AMENDED IN SENATE AUGUST 17, 2010

AMENDED IN SENATE AUGUST 2, 2010

AMENDED IN SENATE JULY 15, 2010

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 1653

Introduced by Assembly Member Jones
(Principal coauthor: Senator Alquist)

January 14, 2010

An act to amend Sections 14167.1, 14167.2, 14167.3, 14167.5, 14167.6, 14167.10, 14167.11, 14167.12, 14167.14, 14167.15, 14167.31, ~~and~~ 14167.32, 14167.35, and 14167.36 of, ~~to add Article 5.227 (commencing with Section 14168) to Chapter 7 of Part 3 of Division 9 of,~~ and to repeal and add Section 14167.9 of, the Welfare and Institutions Code, relating to Medi-Cal, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 1653, as amended, Jones. Medi-Cal: hospitals: managed health care plans: mental health plans: quality assurance fee.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions.

Existing law, subject to federal approval, requires the department to make supplemental payments for certain services, as specified, to private hospitals, nondesignated public hospitals, and designated public hospitals, as defined, for subject federal fiscal years, as defined.

This bill would make various changes to the formulas used to determine the amount of supplemental payments made to private and designated public hospitals. *This bill would expand the definition of a nondesignated public hospital.*

Existing law ~~proscribes~~ *prescribes* certain deadlines by which the above-described supplemental payments are required to be made to hospitals depending upon the federal fiscal year for which the payment is to be made.

This bill would require the department to make to hospitals the supplemental payments for the 2008–09, 2009–10, and 2010–11 federal fiscal years in 7 payments, as specified.

Existing law requires the department to make enhanced payments to managed health care plans, as defined, and requires the state to make enhanced payments to mental health plans, as defined, for each subject federal fiscal year, as specified. Existing law requires the managed health care plans and mental health plans that received enhanced payments to make supplemental payments to subject hospitals, as defined, pursuant to specified formulas.

This bill would, instead, refer to the payments made by the department to the managed health care plans and mental health plans as increased capitation payments. The bill would require the department to determine the amount of increased capitation payments for each Medi-Cal managed care plan and to consider certain factors in making that determination. The bill would prohibit the amount of increased capitation payments to each Medi-Cal managed *health* care ~~health~~ plan from exceeding an amount that results in capitation payments that are certified by the state's actuary as meeting federal requirements. The bill would require each managed health care plan to expend 100% of any increased capitation payments it receives from the department on hospital services.

Existing law, subject to federal approval, also imposes, as a condition of participation in state-funded health insurance programs other than the Medi-Cal program, a quality assurance fee, as specified, on certain general acute care hospitals through and including December 31, 2010. Existing law creates the Hospital Quality Assurance Revenue Fund in the State Treasury and requires that the money collected from the quality assurance fee be deposited into the fund. Existing law provides that the moneys in the fund shall, upon appropriation by the Legislature, be available only for certain purposes, including providing the above-described supplemental payments to hospitals and health care coverage for children.

This bill would modify the formulas used in calculating the amount of the quality assurance fee imposed on acute care hospitals pursuant to the above-described provisions.

The bill would provide that the quality assurance fee shall not be imposed on a converted hospital, as defined, for a subject federal fiscal year in which the hospital becomes a converted hospital or for subsequent federal fiscal years.

Prior to federal approval of implementation of the above-described provisions, existing law requires each general acute care hospital that is not an exempt facility to certify to the best of its knowledge that the hospital is prepared to pay the aggregate quality assurance fee, as defined.

This bill would delete the above-described certification requirement. The bill would require hospitals to pay the quality assurance fee in 7 equal installments, as specified and subject to federal approval of the above-described provisions.

Existing law authorizes the department, as necessary to receive federal approval for the implementation of the above-described provisions, to increase or decrease certain amounts used to calculate the quality assurance fee.

This bill would delete the above-described authorization.

~~Existing law, effective January 1, 2011, and subject to the authority of a subsequent statute enacted to take effect on or after January 1, 2011, that meets certain conditions, imposes a quality assurance fee in a manner necessary to obtain federal Medicaid matching funds that shall be due and payable to the department by each general acute care hospital at specified rates for the purpose of making Medi-Cal payments to hospitals.~~

~~This bill would, effective January 1, 2011, impose on each general acute care hospital that is not an exempt facility, as defined, a quality assurance fee, as a condition of participation in state-funded health insurance programs, other than the Medi-Cal program. This bill would require the quality assurance fee to be computed starting on the effective date of the bill and continue through and including June 30, 2011. The bill would require the proceeds from the fee to be used for the same purposes as the above-described quality assurance fee that is imposed on hospitals through and including December 31, 2010. The bill would provide that the method of calculation and collection of the quality assurance fee is to be determined in an unspecified manner.~~

~~This bill would require the director to seek federal approvals or waivers as may be necessary to implement the above-described provisions and to obtain federal financial participation to the maximum extent possible with the proceeds from the quality assurance fee paid pursuant to those provisions.~~

~~This bill would require the fee payments and any related federal reimbursement under the above-described provisions that become effective January 1, 2011, to be deposited in the Hospital Quality Assurance Revenue Fund. The bill would continuously appropriate these moneys in an unspecified manner.~~

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

Vote: ⅔. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 14167.1 of the Welfare and Institutions Code is amended to read:

14167.1. (a) "Acute psychiatric days" means the total number of Short-Doyle administrative days, Short-Doyle acute care days, acute psychiatric administrative days, and acute psychiatric acute days identified in the Final Medi-Cal Utilization Statistics for the 2008–09 state fiscal year as calculated by the department on September 15, 2008.

(b) ~~(1)~~ "Converted hospital" means a private hospital that becomes a designated public hospital or a nondesignated public hospital after the implementation date, a nondesignated public hospital that becomes a private hospital or a designated public hospital after the implementation date, or a designated public hospital that becomes a private hospital or a nondesignated public hospital after the implementation date.

~~(2) A private hospital shall be considered a converted hospital if both of the following apply:~~

~~(A) After the implementation date, the hospital's ownership is transferred to a nonprofit corporation and that corporation's sole corporate member is a health care district governed by Division 23 (commencing with Section 32000) of the Health and Safety Code.~~

~~(B) The hospital is operating a hospital owned by a health care district.~~

(c) "Current Section 1115 Waiver" means California's Medi-Cal Hospital/Uninsured Care Section 1115 Waiver Demonstration in effect on the effective date of the article.

(d) "Designated public hospital" shall have the meaning given in subdivision (d) of Section 14166.1 as that section may be amended from time to time.

(e) "General acute care days" means the total number of Medi-Cal general acute care days paid by the department to a hospital in the 2008 calendar year, as reflected in the state paid claims files on July 10, 2009.

(f) "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 during the 2008 calendar year, as reflected in the state paid claims files on July 10, 2009.

(g) "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 include physician services only where the service is furnished to a hospital inpatient, the physician is compensated by the hospital for the service, and the service is billed to Medi-Cal by the hospital under a provider number assigned to the hospital. Hospital inpatient services do not include services for which a managed health care plan is financially responsible.

(h) "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 include physician services only where the service is furnished to a hospital outpatient, the physician is compensated by the hospital for the service, and the service is billed to Medi-Cal by the hospital under a provider number assigned to the hospital. 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.

(i) (1) "Implementation date" means the latest effective date of all federal approvals or waivers necessary for the implementation of this article and Article 5.22 (commencing with Section 14167.31), including, but not limited to, any approvals on amendments to contracts between the department and managed health care plans or mental health plans necessary for the implementation of this article. The effective date of a federal approval of a contract amendment shall be the earliest date to which the computation of payments under the contract amendment is applicable that may be prior to the date on which the contract amendment is executed.

(2) If federal approval is sought initially for only the 2008–09 federal fiscal year and separately secured for subsequent federal fiscal years, the implementation date for the 2008–09 federal fiscal year shall occur when all necessary federal approvals have been secured for that federal fiscal year.

(j) "Individual hospital acute psychiatric supplemental payment" means the total amount of acute psychiatric hospital supplemental payments to a subject hospital for a quarter for which the supplemental payments are made. The "individual hospital acute psychiatric supplemental payment" shall be calculated for subject hospitals by multiplying the number of acute psychiatric days for the individual hospital for which a mental health plan was financially responsible by four hundred eighty-five dollars ($485) and dividing the result by 4.

(k) (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, but are not limited to, county organized health systems, prepaid health plans, and entities contracting with the department to provide services pursuant to two-plan models and geographic managed care. Entities providing these services contract with the department pursuant to any of the following:

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

(ii) Article 2.8 (commencing with Section 14087.5).
(iii) Article 2.81 (commencing with Section 14087.96).
(iv) Article 2.91 (commencing with Section 14089).
(v) Article 1 (commencing with Section 14200) of Chapter 8.
(vi) Article 7 (commencing with Section 14490) of Chapter 8.
(B) Managed health care plans do not include any mental health plan contracting to provide mental health care for Medi-Cal beneficiaries pursuant to Part 2.5 (commencing with Section 5775) of Division 5.

(*l*) "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 2008–09 state fiscal year, as calculated by the department on September 15, 2008, except that the general acute care days, including well baby days, for the Santa Barbara Health Care Initiative shall be derived from the Final Medi-Cal Utilization Statistics for the 2007–08 state fiscal year.

(m) "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 disproportionate share hospital eligibility list for the 2008–09 state fiscal year released by the department on October 22, 2008.

(n) "Mental health plan" means a mental health plan that contracts with the State Department of Mental Health to furnish or arrange for the provision of mental health services to Medi-Cal beneficiaries pursuant to Part 2.5 (commencing with Section 5775) of Division 5.

(o) "New hospital" means a hospital that was not in operation under current or prior ownership as a private hospital, a nondesignated public hospital, or a designated public hospital for any portion of the 2008–09 state fiscal year.

~~(p) "Nondesignated public hospital" means 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 annual financial disclosure report for the hospital's latest fiscal year ending in 2007, and satisfies the definition in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.~~

(p) "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 annual financial disclosure report for the hospital's latest fiscal year ending in 2007, 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 annual financial disclosure report for the hospital's latest fiscal year ending in 2007, 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.

(q) "Outpatient base amount" means the total amount of payments for hospital outpatient services made to a hospital in the 2007 calendar year, as reflected in state paid claims files on January 26, 2008.

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

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

(2) Is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, or is not designated as a specialty hospital in the hospital's Office of Statewide Health Planning and Development Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2007.

(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.

(s) "Subject federal fiscal year" means a federal fiscal year that ends after the implementation date and begins before December 31, 2010.

(t) "Subject hospital" shall mean a hospital that meets all of the following conditions:

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

(2) Is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, or is not designated as a specialty hospital in the hospital's Office of Statewide Health Planning and Development Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2007.

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

(u) "Subject month" means a calendar month beginning on or after the implementation date and ending before January 1, 2011.

(v) "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.

SEC. 2. Section 14167.2 of the Welfare and Institutions Code is amended to read:

14167.2. (a) Private hospitals shall be paid supplemental amounts for the provision of hospital outpatient services as set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services and shall not affect any other payments to hospitals.

(b) Except as set forth in subdivisions (e) and (f), each private hospital shall be paid an amount for each subject federal fiscal year equal to a percentage of the hospital's outpatient base amount. The percentage shall be the same for each hospital for a subject federal fiscal year and shall result in payments to hospitals that equal the applicable federal upper payment limit.

(c) In the event federal financial participation for a subject federal fiscal year is not available for all of the supplemental amounts payable to private hospitals under subdivision (b) due to the application of a federal upper 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 federal 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 federal 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) The supplemental amounts set forth in this section are inclusive of federal financial participation.

(e) No payments shall be made under this section to a new hospital.

(f) No payments shall be made under this section to a converted hospital for the subject federal fiscal year in which the hospital becomes a converted hospital or for subsequent subject federal fiscal years.

SEC. 3. Section 14167.3 of the Welfare and Institutions Code is amended to read:

14167.3. (a) Private hospitals shall be paid supplemental amounts for the provision of hospital inpatient services and subacute 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.

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

(1) Six hundred forty dollars and forty-six cents ($640.46) multiplied by the hospital's general acute care days.

(2) Four hundred eighty-five dollars ($485) multiplied by the hospital's acute psychiatric days that were paid directly by the department and were not the financial responsibility of a mental health plan.

(3) One thousand three hundred fifty dollars ($1,350) multiplied by the number of the hospital's high acuity days if the hospital's Medicaid inpatient utilization rate is less than 41.1 percent and greater than 5 percent and at least 5 percent of the hospital's general acute care days are high acuity days. This amount shall be in addition to the amounts specified in paragraphs (1) and (2).

(4) One thousand three hundred fifty dollars ($1,350) 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. This amount shall be in addition to the amounts specified in paragraphs (1), (2), and (3).

(c) A private hospital that provides Medi-Cal subacute services during a subject federal fiscal year and has a Medicaid inpatient utilization rate that is greater than 5.0 percent and less than 41.1 percent shall be paid for the provision of subacute services during each subject federal fiscal year a supplemental amount equal to 40 percent of the Medi-Cal subacute payments made to the hospital during the 2008 calendar year.

(d) (1) In the event federal financial participation for a subject federal fiscal year is not available for all of the supplemental amounts payable to private hospitals under subdivision (b) due to the application of a federal limit or for any other reason, both of the following shall apply:

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

(B) The amount payable under subdivision (b) to each private hospital for the subject federal 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).

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

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

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

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

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

(g) No payments shall be made under this section to a new hospital.

(h) No payments shall be made under this section to a converted hospital for the subject federal fiscal year in which the hospital becomes a converted hospital or for subsequent subject federal fiscal years.

SEC. 4. Section 14167.5 of the Welfare and Institutions Code is amended to read:

14167.5. (a) 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 Article 5.22 (commencing with Section 14167.31). The aggregate amount of the grants to designated public hospitals for each subject federal fiscal year shall be two hundred ninety-five million dollars ($295,000,000).

(b) The director shall allocate the amount specified in subdivision (a) among the designated public hospitals in accordance with this subdivision. In determining the allocation, the director shall rely on data from the Interim Hospital Payment Rate Workbooks. For purposes of this section, “Interim Hospital Payment Rate Workbook” means the Interim Hospital Payment Rate Workbook, developed by the department and approved by the federal Centers for Medicare and Medicaid Services for use in connection with the Medi-Cal Hospital/Uninsured Care 1115 Waiver Demonstration, as submitted by each designated public hospital, or the governmental entity with which the hospital is affiliated, on or around June 2009 for the period of July 1, 2007, to June 30, 2008, inclusive.

(1) Each designated public hospital’s share of 80 percent of the amount specified in subdivision (a) shall be determined by applying a fraction, the numerator of which is the certified public expenditures reported by the designated public hospital as

allowable Medi-Cal inpatient expenditures on Schedule 2.1, Column 5, Step 5 of the Interim Hospital Payment Rate Workbook, and the denominator of which is the total amount of certified public expenditures reported as allowable Medi-Cal inpatient expenditures by all designated public hospitals on Schedule 2.1, Column 5, Step 5 of the Interim Hospital Payment Rate Workbooks.

(2) Each designated public hospital's share of 20 percent of the amount described in subdivision (a) shall be determined by applying a fraction, the numerator of which is the sum of the uninsured days of inpatient hospital services reported by the designated public hospital on Schedule 1, Column 5a, lines 25 through 33 of the Interim Hospital Payment Rate Workbook, and the denominator of which is the total uninsured days of inpatient hospital services reported by all designated public hospitals on Schedule 1, Column 5a, lines 25 through 33 of the Interim Hospital Payment Rate Workbooks.

(c) In the event federal financial participation for a subject federal fiscal year is not available for all of the supplemental amounts payable to private hospitals under Section 14167.3, due to the limitations on supplemental payments based on a partial-year federal upper payment limit, the amount payable to each designated public hospital under subdivision (b) shall equal the designated public hospital's allocated grant amount under subdivision (b) multiplied by a fraction, the numerator of which is the total number of months in the subject federal fiscal year for which federal financial participation is available for supplemental payment amounts to private hospitals up to the federal upper payment limit, and the denominator of which is 12.

(d) Designated public hospitals shall be paid supplemental Medi-Cal amounts for acute inpatient psychiatric services that are paid directly by the department and are not the financial responsibility of a mental health plan, as set forth in this subdivision. The supplemental amounts shall be in addition to any other amounts payable to designated public hospitals, or a governmental entity with which the hospital is affiliated, with respect to those services and shall not affect any other payments to hospitals or to any governmental entity with which the hospital is affiliated.

(1) Each designated public hospital shall be paid an amount for each subject federal fiscal year equal to four hundred eighty-five

dollars ($485) multiplied by the hospital's acute psychiatric days that were paid directly by the department and were not the financial responsibility of a mental health plan, inclusive of federal financial participation.

(2) In the event federal financial participation for a subject federal fiscal year is not available for all of the supplemental amounts payable to designated public hospitals under paragraph (1) due to the application of a federal upper payment limit or for any other reason, both of the following shall apply:

(A) The total amount payable to designated public hospitals under paragraph (1) for the subject federal fiscal year shall be reduced to the amount for which federal financial participation is available.

(B) The amount payable under paragraph (1) to each designated public hospital for the subject federal fiscal year shall be equal to the amount computed under paragraph (1) multiplied by the ratio of the total amount for which federal financial participation is available to the total amount computed under paragraph (1).

(3) In the event the amount otherwise payable to a designated public hospital under this subdivision for a subject federal fiscal year exceeds the amount for which federal financial participation is available for that hospital, the amount due to the hospital for that federal fiscal year shall be reduced to the amount for which federal financial participation is available.

SEC. 5. Section 14167.6 of the Welfare and Institutions Code is amended to read:

14167.6. (a) The department shall increase capitation payments to Medi-Cal managed health care plans for the subject federal fiscal years as set forth in this section.

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

(c) The aggregate amount of increased capitation payments to all Medi-Cal managed health care plans for a subject federal fiscal year shall be seven hundred twenty-nine million eight hundred twenty-nine thousand two hundred two dollars ($729,829,202) multiplied by the fee percentage of the subject federal fiscal year.

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

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

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

(f) 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 be made as follows:

(1) The increased capitation payments shall commence during the second month following the month during which the quality assurance fee set forth in Article 5.22 (commencing with Section 14167.31) is due and payable from hospitals if the quality assurance fee includes funds for increased capitation payments to managed health care plans. The last increased capitation payments made pursuant to this section shall be made during December 2010.

(2) The increased capitation payments made during the first month in which increased payments are made pursuant to this section shall include the sum of the increased payments for all prior months for which payments are due and actuarial certification was received.

(g) Payments to managed health care plans that would be paid consistent with actuarial certification and enrollment in the absence of the payments made pursuant to this section shall not be reduced as a consequence of payment under this section.

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

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

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

(j) 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.

SEC. 6. Section 14167.9 of the Welfare and Institutions Code is repealed.

SEC. 7. Section 14167.9 is added to the Welfare and Institutions Code, to read:

14167.9. Subject to the limitations in Section 14167.14, the following shall apply:

(a) (1) The department shall make to hospitals the payments described in Sections 14167.2, 14167.3, 14167.4, and subdivision (d) of Section 14167.5 for the 2008–09, 2009–10, and 2010–11 federal fiscal years in seven payments.

(2) (A) The first payment shall be made on or before the later of September 30, 2010, or the ~~30~~ *30th* day after the notice described in Section 14167.32 is sent to each hospital.

(B) The subsequent payments shall be made in six consecutive semimonthly payments that shall be made on or before the later of each of the ~~14 and 30~~ *14th and 30th* days of October, November, and December 2010, or the ~~30~~ *30th* day after the notice described in Section 14167.32 is sent to each hospital.

(3) The amount of each payment made pursuant to this subdivision shall be one-seventh of the amount of payments calculated for each hospital under Sections 14167.2, 14167.3, 14167.4, and subdivision (d) of Section 14167.5.

(b) Notwithstanding subdivision (a), all amounts due to hospitals under Sections 14167.2, 14167.3, 14167.4, and subdivision (d) of Section 14167.5 that have not been paid to hospitals before December 30, 2010, pursuant to subdivision (a), shall be paid to hospitals no later than December 30, 2010.

(c) (1) The department shall make to hospitals the payments described in subdivisions (a), (b), and (c) of Section 14167.5 in seven payments.

(2) (A) (i) The first six payments shall be made in consecutive semimonthly payments that shall be made on or before the later of each of the first and 15th days of October, November, and December 2010, or the 30th day after the notice described in Section 14167.32 is sent to each hospital.

(ii) The amount of each of the first six payments shall be one-seventh of the amount of payments calculated for each hospital under subdivisions (a), (b), and (c) of Section 14167.5.

(B) (i) The seventh payment shall be made on or before December 30, 2010.

(ii) The amount of the seventh payment shall be the total amount due to hospitals under subdivisions (a), (b), and (c) of Section 14167.5 minus the amounts previously paid to the hospitals under subparagraph (A).

SEC. 8. Section 14167.10 of the Welfare and Institutions Code is amended to read:

14167.10. (a) Each managed health care plan receiving increased capitation payments under Section 14167.6 shall expend the capitation rate increases in a manner consistent with actuarial certification, enrollment, and utilization on hospital services within 30 days of receiving the increased capitation payments.

(b) For each subject federal fiscal year, 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 14167.6.

(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 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) Consistent with actuarial certification, enrollment, and utilization, managed health care plans shall in no event be obligated under this section to expend the capitation rate increases on hospital services that exceed the increased capitation payments made to the managed health care plans under Section 14167.6.

SEC. 9. Section 14167.11 of the Welfare and Institutions Code is amended to read:

14167.11. (a) The department shall increase payments to mental health plans for the subject federal fiscal years as set forth in this section.

(b) For each fiscal quarter that begins on or after the implementation date, the state shall make increased capitation payments to each mental health plan. The amount of those increased capitation payments to a mental health plan shall be the sum of all individual hospital acute psychiatric supplemental payments for subject hospitals located in each county in which the mental health plan operates.

(c) The state shall make increased capitation payments to mental health plans exclusively for the purpose of making supplemental payments to hospitals, in order to support the availability of hospital mental health services and ensure access for Medi-Cal beneficiaries to hospital mental health services. The increased capitation payments to mental health plans shall be made as follows:

(1) The increased capitation payments shall commence on or before the later of the last day of the second month of the quarter in which federal approval is granted or the 45th day following the day on which federal approval is granted. Subsequent increased capitation payments shall be made on the last day of the second month of each quarter. The last increased capitation payments made pursuant to this section shall be made during November 2010.

(2) The increased capitation payments made for the first quarter for which increased capitation payments are made under this section shall include the sum of increased capitation payments for all prior quarters for which payments are due under subdivision (b).

(3) The increased capitation payments made during November 2010 shall include payments computed under subdivision (b) for

all quarters in the 2010–11 federal fiscal year to the extent that federal financial participation is available for the payments.

(d) (1) Each mental health plan shall expend, in the form of additional payments to hospitals, 100 percent of any increased capitation payments it receives under this section, pursuant to Section 14167.12.

(2) At the discretion of the director, the plans shall receive an administrative fee, in an amount determined by the department, that is in addition to the increased capitation payments, that is reflective of actual administrative costs and that shall be paid from the fund created in Article 5.22 (commencing with Section 14167.31).

(e) In the event federal financial participation for a subject federal fiscal year is not available for all of the increased capitation acute psychiatric payments determined for a quarter pursuant to this section for any reason, the increased capitation payments mandated by this section for that quarter shall be reduced proportionately to the amount for which federal financial participation is available.

(f) Payments to mental health plans that would be paid in the absence of the payments made pursuant to this section shall not be reduced as a consequence of the payments under this section.

(g) In the event the director determines that payment of the individual acute psychiatric supplemental payments may be made by the department directly to the hospitals under this section and Section 14167.12 without the need for transmitting the funds through the mental health plans, those direct payments shall be made notwithstanding any other provision of this article or Article 5.22 (commencing with Section 14167.31).

(h) The department may, as necessary, allocate money appropriated to it from the Hospital Quality Assurance Revenue Fund to the State Department of Mental Health for the purposes of making increased payments to mental health plans pursuant to this article.

SEC. 10. Section 14167.12 of the Welfare and Institutions Code is amended to read:

14167.12. (a) At the same time that the state makes an increased capitation payment to a mental health plan under Section 14167.11, the state shall notify the mental health plan that the plan shall make payments in the amount of the individual hospital acute

psychiatric supplemental payment to each subject hospital located in each county in which the mental health plan operates as a consequence of receiving the increased capitation payment and the amount of the individual hospital acute psychiatric supplemental payment due to each hospital, subject to the following:

(1) In the case of the increased capitation payments made to a mental health plan during the first quarter in which the payments are made to the plan, the notice shall direct mental health plans to make supplemental payments to each hospital in an amount equal to each hospital's individual hospital acute psychiatric supplemental payment multiplied by the number of quarters for which the enhance payments were made.

(2) The notice provided by the department in connection with the increased capitation payments to each mental health plan during November 2010 shall also direct the mental health plan to make quarterly supplemental payments to hospitals for quarters, if any, between January 2011 and September 2011, inclusive, for which federal financial participation is available as described in paragraph (3) of subdivision (c) of Section 14167.11 and the amount of the supplemental payments as calculated pursuant to this subdivision.

(b) Each mental health plan receiving payments under Section 14167.11 shall make supplemental payments to hospitals within 30 days of receiving the payments under Section 14167.11, except that if the mental health plan receives increased capitation payments during November 2010, which include payments relating to some or all of the quarters between January 2011 and September 2011, inclusive, the mental health plan shall make payments relating to the quarters between January 2011 and September 2011, inclusive, on or before the end of each quarter to which the payment relates. The payments shall be made to those hospitals and in those amounts set forth by the department in its notice provided pursuant to subdivision (a).

(c) The supplemental payments made to hospitals pursuant to this section shall be in addition to any other amounts payable to hospitals by a mental health plan or otherwise and shall not affect any other payments to hospitals.

(d) For each subject federal fiscal year, the sum of all supplemental payments made by a mental health plan to subject hospitals pursuant to this section shall equal all increased capitation

payments received by the mental health plan from the state pursuant to Section 14167.11.

(e) Mental health plans shall not take into account payments made pursuant to this article in negotiating the amount of payments to hospitals that are not made pursuant to this article.

(f) A mental health plan is obligated to make payments under this section only to the extent of the payments it receives under Section 14167.11. A mental health plan may retain any interest it earns on funds it receives under Section 14167.11 prior to making payments of the funds to hospitals under this section.

(g) No payments shall be made under this section to a new hospital.

(h) In the event federal financial participation for a quarter is not available for all of the increased capitation mental health payments made pursuant to Section 14167.11 for any reason, the supplemental payments to hospitals under this section shall be reduced proportionately to the amount for which federal financial participation is available and the department's notice under subdivision (a) shall reflect the reduction.

SEC. 11. Section 14167.14 of the Welfare and Institutions Code is amended to read:

14167.14. (a) The director shall do all of the following:

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

(2) Seek federal approval for the use of the entire federal upper payment limits applicable to hospital services for payments under this article for the 2008–09, 2009–10, and 2010–11 federal fiscal years.

(3) 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.

(4) Amend the contracts between the managed health care plans and the department as necessary to incorporate the provisions of Sections 14167.6 and 14167.10 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 Article 5.22 (commencing with Section 14167.31), and shall not wait for federal approval of this article or Article 5.22 (commencing with Section 14167.31) prior to pursuing amendments to the contracts. The amendments to the

contracts shall, among other provisions, set forth an agreement to increase payment rates to managed health care plans under Section 14166.6 and increase payments to hospitals under Section 14166.10 effective April 2009 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 or Article 5.22 (commencing with Section 14167.31) shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

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

(1) In the event, and on the effective date, of a final judicial determination made by any court of appellate jurisdiction or a final determination by the federal Department of Health and Human Services or the federal Centers for Medicare and Medicaid Services that any element of this article cannot be implemented.

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

(A) The federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before January 1, 2012, the implementation of Article 5.22 (commencing with Section 14167.31) or this article.

(B) Either or both articles cannot be modified by the department pursuant to subdivision (e) of Section 14167.35 in order to meet the requirements of federal law or to obtain federal approval.

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

(e) In the event any hospital, or any party on behalf of a hospital, shall initiate 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) No payments shall 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 section for a project 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.

(f) No payment shall be made under this article until all necessary federal approvals for the payment and for the fee provisions in Article 5.22 (commencing with Section 14167.31) have been obtained and the fee has been imposed and collected. Payments under this article shall be made only to the extent that the fee established in Article 5.22 (commencing with Section 14167.31) is collected and available to support the payments.

(g) Supplemental payments for the 2008–09 federal fiscal year shall not reduce the maximum federal funds available annually pursuant to the Special Terms and Conditions, as amended October 5, 2007, of the Current Section 1115 Waiver.

(h) (1) The director shall negotiate the federal approvals required to implement this article and Article 5.22 (commencing with Section 14167.31) for the 2009–10 and 2010–11 federal fiscal years concurrently with the negotiation of a federal waiver that will replace the Current Section 1115 Waiver, with a goal of obtaining federal approvals that do not adversely impact the federal funds that would otherwise be available for services to Medi-Cal beneficiaries and the uninsured. The director may initiate the concurrent negotiations required by this subdivision by submitting a concept paper to the federal Centers for Medicare and Medicaid Services outlining the key elements of the replacement waiver consistent with the goals set forth in this subdivision.

(2) In negotiating the terms of a federal waiver that will replace the Current 1115 Waiver, the department shall explore opportunities for reform of the Medi-Cal program and strengthen California's health care safety net. Subject to subsequent legislative approval, the department shall explore program reforms, that may include, but need not be limited to, strategies to accomplish payment system reforms for hospital inpatient and outpatient care, including incentive based payments, new payment methodologies

such as diagnostic-related group-based (DRG-based), or similar methodologies, patient safety protocols, and quality measurement.

(3) This article and Article 5.22 (commencing with Section 14167.31) shall not be implemented with respect to the 2009–10 and 2010–11 federal fiscal years until the earlier of April 30, 2010, or the date the federal government approves a federal waiver for a demonstration that will replace the Current Section 1115 Waiver.

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

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

(1) The quality assurance fee set forth in Article 5.22 (commencing with Section 14167.31) and due and payable on or before December 31, 2010.

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

SEC. 12. Section 14167.15 of the Welfare and Institutions Code is amended to read:

14167.15. Notwithstanding any other provision of this article or Article 5.22 (commencing with Section 14167.31), the director may proportionately reduce the amount of any supplemental payments, increased capitation payments, or grants under this article to the extent that the payment or grant would result in the reduction of other amounts payable to a hospital or managed health care plan or mental health plan due to the application of federal law.

SEC. 13. Section 14167.31 of the Welfare and Institutions Code is amended to read:

14167.31. (a) (1) "Aggregate annual 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.

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

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

(2) "Aggregate 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.

(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.

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

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

(3) "Aggregate quality assurance fee after the application of the fee percentage" shall be determined separately for each subject federal fiscal year and means the aggregate annual quality assurance fee multiplied by the fee percentage for the subject federal fiscal year.

(4) "Aggregate quality assurance fee" means the sum of the aggregate quality assurance fee after the application of the fee percentage for a hospital for each subject federal fiscal year.

(b) "Annual fee-for-service days" means the number of fee-for-service days of each hospital subject to the quality assurance fee in the 2007 calendar year, as reported on the days data source.

(c) "Annual managed care days" means the number of managed care days of each hospital subject to the quality assurance fee in the 2007 calendar year, as reported on the days data source.

(d) "Annual Medi-Cal days" means the number of Medi-Cal days of each hospital subject to the quality assurance fee in the 2007 calendar year, as reported on the days data source.

(e) "Converted hospital" shall have the meaning given in subdivision (b) of Section 14167.1.

(f) "Days data source" means the following:

(1) For a hospital that did not submit an Annual Financial Disclosure Report to the Office of Statewide Health Planning and Development for a fiscal year ending during 2007, but submitted

that report for a fiscal period ending in 2008 that includes at least 10 months of 2007, the Annual Financial Disclosure Report submitted by the hospital to the Office of Statewide Health Planning and Development for the fiscal period in 2008 that includes at least 10 months of 2007.

(2) For a hospital owned by Kaiser Foundation Hospitals that submitted corrections to reported patient days to the Office of Statewide Health Planning and Development for its fiscal year ending in 2007 before July 31, 2009, the corrected data.

(3) For all other hospitals, the hospital's Annual Financial Disclosure Report in the Office of Statewide Health Planning and Development files as of October 31, 2008, for its fiscal year ending during 2007.

(g) "Designated public hospital" shall have the meaning given in subdivision (d) of Section 14166.1 as that section may be amended from time to time.

(h) "Exempt facility" means any of the following:

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

(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 a hospital designated as a specialty hospital in the hospital's Office of Statewide Health Planning and Development Hospital Annual Disclosure Report for the hospital's fiscal year ending in the 2007 calendar year.

(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 Office of Statewide Health Planning and Development Hospital Annual Disclosure Report for the hospital's fiscal year ending in the 2007 calendar year.

(i) (1) "Federal approval" means the last approval by the federal government required for the implementation of this article and Article 5.21 (commencing with Section 14167.1).

(2) If federal approval is sought initially for only the 2008–09 federal fiscal year and separately secured for subsequent federal fiscal years, the implementation date, as defined in subdivision (i) of Section 14167.1, for the 2008–09 federal fiscal year shall occur

when all necessary federal approvals have been secured for that federal fiscal year.

(j) "Fee-for-service per diem quality assurance fee rate" means a fixed fee on fee-for-service days of two hundred fifteen dollars and thirty cents ($215.30) per day.

(k) "Fee-for-service days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "chemical dependency care and rehabilitation care," and the payer category is reported as "Medicare traditional," "county indigent programs–traditional," "other third parties–traditional," "other indigent," and "other payers," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(*l*) "Fee percentage" means, for each subject federal fiscal year, a fraction, expressed as a percentage, the numerator of which is the amount of payments for the subject federal fiscal year under Sections 14167.2, 14167.3, and 14167.4, subdivision (d) of Section 14167.5, and Section 14167.6 for which federal financial participation is available and the denominator of which is two billion nine hundred eighty-two million one hundred twenty-one thousand five hundred sixty dollars ($2,982,121,560).

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

(n) "Hospital community" means any hospital industry organization or system that represents children's hospitals, nondesignated public hospitals, designated public hospitals, private safety-net hospitals, and other public or private hospitals.

(o) "Managed care days" means inpatient hospital days in the 2007 calendar year as reported on the days data source where the service type is reported as "acute care," "psychiatric care," and "chemical dependency care and rehabilitation care," and the payer category is reported as "Medicare managed care," "county indigent programs–managed care," and "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.

(p) "Managed care per diem quality assurance fee rate" means a fixed fee on managed care days of twenty-two dollars and fifty cents ($22.50) per day.

(q) "Medi-Cal days" means inpatient hospital days in the 2007 calendar year as reported on the days data source where the service type is reported as "acute care," "psychiatric care," and "chemical dependency care and rehabilitation care," and the payer category is reported as "Medi-Cal–traditional" and "Medi-Cal–managed care," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(r) "Medi-Cal fee-for-service days" means inpatient hospital days in the 2007 calendar year as reported on the days data source where the service type is reported as "acute care," "psychiatric care," and "chemical dependency care and 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.

(s) "Medi-Cal managed care days" means inpatient hospital days in the 2007 calendar year as reported on the days data source where the service type is reported as "acute care," "psychiatric care," and "chemical dependency care and 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.

(t) "Medi-Cal per diem quality assurance fee rate" means a fixed fee on Medi-Cal days of two hundred thirty-two dollars ($232) per day.

(u) "Nondesignated public hospital" means a public hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code and is defined in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(v) "Prepaid health plan hospital" means a hospital that is in the Prepaid Health Plan Hospital peer group described in the 1991 Hospital Peer Grouping Report published by the department.

(w) "Prepaid health plan hospital managed care per diem quality assurance fee rate" means a fixed fee on non-Medi-Cal managed care days for prepaid health plan hospitals of twelve dollars and sixty cents ($12.60) per day.

(x) "Prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate" means a fixed fee on Medi-Cal

managed care days for prepaid health plan hospitals of one hundred twenty-nine dollars and ninety-two cents ($129.92) per day.

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

(z) "Private hospital" means a hospital licensed under subdivision (a) of Section 1250 of the Health and Safety Code that 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.

(aa) "Subject federal fiscal year" means a federal fiscal year ending after the implementation date, as defined in Section 14167.1, and beginning before December 31, 2010.

(ab) "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.

SEC. 14. Section 14167.32 of the Welfare and Institutions Code is amended to read:

14167.32. (a) There shall be imposed on each general acute care hospital that is not an exempt facility a quality assurance fee, as a condition of participation in state-funded health insurance programs, other than the Medi-Cal program, provided that a quality assurance fee shall not be imposed on a converted hospital for a subject federal fiscal year in which the hospital becomes a converted hospital or for subsequent federal fiscal years.

(b) The quality assurance fee shall be computed starting on the implementation date, as defined in Section 14167.1, and continue through and including December 31, 2010.

(c) Upon receipt of federal approval, the following shall become operative:

(1) Within 30 days following receipt of the notice of federal approval from the federal government, the department shall send notice to each hospital subject to the quality assurance fee, and publish on its Internet Web site, the following information:

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

(B) The fee percentage or percentages for each subject federal fiscal year.

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

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

(B) The aggregate quality assurance fee.

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

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

(3) (A) The hospitals shall pay the aggregate quality assurance fee in seven equal installments.

(B) (i) The first installment payment shall be made on or before the later of September 14, 2010, or the 14th day after the notice described in this section is sent to each hospital.

(ii) The additional installment payments shall be made in six consecutive semimonthly payments that shall be due and payable on or before the later of each of the first and 15th days of October, November, and December 2010, or the 14th day after the notice described in this section is sent to each hospital.

(4) Notwithstanding paragraph (3), the amount of each hospital's aggregate quality assurance fee that has not been paid by the hospital before December 15, 2010, pursuant to paragraph (3), shall be paid by the hospital no later than December 15, 2010.

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

(e) This section shall become inoperative if the federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before January 1, 2012, the implementation of this article or Article 5.21 (commencing with Section 14167.1), and either or both articles cannot be modified by the department pursuant to subdivision (e) of Section 14167.35 in order to meet the requirements of federal law or to obtain federal approval.

(f) In no case shall the aggregate fees collected in a subject federal fiscal year pursuant to this section 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 within 10 days of the date that payment is due, the department may deduct the unpaid assessment and interest owed from any Medi-Cal payments or other state payments to the hospital in accordance with Section 12419.5 of the Government Code 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 the quality assurance fee.

(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 as they existed on the effective date of this article, to limit the amount of the proceeds of the quality assurance fee to be used to pay for the health care coverage of children to the amounts specified in this article and to make any payments for the department's costs of administration to the amounts set forth in this article on the effective date of this article to maintain and continue prior reimbursement levels as set forth in Article 5.21 (commencing with Section 14167.1) on the effective date of that article, and to otherwise comply with all its

obligations set forth in Article 5.21 (commencing with Section 14167.1) and this article.

(*l*) For the purpose of this article, references to the receipt of notice by the state of federal approval of the implementation of this article shall refer to the last date that the state receives notice of all federal approval or waivers required for implementation of this article and Article 5.21 (commencing with Section 14167.1), subject to Section 14167.14.

(m) (1) Effective January 1, 2011, the rates payable to hospitals and managed health care plans under Medi-Cal shall be the rates then payable without the supplemental and increased capitation payments set forth in Article 5.21 (commencing with Section 14167.1).

(2) The supplemental payments and other payments under Article 5.21 (commencing with Section 14167.1) 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.

SEC. 15. 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 and any related federal reimbursement 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 quarter for which payments are made under Article 5.21 (commencing with Section 14167.1). In any quarter for which payments reflect room under the upper payment limit that was available from prior or subsequent quarters, the prior or subsequent quarters shall constitute quarters for purposes of the payment for health care coverage for children required by this paragraph.

(3) To make increased payments to hospitals pursuant to Article 5.21 (commencing with Section 14167.1).

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

(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 (1) and (2) of subdivision (e) 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.

SEC. 16. Section 14167.36 of the Welfare and Institutions Code is amended to read:

14167.36. (a) This article shall only be implemented so long as the following conditions are met:

(1) Subject to Section 14167.35, the quality assurance fee is established in a manner that is fundamentally consistent with this article.

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

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

(b) No hospital shall be required to pay the quality assurance fee to the department unless and until the state receives and maintains federal approval of the quality assurance fee and Article 5.21 (commencing with Section 14167.1) from the federal Centers for Medicare and Medicaid Services.

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

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

(2) Article 5.21 (commencing with Section 14167.1) is enacted and remains in effect and hospitals are reimbursed the increased rates beginning on the implementation date, as defined in Section 14167.1.

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

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

(1) In the event, and on the effective date, of a final judicial determination made by any court of appellate jurisdiction or a final determination by the federal Department of Health and Human Services or the federal Centers for Medicare and Medicaid Services that any element of this article cannot be implemented.

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

(A) The federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before January 1, 2012, the implementation of Article 5.21 (commencing with Section 14167.1) or this article.

(B) Either or both articles cannot be modified by the department pursuant to subdivision (e) of Section 14167.35 in order to meet the requirements of federal law or to obtain federal approval.

(e) If this article becomes inoperative pursuant to paragraph (1) of subdivision (d) and the determination applies to any period or periods of time prior to the effective date of the determination, the department may recoup all payments made pursuant to Article 5.21 (commencing with Section 14167.1) during that period or those periods of time.

(f) This article and Article 5.21 (commencing with Section 14167.1) shall not be implemented with respect to the 2009–10 and 2010–11 federal fiscal years until the earlier of April 30, 2010, or the date the federal government approves a federal waiver for a demonstration that will replace the Current Section 1115 Waiver, as defined in subdivision (c) of Section 14167.1.

~~SEC. 17. Article 5.227 (commencing with Section 14168) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:~~

~~Article 5.227. Quality Assurance Fee Act~~

~~14168. (a) (1) "Exempt facility" means any of the following:~~

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

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

~~(ii) 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.~~

~~(B) 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 Office of Statewide Health Planning and Development Hospital Annual Disclosure Report for the hospital's fiscal year ending in the 2007 calendar year.~~

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

~~(D) A small and rural hospital as specified in Section 124840 of the Health and Safety Code, designated as that in the hospital's Office of Statewide Health Planning and Development Hospital Annual Disclosure Report for the hospital's fiscal year ending in the 2007 calendar year.~~

~~(2) "General acute care hospital" shall mean any hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.~~

~~(b) Effective January 1, 2011, there shall be imposed on each general acute care hospital that is not an exempt facility a quality assurance fee, as a condition of participation in a state-funded health insurance program, other than the Medi-Cal program.~~

~~(c) (1) The quality assurance fee shall be computed starting on the effective date of this article and continue through and including June 30, 2011.~~

~~(2) The method of calculation and collection of the quality assurance fee shall be determined pursuant to ____.~~

~~(3) The quality assurance fee shall be used solely for the purposes specified in Article 5.21 (commencing with Section 14167.1) and Article 5.22 (commencing with Section 14167.31).~~

~~(d) The director shall do all of the following:~~

~~(1) Seek federal approvals or waivers as may be necessary to implement this article.~~

~~(2) Obtain federal financial participation to the maximum extent possible with the proceeds from the quality assurance fee paid pursuant to this article.~~

~~(e) (1) The fee payments and any related federal reimbursement shall be deposited in the Hospital Quality Assurance Revenue Fund.~~

~~(2) Notwithstanding Section 13340 of the Government Code, any moneys deposited in the Hospital Quality Assurance Revenue Fund pursuant to paragraph (1) shall be continuously appropriated, without regard to fiscal year, as follows:____.~~

~~SEC. 18.~~

SEC. 17. 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 statutory changes to increase Medi-Cal payments to hospitals and improve access, at the earliest possible time, it is necessary that this act take effect immediately.

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