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 5.15. Medi-Cal Funding for South Los Angeles [14165.50 - 14165.51] *(Article 5.15 added by Stats. 2010, Ch. 267, Sec. 2.)*

14165.50. (a) To facilitate the financial viability of the Martin Luther King, Jr. Community Hospital, a private nonprofit hospital that serves the population of South Los Angeles that was formerly served by the Los Angeles County Martin Luther King, Jr.-Harbor Hospital, Medi-Cal funding shall, at a minimum, be made available, as specified in this section, or pursuant to mechanisms that provide equivalent funding under successor or modified Medi-Cal payment systems.

(b) Medi-Cal payment for hospital services provided by the hospital, exclusive of any payments pursuant to the Medi-Cal Hospital Reimbursement Improvement Act of 2013 (Article 5.230 (commencing with Section 14169.50)) or funded by another statewide hospital fee program, and exclusive of the supplemental payments specified in subdivision (d), shall include consideration of the hospital's projected Medi-Cal costs for providing the services as set forth in this section.

(1) (A) Subject to paragraph (2) of subdivision (c), and notwithstanding any other law, Medi-Cal payments made to the hospital on a fee-for-service basis, including payments made pursuant to the methodology authorized under Section 14105.28 or successor or modified methodologies, shall provide compensation that is, at a minimum, equal to 100 percent of the hospital's projected Medi-Cal costs for each fiscal year.

(B) To the extent Medi-Cal supplemental payments are necessary for any fiscal year to meet the applicable minimum reimbursement level, as described in subparagraph (A), the department shall seek federal approval, as necessary, to make the Medi-Cal supplemental payments.

(2) (A) To the extent permitted under federal law, except as specified in paragraph (3) of subdivision (b) of Section 14165.51, the department shall require Medi-Cal managed care plans serving Medi-Cal beneficiaries in the County of Los Angeles to pay the hospital amounts determined necessary to meet compensation levels for services provided to Medi-Cal managed care enrollees that are no less than the amount that the hospital would have received on a fee-for-service basis pursuant to paragraph (1). The amounts shall be determined in consultation with the hospital, the County of Los Angeles, and the Medi-Cal managed care plan, and shall be subject to paragraph (2) of subdivision (c).

(B) Consistent with federal law, the capitation rates paid to Medi-Cal managed care plans serving Medi-Cal beneficiaries in the County of Los Angeles shall be determined to reflect the obligations described in subparagraph (A). The increased payments to Medi-Cal managed care plans that would be paid consistent with actuarial certification and enrollment in the absence of this paragraph shall not be reduced as a consequence of this paragraph.

(C) A Medi-Cal managed care plan receiving the increased payments described in subparagraph (B) shall not impose a fee or retention amount, or reduce other payments to the hospital that would result in a direct or indirect reduction to the amounts required to be paid under subparagraph (A).

(3) This subdivision shall not be construed to result in payments that are less than the rates of compensation that would be payable to the hospital for Medi-Cal services without regard to the requirements of paragraphs (1) and (2).

(c) If the applicable minimum reimbursement levels required in subdivision (b) result in payments to the hospital that are above the levels of compensation that would have been payable absent that requirement, and to the extent a nonfederal share is necessary with respect to the additional compensation, the following provisions shall apply:

(1) (A) For each fiscal year through the 2016–17 fiscal year, General Fund amounts appropriated in the annual Budget Act for the Medi-Cal program shall fund the nonfederal share of the additional payments to the extent that the rates of compensation for inpatient hospital services provided by the hospital that would have been payable in the absence of the requirements of subdivision (b) are less than 77 percent of the hospital's projected Medi-Cal costs. With respect to the nonfederal share of the additional payments described in paragraph (2) of subdivision (b), however, this subparagraph shall be applicable only for inpatient services provided in conjunction with the implementation of Section 14182, and other mandatory managed care enrollment provisions implemented subsequent to January 1, 2011.

(B) For the 2017–18 fiscal year and each fiscal year thereafter, General Fund amounts appropriated in the annual Budget Act for the Medi-Cal program shall fund the nonfederal share of the additional payments to the extent that the rates of compensation for inpatient hospital services provided by the hospital that would have been payable in the absence of the requirements of subdivision (b) are less than 72 percent of the hospital's projected Medi-Cal costs. With respect to the nonfederal share of the additional payments described in paragraph (2) of subdivision (b), however, this subparagraph shall be applicable only for inpatient services provided in conjunction with the implementation of Section 14182, and other mandatory managed care enrollment provisions implemented subsequent to January 1, 2011.

(2) (A) The remaining necessary nonfederal share of the additional payments, after taking into account the General Fund amounts described in paragraph (1), may be funded with public funds that are transferred to the state from the County of Los Angeles, at the county's election, pursuant to Section 14164. To the extent the county elects not to fund any portion of the remaining necessary nonfederal share, the applicable minimum reimbursement levels required in subdivision (b) shall be reduced accordingly.

(B) Public funds transferred to the state for payments to the hospital, as described in this paragraph with respect to a fiscal period, shall be expended solely for the nonfederal share of the payments. Notwithstanding any other law, and except as provided in subdivision (m), the department shall not impose any fee or assessment in connection with the transferred funds or the payments provided for under this section, including, but not limited to, reimbursement for state staffing or administrative costs.

(C) If any portion of the funds transferred pursuant to this paragraph is not expended, or not expected to be expended, for the specified rate amounts required in subdivision (b), the unexpended funds shall be returned promptly to the transferring county.

(3) This subdivision shall not be construed to reduce the nonfederal share of payments funded by General Fund amounts below the amounts that would be funded without regard to the minimum payment levels required under this section.

(d) (1) In addition to payments meeting the applicable minimum reimbursement levels described in subdivision (b), except as specified in paragraph (3) of subdivision (b) of Section 14165.51, the hospital shall be eligible to receive supplemental payments. The supplemental payments shall be provided annually in amounts determined in consultation with the hospital and the County of Los Angeles, and subject to paragraph (3).

(2) The department shall seek federal approval, as necessary, to enable the hospital to receive supplemental payments that are in addition to the applicable minimum reimbursement levels required in subdivision (b). The supplemental payments may be provided for under the mechanisms described in Sections 14166.12 and 14301.4 or successor or modified mechanisms, or any other federally permissible payment mechanism. Supplemental payments that are payable through a Medi-Cal managed care plan shall be subject to the same requirements described in subparagraph (C) of paragraph (2) of subdivision (b).

(3) If a nonfederal share is necessary to fund the supplemental payments, the County of Los Angeles may voluntarily provide public funds that are transferred to the state pursuant to Section 14164. The county may specify the type of supplemental payment for which it is transferring funds, and any other category relevant to the payment, including, but not limited to, fee-for-service supplemental payment, managed care rate range payment, and payment for services rendered to newly eligible beneficiaries as defined in subdivision (s) of Section 17612.2.

(4) Public funds transferred to the state for supplemental payments to the hospital, as described in this subdivision with respect to a fiscal period, shall be expended solely for the nonfederal share of the supplemental payments as specified pursuant to paragraph (3). Notwithstanding any other law, subdivision (o) of Section 14166.12 shall not apply, and the department shall not assess the fee described in subdivision (d) of Section 14301.4, or any other similar fee, except as provided in subdivision (m). If any portion of the funds transferred pursuant to this subdivision is not expended, or not expected to be expended, for the specified supplemental payments, the unexpended funds shall be returned promptly to the transferring county.

(e) Notwithstanding any other law, all payments provided for under this section shall be treated as having been paid for purposes of any determination of available room under the federal upper payment limit, as specified in Part 447 of Title 42 of the Code of Federal Regulations, with respect to the applicable class of services and class of health care provider.

(f) For purposes of this article, the following definitions shall apply:

(1) “Hospital” means a health facility that is certified under Title XVIII and Title XIX of the federal Social Security Act, and is licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code to provide acute inpatient hospital services, and includes all components of the facility, with an inpatient hospital service location on the campus of the Martin Luther King, Jr. Community Hospital.

(2) “Medi-Cal managed care plan” means any individual, organization, or entity that enters into a comprehensive risk contract with the department to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries pursuant to any provision of this chapter or Chapter 8 (commencing with Section 14200).

(g) For purposes of this article, the hospital’s projected Medi-Cal costs shall be based on the cost finding principles applied under subdivision (b) of Section 14166.4, except that the projected costs shall not be multiplied by the federal medical assistance percentage and are not subject to the reimbursement limitations set forth in Article 7.5 (commencing with Section 51536) of Chapter 3 of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations. The projected Medi-Cal costs shall be determined prior to the start of each fiscal year in consultation with the hospital, using the best available and reasonable current estimates or projections made with respect to the hospital for an annual period, and shall be considered final as of the start of the fiscal year for purposes of the minimum payment levels described in subdivision (b).

(h) Notwithstanding any other law, the hospital shall not be eligible to receive payments pursuant to Section 14166.11. This subdivision, however, shall not be construed to preclude the hospital from eligibility for disproportionate share status, or from receipt of any federal Medicaid disproportionate share hospital payments to which it would be entitled, pursuant to the Medi-Cal State Plan.

(i) Except as specified in subdivision (h) and paragraph (3) of subdivision (b) of Section 14165.51, this section shall not be construed to preclude the hospital from receiving any other payment for which it is eligible in addition to the payments provided for by this section.

(j) Notwithstanding any other law, for purposes of Article 12 (commencing with Section 17612.1) of Chapter 6 of Part 5, the intergovernmental transfers described in this section as reflected in the actual net expenditures for all operating budget units of the County of Los Angeles Department of Health Services shall not be reduced in any manner in the determination of total costs under paragraph (6) of subdivision (b) of Section 17612.5, by application of the imputed other entity intergovernmental transfer amounts or otherwise.

(k) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of all-facility letters, all-county letters, or similar instructions, without taking further regulatory action. This section shall not be construed to preclude the department from adopting regulations.

(l) (1) The department shall obtain federal approvals or waivers as necessary to implement this section and to obtain federal matching funds to the maximum extent permitted by federal law. This section shall be implemented only if, and to the extent that, federal financial participation is available and this section does not jeopardize the federal financial participation available for any other state program.

(2) This section shall be implemented only if, and to the extent that, any necessary federal approvals are obtained.

(m) As part of its voluntary participation to provide the nonfederal share of payments under this section, the County of Los Angeles shall agree to reimburse the state for the nonfederal share of state staffing and administrative costs directly attributable to the cost of administrating the payments and associated intergovernmental transfers pursuant to this section. The costs shall be documented and subject to review by the county.

(Amended by Stats. 2024, Ch. 999, Sec. 7. (AB 177) Effective September 30, 2024.)

14165.51. (a) (1) For dates of service commencing no later than January 1, 2026, the department shall establish a Medi-Cal managed care directed payment reimbursement methodology in accordance with Section 438.6(c) of Title 42 of the Code of Federal Regulations applicable to the hospital.

(2) The directed payment reimbursement methodology shall, at minimum:

(A) Provide reimbursement for contracted hospital inpatient services such that aggregate managed care reimbursement to the hospital for hospital inpatient services, exclusive of any payments pursuant to Article 5.230 (commencing with Section 14169.50), is projected by the department to be at least equal to 72 percent of the hospital’s projected Medi-Cal costs for hospital inpatient services associated with the implementation of Section 14182, and other mandatory managed care enrollment provisions implemented subsequent to January 1, 2011.

(B) Provide additional reimbursements to the hospital for contracted hospital inpatient and hospital outpatient services in a form and manner that is projected by the department to total twenty-five million dollars ($25,000,000) annually in addition to the amount described in subparagraph (A).

(C) Align with the goals and objectives of the department's comprehensive quality strategy.

(D) To the extent appropriate, link payments to value and outcomes, consistent with measures selected by the department consistent with subparagraph (C), in addition to access to and utilization of services.

(E) Be developed with consideration of the stability of the hospital's cash flow.

(F) Be developed in consultation with the hospital.

(3) (A) The department shall, annually on a prospective basis, make the projections pursuant to subparagraphs (A) and (B) of paragraph (2), and may develop the projections on either an aggregate or individual service level, or both.

(B) The department may require Medi-Cal managed care plans and the hospital to submit information regarding contract rates and expected or actual utilization of services, at the times and in the form and manner specified by the department.

(C) In the event payments to the hospital at the level set forth in paragraph (2), in combination with any other reimbursement, exceed any federal statutory or regulatory limits on Medicaid reimbursement, the amount of payments that the Medi-Cal managed care plans make shall be reduced to comply with the applicable federal limitation.

(D) In establishing the reimbursement methodology pursuant to paragraph (1) and the parameters for Medi-Cal managed care plans in the County of Los Angeles to make increased payments to the hospital pursuant to subdivision (b), the department shall consider strategies that are designed to result in the hospital receiving the payments pursuant to this section as quickly as practicable and on an ongoing or periodic basis that supports the stability of the hospital's cash flow.

(4) To the extent necessary to meet the objectives identified in paragraph (2) or to comply with federal requirements, the department may, in consultation with the hospital, adjust or modify the directed payment reimbursement methodology to meet applicable federal requirements and be consistent with actuarial rate development principles and standards.

(b) (1) Medi-Cal managed care plans in the County of Los Angeles shall increase payments to the hospital in accordance with the requirements of the directed payment methodology established by the department pursuant to this section and guidance issued pursuant to subdivision (c).

(2) Except as provided in paragraph (3), this section shall not be construed to preclude the hospital from receiving any other payment for which it is eligible in addition to the payments provided for by this section.

(3) For any dates of service for which this section is implemented, in whole or in part, and notwithstanding any other law, a Medi-Cal managed care plan shall not be required to make any payments pursuant to Section 14165.50.

(c) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or similar instructions, without taking any further regulatory action.

(d) (1) The department shall seek any federal approvals it deems necessary to implement this section.

(2) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(e) (1) The nonfederal share of increases to Medi-Cal managed care plan capitation rates made in accordance with this section shall be funded using General Fund moneys or other state funds appropriated to the department as the state share in the annual Budget Act.

(2) Implementation of this section in each applicable fiscal year is subject to an appropriation in the annual Budget Act or another statute for the express purpose of this section.

(Added by Stats. 2024, Ch. 999, Sec. 8. (AB 177) Effective September 30, 2024.)