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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 5.228. Medi-Cal Hospital Provider Rate Improvement Act of 2011 [14169.1 - 14169.19] (*Article 5.228 added by Stats. 2011, Ch. 286, Sec. 7.*)

14169.1. For the 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 Tentative Medi-Cal Utilization Statistics for the 2011–12 state fiscal year as calculated by the department as of July 21, 2011.
- (b) "Converted hospital" means a private hospital that becomes a designated public hospital or a nondesignated public hospital on or after July 1, 2011.
- (c) "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.
- (d) "Designated public hospital" shall have the meaning given in subdivision (d) of Section 14166.1 as of July 1, 2011.
- (e) "General acute care days" means the total number of Medi-Cal general acute care days paid by the department to a hospital for services in the 2009 calendar year, as reflected in the state paid claims file on July 15, 2011.
- (f) "High acuity days" means Medi-Cal coronary care unit days, pediatric intensive care unit days, intensive care unit days, neonatal intensive care unit days, and burn unit days paid by the department during the 2009 calendar year, as reflected in the state paid claims file prepared by the department on July 15, 2011.
- (g) "Hospital inpatient services" means all services covered under Medi-Cal and furnished by hospitals to patients who are admitted as hospital inpatients and reimbursed on a fee-for-service basis by the department directly or through its fiscal intermediary. Hospital inpatient services include outpatient services furnished by a hospital to a patient who is admitted to that hospital within 24 hours of the provision of the outpatient services that are related to the condition for which the patient is admitted. Hospital inpatient services do not include services for which a managed health care plan is financially responsible.
- (h) "Hospital outpatient services" means all services covered under Medi-Cal furnished by hospitals to patients who are registered as hospital outpatients and reimbursed by the department on a fee-for-service basis directly or through its fiscal intermediary. Hospital outpatient services do not include services for which a managed health care plan is financially responsible, or services rendered by a hospital-based federally qualified health center for which reimbursement is received pursuant to Section 14132.100.
- (i) "Individual hospital acute psychiatric supplemental payment" means the total amount of acute psychiatric hospital supplemental payments to a subject hospital for a quarter for which the supplemental payments are made. The "individual hospital acute psychiatric supplemental payment" shall be calculated for subject hospitals by multiplying the number of acute psychiatric days for the individual hospital for which a mental health plan was financially responsible by the amount calculated in accordance with paragraph (2) of subdivision (b) of Section 14169.3 and dividing the result by four.
- (j) (1) "Managed health care plan" means a health care delivery system that manages the provision of health care and receives prepaid capitated payments from the state in return for providing services to Medi-Cal beneficiaries.
- (2) (A) Managed health care plans include county organized health systems and entities contracting with the department to provide services pursuant to two-plan models and geographic managed care. Entities providing these services contract with the department pursuant to any of the following:

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

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

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

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

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

(i) Mental health 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).

(k) "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 Tentative Medi-Cal Utilization Statistics for the 2011–12 fiscal year, as calculated by the department as of July 21, 2011.

(l) "Medicaid inpatient utilization rate" means Medicaid inpatient utilization rate as defined in Section 1396r-4 of Title 42 of the United States Code and as set forth in the final disproportionate share hospital eligibility list for the 2010–11 fiscal year released by the department as of May 1, 2011.

(m) "Mental health plan" means a mental health plan that contracts with the state to furnish or arrange for the provision of mental health services to Medi-Cal beneficiaries pursuant to Chapter 8.9 (commencing with Section 14700).

(n) "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.

(o) "New noncontract hospital" means a private hospital that was a contract hospital on March 1, 2011, and elects to become a noncontract hospital at any time between March 1, 2011, and the end of the program period.

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

(1) A public hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 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.

(q) "Outpatient base amount" means the total amount of payments for hospital outpatient services made to a hospital in the 2009 calendar year, as reflected in the state paid claims files prepared by the department on June 2, 2011.

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

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

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

(s) "Program period" means the period from July 1, 2011, to December 31, 2013, inclusive.

(t) "Subject fiscal quarter" means a state fiscal quarter beginning on or after July 1, 2011, and ending before January 1, 2014.

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

(v) "Subject 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.

(w) "Subject month" means a calendar month beginning on or after July 1, 2011, and ending before January 1, 2014.

(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.

(Amended by Stats. 2012, Ch. 34, Sec. 233. (SB 1009) Effective June 27, 2012. Operative July 1, 2012, by Sec. 254 of Ch. 34. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), para. (1)) and 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16.)

14169.2. (a) Private hospitals shall be paid supplemental amounts for the provision of hospital outpatient services as set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services and shall not affect any other payments to hospitals. The supplemental amounts shall result in payments equal to the statewide aggregate upper payment limit for private hospitals as it may be modified by Section 14169.19.

(b) Except as set forth in subdivisions (e) and (f), each private hospital shall be paid an amount for each subject fiscal year equal to a percentage of the hospital's outpatient base amount. The percentage shall be the same for each hospital for a subject fiscal year. The percentage shall result in payments to hospitals that equal the applicable federal upper payment limit as provided in Section 14169.19 for a subject fiscal year, except for the 2011–12 state fiscal year during which the percentage shall result in payments to hospitals that equal the applicable federal upper payment limit for the 2011–12 state fiscal year, less any amounts paid pursuant to Section 14168.2 and accounted toward the federal upper payment limits for the entire 2011–12 state fiscal year. For purposes of this subdivision the applicable federal upper payment limit shall be the federal upper payment limit for hospital outpatient services furnished by private hospitals for each subject fiscal year.

(c) In the event federal financial participation for a subject fiscal year is not available for all of the supplemental amounts payable to private hospitals under subdivision (b) due to the application of 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.

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

(Added by Stats. 2011, Ch. 286, Sec. 7. (SB 335) Effective September 16, 2011. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), para. (1)) and 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16.)

14169.3. (a) Except as provided in Section 14169.19, private hospitals shall be paid supplemental amounts for the provision of hospital inpatient services for the program period as set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services and shall not affect any other payments to hospitals. The 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 14169.19.

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

(1) Nine hundred seventy-four dollars and ten cents (\$974.10) multiplied by the hospital's general acute care days for supplemental payments for the 2011–12 subject fiscal year, one thousand eighty-nine dollars and ninety-two cents (\$1,089.92) multiplied by the hospital's general acute care days for supplemental payments for the 2012–13 subject fiscal year, and one thousand two hundred sixty-four dollars and six cents (\$1,264.06) multiplied by the hospital's general acute care days for supplemental payments for the 2013–14 subject fiscal year, divided by two.

(2) For the hospital's acute psychiatric days that were paid directly by the department and were not the financial responsibility of a mental health plan, six hundred ninety-five dollars (\$695) multiplied by the hospital's acute psychiatric days for supplemental payments for the 2011–12 subject fiscal year, seven hundred ninety dollars (\$790) multiplied by the hospital's acute psychiatric days for supplemental payments for the 2012–13 subject fiscal year, and nine hundred fifty-five dollars (\$955) multiplied by the hospital's acute psychiatric days for supplemental payments for the 2013–14 subject fiscal year, divided by two.

(3) (A) For the 2011–12 and 2012–13 subject fiscal years, one thousand three hundred fifty dollars (\$1,350) multiplied by the number of the hospital's high acuity days if the hospital's Medicaid inpatient utilization rate is less than 41.6 percent and greater than 5 percent and at least 5 percent of the hospital's general acute care days are high acuity days.

(B) For the 2013–14 subject fiscal year, one thousand three hundred fifty dollars (\$1,350) multiplied by the number of the hospital's high acuity days, divided by two, if the hospital's Medicaid inpatient utilization rate is less than 41.6 percent and greater than 5 percent and at least 5 percent of the hospital's general acute care days are high acuity days.

(C) The amount under this paragraph shall be in addition to the amounts specified in paragraphs (1) and (2).

(4) (A) For the 2011–12 and 2012–13 subject fiscal years, one thousand three hundred fifty dollars (\$1,350) multiplied by the number of the hospital's high acuity days if the hospital qualifies to receive the amount set forth in paragraph (3) and has been designated as a Level I, Level II, Adult/Ped Level I, or Adult/Ped Level II trauma center by the Emergency Medical Services Authority established pursuant to Section 1797.1 of the Health and Safety Code.

(B) For the 2013–14 subject fiscal year, one thousand three hundred fifty dollars (\$1,350) multiplied by the number of the hospital's high acuity days, divided by two, 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.

(C) The amount under this paragraph shall be in addition to the amounts specified in paragraphs (1), (2), and (3).

(c) A private hospital that provided Medi-Cal subacute services during the 2009 calendar year and has a Medicaid inpatient utilization rate that is greater than 5 percent and less than 41.6 percent shall be paid a supplemental amount during each subject fiscal year equal to 40 percent of the Medi-Cal subacute payments paid by the department to the hospital during the 2009 calendar year, as reflected in the state paid claims file prepared by the department on July 14, 2011, except for the 2013–14 subject fiscal year during which the supplemental amount shall be equal to 20 percent of the Medi-Cal subacute payments paid by the department to the hospital during the 2009 calendar year, as reflected in the state paid claims file prepared by the department on July 14, 2011.

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

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

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

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

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

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

(e) 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.

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

(g) Payments shall not be made under this section to a new hospital.

(h) Payments shall not be made under this section to a converted hospital.

(i) (1) The department shall increase payments to mental health plans for the program period exclusively for the purpose of making payments to private hospitals. The aggregate amount of the increased payments for a subject fiscal quarter shall be the total of the individual hospital acute psychiatric supplemental payment amounts for all hospitals for which federal financial participation is available.

(2) The payments described in paragraph (1) may be made directly by the department to hospitals when federal law does not require that the payments be transmitted to hospitals via mental health plans.

(Amended by Stats. 2012, Ch. 452, Sec. 2. (SB 920) Effective September 22, 2012. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), para. (1)) and 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16.)

14169.5. (a) The department shall increase capitation payments to Medi-Cal managed health care plans for each subject fiscal year as set forth in this section.

(b) 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 shall be the maximum amount for which federal financial participation is available on an aggregate statewide basis for the applicable subject fiscal year as it may be adjusted pursuant to Section 14169.19.

(d) The department shall determine the amount of the increased capitation payments for each managed health care plan. The department shall consider the composition of Medi-Cal enrollees in the plan, the anticipated utilization of hospital services by the plan's Medi-Cal enrollees, and other factors that the department determines are reasonable and appropriate to ensuring access to high-quality hospital services by the plan's enrollees.

(e) The amount of increased capitation payments to each Medi-Cal managed 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 no later than the later of December 31, 2011, or 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) (A) 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 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, 2013.

(B) To the extent feasible, the department shall accumulate funds under subparagraph (A) by retaining 10 percent of the total necessary funding from each of the 10 installments of the quality assurance fee received from hospitals under Article 5.229 (commencing with Section 14169.31), provided that the department may adjust the applicable dates and amounts as necessary to accumulate sufficient funding by December 31, 2013.

(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 payment under this section.

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

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

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

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

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

(j) It is the intent of the Legislature that payments made available to designated public hospitals under this section shall replace, to the extent feasible, increased revenues that could be available to the hospitals under Section 14168.7 in the absence of this section and assuming other federal funds to the hospitals would not be reduced as a result of the payments. If this intent cannot be effectuated under this act, it is the intent of the Legislature to enact subsequent legislation to accomplish this purpose through other means.

(Amended by Stats. 2012, Ch. 452, Sec. 3. (SB 920) Effective September 22, 2012. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), para. (1)) and 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16.)

14169.6. (a) Each managed health care plan receiving increased capitation payments under Section 14169.5 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 14169.5.

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

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

(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.

(Added by Stats. 2011, Ch. 286, Sec. 7. (SB 335) Effective September 16, 2011. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), para. (1)) and 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16.)

14169.7. (a) (1) 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 5.229 (commencing with Section 14169.31). The aggregate amount of the grants to designated public hospitals shall be fifty million dollars (\$50,000,000) for the 2011–12 fiscal year, forty-three million dollars (\$43,000,000) for the 2012–13 fiscal year, and twenty-one million five hundred thousand dollars (\$21,500,000) for the 2013–14 fiscal year. The director shall allocate the amounts specified in this paragraph pursuant to paragraph (2).

(2) For the 2011–12 fiscal year, the director shall allocate the fifty million dollars (\$50,000,000) identified in paragraph (1) among the designated public hospitals pursuant to a methodology developed in consultation with the designated public hospitals. For the 2012–13 fiscal year, the director shall allocate the forty-three million dollars (\$43,000,000) identified in paragraph (1) among the designated public hospitals pursuant to a methodology developed in consultation with the designated public hospitals. For the 2013–14 fiscal year, the state shall retain the twenty-one million five hundred thousand dollars (\$21,500,000) identified in paragraph (1) to pay for health care coverage for children in addition to the amounts identified in Section 14169.33.

(b) Nondesignated public hospitals shall be paid direct grants in support of health care expenditures, and shall be funded by the quality assurance fee set forth in Article 5.229 (commencing with Section 14169.31). The aggregate amount of the grants to nondesignated public hospitals for each subject fiscal year shall be eighteen million six hundred thousand dollars (\$18,600,000), except that for the 2013–14 subject fiscal year, the aggregate amount of the grants shall be nine million three hundred thousand dollars (\$9,300,000). The director shall allocate the amounts specified in this subdivision among the nondesignated public hospitals pursuant to a methodology developed in consultation with the nondesignated public hospitals.

(Amended by Stats. 2012, Ch. 452, Sec. 4. (SB 920) Effective September 22, 2012. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), para. (1)) and 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16.)

14169.7.5. (a) The Low Income Health Program MCE Out-of-Network Emergency Care Services Fund is hereby established in the State Treasury. The moneys in the fund shall, upon appropriation by the Legislature to the department, be used solely for the

purposes specified in this section. Notwithstanding Section 16305.7 of the Government Code, any and all interest and dividends earned on money in the fund shall be used exclusively for the purposes of this section.

(b) The fund shall consist of the following:

(1) Funds transferred from governmental entities, at the option of the governmental entity, to the state for deposit into the fund in an aggregate amount of twenty million dollars (\$20,000,000) per subject fiscal year, except that for the 2013–14 subject fiscal year, the aggregate amount of the transfer shall be ten million dollars (\$10,000,000).

(2) Proceeds of the quality assurance fee set forth in Article 5.229 (commencing with Section 14169.31) that, subject to paragraph (1) of subdivision (a) of Section 14169.36, are transferred from the Hospital Quality Assurance Revenue Fund and deposited into the fund in an aggregate amount of sixty-six million four hundred thousand dollars (\$66,400,000) per subject fiscal year, except that for the 2013–14 subject fiscal year, the aggregate amount of the proceeds of the quality assurance fee deposited into the fund shall be thirty-three million two hundred thousand dollars (\$33,200,000).

(c) Any amounts of the quality assurance fee deposited to the fund in excess of the funds required to implement this section shall be returned to the Hospital Quality Assurance Revenue Fund.

(d) Any amounts deposited to the fund as described in paragraph (1) of subdivision (b) that are in excess of the funds required to implement this section shall be returned to the transferring entity.

(e) Consistent with the Special Terms and Conditions for the California's Bridge to Reform Section 1115(a) Medicaid Demonstration (11-W-00193/9), moneys in the fund shall be used with respect to Low Income Health Programs (LIHPs) operating pursuant to Part 3.6 (commencing with Section 15909) as the source for the nonfederal share of expenditures for coverage for the Medicaid Coverage Expansion (MCE) population of medically necessary hospital emergency services for emergency medical conditions and required poststabilization care furnished by private hospitals that are outside the LIHP coverage network, subject to the following:

(1) Moneys in the fund shall only be used to fund the nonfederal share of supplemental payments made to private hospital out-of-network emergency care services providers by the LIHP for the MCE population in accordance with this section.

(2) Supplemental payments under this section shall supplement but shall not supplant amounts that would have been paid absent the provisions of this section.

(f) Moneys in the fund shall be allocated with respect to each subject fiscal year as follows:

(1) Within 60 days after the last day of each subject fiscal year, each LIHP shall report utilization data to the department on approved hospital emergency services for emergency medical conditions and required poststabilization care, in accordance with Paragraph 63.f.ii of the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Medicaid Demonstration (11-W-00193/9), provided to MCE enrollees by out-of-network private hospitals during that year. The reported data shall be as specified by the department, and shall include the number of emergency room encounters and the number of inpatient hospital days.

(2) The department shall, in consultation with the hospital community, determine the amount of funding for the nonfederal share of supplemental payments available for each reported emergency room encounter or inpatient day by dividing the total funds available by the total number of inpatient days or emergency visits in accordance with subparagraphs (A) and (B).

(A) Seventy percent of the moneys in the fund shall be allocated for the nonfederal share of supplemental payments to private hospitals for approved out-of-network inpatient hospital emergency and poststabilization care, in accordance with Paragraph 63.f.ii of the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Medicaid Demonstration (11-W-00193/9).

(B) Thirty percent of the available funds shall be allocated for the nonfederal share of supplemental payments to private hospitals for approved out-of-network hospital emergency room services (excluding emergency room visits, in accordance with Paragraph 63.f.ii of the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Medicaid Demonstration (11-W-00193/9), that resulted in an approved out-of-network inpatient hospital stay), provided that for any emergency room visit that results in a hospital stay for which a supplemental payment is available under subparagraph (A), no supplemental payment shall be available under this subparagraph.

(C) The allocations and total available fund amount shall be adjusted as necessary so as to be consistent with the requirement in paragraph (1) of subdivision (g).

(g) (1) The department shall obtain federal financial participation for moneys in the fund to the full extent permitted by federal law. Moneys shall be allocated from the fund by the department to be matched by federal funds in accordance with the Special Terms and Conditions for the Medicaid Demonstration, or pursuant to other federal approvals or waivers as necessary.

(2) The department shall disburse moneys from the fund to the LIHPs in accordance with the calculations in subdivision (f) within 60 days after completing the calculations. The moneys shall be distributed to the LIHPs solely for purposes of funding the

nonfederal portion of the supplemental out-of-network amounts determined for each service in subdivision (f) to out-of-network hospital emergency care services providers.

(3) The LIHPs shall make the supplemental payments described in paragraph (2) within 30 days of receiving the nonfederal share from the department.

(h) It is the intent of the Legislature that for each subject fiscal year, the first twenty million dollars (\$20,000,000), or, for subject fiscal year 2013–14, the first ten million dollars (\$10,000,000), of the nonfederal share for the emergency hospital services payments are funded with intergovernmental transfers described in paragraph (1) of subdivision (b).

(i) This section shall be implemented only if, and to the extent that, both of the following conditions exist:

(1) All necessary federal approvals have been obtained for the implementation of this section and federal financial participation is available.

(2) The ability of the department to maximize federal funding is not jeopardized.

(j) In designing and implementing the program for supplemental payments created under this section, the director shall have discretion, after consultation with the hospital community and the LIHPs, to modify timelines and to make modifications to the operational requirements of this section, but only to the extent necessary to secure federal approval or to ensure successful operation of the program and to effectuate the intent of this section.

(k) Notwithstanding any other provision of this article or Article 5.229 (commencing with Section 14169.31), federal disapproval of the program developed pursuant to the requirements of this section shall not affect the implementation of the remainder of this article or Article 5.229 (commencing with Section 14169.31).

(l) As an alternative to, and in lieu of, disbursing moneys from the fund to the LIHPs under this section, the department may make supplemental payments from the fund directly to hospitals as determined in accordance with subdivision (f) when federal financial participation is available for those payments.

(Amended by Stats. 2012, Ch. 452, Sec. 5. (SB 920) Effective September 22, 2012. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), para. (1)) and 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16.)

14169.8. (a) The amount of any payments made under this article to private hospitals, including the amount of payments made under Sections 14169.2, 14169.3, and 14169.7.5 and additional payments to private hospitals by managed health care plans pursuant to Section 14169.5, 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).

(Added by Stats. 2011, Ch. 286, Sec. 7. (SB 335) Effective September 16, 2011. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), para. (1)) and 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16.)

14169.9. The payments to a hospital under this article shall not be made for any portion of a subject fiscal year during which the hospital is closed. A hospital shall be deemed to be closed on the first day of any period during which the hospital has no acute inpatients for at least 30 consecutive days. Payments under this article to a hospital that is closed during any portion of a subject fiscal year 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 year that the hospital is closed and the denominator of which shall be 365.

(Added by Stats. 2011, Ch. 286, Sec. 7. (SB 335) Effective September 16, 2011. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), para. (1)) and 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16.)

14169.10. (a) For only as long as the selective provider contracting program pursuant to Article 2.6 (commencing with Section 14081) is in effect, the amount of any supplemental payment under this article for a new noncontract hospital shall be reduced by the amount by which that hospital's overall payment for services for Medi-Cal patients during the program period was increased by reason of its becoming a noncontract hospital.

(b) The amount of the nonfederal share of any supplemental payment reduction under subdivision (a) shall be transferred from the Hospital Quality Assurance Revenue Fund to the General Fund at the time the reduced supplemental payment under subdivision (a) is made.

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

(Added by Stats. 2011, Ch. 286, Sec. 7. (SB 335) Effective September 16, 2011. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), para. (1)) and 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16.)

14169.11. The department shall make disbursements from the Hospital Quality Assurance Revenue Fund consistent with the following:

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

(b) The funds shall be disbursed in accordance with the order of priority set forth in subdivision (b) of Section 14169.33, except that funds may be set aside for increased capitation payments to managed care health plans pursuant to subdivision (f) of Section 14169.5.

(c) The funds shall be disbursed in each payment cycle in accordance with the order of priority set forth in subdivision (b) of Section 14169.33 as modified by subdivision (b), and so that the supplemental payments and grants to hospitals, increased capitation payments to managed health care plans, increased payments to mental health plans, direct payments to hospitals of acute psychiatric supplemental payments, and supplemental payments for out-of-network emergency and poststabilization services for the Low Income Health Program 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 quality assurance fund and the timing of federal approvals, the supplemental payments and grants to hospitals, increased capitation payments to managed health care plans, and increased payments to mental health plans under this article shall be made before December 31, 2013, except that supplemental payments for out-of-network emergency and poststabilization services for the Low Income Health Program shall be made before April 1, 2014.

(e) The aggregate amount of funds to be disbursed to private hospitals shall be determined under Sections 14169.2 and 14169.3. The aggregate amount of funds to be disbursed to managed health care plans shall be determined under Section 14169.5. The aggregate amount of direct grants to designated and nondesignated public hospitals shall be determined under Section 14169.7. The aggregate amount of supplemental payments to be disbursed to private hospitals for out-of-network and poststabilization services for the Low Income Health Program shall be determined under Section 14169.7.5.

(Amended by Stats. 2012, Ch. 452, Sec. 6. (SB 920) Effective September 22, 2012. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), para. (1)) and 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16.)

14169.12. (a) Exclusive of payments made under Article 5.21 (commencing with Section 14167.1) and Article 5.226 (commencing with Section 14168.1), payment rates for hospital outpatient services, furnished by private hospitals, nondesignated public hospitals, and designated public hospitals before December 31, 2013, exclusive of amounts payable under this article, shall not be reduced below the rates in effect on July 1, 2011.

(b) Rates payable to hospitals for hospital inpatient services furnished before December 31, 2013, 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 July 1, 2011. 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 Section 14167.13.

(c) Notwithstanding Section 14105.281, exclusive of payments made under Article 5.21 (commencing with Section 14167.1) and Article 5.226 (commencing with Section 14168.1), 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) Upon the implementation of the new Medi-Cal inpatient hospital reimbursement methodology based on diagnosis-related groups pursuant to Section 14105.28, the requirements in subdivisions (b) and (c) shall be met if the rates paid under the new 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 fiscal year ending June 30, 2012, 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 for the 2011–12 fiscal year shall be not less than the amount determined pursuant to Section 14166.11 as reduced pursuant to paragraph (3) of subdivision (b) of Section 14166.115. Disproportionate share replacement payments to private hospitals for the 2012–13 fiscal year shall not be less than the amount determined pursuant to Section 14166.11, as reduced pursuant to paragraph (4) of subdivision (b) of Section 14166.115. Disproportionate share replacement payments to private hospitals for the period of July 1, 2013, through December 31, 2013, shall be not less than the amount determined pursuant to Section 14166.11, as reduced by paragraph (5) of subdivision (b) of Section 14166.115. 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.

(Added by Stats. 2011, Ch. 286, Sec. 7. (SB 335) Effective September 16, 2011. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), para. (1)) and 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16.)

14169.13. (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 14169.5 and 14169.6 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 5.229 (commencing with Section 14169.31), and shall not wait for federal approval of this article or Article 5.229 (commencing with Section 14169.31) 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 14169.5 and increase payments to hospitals under Section 14169.6 in a manner that relates back to July 1, 2011, 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 5.229 (commencing with Section 14169.31) shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

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

(1) In the event, and on the effective date, of a final judicial determination made by any court of appellate jurisdiction or a final determination by the federal Department of Health and Human Services or the federal Centers for Medicare and Medicaid Services that Section 14169.2, Section 14169.3, 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, 2013, the implementation of Section 14169.2, Section 14169.3, or the quality assurance fee established pursuant to Article 5.229 (commencing with Section 14169.31).

(B) Section 14169.2, Section 14169.3, or Article 5.229 (commencing with Section 14169.31) cannot be modified by the department pursuant to subdivision (e) of Section 14169.33 in order to meet the requirements of federal law or to obtain federal approval.

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

(e) In the event any hospital, or any party on behalf of a hospital, shall initiate a case or proceeding in any state or federal court in which the hospital seeks any relief of any sort whatsoever, including, but not limited to, monetary relief, injunctive relief, declaratory relief, or a writ, based in whole or in part on a contention that any or all of this article or Article 5.229 (commencing with Section 14169.31) 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 section for a project year shall be withheld by the department and shall be paid to the hospital only after the case or proceeding is finally resolved, including the final disposition of all appeals.

(f) Subject to Section 14169.34, no payment shall be made under this article until all necessary federal approvals for the payment and for the fee provisions in Article 5.229 (commencing with Section 14169.31) have been obtained and the fee has been imposed and collected. Notwithstanding any other provision of law, payments under this article shall be made only to the extent that the fee established in Article 5.229 (commencing with Section 14169.31) 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, managed health care plans, and mental health plans under this article shall be made only from the following:

(1) The quality assurance fee set forth in Article 5.229 (commencing with Section 14169.31) and due and payable on or before December 31, 2013, along with any interest or other investment income thereon.

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

(Amended by Stats. 2012, Ch. 23, Sec. 101. (AB 1467) Effective June 27, 2012. Conditionally inoperative as provided in this section (subd. (c), para. (1)) and Section 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16. Note: Provisions for inoperation affect Article 5.228, commencing with Section 14169.1.)

14169.14. Notwithstanding any other provision of this article or Article 5.229 (commencing with Section 14169.31), 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 or mental health plan due to the application of federal law.

(Added by Stats. 2011, Ch. 286, Sec. 7. (SB 335) Effective September 16, 2011. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), para. (1)) and 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16.)

14169.15. The director may, pursuant to Section 14169.40, decide not to implement or to discontinue implementation of this article and Article 5.229 (commencing with Section 14169.31), and to retroactively invalidate the requirements for supplemental payments or other payments under this article.

(Added by Stats. 2011, Ch. 286, Sec. 7. (SB 335) Effective September 16, 2011. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), para. (1)) and 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16.)

14169.16. (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 Article 5.229 (commencing Section 14169.31).

(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, 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. 7. (SB 920) Effective September 22, 2012. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), 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 5.228, commencing with Section 14169.1.)

14169.17. Notwithstanding any other provision of law, if 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.

(Amended by Stats. 2012, Ch. 452, Sec. 8. (SB 920) Effective September 22, 2012. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), para. (1)) and 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16. Note: Conditions in this section for repeal of Article 5.228 (commencing with Section 14169.1) failed.)

14169.17.5. 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. 7. (SB 335) Effective September 16, 2011. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), para. (1)) and 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16.)

14169.18. If the director determines that this article has become inoperative pursuant to Section 14169.13, 14169.16, 14169.17, or 14169.40, 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. 9. (SB 920) Effective September 22, 2012. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), para. (1)) and 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16.)

14169.19. (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 subdivision (b) of Section 14169.2, subdivision (a) of Section 14169.3, and subdivision (c) of Section 14169.5, and to adopt a corresponding increase in the fee imposed pursuant to Article 5.229 (commencing with Section 14169.31), consistent with federal law and regulations, if the director determines that the maximum available upper payment limits in subdivision (b) of Section 14169.2 or subdivision (a) of Section 14169.3, or the amount of federal financial participation for increased capitation payments to managed care health plans in subdivision (c) of Section 14169.5, have increased during the program period.

(b) It is the intent of the Legislature that 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 (b) of Section 14169.2 or subdivision (a) of Section 14169.3, or the amount of federal financial participation for increased capitation payments to managed care health plans in subdivision (c) of Section 14169.5, 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 5.229 (commencing with Section 14169.31), 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 5.229 (commencing with Section 14169.31).

(Added by Stats. 2011, Ch. 286, Sec. 7. (SB 335) Effective September 16, 2011. Conditionally inoperative as provided in Sections 14169.13 (subd. (c), para. (1)) and 14169.40, or on date prescribed in Section 14169.16. Repealed on or after January 1, 2015, as provided in Section 14169.16.)