Senate Bill No. 208

CHAPTER 714

An act to amend Sections 14105.24, 14167.1, 14167.2, 14167.3, 14167.4, 14167.5, 14167.6, 14167.8, 14167.9, 14167.10, 14167.11, 14167.12, 14167.14, 14167.31, 14167.32, 14167.35, and 14167.354 of, to amend and renumber and add Section 14182 of, and to add Sections 14089.07, 14132.275, 14166.252, 14182.1, 14182.15, 14182.2, 14182.3, and 14182.4 to, 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 19, 2010. Filed with Secretary of State October 19, 2010.]

LEGISLATIVE COUNSEL'S DIGEST

SB 208, Steinberg. Medi-Cal.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions.

Under existing law, the department is authorized to contract for the provision of Medi-Cal services through certain managed care options, including the geographic managed care model. Under existing law, Sacramento County provides, in part, Medi-Cal services through a geographic managed care health plan.

This bill would permit the Sacramento County Department of Health and Human Services to establish a stakeholder advisory committee to provide input to the department on the delivery of health care services provided in the county, as specified. This bill would, except under specified circumstances, permit the advisory committee to request in writing and receive final reports submitted to the department by any managed care health plan operating in Sacramento County.

Existing law provides that clinics and hospital outpatient departments, except for emergency rooms, that are owned and operated by Los Angeles County and participated in a specified Medicaid demonstration project for Los Angeles County, shall be reimbursed under a cost-based methodology, as specified, on and after July 1, 2005.

This bill would provide that, to the extent permitted by federal law and that federal financial participation is available, if the department implements a Medi-Cal managed care expansion program that includes beneficiaries who are seniors or persons with disabilities, payments received by the clinics and outpatient departments described above shall be equivalent to what otherwise would have been received on a fee-for-service basis.

Existing federal law provides for the federal Medicare Program, which is a public health insurance program for persons 65 years of age and older and specified persons with disabilities who are under 65 years of age.

This bill would, to the extent that federal financial participation is available, and pursuant to a demonstration project or waiver of federal law, require the department to establish pilot projects in up to 4 counties, as specified, to develop effective health care models to provide services to persons who are dually eligible under both the Medi-Cal and Medicare programs. This bill would require the department to, not sooner than March 1, 2011, identify health care models that may be included in a pilot project, to develop a timeline and process for selecting, financing, monitoring, and evaluating the pilot projects, and to provide this timeline and process to certain committees of the Legislature.

Existing law establishes the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, which revises hospital supplemental payment methodologies under the Medi-Cal program in order to maximize the use of federal funds consistent with federal Medicaid law and to stabilize the distribution of funding for hospitals that provide care to Medi-Cal beneficiaries and uninsured patients. This demonstration project provides for funding, in supplementation of Medi-Cal reimbursement, to various hospitals, including designated public hospitals, nondesignated public hospitals, and private hospitals, as defined, in accordance with certain provisions relating to disproportionate share hospitals.

This bill would provide that, in the event of a partial-year extension of the demonstration project, the director shall have discretion to determine allocations for the extension period, as specified.

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, instead, require that the department make the supplemental payments described above for subject fiscal years, as defined. This bill would make various changes to the formulas used to determine the amount of the supplemental payments to the hospitals.

Existing law provides that no payments shall be made to a converted, private or nondesignated hospital, for the subject federal fiscal year in which the hospital becomes a converted hospital or for subsequent federal fiscal years.

This bill would, instead, provide that no payments shall be made to a converted hospital, as described above, for the portion of the subject fiscal year that begins October 1 and ends June 30, for the subject fiscal year that includes the first day of the subject federal fiscal year in which the hospital becomes a converted hospital, and for all subsequent subject fiscal years.

Existing law requires the director to seek federal approval to allow payments to specified converted, nondesignated public hospitals for the period beginning July 1, 2010, and ending December 31, 2010.

This bill would, instead, require the director to seek federal approval to allow these payments for the period beginning July 1, 2010, and ending June 30, 2011.

Existing law requires that designated public hospitals be paid direct grants in support of health care expenditures, as specified. Under existing law, the aggregate amount of these grants for each subject federal fiscal year shall be $295,000,000.

This bill would, instead, provide that the aggregate amount of the grants shall be $73,750,000 for each subject fiscal quarter, as defined.

Existing law requires the department to increase capitation payments to Medi-Cal managed health care plans and to increase payments to mental health plans, for specified subject federal fiscal years. Under existing law, the aggregate amount of increased capitation payments for a federal fiscal year shall be $729,829,205 multiplied by the percentage of the subject federal fiscal year for which federal approval is obtained, as specified.

This bill would, instead, provide that the increased capitation payments to Medi-Cal managed health care plans shall be made for subject fiscal years, as defined, and that the aggregate amount for all subject fiscal years shall be $1,277,201,209, or the maximum amount for which federal financial participation is available, whichever is lower. This bill would also provide that the aggregate amount of the increased payments to mental health plans for a subject fiscal quarter shall be the total of the individual hospital acute psychiatric supplemental payment amounts for all hospitals for which federal financial participation is available.

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, in a specified order of priority.

This bill would delete the provision that specifies that the fee shall be imposed only as a condition of participation in state-funded health insurance programs. This bill would also modify the order of priority of the purposes for which the money in the Hospital Quality Assurance Revenue Fund shall be appropriated.

Existing law requires the department to seek a demonstration project or federal waiver of Medicaid law to implement specified objectives, which may include better care coordination for seniors and persons with disabilities and children with special health care needs.

This bill would, in this regard, provide that to the extent the provisions under the Medi-Cal Hospital/Uninsured Care Demonstration Project Act do not conflict with the provisions of, or the terms and conditions of, the above-described demonstration project, the provisions of the Medi-Cal Hospital/Uninsured Care Demonstration Project Act shall apply.

This bill would, in furtherance of the waiver or demonstration project and to the extent that federal financial participation is available, permit the department to require seniors and persons with disabilities who do not have other health coverage to be assigned as mandatory enrollees into new and existing managed care health plans, as specified. This bill would provide that enrollment of seniors and persons with disabilities shall be accomplished using a phased-in process and shall not commence until necessary federal approvals have been acquired, or until June 1, 2011, whichever is later. The bill would impose various requirements upon managed care health plans participating in the demonstration project.

This bill would, beginning January 1, 2012, require managed care health plans to comply with quality submission standards developed by the department as prescribed.

This bill would provide that, in implementing the provision described above that would require seniors and persons with disabilities who do not have other health coverage to be assigned as mandatory enrollees into new or existing managed care health plans, a public entity, as defined, may, if specified requirements are met, elect to, on a voluntary basis, participate in intergovernmental transfers to be used solely as the nonfederal share of Medi-Cal payments to managed care health plans for the provision of services to Medi-Cal beneficiaries.

This bill would require, to the extent authorized under a federal waiver or demonstration project described above, the department to develop a program of investment, improvement, and incentive payments for designated public hospitals to encourage and incentivize delivery system transformation and innovation in preparation for the implementation of federal health care reform. This bill would establish the Public Hospital Investment, Improvement, and Incentive Fund in the State Treasury, which shall consist of any moneys transferred by a county, other political subdivision of the state, or other governmental entity in the state for deposit in the fund. The bill would provide that the fund shall be continuously appropriated to the department to be used as the source for the nonfederal share of investment, improvement, and incentive payments to participating designated public hospitals, as specified.

Existing law, the Robert W. Crown California Children's Services Act, requires the department and each county to administer the California Children Services (CCS) program for treatment services for persons under 21 years of age diagnosed with severe chronic disease or severe physical limitations, as specified.

This bill also would, in furtherance of the waiver or demonstration project, require the Director of Health Care Services to establish, by January 1, 2012, models of organized health care delivery systems, as specified, for children eligible for services under the CCS program. This bill would provide that, to the extent permitted by federal law, the department may require eligible individuals to enroll in these models. This bill would also permit the Managed Risk Medical Insurance Board to elect, with the consent of the director, to permit children enrolled in the Healthy Families Program who

are eligible for CCS services to enroll in these organized health care delivery models.

This bill would become operative only if AB 342 of the 2009–10 Regular Session of the Legislature is enacted.

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 14089.07 is added to the Welfare and Institutions Code, to read:

14089.07. (a) The Sacramento County Department of Health and Human Services may establish a stakeholder advisory committee to provide input on the delivery of health care services provided in the county pursuant to this article, Section 14182, and Part 3.6 (commencing with Section 15909). The advisory committee shall include, but not be limited to, Medi-Cal beneficiaries, patient representatives, health care providers, and representatives of Medi-Cal managed care health plans.

(b) The advisory committee may submit written input to the State Department of Health Care Services regarding policies that improve coordination with traditional and safety net providers, enhance the capacity of the county's health care delivery system, and improve health care services and health outcomes.

(c) The advisory committee may request, in writing, and receive final reports submitted to the department by any managed care health plan operating in Sacramento County as long as the report is not exempt from disclosure pursuant to Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, or any other contractual, statutory, or legal exemption, or privilege. The advisory committee may review and provide written comments to the department on these reports, that may include issues such as evaluation of access, quality, and consumer protections.

(d) No state General Fund moneys shall be used to fund advisory committee costs, nor to fund any related administrative costs incurred by the county.

SEC. 2. Section 14105.24 of the Welfare and Institutions Code is amended to read:

14105.24. (a) Clinics and hospital outpatient departments, except for emergency rooms, owned or operated by Los Angeles County that participated in the California Section 1115 Medicaid Demonstration Project for Los Angeles County (No. 11-W-00076/9) and received 100 percent cost-based reimbursement pursuant to the Special Terms and Conditions of that waiver shall continue to be reimbursed under a cost-based methodology on and after July 1, 2005.

(b) Reimbursement to clinics and hospitals described in subdivision (a) shall be at 100 percent of reasonable and allowable costs for Medi-Cal services rendered to Medi-Cal beneficiaries. Reasonable and allowable costs shall be determined in accordance with applicable cost-based reimbursement provisions of the following regulations and publications:

(1) The Medicare reimbursement methodology as specified at Sections 405.2460 to 405.2470, inclusive, of Title 42 of the Code of Federal Regulations, together with applicable definitions in Subpart X of Part 405 of Title 42 of the Code of Federal Regulations to the extent those definitions are applied by the department in connection with payments to federally qualified health centers in California.

(2) Cost reimbursement principles outlined in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations. In the event of a conflict between the provisions of Part 405 and Part 413, the provisions of Part 405 shall govern.

(3) "Cost Principles for State, Local, and Indian Tribe Governments" (OMB Circular A-87).

(4) "Rural Health and FQHC Manual" (CMS Publication 27).

(5) Subdivision (e) of Section 14087.325 and any implementing regulations.

(c) The methodology for reimbursement adopted by the state to comply with Section 1396a(aa) of Title 42 of the United States Code shall not be applicable to clinics and hospitals that are paid pursuant to this section.

(d) This section shall be implemented on the effective date established by the federal Centers for Medicare and Medicaid Services for an amendment to the California Medicaid State Plan that approves the cost-based reimbursement methodology for the clinics and hospitals described in subdivision (b).

(e) (1) Payments received by clinics and hospital outpatient departments described in subdivision (a), for services rendered to populations described in Section 14182, shall be equivalent to what otherwise would have been received under this section on a fee-for-service basis.

(2) This subdivision shall be implemented only to the extent permitted under federal law and when federal financial participation is available.

(f) Notwithstanding subdivision (a) of Section 14105, and the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer the cost-based rates of reimbursement described in this section by means of provider bulletins or manuals, or similar instructions.

SEC. 3. Section 14132.275 is added to the Welfare and Institutions Code, to read:

14132.275. (a) The department shall seek federal approval to establish pilot projects described in this section pursuant to a Medicare or a Medicaid demonstration project or waiver, or a combination thereof. Under a Medicare demonstration, the department may operate the Medicare component of a pilot project as a delegated Medicare benefit administrator, and may enter

into financing arrangements with the federal Centers for Medicare and Medicaid Services to share in any Medicare program savings generated by the operation of any pilot project.

(b) After federal approval is obtained, the department shall establish pilot projects that enable dual eligibles to receive a continuum of services, and that maximize the coordination of benefits between the Medi-Cal and Medicare programs and access to the continuum of services needed. The purpose of the pilot projects is to develop effective health care models that integrate services authorized under the federal Medicaid Program (Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.)) and the federal Medicare Program (Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.)). These pilot projects may also include additional services as approved through a demonstration project or waiver, or a combination thereof.

(c) Not sooner than March 1, 2011, the department shall identify health care models that may be included in a pilot project, shall develop a timeline and process for selecting, financing, monitoring, and evaluating these pilot projects, and shall provide this timeline and process to the appropriate fiscal and policy committees of the Legislature. The department may implement these pilot projects in phases.

(d) Goals for the pilot projects shall include all of the following:

(1) Coordinating Medi-Cal benefits, Medicare benefits, or both, across health care settings and improving continuity of acute care, long-term care, and home- and community-based services.

(2) Coordinating access to acute and long-term care services for dual eligibles.

(3) Maximizing the ability of dual eligibles to remain in their homes and communities with appropriate services and supports in lieu of institutional care.

(4) Increasing the availability of and access to home- and community-based alternatives.

(e) Pilot projects shall be established in up to four counties, and shall include at least one county that provides Medi-Cal services via a two-plan model pursuant to Article 2.7 (commencing with Section 14087.3) and at least one county that provides Medi-Cal services under a county organized health system pursuant to Article 2.8 (commencing with Section 14087.5). In determining the counties in which to establish a pilot project, the director shall consider the following:

(1) Local support for integrating medical care, long-term care, and home- and community-based services networks.

(2) A local stakeholder process that includes health plans, providers, community programs, consumers, and other interested stakeholders in the development, implementation, and continued operation of the pilot project.

(f) The director may enter into exclusive or nonexclusive contracts on a bid or negotiated basis and may amend existing managed care contracts to provide or arrange for services provided under this section. Contracts entered into or amended pursuant to this section shall be exempt from the provisions

of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government Code.

(g) Services under Section 14132.95, 14132.952, or Article 7 (commencing with Section 12300) of Chapter 3 that are provided under the pilot projects established by this section shall be provided through direct hiring of personnel, contract, or establishment of a public authority or nonprofit consortium, in accordance with, and subject to, the requirements of Section 12302 or 12301.6, as applicable.

(h) Notwithstanding any other provision of state law, the department may require that dual eligibles be assigned as mandatory enrollees into managed care plans established or expanded as part of a pilot project established under this section. Mandatory enrollment in managed care for dual eligibles shall be applicable to the beneficiary's Medi-Cal benefits only. Dual eligibles shall have the option to enroll in a Medicare Advantage special needs plan (SNP) offered by the managed care plan established or expanded as part of a pilot project established pursuant to (e). To the extent that mandatory enrollment is required, any requirement of the department and the health plans, and any requirement of continuity of care protections for enrollees, as specified in Section 14182, shall be applicable to this section. Dual eligibles shall have the option to forgo receiving Medicare benefits under a pilot project. Nothing in this section shall be interpreted to reduce benefits otherwise available under the Medi-Cal program or the Medicare Program.

(i) For purposes of this section, a "dual eligible" means an individual who is simultaneously eligible for full scope benefits under Medi-Cal and the federal Medicare Program.

(j) Persons meeting requirements for Program of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter 8.75 (commencing with Section 14590), may select a PACE plan if one is available in that county.

(k) Notwithstanding Section 10231.5 of the Government Code, the department shall conduct an evaluation to assess outcomes and the experience of dual eligibles in these pilot projects and shall provide a report to the Legislature after the first full year of pilot operation, and annually thereafter. A report submitted to the Legislature pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code. The department shall consult with stakeholders regarding the scope and structure of the evaluation.

(*l*) This section shall be implemented only if and to the extent that federal financial participation or funding is available to establish these pilot projects.

(m) 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, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with

stakeholders, including advocates, providers, and beneficiaries. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

SEC. 4. Section 14166.252 is added to the Welfare and Institutions Code, to read:

14166.252. (a) In the event of a partial year extension of a demonstration project pursuant to this article, the director shall have discretion to determine allocations for the extension period on either an annual or partial year basis, consistent with any requirements in the letter from the federal Centers for Medicare and Medicaid Services granting the extension.

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

SEC. 5. Section 14167.1 of the Welfare and Institutions Code is amended to read:

14167.1. For purposes of this article, the following definitions shall apply:

(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) "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.

(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 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 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 or waiver shall be the earlier of the stated effective date or the first day of the first quarter to which the computation of the payments or fee under the federal approval or waiver is applicable, which may be prior to the date that the federal approval or waiver is granted or the applicable contract is amended.

(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 county organized health systems 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).

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

(i) 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.

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

(iii) Long-Term Care Demonstration Projects for All-Inclusive Care for the Elderly operating pursuant to Chapter 8.75 (commencing with Section 14590).

(*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 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 fiscal quarter" means a fiscal quarter beginning on or after the implementation date and ending before January 1, 2011.

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

(v) "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.

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

(x) "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. 6. 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 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 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 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 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) 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 portion of the subject fiscal year that begins on October 1 and ends on June 30 for the subject fiscal year that includes the first day of the subject federal fiscal year in which the hospital becomes a converted hospital, and for all subsequent subject fiscal years. In the event of a conflict between the provisions of this subdivision and the terms of a state plan amendment required for the receipt of approval by the federal Centers for Medicare and Medicaid Services, the state plan amendment shall control.

(g) In the event that the amounts payable as calculated under subdivision (b) for the 2008–09 subject fiscal year are reduced by the operation of subdivision (c) and the ratio for the 2008–09 subject fiscal year described in paragraph (2) of subdivision (c) is less than 0.25, the difference between 25 percent of the amounts payable as calculated under subdivision (b) and the amounts payable after the application of subdivision (c) shall be added to the supplemental payments for each private hospital calculated under subdivision (b) for the 2009–10 subject fiscal year.

(h) In the event that the amounts payable as calculated under subdivision (b) for the 2009–10 subject fiscal year, including any carryover amounts determined under subdivision (g), are reduced by the operation of subdivision (c), the difference between the amounts payable as calculated under subdivision (b), including any carryover amounts, and the amounts payable after the application of subdivision (c) shall be added to the supplemental payments for each private hospital calculated under subdivision (b) for the 2010–11 subject fiscal year.

SEC. 7. 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 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 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 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 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 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 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 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 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 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 fiscal year exceeds the amount for which federal financial participation is available for that hospital, the amount due to the hospital for that 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 portion of the subject fiscal year that begins on October 1 and ends on June 30 for the subject fiscal year that includes the first day of the subject federal fiscal year in which the hospital becomes a converted hospital, and for all subsequent subject fiscal years. In the event of a conflict between the provisions of this subdivision and the terms of a state plan amendment required for receipt of approval by the federal Centers for Medicare and Medicaid Services, the state plan amendment shall control.

(i) In the event that the amounts payable as calculated under subdivision (b) for the 2008–09 subject fiscal year are reduced by the operation of subdivision (d) and the ratio for the 2008–09 subject fiscal year described in subparagraph (B) of paragraph (1) of subdivision (d) is less than 0.25, the difference between 25 percent of the amounts payable as calculated under subdivision (b) and the amounts payable after the application of subdivision (d) shall be added to the supplemental payments for each private hospital calculated under subdivision (b) for the 2009–10 subject fiscal year.

(j) In the event that the amounts payable as calculated under subdivision (b) for the 2009–10 subject fiscal year, including any carryover amounts determined under subdivision (i), are reduced by the operation of subdivision (d), the difference between the amounts payable as calculated under subdivision (b), including any carryover amounts, and the amounts payable after the application of subdivision (d) shall be added to the supplemental payments for each private hospital calculated under subdivision (b) for the 2010–11 subject fiscal year.

(k) In the event that the amounts payable as calculated under subdivision (c) for the 2008–09 subject fiscal year are reduced by the operation of subdivision (d) and the ratio for the 2008–09 subject fiscal year described in subparagraph (B) of paragraph (2) of subdivision (d) is less than 0.25, the difference between 25 percent of the amounts payable as calculated under subdivision (c) and the amounts payable after the application of

subdivision (d) shall be added to the supplemental payments for each private hospital calculated under subdivision (c) for the 2009–10 subject fiscal year.

(*l*) In the event that the amounts payable as calculated under subdivision (c) for the 2009–10 subject fiscal year, including any carryover amounts determined under subdivision (k), are reduced by the operation of subdivision (d), the difference between the amounts payable as calculated under subdivision (c), including any carryover amounts, and the amounts payable after the application of subdivision (d) shall be added to the supplemental payments for each private hospital calculated under subdivision (c) for the 2010–11 subject fiscal year.

SEC. 8. Section 14167.4 of the Welfare and Institutions Code is amended to read:

14167.4. (a) Nondesignated public hospitals shall be paid supplemental amounts for the provision of hospital inpatient 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 (f) and (g), each nondesignated public hospital shall be paid the following amounts for each subject fiscal year:

(1) Two hundred eighteen dollars and eighty-two cents ($218.82) 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.

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

(1) The total amount payable to nondesignated public 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 nondesignated public 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) In the event 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 federal fiscal year shall be reduced to the amount for which federal financial participation is available.

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

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

(g) (1) No payments shall be made under this section to a converted hospital for the portion of the subject fiscal year that begins on October 1 and ends on June 30 for the subject fiscal year that includes the first day of the subject federal fiscal year in which the hospital becomes a converted hospital, and for all subsequent subject fiscal years. In the event of a conflict between the provisions of this subdivision and the terms of a state plan amendment required for receipt of approval by the federal Centers for Medicare and Medicaid Services, the state plan amendment shall control.

(2) Notwithstanding paragraph (1), the director shall seek federal approval to allow payments to be made under this section for the period beginning July 1, 2010, and ending June 30, 2011, to a converted hospital which is a hospital described in paragraph (2) of subdivision (p) of Section 14167.1, and shall make payments under this section consistent with any approvals, subject to all of the following:

(A) Federal approval shall be sought after all final federal approvals necessary to implement this article and Article 5.22 (commencing with Section 14167.31) are received by the department.

(B) The director shall have determined prior to seeking federal approval that obtaining federal approval and implementing the payments described in this paragraph will not jeopardize the implementation of this article or Article 5.22 (commencing with Section 14167.31), or delay any payments to hospitals and managed health care plans under this article or Article 5.22 (commencing with Section 14167.31), or the collection of the quality assurance fee from hospitals under Article 5.22 (commencing with Section 14167.31), beyond December 31, 2010.

(C) The director shall withdraw any request for federal approval made under this paragraph if, after submitting the request, the director has determined that obtaining federal approval and implementing the payments described in this paragraph will jeopardize the implementation of this article or Article 5.22 (commencing with Section 14167.31) or delay any payments to hospitals and managed health care plans under this article or Article 5.22, (commencing with Section 14167.31) or the collection of the quality assurance fee from hospitals under Article 5.22, (commencing with Section 14167.31) beyond December 31, 2010.

(h) In the event that the amounts payable as calculated under subdivision (b) for the 2008–09 subject fiscal year are reduced by the operation of subdivision (c) and the ratio for the 2008–09 subject fiscal year described in paragraph (2) of subdivision (c) is less than 0.25, the difference between 25 percent of the amounts payable as calculated under subdivision (b) and the amounts payable after the application of subdivision (c) shall be added to the supplemental payments for each nondesignated public hospital calculated under subdivision (b) for the 2009–10 subject fiscal year.

(i) In the event that the amounts payable as calculated under subdivision (b) for the 2009–10 subject fiscal year, including any carryover amounts determined under subdivision (h), are reduced by the operation of subdivision (c), the difference between the amounts payable as calculated under subdivision (b), including any carryover amounts, and the amounts payable

after the application of subdivision (c) shall be added to the supplemental payments for each nondesignated public hospital calculated under subdivision (b) for the 2010–11 subject fiscal year.

SEC. 9. 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 fiscal quarter shall be seventy-three million seven hundred and fifty thousand dollars ($73,750,000).

(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 fiscal quarter 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 fiscal quarter 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 three.

(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 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 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 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 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 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) Notwithstanding subdivision (a) and subject to subdivisions (g) and (h) of Section 14166.221, the state may retain for the state's use the funds described in subdivision (a) that would otherwise be payable pursuant to subdivision (c) of Section 14167.9 in an aggregate amount not to exceed four hundred twenty million dollars ($420,000,000) for the period in which this article and Article 5.22 (commencing with Section 14167.31) are in effect, provided that the state allocates to the designated public hospitals an equal amount of federal funds available under the Medi-Cal Hospital/Uninsured Care Demonstration Project pursuant to subdivision (c) of Section 14166.221, and the state has determined, after consultation with the designated public hospitals, that the designated public hospitals, or the governmental entities with which they are affiliated, have incurred sufficient expenditures so that the full amount allocated can be received as federal matching funds. Federal funds allocated to the designated public hospitals

under this subdivision and claimed under subdivision (g) of Section 14166.221 shall be distributed among the designated public hospitals in accordance with subdivision (b).

(f) In the event that the amounts payable as calculated under paragraph (1) of subdivision (d) for the 2008–09 subject fiscal year are reduced by the operation of paragraph (2) of subdivision (d) and the ratio for the 2008–09 subject fiscal year described in subparagraph (B) of paragraph (2) of subdivision (d) is less than 0.25, the difference between 25 percent of the amounts payable as calculated under paragraph (1) of subdivision (d) and the amounts payable after the application of paragraph (2) of subdivision (d) shall be added to the supplemental payments for each private hospital calculated under paragraph (1) of subdivision (d) for the 2009–10 subject fiscal year.

(g) In the event that the amounts payable as calculated under paragraph (1) of subdivision (d) for the 2009–10 subject fiscal year, including any carryover amounts determined under subdivision (f), are reduced by the operation of paragraph (2) of subdivision (d), the difference between the amounts payable as calculated under paragraph (1) of subdivision (d), including any carryover amounts, and the amounts payable after the application of paragraph (2) of subdivision (d) shall be added to the supplemental payments for each private hospital calculated under paragraph (1) of subdivision (d) for the 2010–11 subject fiscal year.

SEC. 10. 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 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 all subject fiscal years shall be one billion two hundred seventy-seven million two hundred one thousand two hundred nine dollars ($1,277,201,209), or the maximum amount for which federal financial participation is available, whichever is lower.

(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) (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 no later than December 31, 2010, 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 Fee Fund for the purpose of funding managed 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 care payments by December 1, 2010. To the extent feasible, the funds shall be accumulated as follows, provided that the department may adjust the following dates and amounts as necessary to accumulate sufficient funding by December 1, 2010:

(A) Thirty percent of total necessary funding shall be accumulated from each of the first three installments of quality assurance fees received from the hospitals.

(B) Ten percent of total funding necessary shall be retained from the fourth installment of quality assurance fees received from the hospitals.

(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.

(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 California Medical Assistance Commission.

(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. 11. Section 14167.8 of the Welfare and Institutions Code is amended to read:

14167.8. The payments to a hospital under this article shall not be made for a subject fiscal year or any portion of a subject fiscal year 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 acute inpatients for at least 30 consecutive days. A hospital's payments under this article for a subject fiscal year during which a hospital is closed for a portion of the subject fiscal year shall be reduced by applying a fraction, expressed as a percentage, the numerator of which shall be the number of days after the implementation date during the subject fiscal year that the hospital is closed and the denominator of which is the number of days in the subject fiscal year after the implementation date.

SEC. 12. Section 14167.9 of the Welfare and Institutions Code is amended 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 subject fiscal years in seven payments.

(2) (A) The first payment shall be made on or before the later of September 30, 2010, or the 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 14th and 30th days of October, November, and December 2010, or the 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. 13. 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. 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) For each subject 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.

SEC. 14. 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 fiscal years as set forth in this section. The aggregate amount of the increased payments for a subject fiscal quarter shall be the total of the individual hospital acute psychiatric supplemental payment amounts for all hospitals for which federal financial participation is available.

(b) For each subject fiscal quarter, the state shall make increased payments to each mental health plan. The department shall consider the composition of Medi-Cal enrollees in the mental health plan, the anticipated utilization of hospital services by the mental health 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 mental health plan's enrollees.

(c) The state shall make increased payments to mental health plans exclusively for the purpose of making 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 payments to mental health plans shall be made as follows:

(1) The increased 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 payments shall be made on the last day of the second month of each quarter. The last increased payments made pursuant to this section shall be made during November 2010.

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

(3) The increased payments made during November 2010 shall include payments computed under subdivision (b) for all quarters in the 2010–11 subject fiscal year to the extent that federal financial participation is available for the payments.

(4) If all necessary federal approvals are not received on or before September 1, 2010, the department shall make semimonthly payments starting within one month of receipt of all necessary federal approvals until December 31, 2010.

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

(e) In the event federal financial participation for a subject fiscal year is not available for all of the increased acute psychiatric payments determined for a quarter pursuant to this section for any reason, the increased 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) Notwithstanding any other provision of this article or Article 5.22 (commencing with Section 14167.31), individual hospital acute psychiatric supplemental payments under this section and Section 14167.12 may be made directly by the department to hospitals in accordance with Section 14167.9 when federal law does not require that the payments be transmitted to the hospitals via mental health plans.

(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.

(i) The amount, if any, by which the aggregate individual hospital acute psychiatric supplemental payment amounts for a subject fiscal quarter, including any carryover amount under this subdivision, exceeds the amount for which federal financial participation is available for that quarter due to the application of a federal upper payment limit shall be added to the aggregate individual hospital acute psychiatric supplemental payment

amounts for the succeeding subject fiscal quarter. In the event there is a carryover amount for the subject fiscal quarter ending December 31, 2010, the amount shall be payable under this section for the quarter ending March 31, 2011, and, if necessary due to the application of a federal upper payment limit, the quarter ending June 30, 2011.

SEC. 15. 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 payment to a mental health plan under Section 14167.11, the state shall notify the mental health plan that the plan shall make payments to each subject hospital located in each county in which the mental health plan operates as a consequence of receiving the increased payment.

(b) The 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.

(c) For each subject fiscal year, the sum of all payments made by a mental health plan to subject hospitals pursuant to this section shall equal all increased payments received by the mental health plan from the state pursuant to Section 14167.11.

(d) 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.

(e) 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.

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

(g) In the event federal financial participation for a quarter is not available for all of the increased mental health payments made pursuant to Section 14167.11 for any reason, the 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. 16. 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 subject 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) Subject to Section 14167.352, 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. Notwithstanding any other provision of law, 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 cover the nonfederal share of 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. 16.5. Section 14167.31 of the Welfare and Institutions Code is amended to read:

14167.31. For the purposes of this article, the following definitions shall apply:

(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 annual 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 mean a hospital described 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, 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 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 Sections 14167.6 and 14167.11, including payments made directly to hospitals pursuant to subdivision (g) of Section 14167.11, for which federal financial participation is available and the denominator of which is two billion nine hundred eighty-two million one hundred twenty thousand five hundred sixty dollars ($2,982,120,560).

(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 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 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 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 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 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.

(v) "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.

(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 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.

(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) "Subject fiscal quarter" means a state fiscal quarter ending after the implementation date, as defined in Section 14167.1, and beginning before January 1, 2011.

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

(ad) "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. 17. 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, provided that a quality assurance fee under this article 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) Subject to Section 14167.352, 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 on or before the date that payment is due, the department may the following day immediately begin to 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 provided that the following amendments to this article or Article 5.21 (commencing with Section 14167.1) made during the 2010 portion of the 2009–10 Regular Session, or included in Senate Bill 208 of the 2009–10 Regular Session, shall control for purposes of this section:

(1) Amendments affecting the timing of the fee to be imposed or the payments to be made to a hospital or hospital group.

(2) Amendments affecting the amount of fee to be imposed on a hospital or hospital group, or the amount or method of payments to be made to any hospital or hospital group that are contained in Assembly Bill 1653, if enacted in the 2009–10 Regular Session, or arise from, or have as a basis, 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 or Article 5.21 (commencing with Section 14167.1).

(3) Amendments modifying the priority given to Medi-Cal managed care payments.

(4) Amendments modifying the responsibility of nonexempt hospitals to make fee payments.

(*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.

(n) (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 healthcare 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.

SEC. 18. 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 (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. 18.5. Section 14167.354 of the Welfare and Institutions Code is amended to read:

14167.354. (a) (1) Upon receipt of a letter that indicates likely federal approval that the director determines is sufficient for implementation under Section 14167.352, or upon the receipt of all final federal approvals necessary for the implementation of this article and Article 5.21 (commencing with Section 14167.1), the following shall occur:

(A) 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 14167.2, 14167.3, 14167.4, 14167.6, and 14167.11, and subdivision (d) of Section 14167.5, including, but not limited to, supplemental payments and increased capitation payments, prior to January 1, 2011.

(B) The department shall make supplemental payments to hospitals under Article 5.21 (commencing with Section 14167.1) consistent with the timeframe described in Section 14167.9 or a modified timeline developed pursuant to Section 14167.353.

(2) (A) In determining the amount available for the nonfederal share of payments in a particular payment cycle, the department shall deduct no more than the following amounts to account for the priority payments to the state under paragraph (2) of subdivision (c) of Section 14167.35:

(i) Eighty million dollars ($80,000,000) for children's health coverage for each subject fiscal quarter for which some or all supplemental payments to hospitals have already been made.

(ii) Eighty million dollars ($80,000,000) for children's health coverage for each subject fiscal quarter for which supplemental payments are being

calculated to be paid to hospitals, subject to the availability of funding, in the current payment cycle.

(B) Notwithstanding any other provision of law, in determining the amount available for the nonfederal share of payments in a payment cycle described in subparagraph (A), the department shall not consider any payments for children's health care coverage previously made under paragraph (2) of subdivision (c) of Section 14167.35.

(3) (A) In determining the amount available in a particular payment cycle, the department shall deduct no more than the following amounts whether made directly to the designated public hospitals or retained by the state:

(i) Seventy-three million seven hundred fifty thousand dollars ($73,750,000) for each subject fiscal quarter for which some or all supplemental payments to hospitals have already been made.

(ii) Seventy-three million seven hundred fifty thousand dollars ($73,750,000) for each subject fiscal quarter for which supplemental payments are being calculated to be paid to hospitals, subject to the availability of funding, in the current payment cycle.

(B) Notwithstanding any other provision of law, in determining the amount available for a payment cycle described in subparagraph (A), the department shall not consider any payments of direct grants previously made to the designated public hospitals or transferred to the state from the Quality Assurance Revenue Fund under Section 14167.5 to account for the direct grants described in Section 14167.5.

(b) Notwithstanding any other provision of this article or Article 5.21 (commencing with Section 14167.1), if the director determines, on or after December 15, 2010, that there are insufficient funds available in the Hospital Quality Assurance Revenue Fund to make all scheduled payments under Article 5.21 (commencing with Section 14167.1) by the end of the 2010 calendar year, he or she shall consult with representatives of the hospital community to develop an acceptable plan for making additional payments to providers in the first two quarters of 2011 to maximize the use of delinquent fee payments or other deposits or interest projected to become available in the fund after December 15, 2010, but before June 30, 2011.

(c) Nothing in this section shall require the department to continue to make payments under Article 5.21 (commencing with Section 14167.1) if, after the consultation required under subdivision (b), the director determines in the exercise of his or her sole discretion that a workable plan for the continued payments cannot be developed.

(d) Subdivisions (b) and (c) shall be implemented only if and to the extent federal financial participation is available for continued supplemental payments to providers.

(e) 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.

(f) Nothing in this section shall be read as affecting the department's ongoing authority to continue, after December 31, 2010, to collect quality assurance fees imposed on or before December 31, 2010.

SEC. 19. Section 14182 of the Welfare and Institutions Code is amended and renumbered to read:

14182.9. Notwithstanding the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the provisions of this article through all-county welfare director letters or similar instruction, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries, in implementing, interpreting, or making specific this article. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

SEC. 20. Section 14182 is added to the Welfare and Institutions Code, to read:

14182. (a) (1) In furtherance of the waiver or demonstration project developed pursuant to Section 14180, the department may require seniors and persons with disabilities who do not have other health coverage to be assigned as mandatory enrollees into new or existing managed care health plans. To the extent that enrollment is required by the department, an enrollee's access to fee-for-service Medi-Cal shall not be terminated until the enrollee has been assigned to a managed care health plan.

(2) For purposes of this section:

(A) "Other health coverage" means health coverage providing the same full or partial benefits as the Medi-Cal program, health coverage under another state or federal medical care program, or health coverage under contractual or legal entitlement, including, but not limited to, a private group or indemnification insurance program.

(B) "Managed care health plan" means an individual, organization, or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.81 (commencing with Section 14087.96), Article 2.91 (commencing with Section 14089), or Chapter 8 (commencing with Section 14200).

(b) In exercising its authority pursuant to subdivision (a), the department shall do all of the following:

(1) Assess and ensure the readiness of the managed care health plans to address the unique needs of seniors or persons with disabilities pursuant to the applicable readiness evaluation criteria and requirements set forth in paragraphs (1) to (8), inclusive, of subdivision (b) of Section 14087.48.

(2) Ensure the managed care health plans provide access to providers that comply with applicable state and federal laws, including, but not limited to, physical accessibility and the provision of health plan information in alternative formats.

(3) Develop and implement an outreach and education program for seniors and persons with disabilities, not currently enrolled in Medi-Cal managed care, to inform them of their enrollment options and rights under the demonstration project. Contingent upon available private or public dollars other than moneys from the General Fund, the department or its designated agent for enrollment and outreach may partner or contract with community-based, nonprofit consumer or health insurance assistance organizations with expertise and experience in assisting seniors and persons with disabilities in understanding their health care coverage options. Contracts entered into or amended pursuant to this paragraph shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and any implementing regulations or policy directives.

(4) At least three months prior to enrollment, inform beneficiaries who are seniors or persons with disabilities, through a notice written at no more than a sixth grade reading level, about the forthcoming changes to their delivery of care, including, at a minimum, how their system of care will change, when the changes will occur, and who they can contact for assistance with choosing a delivery system or with problems they encounter. In developing this notice, the department shall consult with consumer representatives and other stakeholders.

(5) Implement an appropriate cultural awareness and sensitivity training program regarding serving seniors and persons with disabilities for managed care health plans and plan providers and staff in the Medi-Cal Managed Care Division of the department.

(6) Establish a process for assigning enrollees into an organized delivery system for beneficiaries who do not make an affirmative selection of a managed care health plan. The department shall develop this process in consultation with stakeholders and in a manner consistent with the waiver or demonstration project developed pursuant to Section 14180. The department shall base plan assignment on an enrollee's existing or recent utilization of providers, to the extent possible. If the department is unable to make an assignment based on the enrollee's affirmative selection or utilization history, the department shall base plan assignment on factors, including, but not limited to, plan quality and the inclusion of local health care safety net system providers in the plan's provider network.

(7) Review and approve the mechanism or algorithm that has been developed by the managed care health plan, in consultation with their stakeholders and consumers, to identify, within the earliest possible timeframe, persons with higher risk and more complex health care needs pursuant to paragraph (11) of subdivision (c).

(8) Provide managed care health plans with historical utilization data for beneficiaries upon enrollment in a managed care health plan so that the plans participating in the demonstration project are better able to assist beneficiaries and prioritize assessment and care planning.

(9) Develop and provide managed care health plans participating in the demonstration project with a facility site review tool for use in assessing

the physical accessibility of providers, including specialists and ancillary service providers that provide care to a high volume of seniors and persons with disabilities, at a clinic or provider site, to ensure that there are sufficient physically accessible providers. Every managed care health plan participating in the demonstration project shall make the results of the facility site review tool publicly available on their Internet Web site and shall regularly update the results to the department's satisfaction.

(10) Develop a process to enforce legal sanctions, including, but not limited to, financial penalties, withholding of Medi-Cal payments, enrollment termination, and contract termination, in order to sanction any managed care health plan in the demonstration project that consistently or repeatedly fails to meet performance standards provided in statute or contract.

(11) Ensure that managed care health plans provide a mechanism for enrollees to request a specialist or clinic as a primary care provider. A specialist or clinic may serve as a primary care provider if the specialist or clinic agrees to serve in a primary care provider role and is qualified to treat the required range of conditions of the enrollee.

(12) Ensure that managed care health plans participating in the demonstration project are able to provide communication access to seniors and persons with disabilities in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language interpreters, captioning, pad and pencil, plain language or written translations and oral interpreters, including for those who are limited English-proficient, or non-English speaking, and that all managed care health plans are in compliance with applicable cultural and linguistic requirements.

(13) Ensure that managed care health plans participating in the demonstration project provide access to out-of-network providers for new individual members enrolled under this section who have an ongoing relationship with a provider if the provider will accept the health plan's rate for the service offered, or the applicable Medi-Cal fee-for-service rate, whichever is higher, and the health plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues.

(14) Ensure that managed care health plans participating in the demonstration project comply with continuity of care requirements in Section 1373.96 of the Health and Safety Code.

(15) Ensure that the medical exemption criteria applied in counties operating under Chapter 4.1 (commencing with Section 53800) or Chapter 4.5 (commencing with Section 53900) of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations are applied to seniors and persons with disabilities served under this section.

(16) Ensure that managed care health plans participating in the demonstration project take into account the behavioral health needs of enrollees and include behavioral health services as part of the enrollee's care management plan when appropriate.

(17) Develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the subset of enrollees who are seniors and persons with disabilities. These performance measures may include measures from the Healthcare Effectiveness Data and Information Set (HEDIS) or measures indicative of performance in serving special needs populations, such as the National Committee for Quality Assurance (NCQA) Structure and Process measures, or both.

(18) Conduct medical audit reviews of participating managed care health plans that include elements specifically related to the care of seniors and persons with disabilities. These medical audits shall include, but not be limited to, evaluation of the delivery model's policies and procedures, performance in utilization management, continuity of care, availability and accessibility, member rights, and quality management.

(19) Conduct financial audit reviews to ensure that a financial statement audit is performed on managed care health plans annually pursuant to the Generally Accepted Auditing Standards, and conduct other risk-based audits for the purpose of detecting fraud and irregular transactions.

(c) Prior to exercising its authority under this section and Section 14180, the department shall ensure that each managed care health plan participating in the demonstration project is able to do all of the following:

(1) Comply with the applicable readiness evaluation criteria and requirements set forth in paragraphs (1) to (8), inclusive, of subdivision (b) of Section 14087.48.

(2) Ensure and monitor an appropriate provider network, including primary care physicians, specialists, professional, allied, and medical supportive personnel, and an adequate number of accessible facilities within each service area. Managed care health plans shall maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients and shall make it available to enrollees, at a minimum, by phone, written material, or Internet Web site.

(3) Assess the health care needs of beneficiaries who are seniors or persons with disabilities and coordinate their care across all settings, including coordination of necessary services within and, where necessary, outside of the plan's provider network.

(4) Ensure that the provider network and informational materials meet the linguistic and other special needs of seniors and persons with disabilities, including providing information in an understandable manner in plain language, maintaining toll-free telephone lines, and offering member or ombudsperson services.

(5) Provide clear, timely, and fair processes for accepting and acting upon complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits. Each managed care health plan participating in the demonstration project shall have a grievance process that complies with Section 14450, and Sections 1368 and 1368.01 of the Health and Safety Code.

(6) Solicit stakeholder and member participation in advisory groups for the planning and development activities related to the provision of services for seniors and persons with disabilities.

(7) Contract with safety net and traditional providers as defined in subdivisions (hh) and (jj) of Section 53810, of Title 22 of the California Code of Regulations, to ensure access to care and services. The managed care health plan shall establish participation standards to ensure participation and broad representation of traditional and safety net providers within a service area.

(8) Inform seniors and persons with disabilities of procedures for obtaining transportation services to service sites that are offered by the plan or are available through the Medi-Cal program.

(9) Monitor the quality and appropriateness of care for children with special health care needs, including children eligible for, or enrolled in, the California Children Services Program, and seniors and persons with disabilities.

(10) Maintain a dedicated liaison to coordinate with each regional center operating within the plan's service area to assist members with developmental disabilities in understanding and accessing services and act as a central point of contact for questions, access and care concerns, and problem resolution.

(11) At the time of enrollment apply the risk stratification mechanism or algorithm described in paragraph (7) of subdivision (b) approved by the department to determine the health risk level of beneficiaries.

(12) (A) Managed health care plans shall assess an enrollee's current health risk by administering a risk assessment survey tool approved by the department. This risk assessment survey shall be performed within the following timeframes:

(i) Within 45 days of plan enrollment for individuals determined to be at higher risk pursuant to paragraph (11).

(ii) Within 105 days of plan enrollment for individuals determined to be at lower risk pursuant to paragraph (11).

(B) Based on the results of the current health risk assessment, managed care health plans shall develop individual care plans for higher risk beneficiaries that shall include the following minimum components:

(i) Identification of medical care needs, including primary care, specialty care, durable medical equipment, medications, and other needs with a plan for care coordination as needed.

(ii) Identification of needs and referral to appropriate community resources and other agencies as needed for services outside the scope of responsibility of the managed care health plan.

(iii) Appropriate involvement of caregivers.

(iv) Determination of timeframes for reassessment and, if necessary, circumstances or conditions that require redetermination of risk level.

(13) (A) Establish medical homes to which enrollees are assigned that include, at a minimum, all of the following elements, which shall be considered in the provider contracting process:

(i) A primary care physician who is the primary clinician for the beneficiary and who provides core clinical management functions.

(ii) Care management and care coordination for the beneficiary across the health care system including transitions among levels of care.

(iii) Provision of referrals to qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the managed care health plan.

(iv) Use of clinical data to identify beneficiaries at the care site with chronic illness or other significant health issues.

(v) Timely preventive, acute, and chronic illness treatment in the appropriate setting.

(vi) Use of clinical guidelines or other evidence-based medicine when applicable for treatment of beneficiaries' health care issues or timing of clinical preventive services.

(B) In implementing this section, and the terms and conditions of the demonstration project, the department may alter the medical home elements described in this paragraph as necessary to secure the increased federal financial participation associated with the provision of medical assistance in conjunction with a health home, as made available under the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and codified in Section 1945 of Title XIX of the federal Social Security Act. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to alter medical home elements under this section at least five days in advance of taking this action.

(14) Perform, at a minimum, the following care management and care coordination functions and activities for enrollees who are seniors or persons with disabilities:

(A) Assessment of each new enrollee's risk level and health needs shall be conducted through a standardized risk assessment survey by means such as telephonic, Web-based, or in-person communication or by other means as determined by the department.

(B) Facilitation of timely access to primary care, specialty care, durable medical equipment, medications, and other health services needed by the enrollee, including referrals for any physical or cognitive barriers to access.

(C) Active referral to community resources or other agencies for needed services or items outside the managed care health plans responsibilities.

(D) Facilitating communication among the beneficiaries' health care providers, including mental health and substance abuse providers when appropriate.

(E) Other activities or services needed to assist beneficiaries in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health status.

(d) Except in a county where Medi-Cal services are provided by a county organized health system, and notwithstanding any other provision of law, in any county in which fewer than two existing managed care health plans

contract with the department to provide Medi-Cal services under this chapter, the department may contract with additional managed care health plans to provide Medi-Cal services for seniors and persons with disabilities and other Medi-Cal beneficiaries.

(e) Beneficiaries enrolled in managed care health plans pursuant to this section shall have the choice to continue an established patient-provider relationship in a managed care health plan participating in the demonstration project if his or her treating provider is a primary care provider or clinic contracting with the managed care health plan and agrees to continue to treat that beneficiary.

(f) The department, or as applicable, the California Medical Assistance Commission, may contract with existing managed care health plans to operate under the demonstration project to provide or arrange for services under this section. Notwithstanding any other provision of law, the department, or as applicable, the commission, may enter into the contract without the need for a competitive bid process or other contract proposal process, provided the managed care health plan provides written documentation that it meets all qualifications and requirements of this section.

(g) This section shall be implemented only to the extent that federal financial participation is available.

(h) (1) The development of capitation rates for managed care health plan contracts shall include the analysis of data specific to the seniors and persons with disabilities population. For the purposes of developing capitation rates for payments to managed care health plans, the director may require managed care health plans, including existing managed health care plans, to submit financial and utilization data in a form, time, and substance as deemed necessary by the department.

(2) Notwithstanding Section 14301, the department may incorporate, on a one-time basis for a three-year period, a risk sharing mechanism in a contract with the local initiative health plan in the county with the highest normalized fee-for-service risk score over the normalized managed care risk score listed in Table 1.0 of the Medi-Cal Acuity Study Seniors and Persons with Disabilities (SPD) report written by Mercer Government Human Services Consulting and dated September 28, 2010. The Legislature finds and declares that this risk sharing mechanism will limit the risk of beneficial or adverse effects associated with a contract to furnish services pursuant to this section on an at-risk basis.

(i) Persons meeting participation requirements for the Program of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter 8.75 (commencing with Section 14590), may select a PACE plan if one is available in that county.

(j) Persons meeting the participation requirements in effect on January 1, 2010, for a Medi-Cal primary care case management (PCCM) plan in operation on that date, may select that PCCM plan or a successor health care plan that is licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division

2 of the Health and Safety Code) to provide services within the same geographic area that the PCCM plan served on January 1, 2010.

(k) 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, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

(*l*) Consistent with state law that exempts Medi-Cal managed care contracts from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code, and in order to achieve maximum cost savings, the Legislature hereby determines that an expedited contract process is necessary for contracts entered into or amended pursuant to this section. The contracts and amendments entered into or amended pursuant to this section shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and the requirements of State Administrative Management Manual Memo 03-10. The department shall make the terms of a contract available to the public within 30 days of the contract's effective date.

(m) In the event of a conflict between the terms and conditions of the approved demonstration project, including any attachment thereto, and any provision of this part, the terms and conditions shall control. If the department identifies a specific provision of this article that conflicts with a term or condition of the approved waiver or demonstration project, or an attachment thereto, the term or condition shall control, and the department shall so notify the appropriate fiscal and policy committees of the Legislature within 15 business days.

(n) In the event of a conflict between the provisions of this article and any other provision of this part, the provisions of this article shall control.

(o) Any otherwise applicable provisions of this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14500) not in conflict with this article or with the terms and conditions of the demonstration project shall apply to this section.

(p) To the extent that the director utilizes state plan amendments or waivers to accomplish the purposes of this article in addition to waivers granted under the demonstration project, the terms of the state plan amendments or waivers shall control in the event of a conflict with any provision of this part.

(q) (1) Enrollment of seniors and persons with disabilities into a managed care health plan under this section shall be accomplished using a phased-in process to be determined by the department and shall not commence until

necessary federal approvals have been acquired or until June 1, 2011, whichever is later.

(2) Notwithstanding paragraph (1), and at the director's discretion, enrollment in Los Angeles County of Seniors and persons with disabilities may be phased-in over a 12-month period using a geographic region method that is proposed by Los Angeles County subject to approval by the department.

(r) A managed care health plan established pursuant to this section, or under the terms and conditions of the demonstration project pursuant to Section 14180, shall be subject to, and comply with, the requirement for submission of encounter data specified in Section 14182.1.

(s) (1) Commencing January 1, 2011, and until January 1, 2014, the department shall provide the fiscal and policy committees of the Legislature with semiannual updates regarding core activities for the enrollment of seniors and persons with disabilities into managed care health plans pursuant to the pilot program. The semiannual updates shall include key milestones, progress towards the objectives of the pilot program, relevant or necessary changes to the program, submittal of state plan amendments to the federal Centers for Medicare and Medicaid Services, submittal of any federal waiver documents, and other key activities related to the mandatory enrollment of seniors and persons with disabilities into managed care health plans. The department shall also include updates on the transition of individuals into managed care health plans, the health outcomes of enrollees, the care management and coordination process, and other information concerning the success or overall status of the pilot program.

(2) (A) The requirement for submitting a report imposed under paragraph (1) is inoperative on January 1, 2015, pursuant to Section 10231.5 of the Government Code.

(B) A report to be submitted pursuant to paragraph (1) shall be submitted in compliance with Section 9795 of the Government Code.

(t) The department, in collaboration with the State Department of Social Services and county welfare departments, shall monitor the utilization and caseload of the In-Home Supportive Services (IHSS) program before and during the implementation of the pilot program. This information shall be monitored in order to identify the impact of the pilot program on the IHSS program for the affected population.

(u) Services under Section 14132.95 or 14132.952, or Article 7 (commencing with Section 12300) of Chapter 3 that are provided to individuals assigned to managed care health plans under this section shall be provided through direct hiring of personnel, contract, or establishment of a public authority or nonprofit consortium, in accordance with and subject to the requirements of Section 12302 or 12301.6, as applicable.

(v) The department shall, at a minimum, monitor on a quarterly basis the adequacy of provider networks of the managed care health plans.

(w) The department shall suspend new enrollment of seniors and persons with disabilities into a managed care health plan if it determines that the

managed care health plan does not have sufficient primary or specialty providers to meet the needs of their enrollees.

SEC. 21. Section 14182.1 is added to the Welfare and Institutions Code, to read:

14182.1. (a) Beginning March 2011, the department shall convene a stakeholder workgroup to review the existing encounter, claims, and financial data submission process required by the department under managed care health plan contracts. The workgroup members shall be selected by the department and shall include interested representatives from Medi-Cal managed care health plans, managed care health plan associations, hospitals, individual health care providers, physician groups, and consumer representatives. In reviewing the process, the department shall consider input from the stakeholder workgroup and develop data quality submission standards by October 2011.

(b) Beginning January 1, 2012, managed care health plans shall comply with the quality submission standards developed pursuant to subdivision (a) when submitting data to the department. The director may impose a penalty for each month that a managed care health plan fails to submit data in compliance with these standards. The penalty shall be in proportion to that plan's failure to comply with the data submission standards, as the director in his or her sole discretion determines, and in no event shall the penalty exceed 2 percent of the total monthly capitation rate for that plan or alternative model.

(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, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance. If the department elects to adopt regulations, the adoption of regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

SEC. 22. Section 14182.15 is added to the Welfare and Institutions Code, to read:

14182.15. (a) It is the intent of the Legislature that, to the extent that it does not jeopardize other federal funding and is permitted by federal law, the intergovernmental transfers described in this section provide support for the nonfederal share of risk-based payments to managed care health plans to enable those plans to compensate designated public hospitals in a sufficient amount to preserve and strengthen the availability and quality of services provided by those hospitals and their affiliated public providers. It is further the intent of the Legislature that transferring public entities elect to provide intergovernmental transfers in an amount that is at least equivalent

to the amount of the nonfederal share that they would provide under fee-for-service, as adjusted for utilization.

(b) (1) In conjunction with the implementation of Section 14182, a public entity may elect to transfer public funds to the state to be used solely as the nonfederal share of Medi-Cal payments to managed care health plans for the provision of services to Medi-Cal beneficiaries.

(2) For purposes of this section, "public entity" means a designated public hospital as defined in subdivision (d) of Section 14166.1, the University of California, or a county or city and county or local hospital authority that is licensed to operate one or more of the designated public hospitals.

(c) If a public entity elects to make intergovernmental transfers pursuant to this section, all of the following shall apply:

(1) To ensure that the implementation of Section 14182 does not jeopardize the ability of designated public hospitals and their affiliated public providers to continue serving Medi-Cal beneficiaries, to the extent permitted under federal law, the department shall require managed care health plans to pay the designated public hospital and other governmental providers affiliated with the transferring public entity for services rendered to Medi-Cal beneficiaries, amounts that are no less than the amount to which the providers would have otherwise been entitled, including the federal and nonfederal share, on a fee-for-service basis, for the full scope of Medi-Cal services, including supplemental payments and any additional federally permissible amount. The payment amounts required by this paragraph shall be based upon the volume of Medi-Cal services provided by the designated public hospitals and other governmental providers affiliated with the transferring public entity.

(2) Except as provided in Section 14105.24, to the extent that the payments described in paragraph (1) result in increased payments by the managed care health plans to the designated public hospitals and other governmental providers affiliated with the transferring public entity that are the basis of increased rates paid by the department to the managed care health plans above the amount that would have been paid in the absence of paragraph (1), the nonfederal share of the increased rates shall be borne by the transferring entity as described in subdivision (d) and there shall be no additional impact on state General Fund expenditures. Additionally, the payment rates shall only be paid to the extent they can be certified as actuarially sound and as permitted under federal law.

(d) The department shall meet and confer with the public entities regarding their election to contribute to the nonfederal share of federal Medicaid expenditures under this section and to determine each public entity's intergovernmental transfer amount, which shall be comprised of the following:

(1) An amount that is equivalent to the nonfederal share of the rates of compensation the public entity's designated public hospital would receive from managed care health plans, without regard to the requirement of paragraph (1) of subdivision (c), for Medi-Cal inpatient days of service that otherwise would have been rendered on a fee-for-service basis in the absence

of the implementation of Section 14182 to Medi-Cal enrollees who are seniors and persons with disabilities.

(2) An amount that is equivalent to the nonfederal share of the amount which the designated public hospital and other governmental providers affiliated with the transferring entity would have otherwise incurred on a fee-for-service basis for providing Medi-Cal services to the Medi-Cal managed care health plan enrollees they serve, including supplemental payments, excluding the nonfederal share of those amounts the plan will pay for the services without regard to the requirement of paragraph (1) of subdivision (c), and consistent with Section 14105.24, to the extent otherwise applicable.

(3) Amounts equivalent to the nonfederal share of additional federally permissible payments.

(e) Prior to accepting the transfer amounts from a public entity determined under subdivision (d), the department shall ensure that its contracts with the applicable managed care health plans and the contracts between the managed care health plans and the public entities require, to the extent permitted under federal law, that the managed care health plans pay the designated public hospitals, and other governmental providers affiliated with the transferring entities, amounts that are in furtherance of the intent of this section as described in subdivision (a) and consistent with what the designated public hospital and other governmental providers affiliated with the transferring public entity would have received through fee-for-service, and that the payment amounts meet the requirement of paragraph (1) of subdivision (c).

(f) The department shall obtain federal approvals or waivers as necessary to implement this section and to obtain federal matching funds to the maximum extent permitted by federal law.

(g) Participation in intergovernmental transfers under this section is voluntary on the part of the transferring entity for purposes of all applicable federal laws. As part of its voluntary participation in the nonfederal share of payments under this section by means of intergovernmental transfers, the transferring entity agrees to reimburse the state for the nonfederal share of state staffing or administrative costs directly attributable to implementation of this section. This section shall be implemented only to the extent federal financial participation is not jeopardized.

SEC. 23. Section 14182.2 is added to the Welfare and Institutions Code, to read:

14182.2. (a) Notwithstanding Section 14094.3, in furtherance of the waiver or demonstration project developed pursuant to Section 14180, the director shall establish, by January 1, 2012, organized health care delivery models for children eligible for California Children Services (CCS) under Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code. These models shall be chosen from the following:

(1) An enhanced primary care case management program.

(2) A provider-based accountable care organization.

(3) A specialty health care plan.

(4) A Medi-Cal managed care plan that includes payment and coverage for CCS-eligible conditions.

(b) Each model shall do all of the following:

(1) Establish clear standards and criteria for participation, exemption, enrollment, and disenrollment.

(2) Provide care coordination that links children and youth with special health care needs with appropriate services and resources in a coordinated manner to achieve optimum health.

(3) Establish networks that include CCS-approved providers and maintain the current system of regionalized pediatric specialty and subspecialty services to ensure that children and youth have timely access to appropriate and qualified providers.

(4) Coordinate out-of-network access if appropriate and qualified providers are not part of the network or in the region.

(5) Ensure that children enrolled in the model receive care for their CCS-eligible medical conditions from CCS-approved providers consistent with the CCS standards of care.

(6) Participate in a statewide quality improvement collaborative that includes stakeholders.

(7) (A) Establish and support medical homes, incorporating all of the following principles:

(i) Each child has a personal physician.

(ii) The medical home is a physician-directed medical practice.

(iii) The medical home utilizes a whole child orientation.

(iv) Care is coordinated or integrated across all of the elements of the health care system and the family and child's community.

(v) Information, education, and support to consumers and families in the program is provided in a culturally competent manner.

(vi) Quality and safety practices and measures.

(vii) Provides enhanced access to care, including access to after-hours care.

(viii) Payment is structured appropriately to recognize the added value provided to children and their families.

(B) In implementing this section, and the terms and conditions of the demonstration project, the department may alter the medical home principles described in this paragraph as necessary to secure the increased federal financial participation associated with the provision of medical assistance in conjunction with a health home, as made available under the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and codified in Section 1945 of Title XIX of the federal Social Security Act. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to alter medical home principles under this section at least five days in advance of taking this action.

(8) Provide the department with data for quality monitoring and improvement measures, as determined necessary by the department. The department shall institute quality monitoring and improvement measures that are appropriate for children and youth with special health care needs.

(c) The services provided under these models shall not be limited to medically necessary services required to treat the CCS-eligible medical condition.

(d) Notwithstanding any other provision of law, and to the extent permitted by federal law, the department may require eligible individuals to enroll in these models.

(e) At the election of the Managed Risk Medical Insurance Board, and with the consent of the director, children enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, who are eligible for CCS under Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, may enroll in the organized health care delivery models established under this section.

(f) For the purposes of implementing this section, the department shall seek proposals to establish and test these models of organized health care delivery systems, may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, and may amend existing managed care contracts to provide or arrange for services under this section. Contracts may be statewide or on a more limited geographic basis. Contracts entered into or amended under this section shall be exempt from the provisions of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government Code.

(g) (1) Entities contracting with the department under this section shall report expenditures for the services provided under the contract.

(2) If a contractor is paid according to a capitated or risk-based payment methodology, the rates shall be actuarially sound and take into account care coordination activities.

(h) (1) The department shall conduct an evaluation to assess the effectiveness of each model in improving the delivery of health care services for children who are eligible for CCS. The department shall consult with stakeholders in developing an evaluation for the models being tested.

(2) The evaluation process shall begin simultaneously with the development and implementation of the model delivery systems to compare the care provided to, and outcomes of, children enrolled in the models with those not enrolled in the models. The evaluation shall include, at a minimum, an assessment of all of the following:

(A) The types of services and expenditures for services.

(B) Improvement in the coordination of care for children.

(C) Improvement in the quality of care.

(D) Improvement in the value of care provided.

(E) The rate of growth of expenditures.

(F) Parent satisfaction.

(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, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

SEC. 24. Section 14182.3 is added to the Welfare and Institutions Code, to read:

14182.3. (a) To the extent the provisions of Article 5.2 (commencing with Section 14166) do not conflict with the provisions of this article or the terms and conditions of the new demonstration project created under this article, the provisions of Article 5.2 (commencing with Section 14166) shall continue to apply to the new demonstration project.

(b) In the event of a conflict between any provision of this article and the special terms and conditions required by the federal Centers for Medicare and Medicaid Services for the approval of the demonstration project described in Section 14180, the special terms and conditions shall control.

(c) (1) Under the demonstration project described in Section 14180, the state shall have priority to claim against and retain the first five hundred million dollars ($500,000,000) in federal funds using expenditures incurred under state-only programs or other programs for which the state is authorized to claim under the terms and conditions of the demonstration project.

(2) Notwithstanding paragraph (1), if the director determines that the amount of base funding available under the demonstration project described in Section 14180 is less than the six hundred eighty-one million six hundred forty thousand dollars ($681,640,000) available to public hospitals under the original demonstration project, the state may reallocate an amount from the five hundred million dollars ($500,000,000) described in paragraph (1) to increase the amount of base funding under the new demonstration project to six hundred eighty one million six hundred forty thousand dollars ($681,640,000).

(3) For purposes of this section, the term "base funding" includes funding for the safety net care pool or a similar pool or fund for health coverage expansion, and for an investment, incentive, or similar pool, but shall not include funds made available to hospitals or counties for inpatient or outpatient Medi-Cal reimbursements, expansion of managed care for seniors and persons with disabilities, or other expansions of systems of care for individuals who are eligible under the Medi-Cal state plan.

(d) The director shall have authority to maximize available federal financial participation under the demonstration project described in Section 14180, including, but not limited to, authorizing the use of intergovernmental transfers by district hospitals that are not reimbursed under a contract

negotiated pursuant to the Selective Provider Contracting Program, to fund the nonfederal share of expenditures to the extent permitted by the terms and conditions of the demonstration project.

(e) Participation in intergovernmental transfers under this section is voluntary on the part of the transferring entity for purposes of all applicable federal laws. As part of its voluntary participation in the nonfederal share of payments under this subdivision by means of intergovernmental transfers, the transferring entity agrees to reimburse the state for the nonfederal share of state staffing or administrative costs directly attributable to the state's implementation of these voluntary intergovernmental transfers. This subdivision shall be implemented only to the extent federal financial participation is not jeopardized.

(f) 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, the department may clarify, interpret, or implement the provisions of this section by means of provider bulletins or similar instructions. The department shall notify the fiscal and appropriate policy committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

SEC. 25. Section 14182.4 is added to the Welfare and Institutions Code, to read:

14182.4. (a) To the extent authorized under a federal waiver or demonstration project described in Section 14180 that is approved by the federal Centers for Medicare and Medicaid Services, the department shall establish a program of investment, improvement, and incentive payments for designated public hospitals to encourage and incentivize delivery system transformation and innovation in preparation for the implementation of federal health care reform.

(b) The Public Hospital Investment, Improvement, and Incentive Fund is hereby established in the State Treasury. Notwithstanding Section 13340 of the Government Code, moneys in the fund shall be continuously appropriated, without regard to fiscal years, to the department for the purposes specified in this section.

(c) The fund shall consist of any moneys that a county, other political subdivision of the state, or other governmental entity in the state that may elect to transfer to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.

(d) Moneys in the fund shall be used as the source for the nonfederal share of investment, improvement, and incentive payments as authorized under a federal waiver or demonstration project to participating designated public hospitals defined in subdivision (d) of Section 14166.1, and the governmental entities with which they are affiliated, that provide the intergovernmental transfers for deposit into the fund.

(e) The department shall obtain federal financial participation for moneys in the fund to the full extent permitted by law. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance

with the terms and conditions of the waiver or demonstration project. The moneys disbursed from the fund, and all associated federal financial participation, shall be distributed solely to the designated public hospitals and the governmental entities with which they are affiliated.

(f) Participation under this section is voluntary on the part of the county or other political subdivision for purposes of all applicable federal laws. As part of its voluntary participation in the nonfederal share of payments under this section, the county or other political subdivision agrees to reimburse the state for the nonfederal share of state staffing or administrative costs directly attributable to implementation of this section. This section shall be implemented only to the extent federal financial participation is not jeopardized.

(g) 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, the department may clarify, interpret, or implement the provisions of this section by means of provider bulletins or similar instructions. The department shall notify the fiscal and appropriate policy committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

SEC. 26. The Legislature finds and declares all of the following:

(a) The Legislature continues to recognize the essential role that safety net hospitals play in serving the state's most vulnerable populations, including Medi-Cal beneficiaries and the uninsured. To that end, it has been, and remains, the intent of the Legislature to preserve funding for, and to support, the entire hospital safety net and to obtain all available federal funds for all hospitals.

(b) Recent federal health care reform measures provide, among other things, various programs and funding to expand access to care. These measures will result in numerous policy changes intended to improve delivery of care, achieve greater efficiencies, and increase the accountability and risk borne by hospitals. Payers may include payment incentives and disincentives that are designed to move towards risk-based models to achieve greater effectiveness and efficiencies in delivering health care services.

(c) It is the intent of the Legislature that funding provided to designated public hospitals, private disproportionate share hospitals, and nondesignated public hospitals, through a future hospital quality assurance fee and under a new waiver, is implemented with the goals of creating balance and equity among these hospital groups and increasing access to care. It is also the intent of the Legislature to maximize federal funds with the goal of providing predictable and stable funding to all hospitals to improve their financial viability and provide access to health care services. Hospitals must have sufficient resources to provide more efficient care through the use of various delivery models and achieving other health care reform goals.

(d) It is the intent of the Legislature that the elements addressing balance and equity among the hospital groups include all of the following:

(1) Measurement of the achievement of acceptable levels of the respective Medi-Cal federal upper payment limits.

(2) Measurement of uncompensated and undercompensated care.

(3) Consideration of the source and potential risks of the nonfederal share.

(4) Consideration of the requirements associated with particular funding sources, including whether funding is risk-based.

(5) Consideration of the services that are included in the current waiver pursuant to Article 5.2 (commencing with Section 14166) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(6) With respect to the state fiscal year of the demonstration beginning on July 1, 2011, and periodically thereafter, additional reevaluations shall be considered by the State Department of Health Care Services, in consultation with the hospital community, to determine if there has been a significant change in state or federal Medicaid policy or reimbursement to safety net hospitals resulting in a loss of balance equity among and between the hospitals. The department shall report to the Legislature the findings of any reevaluations it elects to conduct, including proposed changes to the distribution structure no more than once each state fiscal year.

(e) Achievement of balance and equity among the hospital groups is necessary to address all of the following:

(1) Maintaining and expanding access through improved Medi-Cal reimbursement and reducing the uncompensated cost burden for the uninsured borne by safety net hospitals.

(2) The need to support safety net hospitals in advance of health care reform implementation in California.

(3) The goal of providing longer term stability to safety net hospitals.

(f) Given the ongoing negotiations with the federal Centers for Medicare and Medicaid Services on a new Section 1115 Medicaid waiver, the development of the specific mechanisms to achieve the stated goals of this section requires future legislation.

SEC. 27. This act shall become operative only if Assembly Bill 342 of the 2009–10 Regular Session of the Legislature is enacted.

SEC. 28. 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 changes to state funded health care programs at the earliest possible time, it is necessary that this act take effect immediately.

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