An act to amend Section 14169.53 of the Welfare and Institutions Code, relating to Medi-Cal, and making an appropriation therefor.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14169.53 of the Welfare and Institutions Code is amended to read:

14169.53. (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 fund. Notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on deposits in the fund from the proceeds of the fee assessed pursuant to this article shall be retained in the fund for purposes specified in subdivision (b).

(b) (1) Notwithstanding subdivision (c) of Section 14167.35, subdivision (b) of Section 14168.33, and subdivision (b) of Section 14169.33, all funds from the proceeds of the fee assessed pursuant to this article in the fund, together with any interest and dividends earned on money in the fund, shall continue to be used exclusively to enhance federal financial participation for hospital services under the Medi-Cal program, to provide additional reimbursement to, and to support quality improvement efforts of, hospitals, and to minimize uncompensated care provided by hospitals to uninsured patients, as well as to pay for the state's administrative costs and to provide funding for children's health coverage, in the following order of priority:

(A) (i) To pay for the department's staffing and administrative costs directly attributable to implementing this article, not to exceed two hundred fifty thousand dollars ~~($250,000)~~ ($250,000), except as provided in clause (ii), for each subject fiscal quarter, exclusive of any federal matching funds.

(ii) Notwithstanding any other law, during any fiscal quarter for which the department incurs staffing or administrative costs due to the implementation of the federal Medicaid pass-through payment requirements codified in Section 438.6 of Title 42 of the Code of Federal Regulations as of March 20, 2017, or other federal requirements imposed as of the effective date of the act that added this clause, which significantly impact the implementation of this article, to pay for the department's staffing and administrative costs that are directly attributable to implementing this article, not to exceed five hundred thousand dollars ($500,000) for each subject fiscal quarter, exclusive of any federal matching funds.

(B) To pay for the health care coverage, as described in subdivision (g), except that for the two subject fiscal quarters in the 2013–14 fiscal year, the amount for children's health care coverage shall be one hundred fifty-five million dollars ($155,000,000) for each subject fiscal quarter, exclusive of any federal matching funds.

(C) To make increased capitation payments to managed health care plans pursuant to this article and Section 14169.82, including the nonfederal share of capitation payments to managed health care plans pursuant to this article and Section 14169.82 for services provided to individuals who meet the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)).

(D) To make increased payments and direct grants to hospitals pursuant to this article and Section 14169.83, including the nonfederal share of payments to hospitals under this article and Section 14169.83 for services provided to individuals who meet

the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)).

(2) Notwithstanding subdivision (c) of Section 14167.35, subdivision (b) of Section 14168.33, and subdivision (b) of Section 14169.33, and notwithstanding Section 13340 of the Government Code, the moneys in the fund shall be continuously appropriated during the first program period only, without regard to fiscal year, for the purposes of this article, Article 5.229 (commencing with Section 14169.31), Article 5.228 (commencing with Section 14169.1), Article 5.227 (commencing with Section 14168.31), former Article 5.226 (commencing with Section 14168.1), former Article 5.22 (commencing with Section 14167.31), and former Article 5.21 (commencing with Section 14167.1).

(3) Notwithstanding any other law, for the second program period and subsequent program periods, the moneys in the fund shall be continuously appropriated, without regard to fiscal year, for the purposes of this article and Sections 14169.82 and 14169.83.

(c) Any amounts of the quality assurance fee collected in excess of the funds required to implement subdivision (b), including any funds recovered under subdivision (d) of Section 14169.61, 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 used as quality assurance fees for the next program period for general acute care hospitals, pro rata with the amount of quality assurance fees paid by the hospital for the program period.

(d) Any methodology or other provision specified in 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, purposes, and intent of this article and are not inconsistent with the conditions of implementation set forth in Section 14169.72. The department shall notify the Joint Legislative Budget Committee and the fiscal and appropriate policy committees of the Legislature 30 days prior to implementation of a modification pursuant to this subdivision.

(e) The department, in consultation with the hospital community, shall make adjustments, as necessary, to the amounts calculated pursuant to Section 14169.52 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) (1) For purposes of this subdivision, the following definitions shall apply:

(A) "Actual net benefit" means the net benefit determined by the department for a net benefit period after the conclusion of the net benefit period using payments and grants actually made, and fees actually collected, for the net benefit period.

(B) "Aggregate fees" means the aggregate fees collected from hospitals under this article.

(C) "Aggregate payments" means the aggregate payments and grants made directly or indirectly to hospitals under this article, including payments and grants described in Sections 14169.54, 14169.55, 14169.57, and 14169.58, and subdivision (b) of Section 14169.82.

(D) "Net benefit" means the aggregate payments for a net benefit period minus the aggregate fees for the net benefit period.

(E) "Net benefit period" means a subject fiscal year or portion thereof that is in a program period and begins on or after July 1, 2014.

(F) "Preliminary net benefit" means the net benefit determined by the department for a net benefit period prior to the beginning of that net benefit period using estimated or projected data.

(2) The amount of funding provided for children's health care coverage under subdivision (b) for a net benefit period shall be equal to 24 percent of the net benefit for that net benefit period.

(3) The department shall determine the preliminary net benefit for all net benefit periods in the first program period before July 1, 2014. The department shall determine the preliminary net benefit for all net benefit periods in a subsequent program period before the beginning of the program period.

(4) The department shall determine the actual net benefit and make the reconciliation described in paragraph (5) for each net benefit period within six months after the date determined by the department pursuant to subdivision (h).

(5) For each net benefit period, the department shall reconcile the amount of moneys in the fund used for children's health coverage based on the preliminary net benefit with the amount of the fund that may be used for children's health coverage under this subdivision based on the actual net benefit. For each net benefit period, any amounts that were in the fund and used for children's health coverage in excess of the 24 percent of the actual net benefit shall be returned to the fund, and the amount, if any, by which 24 percent of the actual net benefit exceeds 24 percent of the preliminary net benefit shall be available from the fund to the department for children's health coverage. The department shall notify the Joint Legislative Budget Committee and the fiscal and appropriate policy committees of the Legislature of the results of the reconciliation for each net benefit period pursuant to this paragraph within five working days of performing the reconciliation.

(6) The department shall make all calculations and reconciliations required by this subdivision in consultation with the hospital community using data that the department determines is the best data reasonably available.

(h) After consultation with the hospital community, the department shall determine a date upon which substantially all fees have been paid and substantially all supplemental payments, grants, and rate range increases have been made for a program period, which date shall be no later than two years after the end of a program period. After the date determined by the department pursuant to this subdivision, no further supplemental payments shall be made under the program period, and any fees collected

with respect to the program period shall be used for a subsequent program period consistent with this section. ~~Nothing in this subdivision shall~~ This subdivision does not affect the department's authority to collect quality assurance fees for a program period after the end of the program period or after the date determined by the department pursuant to this subdivision. The department shall notify the Joint Legislative Budget Committee and fiscal and appropriate policy committees of that date within five working days of the determination.

(i) Use of the fee proceeds to enhance federal financial participation pursuant to subdivision (b) shall include use of the proceeds to supply the nonfederal share, if any, of payments to hospitals under this article for services provided to individuals who meet the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)) such that expenditures for services provided to the individual are eligible for the enhanced federal medical assistance percentage described in that section.

SEC. 2. The Legislature finds and declares that the amendments made to the Medi-Cal Hospital Reimbursement Improvement Act of 2013 by this act further the purposes of the act within the meaning of Section 3.5 of Article XVI of the California Constitution.

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LEGISLATIVE COUNSEL'S DIGEST

Bill No.
as introduced, _____.
General Subject: Medi-Cal: hospitals: quality assurance fee.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law, the Medi-Cal Hospital Reimbursement Improvement Act of 2013, subject to federal approval, imposes a hospital quality assurance fee, as specified, on certain general acute care hospitals to be deposited into the Hospital Quality Assurance Revenue Fund. Existing law provides that moneys in the Hospital Quality Assurance Revenue Fund are continuously appropriated during the first, 2nd, and subsequent program periods, as specified, and are available only for certain purposes, including, among others, paying the department's staffing and administrative costs directly attributable to implementing the quality assurance fee provisions, not to exceed $250,000, as specified.

The California Constitution, pursuant to Proposition 52 as approved by voters at the November 8, 2016, statewide general election, prohibits a statute amending or adding to the provisions of the act from becoming effective unless approved by the electors, as specified, but authorizes the Legislature, by a ⅔ vote in each house of the Legislature, to amend or add provisions that further the purposes of the act.

This bill would additionally make moneys in the fund available to pay for the department's staffing and administrative costs directly attributable to implementing the quality assurance fee provisions specifically incurred due to the implementation of certain federal Medicaid regulations, not to exceed $500,000, as specified. By expanding the use of moneys in the Hospital Quality Assurance Revenue Fund for additional staffing and administrative costs this bill would make an appropriation. By amending the provisions of the act and expanding the use of moneys in the fund, the bill would require a ⅔ vote of the Legislature.

This bill would declare that its provisions further the purposes of the Medi-Cal Hospital Reimbursement Improvement Act of 2013 within the meaning of a specified provision of the California Constitution.

Vote: 2/3. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.