WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000 - 15771] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 7. Basic Health Care [14000 - 14199.87] *(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

ARTICLE 5.229. Private Hospital Quality Assurance Fee Act of 2011 [14169.31 - 14169.42] *(Article 5.229 added by Stats. 2011, Ch. 286, Sec. 8.)*

14169.31. For the purposes of this article, the following definitions shall apply:

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

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

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

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

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

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

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

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

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

(3) “Aggregate quality assurance fee after the application of the fee percentage” means the aggregate quality assurance fee multiplied by the fee percentage for each subject fiscal year.

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

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

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

(e) “Converted hospital” shall mean a hospital described in subdivision (b) of Section 14169.1.

(f) “Days data source” means the hospital’s Annual Financial Disclosure Report filed with the Office of Statewide Health Planning and Development as of May 5, 2011, for its fiscal year ending during 2009.

(g) “Designated public hospital” shall have the meaning given in subdivision (d) of Section 14166.1 as of January 1, 2011.

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

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

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

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

(2) With the exception of a hospital that is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, a hospital that is a hospital designated as a specialty hospital in the hospital’s Office of Statewide Health Planning and Development Hospital Annual Financial Disclosure Report for the hospital’s fiscal year ending in the 2009 calendar year.

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

(4) A small and rural hospital as specified in Section 124840 of the Health and Safety Code designated as that in the hospital’s Office of Statewide Health Planning and Development Hospital Annual Financial Disclosure Report for the hospital’s fiscal year ending in the 2009 calendar year.

(i) “Federal approval” means the approval by the federal government of both the quality assurance fee established pursuant to this article and the supplemental payments to private hospitals described in Sections 14169.2 and 14169.3.

(j) (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 eight dollars and thirty-six cents ($308.36) per day.

(3) Upon federal approval or conditional federal approval described in Section 14169.34, 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 5.228 (commencing with Section 14169.1), in consultation with the hospital community.

(k) “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.

(l) “Fee percentage” means a fraction, expressed as a percentage, the numerator of which is the amount of payments for each subject fiscal year under Sections 14169.2, 14169.3, 14169.5, and 14169.7.5, for which federal financial participation is available and the denominator of which is four billion eight hundred sixty-six million seven hundred four thousand one hundred fifteen dollars ($4,866,704,115).

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

(n) “Hospital community” means any hospital industry organization or system that represents 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 eighty-six dollars and forty cents ($86.40) per day.

(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 where 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 three hundred eighty-three dollars and twenty cents ($383.20) per day.

(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 liability owed to the state in connection with the Medi-Cal program and the new operator did not assume liability for the outstanding monetary obligation.

(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 Annual Financial Disclosure Report for the hospital’s latest fiscal year ending in 2009, and satisfies the definition in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(2) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital’s Annual Financial Disclosure Report for the hospital’s latest fiscal year ending in 2009, 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.

(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 forty-eight dollars and thirty-eight cents ($48.38) per day.

(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 fourteen dollars and fifty-nine cents ($214.59) per day.

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

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

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

(2) Is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, or is not designated as a specialty hospital in the hospital’s Office of Statewide Health Planning and Development Annual Financial Disclosure Report for the hospital’s latest fiscal year ending in 2009.

(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.

(ab) “Program period” means the period from July 1, 2011, to December 31, 2013, inclusive.

(ac) “Subject fiscal quarter” means a state fiscal quarter during the program period.

(ad) “Subject fiscal year” means a state fiscal year that ends after July 1, 2011, and begins before January 1, 2014.

(ae) “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.

(Amended by Stats. 2012, Ch. 452, Sec. 10. (SB 920) Effective September 22, 2012. Conditionally inoperative as provided in Sections 14169.38 (subd. (d), para. (1)) and 14169.40, or on date prescribed in Section 14169.41. Repealed on or after January 1, 2015, as provided in Section 14169.41.)

14169.32. (a) There shall be imposed on each general acute care hospital that is not an exempt facility a quality assurance fee, provided that a quality assurance fee under this article shall not be imposed on a converted hospital.

(b) The quality assurance fee shall be computed starting on July 1, 2011, and continue through and including December 31, 2013.

(c) Subject to Section 14169.34, 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, and publish on its Internet Web site, the following information:

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

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

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

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

(B) The aggregate quality assurance fee.

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

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

(3) The hospitals shall pay the aggregate quality assurance fee after application of the fee percentage for all subject fiscal years in 10 installments. The department shall establish the date that each installment is due, provided that the first installment shall be due no earlier than 20 days following the department sending the notice pursuant to paragraph (1), and the installments shall be paid at least one month apart, but if possible, the installments shall be paid on a quarterly basis.

(4) Notwithstanding any other provision of this section, the amount of each hospital's aggregate quality assurance fee after the application of the fee percentage for each subject fiscal year that has not been paid by the hospital before December 15, 2013, pursuant to paragraphs (3) and (8), shall be paid by the hospital no later than December 15, 2013.

(5) (A) Notwithstanding subdivision (l) of Section 14169.31, for the purpose of determining the installments under paragraph (3), the department shall use an interim fee percentage as follows:

(i) One hundred percent for subject fiscal year 2011–12 until the federal government has approved or disapproved additional capitation payments described in Section 14169.5 for that subject fiscal year.

(ii) One hundred percent for subject fiscal year 2012–13 until the federal government has approved or disapproved additional capitation payments described in Section 14169.5 for that subject fiscal year.

(iii) Fifty percent for subject fiscal year 2013–14 until the federal government has approved or disapproved additional capitation payments described in Section 14169.5 for that subject fiscal year.

(B) The director may use a lower interim fee percentage for each subject fiscal year under this paragraph as the director, in his or her discretion, determines is reasonable in order to generate sufficient but not excessive installment payments to make the payments described in subdivision (b) of Section 14169.33.

(6) The director shall determine the final fee percentage for each subject fiscal year within 15 days of the approval or disapproval, in whole or in part, by the federal government of all changes to the capitation rates of managed health care plans requested by the department to implement Section 14169.5 for that subject fiscal year, but in no event later than December 1, 2013. At the time the director determines the final fee percentage for a subject fiscal year, the director shall also determine the amount of future installment payments of the quality assurance fee for each hospital subject to the fee, if any are due. The amount of each future installment payment shall be established by the director with the objective that the total of the installment payments of the quality assurance fee due from a hospital shall equal the director's estimate for each subject fiscal year for the hospital of the aggregate quality assurance fee after the application of the fee percentage.

(7) The director, within 15 days of determining the final fee percentage for a subject fiscal year pursuant to paragraph (6), shall send notice to each hospital subject to the quality assurance fee of the following information:

(A) The final fee percentage for each subject fiscal year for which the final fee percentage has been determined.

(B) The fee percentage determined under paragraph (5) for each subject fiscal year for which the final fee percentage has not been determined.

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

(D) The director's estimate of total quality assurance fee payments due from the hospital under this article whether or not paid. This amount shall be the sum of the aggregate quality assurance fee after application of the fee percentage for each subject fiscal year using the fee percentages contained in the notice.

(E) The total quality assurance fee payments that the hospital has made under this article.

(F) The amount, if any, by which the total quality assurance fee payments due from the hospital under this article as described in subparagraph (C) exceed the total quality assurance fee payments that the hospital has made under this article.

(G) The amount of each remaining installment of the quality assurance fee, if any, due from the hospital and the date each installment is due. This amount shall be the amount described in subparagraph (F) divided by the number of installment payments remaining.

(8) Each hospital that is sent a notice under paragraph (7) shall pay the additional installments of the quality assurance fee 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.

(9) The department shall refund to a hospital paying the quality assurance fee the amount, if any, by which the total quality assurance fee payments that the hospital has made under this article for all subject fiscal years exceed the total quality assurance fee payments due from the hospital under this article within 30 days of the date on which the notice is sent to the hospital under paragraph (7).

(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. 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, 2014, the implementation of the quality assurance fee pursuant to this article or the supplemental payments to private hospitals described in Sections 14169.2 and 14169.3, and either or both provisions cannot be modified by the department pursuant to subdivision (d) of Section 14169.33 in order to meet the requirements of federal law or to obtain federal approval.

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

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

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

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

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

(j) The department shall work in consultation with the hospital community to implement this article and Article 5.228 (commencing with Section 14169.1).

(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 September 16, 2011, 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 September 16, 2011, to maintain and continue prior reimbursement levels as set forth in Section 14169.12 on September 16, 2011, and to otherwise comply with all its obligations set forth in Article 5.228 (commencing with Section 14169.1) and this article provided that amendments that arise from, or have as a basis, a decision, advice, or determination by the federal Centers for Medicare and Medicaid Services relating to federal approval of the quality assurance fee or the payments set forth in this article or Article 5.228 (commencing with Section 14169.1) shall control for the purposes of this subdivision.

(l) (1) Effective January 1, 2014, 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 5.228 (commencing with Section 14169.1).

(2) The supplemental payments and other payments under Article 5.228 (commencing with Section 14169.1) shall be regarded as quality assurance payments, the implementation or suspension of which does not affect a determination of the adequacy of any rates under federal law.

(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 is not 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 5.228 (commencing with Section 14169.1), 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, provided, however, that if supplemental payments are not implemented under subsequent legislation, then those fee payments shall be deposited in the Distressed Hospital Fund.

(5) If during the implementation of this article, fee payments that were due under Article 5.21 (commencing with Section 14167.1) and Article 5.22 (commencing with Section 14167.31), or Article 5.227 (commencing with Section 14168.31), 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, those fee payments shall be deposited in the fund to support the uses established by this article.

(Amended by Stats. 2013, Ch. 76, Sec. 220. (AB 383) Effective January 1, 2014. Conditionally inoperative as provided in subd. (e). Conditionally inoperative as provided in Sections 14169.38 (subd. (d), para. (1)) and 14169.40, or on date prescribed in Section 14169.41. Repealed on or after January 1, 2015, as provided in Section 14169.41.)

14169.33. (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) Notwithstanding subdivision (c) of Section 14167.35 and subdivision (b) of Section 14168.33, 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, upon appropriation by the Legislature, 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:

(1) To pay for the department's staffing and administrative costs directly attributable to implementing Article 5.228 (commencing with Section 14169.1) and this article, not to exceed two million five hundred thousand dollars ($2,500,000) for the program period.

(2) To pay for the health care coverage for children in the amount of eighty-five million dollars ($85,000,000) for each subject fiscal quarter during the 2011–12 subject fiscal year, in the amount of one hundred thirty-four million two hundred fifty thousand dollars ($134,250,000) for each subject fiscal quarter during the 2012–13 subject fiscal year, and in the amount of one hundred forty-four million two hundred fifty thousand dollars ($144,250,000) for each subject fiscal quarter during the 2013–14 subject fiscal year.

(3) To make increased capitation payments to managed health care plans pursuant to Article 5.228 (commencing with Section 14169.1).

(4) To reimburse the General Fund for the increase in the overall compensation to a private hospital that is attributable to its change in status from contract hospital to noncontract hospital, pursuant to subdivision (a) of Section 14169.10.

(5) To make increased payments or grants to hospitals pursuant to Article 5.228 (commencing with Section 14169.1).

(6) To make increased payments to mental health plans pursuant to Article 5.228 (commencing with Section 14169.1).

(7) To make supplemental payments for out-of-network emergency and poststabilization services provided by private hospitals to Medicaid Coverage Expansion enrollees in the Low Income Health Program in the amount of thirty-three million two hundred thousand dollars ($33,200,000) for each fiscal quarter pursuant to Section 14169.7.5.

(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 14169.13 or subdivision (e) of Section 14169.38, 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.

(d) Any methodology or other provision specified in Article 5.228 (commencing with Section 14169.1) 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 5.228 (commencing with Section 14169.1) or this article and are not inconsistent with the conditions of implementation set forth in Section 14169.40.

(e) The department, in consultation with the hospital community, shall make adjustments, as necessary, to the amounts calculated pursuant to Section 14169.32 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.

(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 5.228 (commencing with Section 14169.1) 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.

(Amended by Stats. 2012, Ch. 452, Sec. 12. (SB 920) Effective September 22, 2012. Conditionally inoperative as provided in Sections 14169.38 (subd. (d), para. (1)) and 14169.40, or on date prescribed in Section 14169.41. Repealed on or after January 1, 2015, as provided in Section 14169.41.)

14169.34. (a) Notwithstanding any other provision of this article or Article 5.228 (commencing with Section 14169.1) requiring federal approvals, the department may impose and collect the quality assurance fee and may make payments under this article and Article 5.228 (commencing with Section 14169.1), 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 14169.13 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 14169.2 or 14169.3 has been denied, any fees collected pursuant to this section shall be refunded and any payments made pursuant to this article or Article 5.228 (commencing with Section 14169.1) shall be recouped, including, but not limited to, supplemental payments, increased capitation payments, payments to hospitals by health care plans resulting from the increased capitation payments, increased payments to mental health plans, 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 5.228 (commencing with Section 14169.1).

(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.

(Amended by Stats. 2012, Ch. 23, Sec. 105. (AB 1467) Effective June 27, 2012. Conditionally inoperative as provided in Sections 14169.38 (subd. (d), para. (1)) and 14169.40, or on date prescribed in Section 14169.41. Repealed on or after January 1, 2015, as provided in Section 14169.41.)

14169.35. (a) Notwithstanding any other provision of law, the director shall have discretion to modify any timeline or timelines in this article or Article 5.228 (commencing with Section 14169.1) if the letter that indicates likely federal approval, as described in Section 14169.34, is not secured by December 15, 2013, 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.

(Added by Stats. 2011, Ch. 286, Sec. 8. (SB 335) Effective September 16, 2011. Conditionally inoperative as provided in Sections 14169.38 (subd. (d), para. (1)) and 14169.40, or on date prescribed in Section 14169.41. Repealed on or after January 1, 2015, as provided in Section 14169.41.)

14169.36. (a) Upon receipt of a letter that indicates likely federal approval that the director determines is sufficient for implementation under Section 14169.34, 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 14169.2, 14169.3, 14169.5, 14169.7, and 14169.7.5, including, but not limited to, supplemental payments and increased capitation payments, prior to January 1, 2014, except that the increased capitation payments under Section 14169.5 shall not be made until federal approval is obtained for these payments.

(2) The department shall make supplemental payments to hospitals under Article 5.228 (commencing with Section 14169.1) consistent with the timeframe described in Section 14169.11 or a modified timeline developed pursuant to Section 14169.35.

(b) Notwithstanding any other provision of this article or Article 5.228 (commencing with Section 14169.1), if the director determines, on or after December 15, 2013, that there are insufficient funds available in the Hospital Quality Assurance Revenue Fund to make all scheduled payments under Article 5.228 (commencing with Section 14169.1) before January 1, 2014, 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, 2013, but before June 15, 2014.

(c) Nothing in this section shall require the department to continue to make payments under Article 5.228 (commencing with Section 14169.1) if, after the consultation required under subdivision (b), the director determines in the exercise of his or her sole discretion that a workable plan for the continued payments cannot be developed.

(d) Subdivisions (b) and (c) shall be implemented only if and to the extent federal financial participation is available for continued supplemental payments 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, 2013, to collect quality assurance fees imposed on or before December 31, 2013.

(Amended by Stats. 2012, Ch. 23, Sec. 106. (AB 1467) Effective June 27, 2012. Conditionally inoperative as provided in Sections 14169.38 (subd. (d), para. (1)) and 14169.40, or on date prescribed in Section 14169.41. Repealed on or after January 1, 2015, as provided in Section 14169.41.)

14169.37. Notwithstanding any other provision of law, if actual federal approval or a letter that indicates likely federal approval in accordance with Section 14169.34 has not been received on or before December 1, 2013, then this article shall become inoperative, and as of December 1, 2013, is repealed, unless a later enacted statute, that is enacted before December 1, 2013, deletes or extends that date.

(Added by Stats. 2011, Ch. 286, Sec. 8. (SB 335) Effective September 16, 2011. Conditionally inoperative as provided in Sections 14169.38 (subd. (d), para. (1)) and 14169.40, or on date prescribed in Section 14169.41. Repealed on or after January 1, 2015, as provided in Section 14169.41.

Note: Conditions in this section for repeal of Article 5.229 (commencing with Section 14169.31) failed.)

14169.38. (a) This article shall be implemented only as long as all of the following conditions are met:

(1) Subject to Section 14169.33, 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 5.228 (commencing with Section 14169.1) is enacted and remains in effect and hospitals are reimbursed the increased rates for services during the program period, as defined in Section 14169.1.

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

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

(1) In the event, and on the effective date, of a final judicial determination made by any court of appellate jurisdiction or a final determination by the United States Department of Health and Human Services or the federal Centers for Medicare and Medicaid Services that the quality assurance fee established pursuant to this article or any provision of Section 14166.115 cannot be implemented.

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

(A) The federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before January 1, 2014, the implementation of Sections 14169.2 and 14169.3 or this article.

(B) Section 14169.2, Section 14169.3, or this article cannot be modified by the department pursuant to subdivision (d) of Section 14169.33 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 5.228 (commencing with Section 14169.1) during that period or those periods of time.

(f) (1) In the event that all necessary final federal approvals are not received as described and anticipated under this article or Article 5.228 (commencing with Section 14169.1), 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 5.228 (commencing with Section 14169.1).

(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.

(Amended by Stats. 2012, Ch. 23, Sec. 107. (AB 1467) Effective June 27, 2012. Conditionally inoperative as provided in this section (subd. (d), para. (1)) and Section 14169.40, or on date prescribed in Section 14169.41. Repealed on or after January 1, 2015, as provided in Section 14169.41. Note: Provisions for inoperation affect Article 5.229, commencing with Section 14169.31.)

14169.39. Notwithstanding any other provision of this article or Article 5.228 (commencing with Section 14169.1), supplemental payments or other payments under Article 5.228 (commencing with Section 14169.1) shall only be required and payable in any quarter for which a fee payment obligation exists.

(Added by Stats. 2011, Ch. 286, Sec. 8. (SB 335) Effective September 16, 2011. Conditionally inoperative as provided in Sections 14169.38 (subd. (d), para. (1)) and 14169.40, or on date prescribed in Section 14169.41. Repealed on or after January 1, 2015, as provided in Section 14169.41.)

14169.40. (a) This article and Article 5.228 (commencing with Section 14169.1) shall become inoperative and the requirements for supplemental payments or other payments under Article 5.228 (commencing with Section 14169.1) 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, Article 5.228 (commencing with Section 14169.1), or Section 14166.115 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 5.228 (commencing with Section 14169.1) 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 5.228 (commencing with Section 14169.1) if any of the following apply:

(A) Recoupment of payments made under Article 5.228 (commencing with Section 14169.1) is ordered by a court.

(B) Federal financial participation is not available for payments made under Article 5.228 (commencing with Section 14169.1) for which federal financial participation has been sought.

(C) Recoupment of payments made under Article 5.228 (commencing with Section 14169.1) 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 5.228 (commencing with Section 14169.1) 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 5.228 (commencing with Section 14169.1) 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.

(Added by Stats. 2011, Ch. 286, Sec. 8. (SB 335) Effective September 16, 2011. Conditionally inoperative as provided in this section (subd. (a)) and Section 14169.38 (subd. (d), para. (1)), or on date prescribed in Section 14169.41. Repealed on or after January 1, 2015, as provided in Section 14169.41. Note: Provisions for inoperation affect Articles 5.228 (comm. with Section 14169.1) and 5.229 (comm. with Section 14169.31).)

14169.40.5. 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.

(Added by Stats. 2011, Ch. 286, Sec. 8. (SB 335) Effective September 16, 2011. Conditionally inoperative as provided in Sections 14169.38 (subd. (d), para. (1)) and 14169.40, or on date prescribed in Section 14169.41. Repealed on or after January 1, 2015, as provided in Section 14169.41.)

14169.41. (a) This article shall remain operative only until the later of the following:

(1) January 1, 2015.

(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 5.228 (commencing with Section 14169.1).

(b) If this article becomes inoperative under paragraph (1) of subdivision (a), this article shall be repealed on January 1, 2015, 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.

(Amended by Stats. 2012, Ch. 452, Sec. 13. (SB 920) Effective September 22, 2012. Conditionally inoperative as provided in Sections 14169.38 (subd. (d), para. (1)) and 14169.40, or on date prescribed in this section. Repealed on or after January 1, 2015, by its own provisions. Note: Termination provisions affect Article 5.229, commencing with Section 14169.31.)

14169.42. If the director determines that this article has become inoperative pursuant to Section 14169.37, 14169.38, 14169.40, or 14169.41, 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.

(Amended by Stats. 2012, Ch. 452, Sec. 14. (SB 920) Effective September 22, 2012. Conditionally inoperative as provided in Sections 14169.38 (subd. (d), para. (1)) and 14169.40, or on date prescribed in Section 14169.41. Repealed on or after January 1, 2015, as provided in Section 14169.41.)