, the director may correct any identified material and egregious errors in the data, including, but not limited to, the days data source, used for the following: acute psychiatric days, annual fee-for-service days, annual managed care days, annual Medi-Cal days, fee-for-service days, general acute care days, high acuity days, managed care days, Medi-Cal days, Medi-Cal fee-for-service days, Medi-Cal managed care days, Medi-Cal managed care fee days, outpatient base amount, and transplant days. An error is material and egregious if the error is clear to the director based on information the director finds to be reliable and results in an increase or decrease to a hospital's supplemental payment amounts under this article, or in a hospital's quality assurance fee payments, of at least one million dollars ($1,000,000) for any subject fiscal year. The director's determination whether to exercise his or her discretion under this section and any determination made by the director under this section shall not be subject to judicial review, except that a hospital may bring a writ of mandate under Section 1085 of the Code of Civil Procedure to rectify an abuse of discretion by the department in correcting that hospital's data when that correction results in greater fees for that hospital pursuant to Sections 14169.52 and 14169.53 or lower supplemental payments for that hospital pursuant to Section 14169.54 and 14169.55.

14169.63. (a) Notwithstanding any other provision of this article requiring federal approvals, the department may impose and collect the quality assurance fee and may make payments under this article, including increased capitation payments, based upon receiving a letter from the federal Centers for Medicare and Medicaid Services or the United States Department of Health and Human Services that indicates likely federal approval, but only if and to the extent that the letter is sufficient as set forth in subdivision (b).

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

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

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

(c) Nothing in this section shall be construed as modifying the requirement under Section 14169.69 that payments shall be made only to the extent a sufficient amount of funds collected as the quality assurance fee are available to cover the nonfederal share of those payments.

(d) Upon notice from the federal government that final federal approval for the fee model under this article or for the supplemental payments to private hospitals under Section 14169.54 or 14169.55 has been denied, any fees collected pursuant to this section shall be refunded and any payments made pursuant to this article shall be recouped, including, but not limited to, supplemental payments and grants, increased capitation payments, payments to hospitals by health care plans resulting from the increased capitation payments, and payments for the health care coverage of children. To the extent fees were paid by a hospital that also received payments under this section, the payments may first be recouped from fees that would otherwise be refunded to the hospital prior to the use of any other recoupment method allowed under law.

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

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

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

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

(g) The department may draw against the Hospital Quality Assurance Revenue Fund for all administrative costs associated with implementation under this article, consistent with subdivision (b) of Section 14169.53.

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

14169.64. (a) Notwithstanding any other provision in this article, the director may modify any timeline or timelines related to the assessment of the quality assurance fee or Medi-Cal payments under this article, including capitation payments, if the director, upon consultation with the hospital community, determines that it is impossible from an operational perspective to implement a timeline or timelines without the modification.

(b) The department shall notify the Joint Budget Legislative Committee and the fiscal and appropriate policy committees of the Legislature five

working days prior to implementing a modified timeline or timelines under subdivision (a).

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

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

14169.65. (a) Upon receipt of a letter that indicates likely federal approval that the director determines is sufficient for implementation under Section 14169.63, or upon the receipt of federal approval, the following shall occur:

(1) To the maximum extent possible, and consistent with the availability of funds in the Hospital Quality Assurance Revenue Fund, the department shall make all of the payments under Sections 14169.54, 14169.55, and 14169.56, including, but not limited to, supplemental payments and increased capitation payments, prior to the end of a program period, except that the increased capitation payments under Section 14169.56 shall not be made until federal approval is obtained for these payments.

(2) The department shall make supplemental payments to hospitals under this article consistent with the timeframe described in Section 14169.66 or a modified timeline developed pursuant to Section 14169.64.

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

(c) This section shall not affect the department's ongoing authority to continue, after the end of a program period, to collect quality assurance fees imposed on or before the end of the program period.

14169.66. The department shall make disbursements from the Hospital Quality Assurance Revenue Fund consistent with the following:

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

(b) The funds shall be disbursed in accordance with the order of priority set forth in subdivision (b) of Section 14169.53, except that funds may be set aside for increased capitation payments to managed care health plans pursuant to subdivision (e) of Section 14169.56.

(c) The funds shall be disbursed in each payment cycle in accordance with the order of priority set forth in subdivision (b) of Section 14169.53 as modified by subdivision (b), and so that the supplemental payments and direct grants to hospitals and the increased capitation payments to managed health care plans are made to the maximum extent for which funds are available.

(d) To the maximum extent possible, consistent with the availability of funds in the Hospital Quality Assurance Revenue Fund and the timing of federal approvals, the supplemental payments and direct grants to hospitals and increased capitation payments to managed health care plans under this article shall be made before the last day of a program period.

(e) The aggregate amount of funds to be disbursed to private hospitals shall be determined under Sections 14169.54 and 14169.55. The aggregate amount of funds to be disbursed to managed health care plans shall be determined under Section 14169.56. The aggregate amount of direct grants to designated and nondesignated public hospitals shall be determined under Section 14169.58.

14169.67. Notwithstanding any other provision of this article, supplemental payments or other payments under this article shall only be required and payable in any quarter for which a fee payment obligation exists.

14169.68. (a) In order to ensure that the proceeds of the quality assurance fee, the matching amount provided by the federal government, and any interest earned on those proceeds are used to supplement existing funding for hospital services provided to Medi-Cal patients and not supplant such funding, the aggregate fee-for-service payments under the Medi-Cal program to hospitals for hospital services furnished on and after January 1, 2014, for each fiscal year or portion thereof that is in a program period shall not be less than the aggregate amounts that would have been paid for those services under the rates and payment methodologies in effect on December 31, 2013. This provision shall be applied separately for each category of hospital services.

(b) For purposes of this section, all of the following definitions shall apply:

(1) "Aggregate amounts" means payments that would have been made on a fee-for-service basis to a hospital under Medi-Cal where the nonfederal share of the payments would have been appropriated from state general funds with the exception of disproportionate share replacement payments made under Section 14166.11. Aggregate amounts do not include payments made pursuant to Article 5.228 (commencing with Section 14169.1).

(2) "Aggregate fee-for-service payments" means all payments made on a fee-for-service basis to a hospital under Medi-Cal where the nonfederal share of the payments were appropriated from state general funds with the exception of disproportionate share replacement payments made under Section 14166.11. Aggregate fee-for-service payments do not include payments made under this article.

(3) "Hospital services" means all services covered under Medi-Cal furnished by a hospital, including, but not limited to, hospital inpatient services, hospital outpatient services, skilled nursing facility services furnished by a hospital, and subacute services furnished by a hospital.

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

(d) This section shall be implemented only to the extent it does not violate federal law and only to the extent available federal financial participation is not jeopardized.

(e) This section shall not require a rate or level of funding to be maintained where federal financial participation for the rate or level of funding has been reduced or eliminated by federal law.

14169.69. (a) The director shall do all of the following:

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

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

(3) Amend the contracts between the managed health care plans and the department as necessary to incorporate the provisions of Sections 14169.56 and 14169.57 and promptly seek all necessary federal approvals of those amendments. The department shall pursue amendments to the contracts as soon as possible after the effective date of this article, and shall not wait for federal approval of this article prior to pursuing amendments to the contracts. The amendments to the contracts shall, among other provisions, set forth an agreement to increase capitation payments to managed health care plans under Section 14169.56 and increase payments to hospitals under Section 14169.57 in a manner that relates back to the beginning of a program period, or as soon thereafter as possible, conditioned on obtaining all federal approvals necessary for federal financial participation for the increased capitation payments to the managed health care plans.

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

(c) In the event any hospital, or any party on behalf of a hospital, initiates a case or proceeding in any state or federal court in which the hospital seeks any relief of any sort whatsoever, including, but not limited to, monetary relief, injunctive relief, declaratory relief, or a writ, based in whole or in part on a contention that any or all of this article is unlawful and may not be lawfully implemented, both of the following shall apply:

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

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

(d) Subject to Section 14169.63, no payment shall be made under this article until all necessary federal approvals for the payment and for the fee provisions in this article have been obtained and the fee has been imposed and collected. Notwithstanding any other law, payments under this article

shall be made only to the extent that the fee established in this article is collected and available to cover the nonfederal share of the payments.

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

(1) The quality assurance fee set forth in this article, along with any interest or other investment income thereon.

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

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

14169.70. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this article by means of provider bulletins, all plan letters, or other similar instruction, without taking regulatory action. The department shall also provide notification to the Joint Legislative Budget Committee and to the fiscal and appropriate policy committees of the Legislature within five working days when the above-described action is taken in order to inform the Legislature that the action is being implemented.

14169.71. Notwithstanding any other provision of this article, the director may proportionately reduce the amount of any supplemental payments or increased capitation payments under this article to the extent that the payment would result in the reduction of other amounts payable to a hospital or managed health care plan due to the application of federal law.

14169.72. This article shall become inoperative if any of the following occurs:

(a) The effective date of a final judicial determination made by any court of appellate jurisdiction or a final determination by the United States Department of Health and Human Services or the federal Centers for Medicare and Medicaid Services that the quality assurance fee established pursuant to this article, or Section 14169.54 or 14169.55, cannot be implemented. This subdivision shall not apply to any final judicial determination made by any court of appellate jurisdiction in a case brought by hospitals located outside the state.

(b) The federal Centers for Medicare and Medicaid Services denies approval for, or does not approve on or before the last day of a program period, the implementation of Sections 14169.52, 14169.53, 14169.54, and 14169.55, and the department fails to modify Section 14169.52, 14169.53, 14169.54, or 14169.55 pursuant to subdivision (d) of Section 14169.53 in order to meet the requirements of federal law or to obtain federal approval.

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

(1) “General Fund proceeds of taxes appropriated pursuant to Article XIII B of the California Constitution,” as used in subdivision (b) of Section 8 of Article XVI of the California Constitution.

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

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

(e) A lawsuit related to this article is filed against the state and a preliminary injunction or other order has been issued that results in a financial disadvantage to the state. For purposes of this subdivision, "financial disadvantage to the state" means either of the following:

(1) A loss of federal financial participation.

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

(f) The proceeds of the fee and any interest and dividends earned on deposits are not deposited into the Hospital Quality Assurance Revenue Fund or are not used as provided in Section 14169.53.

(g) The proceeds of the fee, the matching amount provided by the federal government, and interest and dividends earned on deposits in the Hospital Quality Assurance Revenue Fund are not used as provided in Section 14169.68.

14169.73. In the event this article becomes inoperative pursuant to Section 14169.72, all of the following shall apply:

(a) No hospital shall be required to pay the fee except for any fee owed prior to the article becoming inoperative.

(b) The director shall execute a declaration stating that he or she has determined that the article is inoperative and shall state the basis for this determination. The director shall retain the declaration and provide a copy, within five working days of the execution of the declaration, to the fiscal and appropriate policy committees of the Legislature. In addition, the director shall post the declaration on the department's Internet Web site and the director shall send the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(c) Upon execution of the declaration described in subdivision (b), the director shall implement a plan, in consultation with the hospital community and the Legislature, to wind down the program consistent with the purposes of the article, including the recoupment of payments made under this article if ordered by a court.

14169.74. Beginning with the proposed budget for the 2014–15 fiscal year, and each fiscal year thereafter, the Department of Finance shall report in the Governor's proposed budget and the May Revision the difference in General Fund benefit for the upcoming fiscal year resulting from this article and what was anticipated at the time the Budget Act of 2013 was enacted. It is the intent of the Legislature that additional General Fund benefit be appropriated to supplement, and not supplant, funding for health and human service programs, which may include the cost of medical interpreters.

14169.75. Notwithstanding Section 14169.72, this article shall become inoperative on January 1, 2017. No hospital shall be required to pay the fee

after that date unless the fee was owed during the period in which the article was operative, and no payments authorized under Section 14169.53 shall be made unless the payments were owed during the period in which the article was operative.

14169.76. This article is repealed on January 1 of the year following the date on which the article becomes inoperative.

SEC. 7. Article 5.231 (commencing with Section 14169.81) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.231. Medi-Cal Hospital Reimbursement Improvement and Restoration Act of 2013

14169.81. (a) Notwithstanding Sections 14105.191 and 14105.192, reimbursement for services provided by skilled nursing facilities that are distinct parts of general acute care hospitals shall be determined, for dates of service on or after October 1, 2013, without application of the reductions and limitations set forth in Sections 14105.191 and 14105.192.

(b) The director shall promptly seek all necessary federal approvals to implement this section.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of provider bulletins or notices, policy letters, or other similar instructions, without taking regulatory action.

14169.82. (a) In consultation with the hospital community, as defined in Section 14169.51, the department shall develop proposed modifications to the quality assurance fee program under Article 5.230 (commencing with Section 14169.50) to collect additional fees solely designated for use under this section. In addition, the department shall consult with the hospital community to enable intergovernmental transfers from nondesignated public hospitals solely designated for use under this section. The department shall notify the Joint Legislative Budget Committee and fiscal and appropriate policy committees 30 working days prior to implementing a modification pursuant to this section.

(b) To the extent federal financial participation is not jeopardized and consistent with federal law, and subject to the conditions set forth in subdivision (c), the department shall pay Medi-Cal managed care plans rate range increases, as defined by paragraph (4) of subdivision (b) of Section 14301.4, for the purpose of increasing payments to private hospitals and nondesignated public hospitals in counties that do not have designated public hospitals. Nondesignated public hospitals shall be given priority relative to accessing rate range funds in counties where a nondesignated public hospital is the only public hospital.

(c) Payments to Medi-Cal managed care plans pursuant to subdivision (b) are conditioned on both of the following:

(A) The Medi-Cal managed care plan shall pay all of the rate range increases provided under this section as additional payments to private hospitals and nondesignated public hospitals for providing and making available services to Medi-Cal enrollees of the plan.

(B) The amount of the increases to Medi-Cal managed care plans shall be limited to the total amount of payments possible, including federal financial participation, based on the amount of fees actually collected and intergovernmental transfers actually provided pursuant to subdivision (a) as the nonfederal share for these payments.

14169.83. To the extent permitted by federal law and other federal requirements, the director shall develop and describe in provider bulletins and on the department's Internet Web site a process by which a private general acute care hospital located outside the state that serves Medi-Cal beneficiaries may opt in to pay the quality assurance fee on all applicable categories of patient days and receive supplemental payments for the Medi-Cal program patient days pursuant to Article 5.230 (commencing with Section 14169.50), in the same manner that the hospital could participate if it were located in the state. Notwithstanding Section 14169.51, the department shall rely on reliable data to make reasonable estimates or projections made with respect to the hospital as to the data, including, but not limited to, the days data source, used for the following: acute psychiatric days, annual fee-for-service days, annual managed care days, annual Medi-Cal days, fee-for-service days, general acute care days, high acuity days, managed care days, Medi-Cal days, Medi-Cal fee-for-service days, Medi-Cal managed care days, Medi-Cal managed care fee days, outpatient base amount, and transplant days, used to calculate the fees due and the supplemental payments. The director may modify the procedure set forth in this section to the minimum extent necessary to comply with applicable law, in consultation with the hospital community as defined in Section 14169.51.

SEC. 8. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

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

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