AMENDED IN ASSEMBLY SEPTEMBER 6, 2013

AMENDED IN ASSEMBLY AUGUST 27, 2013

AMENDED IN ASSEMBLY AUGUST 14, 2013

AMENDED IN SENATE APRIL 17, 2013

SENATE BILL No. 239

Introduced by Senators Hernandez and Steinberg

February 12, 2013

An act to amend Sections 14164, 14165, and 14167.35 of, to add Section 14167.37 to, and to add and repeal Article 5.230 (commencing with Section 14169.51) and Article 5.231 (commencing with Section 14169.71) of Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to Medi-Cal, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 239, as amended, Hernandez. Medi-Cal: hospitals: quality assurance fee.

(1) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law, subject to federal approval, imposes a quality assurance fee, as specified, on certain general acute care hospitals from July 1, 2011, through December 31, 2013. Existing law, subject to federal approval, requires the fee to be deposited into the Hospital Quality Assurance Revenue Fund, and requires that the moneys in the fund be used, upon appropriation by the Legislature, only for certain purposes, including, among other things, paying for health

care coverage for children and making supplemental payments for certain services to private hospitals, increased capitation payments to Medi-Cal managed care plans, and increased payments to mental health plans.

This bill would, subject to federal approval, impose a hospital quality assurance fee, as specified, on certain general acute care hospitals from January 1, 2014, through December 31, 2015, to be deposited into the Hospital Quality Assurance Revenue Fund. This bill would, subject to federal approval, provide that moneys in the Hospital Quality Assurance Revenue Fund shall be continuously appropriated and available only for certain purposes, including paying for health care coverage for children, as specified, and making supplemental payments for certain services to private hospitals and increased capitation payments to Medi-Cal managed care plans. The bill would also ~~authorize~~ *require* the payment of direct grants to designated and nondesignated public hospitals in support of health care expenditures funded by the quality assurance fee. The bill would require the department to make available all public documentation it uses to administer and audit these provisions. The bill would require the department to post specified documents on its Internet Web site relating to these provisions.

The bill would provide that if quality assurance fee payments are remitted to the department after the date determined by the department to be the final date for calculating the final supplemental payments, the fee payments shall be retained in the fund for purposes of funding supplemental payments supported by a hospital quality assurance fee program under subsequent legislation, but if supplemental payments are not implemented under subsequent legislation, then those quality assurance fee payments shall be returned to the private hospitals pro rata, as specified. The bill would also provide that if amounts of the quality assurance fees are collected in excess of the funds required to make the payments above and federal rules prohibit the department from refunding the fee payments to the general acute care hospitals, the excess funds shall be returned to the private hospitals pro rata, as specified. The bill would make other conforming changes.

(2) Existing law provides that any county, other political subdivision of the state, or governmental entity in the state may elect to transfer funds in the form of cash or loans to the department in support of the Medi-Cal program. Existing law provides the department discretion to accept or not accept any elective transfer from a county, political

subdivision, or other governmental entity for purposes of obtaining federal financial participation.

This bill would authorize the Director of Health Care Services to maximize federal financial participation to provide access to services provided by hospitals that are not reimbursed by certified public expenditure, as specified, by authorizing the use of intergovernmental transfers to fund the nonfederal share of supplemental payments as permitted under federal law.

(3) Existing law requires that the California Medical Assistance Commission be dissolved after June 30, 2012, and requires that, upon dissolution of the commission, all powers, duties, and responsibilities of the commission be transferred to the Director of Health Care Services. Existing law provides that upon a determination by the director that a payment system based on diagnosis-related groups, as described, has been developed and implemented, the powers, duties, and responsibilities conferred on the commission and transferred to the director shall no longer be exercised, except as specified.

This bill would add to those exceptions by authorizing the director to continue to administer and distribute payments for the Construction and Renovation Reimbursement Program, which provides supplemental reimbursement to hospitals that contract under the selective provider contracting program or with a county organized health system, as specified. The bill would provide that maintaining or negotiating a selective provider contract or a contract with a county organized health system shall cease to be a requirement for a hospital's participation in the Construction and Renovation Reimbursement Program.

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

Vote: $\frac{2}{3}$. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. The Legislature finds and declares both of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) "Converted hospital" means a private hospital that becomes a designated public hospital or a nondesignated public hospital on or after January 1, 2014.

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

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

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

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

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

(h) "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 2010 calendar year, as reflected in the state paid claims file prepared by the department on April 26, 2013.

(i) "Hospital community" means any general acute care hospital and any hospital industry organization that represents general acute care hospitals.

(j) "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.

(k) "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.

(*l*) (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 2.82 (commencing with Section 14087.98).

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

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

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

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

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

(m) "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 2012–13 fiscal year, as calculated by the department as of December 17, 2012.

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

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

(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 most recently filed Annual Financial Disclosure Report as of January 1, 2014, and satisfies the definition in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(2) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's most recently filed Annual Financial Disclosure Report as of January 1, 2014, 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 2010 calendar year, as reflected in the state paid claims file prepared by the department on April 26, 2013.

(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 most recently filed Office of Statewide Health Planning and Development Annual Financial Disclosure Report as of January 1, 2014.

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

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

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

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

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

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

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

(w) "Transplant days" means the number of Medi-Cal days, as defined in subdivision (q) of Section 14169.71, for MS-DRGs 1, 2, 5 to 10, inclusive, 14, 15, and 652, according to the 2010 Patient Discharge file from the Office of Statewide Health Planning and Development accessed on June 28, 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. The applicable upper payment limit shall be separately calculated for inpatient and outpatient hospital services.

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

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

(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 payment limit or for any other reason, both of the following shall apply:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) If 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 payment limit or for any other reason, both of the following shall apply:

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

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

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

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

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

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

14169.54. (a) The department shall increase capitation payments to Medi-Cal managed health care plans for each subject month 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 each subject fiscal year, or portion thereof in the program period, shall be the maximum amount for which federal financial participation is available on an aggregate statewide basis for the applicable subject fiscal year, or portion thereof in the program period.

(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 ensure access to high-quality hospital services by the plan's enrollees.

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

(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 within 90 days of the date on which all necessary federal approvals have been received, and shall include, but not be limited to, the sum of the increased payments for all prior months for which payments are due.

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

(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, including, but not limited to, payments described in Section 14182.15, shall not be reduced as a consequence of payments 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 department.

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

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

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

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

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

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

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

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

14169.56. (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 5.231 (commencing with Section 14169.71).

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

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

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

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

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

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

among plans pursuant to a methodology developed in consultation with the hospital community.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Amend the contracts between the managed health care plans and the department as necessary to incorporate the provisions of Sections 14169.54 and 14169.55 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 5.231 (commencing with Section 14169.71), and shall not wait for federal approval of this article or Article 5.231 (commencing with Section 14169.71) prior to pursuing amendments to the contracts. The amendments to the contracts shall, among other provisions, set forth an agreement to increase capitation payments to managed health care plans under Section 14169.54 and increase payments to hospitals under Section 14169.55 in a manner that relates back to January 1, 2014, 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 5.231 (commencing with Section 14169.71) 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 Section 14169.52 or ~~Section~~ 14169.53 cannot be implemented. This paragraph shall not apply to a final judicial determination made by any court of appellate jurisdiction in a case brought by hospitals located outside the State of California.

(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, 2016, the implementation of Section 14169.52, Section 14169.53, or the quality assurance fee established pursuant to Article 5.231 (commencing with Section 14169.71).

(B) Section 14169.52, Section 14169.53, or Article 5.231 (commencing with Section 14169.71) cannot be modified by the department pursuant to subdivision (e) of Section 14169.73 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, initiates a case or proceeding in any state or federal court in which the hospital seeks any relief of any sort whatsoever, including, but not limited to, monetary relief, injunctive relief, declaratory relief,

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

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

(2) Any amount computed to be payable to the hospital pursuant to this article 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 14169.74, no payment shall be made under this article until all necessary federal approvals for the payment and for the fee provisions in Article 5.231 (commencing with Section 14169.71) have been obtained and the fee has been imposed and collected. Notwithstanding any other law, payments under this article shall be made only to the extent that the fee established in Article 5.231 (commencing with Section 14169.71) is collected and available to cover the nonfederal share of the payments.

(g) 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.

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

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

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

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

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

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

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

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

(1) January 1, 2017.

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

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

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

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

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

14169.66. 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 article by means of policy letters or similar instructions, without taking further regulatory action.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Article 5.231. Private Hospital Quality Assurance Fee Act of 2013

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

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

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

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

(d) "Converted hospital" means a hospital described in subdivision (b) of Section 14169.51.

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

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

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

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

(i) "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 most recently filed Office of Statewide Health Planning and Development Hospital Annual Financial Disclosure Report as of January 1, 2014.

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

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

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

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

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

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

(*l*) "Fee-for-service days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric 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.

(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 general acute care hospital and any hospital industry organization that represents general acute care hospitals.

(o) "Managed care days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric 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 one hundred forty-five dollars ($145) per day for the 2014 calendar year and one hundred seventy dollars ($170) per day for the 2015 calendar year.

(q) "Medi-Cal days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric 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 where the service type is reported as "acute care," "psychiatric 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 when the service type is reported as "acute care," "psychiatric 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 four hundred seventy-six dollars and twenty-three cents ($476.23) per day for the 2014 calendar year and five hundred forty-seven dollars and sixty-eight cents ($547.68) for the 2015 calendar year.

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

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

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

(2) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's most recently filed Annual Financial Disclosure Report as of January 1, 2014, 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.

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

(x) "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 eighty-one dollars and twenty cents ($81.20) per day for the 2014 calendar year and ninety-five dollars and twenty cents ($95.20) per day for the 2015 calendar year.

(y) "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 two hundred sixty-six dollars and sixty-nine cents ($266.69) per day for the 2014 calendar year and three hundred six dollars and seventy cents ($306.70) per day for the 2015 calendar year.

(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 most recently filed Office of Statewide Health Planning and Development Annual Financial Disclosure Report as of January 1, 2014.

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

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

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

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

(ab) "Quality assurance fee" means the quality assurance fee assessed pursuant to Section 14169.72 and collected on the basis of the quarterly quality assurance fee.

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

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

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

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

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

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

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

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

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

(ad) "Subject fiscal quarter" means a state fiscal quarter during the program period.

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

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

14169.72. (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 the periods when the hospital is a public hospital or a new hospital.

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

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

(1) Within 10 business 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 the following information:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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, to limit 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 Section 14169.60 on the effective date of that section, and to otherwise comply with all its obligations set forth in Article 5.230 (commencing with Section 14169.51) and this article provided that amendments that arise from, or have as a basis for, a decision, advice, or determination by the federal Centers for Medicare and Medicaid Services relating to federal approval of the quality assurance fee or the payments set forth in this article or Article 5.230 (commencing with Section 14169.51) shall control for the purposes of this subdivision.

(*l*) (1) Effective January 1, 2016, 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 5.230 (commencing with Section 14169.51).

(2) The supplemental payments and other payments under Article 5.230 (commencing with Section 14169.51) 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

subdivision (e) of Section 14169.78, 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 returned to the private hospitals pro rata based on each hospital's total fee payments under this article to the extent consistent with federal law.

(d) Any methodology or other provision specified in Article 5.230 (commencing with Section 14169.51) or 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 5.230 (commencing with Section 14169.51) or this article and are not inconsistent with the conditions of implementation set forth in Section 14169.80.

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

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

(g) 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 5.230 (commencing with Section 14169.51) 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Nothing in this section shall require the department to continue to make payments under Article 5.230 (commencing with Section 14169.51) 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 and to providers and continued increased capitation payments to managed health care plans.

(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,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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, 2016, the implementation of Sections 14169.52 and 14169.53 or this article.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) For purposes of this section, "financial disadvantage to the state" means either of the following:

(1) A loss of federal financial participation.

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

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

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

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

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

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

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

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

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

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

14169.81. 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 article by means of policy letters or similar instructions, without taking further regulatory action.

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

(1) January 1, 2017.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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