Department of Health Care Services
Proposed May Revision Trailer Bill Legislation

Reauthorization of AB 1629/Freestanding Skilled Nursing Facility Quality and Accountability

Draft Version: 7-14-2010

(Changes to 7-9-2010 Draft shown in yellow highlight)

Add Section 1417.5 to the Health and Safety Code to read:

The California Department of Public Health, in consultation with stakeholders, shall develop recommendations to address the findings published in the June 2010 report entitled "Department of Public Health: It Reported Inaccurate Financial Information and Can Likely Increase Revenues for the State and Federal Health Facilities Citation Penalties Accounts" (Report 2010-108). The recommendations shall address, but not be limited to, the following:
a) Streamlining the citation appeal process, including the citation review conference process.
b) Increasing citation penalty amounts, including late penalty fees, and annually adjusting penalty amounts to reflect an inflation indicator, such as the Consumer Price Index.
(c) Revising state law to enable the California Department of Public Health to recommend that CMS impose a federal civil money penalty when the division determines that a facility is out of compliance with both state and federal requirements.
(d) Authorizing CDPH to collect citation penalty amounts upon appeal of the citation and allowing the department to place those funds into a special interest bearing account.

The California Department of Public Health shall provide recommendations to the fiscal and policy committees of the Legislature no later than March 1, 2011.

HEALTH & SAFETY CODE PROVISIONS:

Section 1324.20 of the Health and Safety Code is amended to read:
1324.20. For purposes of this article, the following definitions shall apply:
(a) (1) "Continuing care retirement community" means a provider of a continuum of services, including independent living services, assisted living services as defined in paragraph (5) of subdivision (a) of Section 1771, and skilled nursing care, on a single campus, that is subject to Section 1791, or a provider of such a continuum of services on a single campus that has not received a Letter of Exemption pursuant to subdivision (b) of Section 1771.3.

(2) Notwithstanding paragraph (1), beginning with the 2010-11 rate year and every rate year thereafter, the term “continuing care retirement community” shall have the definition contained in paragraph (11) of subdivision (a) of Section 1771.

(b) (1) "Exempt facility" means a skilled nursing facility that is part of a continuing care retirement community, a skilled nursing facility operated by the state or another public entity, a unit that provides pediatric subacute services in a skilled nursing facility, a skilled nursing facility that is certified by the State Department of Mental Health for a special treatment program and is an institution for mental disease as defined in Section 1396d(i) of Title 42 of the United States Code, or a skilled nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital.

(2) Beginning with the 2010-11 rate year, and every rate year thereafter, “exempt facility” means a skilled nursing facility that is part of a continuing care retirement community, as defined in subdivision (a)(2), a skilled nursing facility operated by the state or another public entity, a unit that provides pediatric subacute services in a skilled nursing facility, a skilled nursing facility that is certified by the State Department of Mental Health for a special treatment program and is an institution for mental disease as defined in Section 1396d(i) of Title 42 of the United States Code, or a skilled nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital.

(3) Beginning with the 2010-11 rate year, and every rate year thereafter, a multi-level facility, as defined in subdivision (a)(1), shall not be exempt from the quality assurance fee requirements pursuant to this Article unless it meets the definition of “continuing care retirement community” in paragraph (11) of subdivision (a) of Section 1771.

(c) (1) "Net revenue" means gross resident revenue for routine nursing services and ancillary services provided to all residents by a skilled nursing facility, less Medicare revenue for routine and ancillary services, including Medicare revenue for services provided to residents covered under a Medicare managed care plan, less payer discounts and applicable contractual allowances as permitted under federal law and regulation.

(2) Notwithstanding paragraph (1), for the 2009-10, ~~and~~ 2010-11 and 2011-12 rate years, "net revenue" means gross resident revenue for routine nursing services and ancillary services provided to all residents by a skilled nursing facility, including Medicare revenue for routine and ancillary services and Medicare revenue for services provided to residents covered under a Medicare managed care plan, less payer discounts and applicable contractual allowances as permitted under federal law and regulation. To implement this paragraph, the department shall request federal approval pursuant to Section 1324.27.

(3) "Net revenue" does not mean charitable contributions and bad debt.

(d) "Payer discounts and contractual allowances" means the difference between the facility's resident charges for routine or ancillary services and the actual amount paid.

(e) "Skilled nursing facility" means a licensed facility as defined in subdivision (c) of Section 1250.

(f) Unless otherwise specified, all references to the “department” shall mean the Department of Health Care Services.

Section 1324.21 of the Health and Safety Code is amended to read:
1324.21. (a) a) For facilities licensed under subdivision (c) of Section 1250, there shall be imposed each fiscal year a uniform quality assurance fee per resident day. The uniform quality assurance fee shall be based upon the entire net revenue of all skilled nursing facilities subject to the fee, except an exempt facility, as defined in Section 1324.20, calculated in accordance with subdivision (b).

(b) The amount of the uniform quality assurance fee to be assessed per resident day shall be determined based on the aggregate net revenue of skilled nursing facilities subject to the fee, in accordance with the methodology outlined in the request for federal approval required by Section 1324.27 and in regulations, provider bulletins, or other similar instructions. The uniform quality assurance fee shall be calculated as follows:

(1) (A) For the rate year 2004-05, the net revenue shall be projected for all skilled nursing facilities subject to the fee. The projection of net revenue shall be based on prior rate-year data. Once determined, the aggregate projected net revenue for all facilities shall be multiplied by 2.7 percent, as determined under the approved methodology, and then divided by the projected total resident days of all providers subject to the fee.

(B) Notwithstanding subparagraph (A), the Director of Health Care Services may increase the amount of the fee up to 3 percent of the aggregate projected net revenue if necessary for the implementation of Article 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(2) (A) For the rate year 2005-06 and subsequent rate years through and including the 2009-10 ~~2010-11~~ rate year, the net revenue shall be projected for all skilled nursing facilities subject to the uniform quality assurance fee. The projection of net revenue shall be based on the prior rate year's data. Once determined, the aggregate projected net revenue for all facilities shall be multiplied by 6 percent, as determined under the approved methodology, and then divided by the projected total resident days of all providers subject to the fee. The amounts so determined shall be subject to the provisions of subdivision (d).
(B) For the rate year 2010-11 and subsequent rate years, the net revenue shall be projected for all skilled nursing facilities subject to the uniform quality assurance fee. The projection of net revenue shall be based on the prior rate year’s data trended forward, using historical increases in net revenues. Once determined, the aggregate projected net revenue for all facilities shall be multiplied by 6 percent, as determined under the approved methodology, and then divided by the projected total resident days

of all providers subject to the fee. The amounts so determined shall be subject to the provisions of subdivision (d).

(c) The director may assess and collect a nonuniform fee consistent with the methodology approved pursuant to Section 1324.27.

(d) In no case shall the fees collected annually pursuant to this article, taken together with applicable licensing fees, exceed the amounts allowable under federal law.

(e) If there is a delay in the implementation of this article for any reason, including a delay in the approval of the quality assurance fee and methodology by the federal Centers for Medicare and Medicaid Services, in the 2004-05 rate year or in any other rate year, all of the following shall apply:

(1) Any facility subject to the fee may be assessed the amount the facility will be required to pay to the department, but shall not be required to pay the fee until the methodology is approved and Medi-Cal rates are increased in accordance with paragraph (2) of subdivision (a) of Section 1324.28 and the increased rates are paid to facilities.

(2) The department may retroactively increase and make payment of rates to facilities.

(3) Facilities that have been assessed a fee by the department shall pay the fee assessed within 60 days of the date rates are increased in accordance with paragraph (2) of subdivision (a) of Section 1324.28 and paid to facilities.

(4) The department shall accept a facility's payment notwithstanding that the payment is submitted in a subsequent fiscal year than the fiscal year in which the fee is assessed.

Section 1324.22 of the Health and Safety Code is amended to read:

1324.22. (a) The quality assurance fee, as calculated pursuant to Section 1324.21, shall be paid by the provider to the department for deposit in the State Treasury on a monthly basis on or before the last day of the month following the month for which the fee is imposed, except as provided in subdivision (e) of Section 1324.21.

(b) On or before the last day of each calendar quarter, each skilled nursing facility shall file a report with the department, in a prescribed form, showing the facility's total resident days for the preceding quarter and payments made. If it is determined that a lesser amount was paid to the department, the facility shall pay the amount owed in the preceding quarter to the department with the report. Any amount determined to have been paid in excess to the department during the previous quarter shall be credited to the amount owed in the following quarter.

(c) On or before August 31 of each year, each skilled nursing facility subject to an assessment pursuant to Section 1324.21 shall report to the department, in a prescribed

form, the facility's total resident days and total payments made for the preceding state fiscal year. If it is determined that a lesser amount was paid to the department during the previous year, the facility shall pay the amount owed to the department with the report.

(d) (1) A newly licensed skilled nursing facility~~, as defined by the department,~~ shall complete all requirements of subdivision (a) for any portion of the year in which it commences operations and of subdivision (b) for any portion of the quarter in which it commences operations.
(2) For purposes of this subdivision, a newly licensed skilled nursing facility is a location that has not been previously licensed as a skilled nursing facility.
(3) Nothing in this subdivision shall be construed as a change in previous law enacted by Chapter 875 of the Statutes of 2004, but merely as a clarification of existing law. The Legislature also affirms its intent for this subdivision to be applied to the 2010-11 rate year, and every rate year thereafter.

(e) (1) When a skilled nursing facility fails to pay all or part of the quality assurance fee within 60 days of the date that payment is due, the department may deduct the unpaid assessment and interest owed from any Medi-Cal reimbursement payments to the facility until the full amount is recovered. Any deduction shall be made only after written notice to the facility and may be taken over a period of time taking into account the financial condition of the facility.

(2) In addition to the provisions of paragraph (1), any unpaid quality assurance fee assessed by this article shall constitute a debt due the State of California and may be collected pursuant to Section 12419.5 of the Government Code.

(f) (1) Notwithstanding any other provision of law, the department shall continue to assess and to collect the quality assurance fee, including any previously unpaid quality assurance fee, on each skilled nursing facility irrespective of any changes in ownership, any changes in ownership interest or control, or the transfer of any portion of the assets of a facility to another owner.

(2) Nothing in this subdivision shall be construed as a change in previous law enacted by Chapter 875 of the Statutes of 2004, but merely as a clarification of existing law and codification of rules promulgated by the department under the authority of Section 1324.23. The Legislature also affirms its intent for this subdivision to be applied to the 2010-11 rate year, and every rate year thereafter.

(3) During any period of time in which a temporary manager is appointed to a facility pursuant to Section 1325.5 or during which a receiver is appointed by a court pursuant to Section 1327, the California Department of Public Health shall not be responsible for any unpaid quality assurance fee incurred by the facility prior to the period of temporary management or receivership. Nothing in this paragraph shall affect the responsibility of the facility to make all payments of unpaid or current quality assurance fees, as required by this section and Section 1324.21.

(~~f~~g) Should all or any part of the quality assurance fee remain unpaid, the department may take either or both of the following actions:
(1) Assess a penalty:
(A) Equal to 50 percent of the unpaid fee amount for rate years 2004-05 through and including 2009-10.

(B) Up to 50 percent of the unpaid fee amount beginning rate year 2010-11 and each rate year thereafter.

(2) (A) Delay license renewal.

(B) Beginning rate year 2010-11 and each rate year thereafter, the department may recommend to the California Department of Public Health that license renewal be delayed until the department has recovered the full amount due.

(~~g~~h) In accordance with the provisions of the Medicaid ~~s~~State ~~p~~Plan, the payment of the quality assurance fee shall be considered as an allowable cost for Medi-Cal reimbursement purposes.

(~~h~~i) The assessment process pursuant to this section shall become operative not later than 60 days from receipt of federal approval of the quality assurance fee, unless extended by the department. The department may assess fees and collect payment in accordance with subdivision (e) of Section 1324.21 in order to provide retroactive payments for any rate increase authorized under this article.

Section 1324.23 of the Health and Safety Code is amended to read:
1324.23. (a) The Director of Health Care Services, or his or her designee, shall administer this article.

(b) The director may adopt regulations as are necessary to implement this article. These regulations may be adopted as emergency regulations in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).
For purposes of this article, the adoption of regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The regulations shall include, but need not be limited to, any regulations necessary for any of the following purposes:

(1) The administration of this article, including the proper imposition and collection of the quality assurance fee not to exceed amounts reasonably necessary for purposes of this article.

(2) The development of any forms necessary to obtain required information from facilities subject to the quality assurance fee.

(3) To provide details, definitions, formulas, and other requirements.

(c) As an alternative to subdivision (b), and 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 director may implement this article, in whole or in part, by means of a provider bulletin, or other similar instructions, without taking regulatory action, provided that no such bulletin or other similar instructions shall remain in effect after July 31, ~~2010~~ 2012. It is the intent of the Legislature that the regulations adopted pursuant to subdivision (b) shall be adopted on or before July 31, ~~2010~~2012.

Section 1324.28 of the Health and Safety Code is amended to read:
1324.28 (a) – No change.

(b) This article shall remain operative only as long as all of the following conditions are met:

(1) The federal Centers for Medicare and Medicaid Services continues to allow the use of the provider assessment provided in this article.

(2) The Medi-Cal Long Term Care Reimbursement Act, Article 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, as added during the 2003-04 Regular Session by the act adding this section, is enacted and implemented on or before July 31, 2005, or as extended as provided in that article, and remains in effect thereafter.

(3) The state has continued its maintenance of effort for the level of state funding of nursing facility reimbursement for rate year 2005-06, and for every subsequent rate year continuing through the ~~2010-11~~ 2011-12 rate year, in an amount not less than the amount that specific facilities would have received under the rate methodology in effect on July 31, 2004, plus Medi-Cal's projected proportional costs for new state or federal mandates, not including the quality assurance fee.

(4) The full amount of the quality assurance fee assessed and collected pursuant to this article remains available for the purposes specified in Section 1324.25 and for related purposes.

(c) - (d) - No change.

Section 1324.29 of the Health and Safety Code is amended to read:
1324.29. The quality assurance fee shall cease to be assessed ~~and collected on or~~ after July 31, ~~2011~~ 2012. The department shall continue to collect all quality assurance fees, including penalties and interest, until the amount is paid in full.

Section 1324.30 of the Health and Safety Code is amended to read:
1324.30. This article shall become inoperative ~~on~~ after July 31 ~~August 1~~, ~~2011~~ 2012, and, as of January 1, ~~2012~~ 2013, is repealed, unless a later enacted statute, that becomes operative on or before January 1, ~~2012~~ 2013, deletes or extends the dates on which it becomes inoperative and is repealed.

WELFARE & INSTITUTIONS CODE PROVISIONS:

Section 14126.022 of the Welfare and Institutions Code is added to read:
14126.022. (a) (1) The department shall develop a Skilled Nursing Facility Quality and Accountability Supplemental Payment System (System) by August 1, 2011, subject to federal Centers for Medicare and Medicaid Services approval, and availability of federal, state, or other funds.

(2) The System shall be utilized for providing supplemental payments to skilled nursing facilities that improve the quality and accountability of care rendered to residents in skilled nursing facilities as defined in subdivision (c) of Section 1250 of the Health and Safety Code, and penalizing those facilities that do not meet measurable standards.

(3) The System shall be phased in, beginning with rate year 2010-11.

(4) The department may utilize the System to:
(A) Assess overall facility quality of care and quality of care improvement, and assign quality and accountability payments to skilled nursing facilities pursuant to performance measures described in subdivision (h).

(B) Assign quality and accountability payments or penalties relating to quality of care, and or direct care staffing levels, wages and benefits,

(C) Limit the reimbursement of legal fees incurred by skilled nursing facilities engaged in the defense of governmental legal actions filed against the facilities.

(D) Publish each facility's quality assessment and quality and accountability payments in a manner and form that the Director or designee may choose.

(b) No appropriation associated with this bill is intended to implement the provisions of Section 1276.65 of the Health and Safety Code.

(c) The department shall seek necessary approvals from the federal Centers for Medicare and Medicaid Services to implement this section. The department shall implement this section only in a manner that is consistent with federal Medicaid law and regulations, and only to the extent that federal Centers for Medicare and Medicaid Services approval is obtained and federal financial participation is available.

(d) In implementing this section, the department and the California Department of Public Health may contract as necessary, with California's Medicare Quality Improvement Organization, or other qualified entities deemed qualified by the department or the California Department of Public Health, not associated with a skilled nursing facility, to assist with development, collection, analysis and reporting of the performance data pursuant to subdivision (h), and with demonstrated expertise in long-term care quality, data collection or analysis and accountability performance measurement models pursuant to subdivision (h). This subdivision establishes an accelerated process for issuing any contract pursuant to this section. Any contract entered into pursuant to this

subdivision shall be exempt from the requirements of the Public Contract Code, through December 31, 2012.

(e) The Skilled Nursing Facility Quality and Accountability Fund (Fund) is hereby created in the State Treasury.

(1) Notwithstanding Section 13340 of the Government Code, the Fund and interest derived from the Fund shall be continuously appropriated to the department for the purposes specified in this section.

(2) The Fund shall be utilized as follows:
(A) As the funding source for making quality and accountability payments to facilities that meet or exceed predefined measures as established by this section.

(B) To cover the administrative costs incurred by the California Department of Public Health for positions and contract funding required to implement this section, and contingent upon appropriation.

(C) To cover the administrative costs incurred by the Department of Health Care Services for positions and contract funding required to implement this section and contingent upon appropriation.

(D) To provide funding assistance for the Long-Term Care Ombudsman for activities pursuant to Section 9700, et seq., and contingent upon appropriation.

(f)(1) For 2010-11, $1.9 million is hereby appropriated from the Fund to the California Department of Aging for the Long-Term Care Ombudsman. It is the intent of the Legislature for the $1.9 million from the Fund to be in addition to the $4.168 million proposed in the Governor's May Revision for 2010-11. It is the intent of the Legislature to increase this level of appropriation in subsequent years to provide support sufficient to carry out the mandates and activities pursuant to Section 9700, et seq.

(f)(2) The department, in partnership with the California Department of Aging, shall seek approval from the federal Centers for Medicare and Medicaid Services to obtain federal Medicaid ~~funds for any and all~~ reimbursement for activities conducted by the Long-Term Care Ombudsman. The department shall report to the fiscal committees of the Legislature during budget hearings on progress being made and any unresolved issues during the 2011-12 budget deliberations.

(g) (1) Beginning with rate year 2010-11, the department shall use direct care staffing level data collected by the California Department of Public Health to determine whether a skilled nursing facility has met the nursing hours per patient per day requirements pursuant to Section 1276.5 of the Health and Safety Code.

(2)(A) Beginning with rate year 2010-11, the California Department of Public Health shall assess a skilled nursing facility licensed pursuant to subdivision (c) of Section 1250 of the Health and Safety Code an administrative penalty if the skilled nursing facility fails to meet the nursing hours per patient per day requirements pursuant to Section 1276.5 of the Health and Safety Code as follows:

(i) $15,000 if the facility fails to meet the requirements for 5 percent or more of audited days up to 49 percent

(ii) $30,000 if the facility fails to meet the requirements for 50 percent or more of the audited days.

~~(B) (i) If the skilled nursing facility disputes a determination by the California Department of Public Health regarding the failure to comply with the minimum staffing requirements in Section 1276.5 the skilled nursing facility may, within 10 days request a hearing pursuant to Section 131071 of the Health and Safety Code. A skilled nursing facility that disputes a determination by the California Department of Public Health regarding the failure to comply with the minimum staffing requirements in Section 1276.5, may appeal the determination pursuant to provisions set forth in an All Facilities Letter or other guidance. Both the guidance and appeals process shall be exempt from the Administrative Procedures Act. The provisions of Section 131071 of the Health and Safety Code shall not apply to this process. The appeals process guidance shall include language stating the hearing shall be conducted and a final decision issued within 120 days of the receipt of an appeal notice by the facility. The decision shall be considered the final decision of the California Department of Public Health upon receipt by the facility.~~

(B) (i) If the facility appeals the determination of (2)(A) of subdivision (g), it shall submit to CDPH within 15 days of the facility's receipt of the CDPH determination a detailed statement describing the reason for appeal and include all supporting documents the facility intends to present at hearing.

(ii) (A) Within 15 days of receiving the facility's notice of appeal, CDPH shall request a hearing. CDPH shall include with its request all supporting documents that it intends to present at hearing and submit them to both the department and facility.
(B) Within 15 days of receiving the request for a hearing, the department shall notify the parties of the hearing date.

(iii) (A) Hearing officers for the department shall both hear the appeal and issue a decision within 120 days of CDPH receiving the appeal request. The decision shall be the final decision of the CDPH upon issuance by the department's director or his or her designee.
(B) Both the All Facilities Letter and appeals process shall be exempt from the Administrative Procedures Act. The provisions of Section 131071 of the Health and Safety Code shall not apply to this process.

(ii) When a decision regarding the administrative penalty is in favor of the California Department of Public Health, the skilled nursing facility shall pay the penalty to the

California Department of Public Health within 30 days of receipt of the administrative appeal decision.
(iii) The California Department of Public Health shall deposit the penalty into the Skilled Nursing Facility Minimum Staffing Penalty Account, that is hereby established in the Special Deposit Fund created pursuant to Section 16370 of the Government Code. The California Department of Public Health shall transfer these payments on a monthly basis to the department.

(3) (A) If the skilled nursing facility does not dispute the determination, the penalties shall be paid in full by the licensee to the California Department of Public Health within 30 days and deposited into the Skilled Nursing Facility Minimum Staffing Penalty Account. The California Department of Public Health shall transfer these payments on a monthly basis to the department.

(B) The California Department of Public Health may, upon written notification to the licensee, request that the department offset any moneys owed to the licensee by the Medi-Cal program or any other payment program administered by the department or offset any other payment program administered by the California Department of Public Health, to recoup the penalty.

(C) The assessment of a penalty under this section does not supplant the California Department of Public Health's investigation process or issuance of deficiencies or citations under Section 1423 et seq. of the Health and Safety Code.

(D) Nothing in this section shall impact the effectiveness or utilization of Section 1278.5 of the Health and Safety Code relating to whistleblower protections or Section 1420 of the Health and Safety Code relating to complaints.

(h) The department in consultation with representatives from long-term care industry, organized labor, and consumers, shall establish and publish quality and accountability measures, benchmarks, and data submission deadlines by November 30, 2010.

The methodology developed pursuant to this section shall include, but not be limited to the following requirements and performance measures:

(1) Beginning in rate year 2011-12:
(A) Immunization rates.
(B) Facility acquired pressure ulcer incidence.
(C) The use of physical restraints.
(D) Nursing hours per patient per day requirements pursuant to Section 1276.5 of the Health and Safety Code.
(E) Resident and family satisfaction.

(2) In addition to the performance measures identified in paragraph (1), if this Act is extended beyond the dates on which it becomes inoperative and repealed, beginning in rate year 2012-13, the department in consultation with representatives from the long-

term care industry, organized labor, and consumers, shall incorporate additional performance measures into the Skilled Nursing Facility Quality and Accountability Payment System including, but not limited to,:
~~(A)~~ Centers for Medicare and Medicaid Services identified quality and accountability measures as required by federal health care reform.
Additionally, the department, in consultation with representatives from the long-term care industry, organized labor, and consumers, may incorporate additional performance measures, including, but not limited to:
~~(B)~~ (A) ~~Any other data or measures, such as c~~Compliance with state policy associated with Olmstead requirements.
(B) Direct care staff turnover.
(C) The use of chemical restraints.

(i) The California Department of Public Health shall deposit all penalty payments collected pursuant to subdivision (g) into the Department of Health Care Services' Skilled Nursing Facility Quality and Accountability Special Fund.

(j) Beginning with rate year 2010-11, and pursuant to subdivision (a)(5)(B) of Section 14126.023, the department shall set aside savings achieved from setting the Professional Liability Insurance cost category, including any insurance deductible costs paid by the facility, at the 75th percentile. From this amount, the department shall transfer the General Fund portion into the Skilled Nursing Facility Quality and Accountability Special Fund. Facilities must provide supplemental data on insurance deductible costs to facilitate this adjustment, in the format requested by the department and by the department due dates, or insurance deductible costs will remain in the Administrative Costs category.

(k) Beginning with rate year 2011-12, the department shall set aside 1 percentage point of the increase in the weighted average annual Medi-Cal reimbursement rate. From this amount, the department shall transfer the General Fund portion into the Skilled Nursing Facility Quality and Accountability Special Fund.

(l) If this Act is extended beyond the dates on which it becomes inoperative and repealed, beginning in rate year 2012-13, in addition to subdivision (k), if there is a rate increase, the department shall set aside the first thirty-three and one-third percent, up to a maximum of one (1) percentage point, of the annual increase in the weighted average Medi-Cal reimbursement rate. From this amount, the department shall transfer the General Fund portion into the Skilled Nursing Facility Quality and Accountability Special Fund.

(m) (1) Beginning in rate year 2011-12, the department shall pay a supplemental payment, by April 30, 2012, to skilled nursing facilities based on all of the criteria in subdivision (h) as published by the department, and according to performance measure benchmarks determined by the department in consultation with stakeholders.

(2) Skilled nursing facilities that do not submit required performance data by the department's specified timeframes pursuant to subdivision (i) shall not be eligible to receive supplemental payments.

(3) Notwithstanding paragraph (1), if a facility appeals the performance measure in subdivision(h)(1)(D) to the California Department of Public Health and it is unresolved by the department's published due date, the department shall not use that performance measure when determining the facility's supplemental payment.

(4) Notwithstanding paragraph (1), if the department is unable to pay the supplemental payments by April 30, 2012, then on May 1, 2012, the department shall use the funds available in the Skilled Nursing Facility Quality and Accountability Special Fund as a result of savings identified in subdivisions (k) and (l), less the administrative costs required to implement subdivisions (e)(2)(B) and (e)(2)(C), in addition to any Medicaid funds, that are available as of December 31, 2011 to increase provider rates retroactively to August 1, 2011.

(n) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code:
(1) The director shall implement this section, in whole or in part, by means of provider bulletins, or other similar instructions without taking regulatory action.

(2) The director of the California Department of Public Health may implement this section by means of All Facility Letters, or other similar instructions without taking regulatory action.

(o) Notwithstanding subdivision (m)(3), in the event of a final judicial determination made by any state or federal court that is not appealed, in any action by any party, or a final determination by the administrator of the federal Centers for Medicare and Medicaid Services, that any payments pursuant to subdivisions (a) through (d), (h), and (m) of this section are invalid, unlawful or contrary to any provision of federal law or regulations, or of state law, these subdivisions shall become inoperative and for rate year 2011-12 the rate increase provided under subdivision (a)(4)(A) of Section 14126.033 shall be reduced by the amounts described in subdivisions (j) and (k). For the rate year 2012-13, and future rate years, any rate increase shall be reduced by the amounts described in subdivisions (j) and (l).

Section 14126.023 of the Welfare and Institutions Code is amended to read:
14126.023. (a) The methodology developed pursuant to this article shall be facility specific and reflect the sum of the projected cost of each cost category and passthrough costs, as follows:
(1) Labor costs limited as specified in subdivision (d).
(2) Indirect care nonlabor costs limited to the 75th percentile.
(3) (A) Administrative costs limited to the 50th percentile.

(B) Notwithstanding paragraph (a)(3)(A), beginning with rate year 2010-11 and in each subsequent rate year, the administrative cost category shall not include any legal and consultant fees in connection with a fair hearing or other litigation against or involving any government agency or department until all issues related to the fair hearing or litigation issues are ultimately decided, or resolved. Facilities shall report supplemental data required to disallow costs described in (a)(3)(C) in a format, and before the deadline, determined by the department.

(C) Notwithstanding paragraph (a)(3)(A), beginning with rate year 2010-11, and in each subsequent rate year, the department shall not allow any cost associated with legal or consultant fees in connection with a fair hearing or other litigation against any government agency, or department where:
(i) a decision has been rendered in favor of such governmental agency or department, or
(ii) the determination of the governmental agency or department otherwise stands, or
(iii) a settlement or similar resolution has been reached regarding any citation issued under subdivisions (c), (d) or (e) of Section 1424 of the Health and Safety Code or regarding any remedy imposed under Subpart F of Part 489 of Title 42 of the Code of Federal Regulations, or
(iv) a settlement or similar resolution has been reached under the provisions of Section 14123 or 14171.

(4) Capital costs based on a fair rental value system (FRVS) limited as specified in subdivision (d).

(5) (A) Direct passthrough of proportional Medi-Cal costs for property taxes, facility license fees, new state and federal mandates, caregiver training costs, and liability insurance projected on the prior year's costs.

(B) (i) Notwithstanding paragraph (5)(A), for rate year 2010-11 and each rate year thereafter, professional liability insurance costs, including any insurance deductible costs paid by the facility,shall be limited to the 75th percentile computed on a specific geographic peer group basis.

(ii) Facilities shall report supplemental data described in subdivision (i) in a format and by the deadline determined by the Department, or the insurance deductible costs shall continue to be reimbursed in the Administrative cost category.

(b) (1) The percentiles in paragraphs (1) through (3) of subdivision (a) shall be based on annualized costs divided by total resident days and computed on a specific geographic peer group basis. Costs within a specific cost category shall not be shifted to any other cost category.

(2) Notwithstanding paragraph (b)(1), for the 2010-11 and 2011-12 rate years, the percentiles in paragraphs (1) through (5) of subdivision (a) shall be based on annualized audited costs divided by total resident days and computed on a specific geographic

peer group basis. Costs within a specific category shall not be shifted to any other cost category.

(c) (1) Facilities newly certified to participate in the Medi-Cal program shall receive a reimbursement rate based on the peer-group weighted average Medi-Cal reimbursement rate. Facilities shall continue to receive the peer-group weighted average Medi-Cal reimbursement rate until one of the conditions of subdivision (A) or (B) has been met.

(A) The department shall calculate the Freestanding Skilled Nursing Facility-B facility specific rate when a minimum of six months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Section 14126.021.

(B) The department shall calculate the Freestanding Subacute Skilled Nursing Facility-B facility specific rate when a cost report with a minimum of 12 months of Medi-Cal cost data has been audited. The facility specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Section 14126.021.

(2) Facilities that have been de-certified for less than six months and upon recertification shall continue to receive the facility per diem reimbursement rate in effect prior to decertification. Facilities shall continue to receive the facility per diem reimbursement rate until one of the conditions in paragraph (A) or (B) have been met.

(A) The department shall calculate the Freestanding Skilled Nursing Facility-B facility-specific rate when a minimum of six months of Medi-Cal cost data has been audited. The facility-specific rate based on the audited six months of Medi-Cal cost data shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Section 14126.021.

(B) The department shall calculate the Freestanding Subacute Skilled Nursing Facility-B facility specific rate when a cost report with a minimum of 12 months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Section 14126.021

(3) Facilities that have been de-certified for six months or longer and upon recertification shall receive a reimbursement rate based on the peer-group weighted average Medi-Cal reimbursement rate. Facilities shall continue to receive the peer group weighted average Medi-Cal reimbursement rate until one of the conditions in paragraph (A) or (B) have been met.

(A) The Department shall calculate the Freestanding Skilled Nursing Facility-B facility specific rate when a minimum of six months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Section 14126.021.

(B) The Department shall calculate the Freestanding Subacute Skilled Nursing Facility-B facility specific rate when a cost report with a minimum of twelve months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Section 14126.021.

(4) Facilities that have a change of ownership or changes of the licensed operator shall continue to receive the facility per diem reimbursement rate in effect with the previous owner. Facilities shall continue to receive the facility per diem reimbursement rate until one of the conditions in subsection (A) or (B) have been met.

(A) The Department shall calculate the Freestanding Skilled Nursing Facility-B facility specific rate when a minimum of six months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Section 14126.021.

(B) The Department shall calculate the Freestanding Subacute Skilled Nursing Facility B facility-specific rate when a cost report with a minimum of 12 months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Section 14126.021

(5) This subdivision represents codification of existing rules promulgated by the department under the authority of Section 14126.027.

~~(c)~~ (d) The labor costs category shall be comprised of a direct resident care labor cost category, an indirect care labor cost category, and a labor-driven operating allocation cost category, as follows:

(1) Direct resident care labor cost category which shall include all labor costs related to routine nursing services including all nursing, social services, activities, and other direct care personnel. These costs shall be limited to the 90th percentile.

(2) Indirect care labor cost category which shall include all labor costs related to staff supporting the delivery of patient care including, but not limited to, housekeeping, laundry and linen, dietary, medical records, inservice education, and plant operations and maintenance. These costs shall be limited to the 90th percentile.

(3) (A) Labor-driven operating allocation shall include an amount equal to 8 percent of labor costs, minus expenditures for temporary staffing, which may be used to cover allowable Medi-Cal expenditures. In no instance shall the operating allocation exceed 5 percent of the facility's total Medi-Cal reimbursement rate.

(e) Notwithstanding section (d), beginning 2010-11 rate year and each rate year thereafter, the labor cost category shall not include the labor-driven operating allocation and shall be comprised only of a direct resident care labor cost category and an indirect care labor cost category.

~~(d)~~ (f) The capital cost category shall be based on a FRVS that recognizes the value of the capital related assets necessary to care for Medi-Cal residents. The capital cost category includes mortgage principal and interest, leases, leasehold improvements, depreciation of real property, equipment, and other capital related expenses. The FRVS methodology shall be based on the formula developed by the department that assesses facility value based on age and condition and uses a recognized market interest factor. Capital investment and improvement expenditures included in the FRVS formula shall be documented in cost reports or supplemental reports required by the department. The capital costs based on FRVS shall be limited as follows:

(1) For the 2005-06 rate year, the capital cost category for all facilities in the aggregate shall not exceed the department's estimated value for this cost category for the 2004-05 rate year.

(2) For the 2006-07 rate year and subsequent rate years, the maximum annual increase for the capital cost category for all facilities in the aggregate shall not exceed 8 percent of the prior rate year's FRVS cost component.

(3) If the total capital costs for all facilities in the aggregate for the 2005-06 rate year exceeds the value of the capital costs for all facilities in the aggregate for the 2004-05 rate year, or if that capital cost category for all facilities in the aggregate for the 2006-07 rate year or any rate year thereafter exceeds 8 percent of the prior rate year's value, the department shall reduce the capital cost category for all facilities in equal proportion in order to comply with paragraphs (1) and (2).

~~(e)~~(g) For the 2005-06 and 2006-07 rate years, the facility specific Medi-Cal reimbursement rate calculated under this article shall not be less than the Medi-Cal rate that the specific facility would have received under the rate methodology in effect as of July 31, 2005, plus Medi-Cal's projected proportional costs for new state or federal mandates for rate years 2005-06 and 2006-07, respectively.

~~(f)~~ (h) The department shall update each facility specific rate calculated under this methodology annually. The update process shall be prescribed in the Medicaid state plan, regulations, and the provider bulletins or similar instructions described in Section 14126.027, and shall be adjusted in accordance with the results of facility specific audit and review findings in accordance with subdivisions (h) and (i).

~~(g)~~ (i) (1) The department shall establish rates pursuant to this article on the basis of facility cost data reported in the integrated long-term care disclosure and Medi-Cal cost report required by Section 128730 of the Health and Safety Code for the most recent reporting period available, and cost data reported in other facility financial disclosure reports or supplemental information required by the department in order to implement this article.

(2) Notwithstanding paragraph (1), or any other provision of law, beginning with rate years 2010-11 and 2011-2012, the department shall establish rates pursuant to this

article on the basis of facility audited cost data reported in the integrated long-term care disclosure and Medi-Cal cost report required by Section 128730 of the Health and Safety Code and audited cost data reported in other facility financial disclosure reports or audited supplemental information required by the department in order to implement this article.

(3) Notwithstanding paragraph (1), or any other provision of law, beginning with rate years 2010-11 and each rate year thereafter, the department may determine a facility ineligible to receive supplemental payments pursuant to Section 14126.022, if a facility fails to provide supplemental data as requested by the department.

(4) This subdivision represents codification of existing rules promulgated by the department under the authority of Section 14126.027.

(~~h~~) (j) The department shall conduct financial audits of facility and home office cost data as follows:
(1) The department shall audit facilities a minimum of once every three years to ensure accuracy of reported costs.

(2) It is the intent of the Legislature that the department develop and implement limited scope audits of key cost centers or categories to assure that the rate paid in the years between each full scope audit required in paragraph (1) accurately reflects actual costs.

(3) For purposes of updating facility specific rates, the department shall adjust or reclassify costs reported consistent with applicable requirements of the Medicaid state plan as required by Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations.

(4) Overpayments to any facility shall be recovered in a manner consistent with applicable recovery procedures and requirements of state and federal laws and regulations.

(~~i~~) (k) (1) On an annual basis, the department shall use the results of audits performed pursuant to subdivision (i), the results of any federal audits, and facility cost reports, including supplemental reports of actual costs incurred in specific cost centers or categories as required by the department, to determine any difference between reported costs used to calculate a facility's rate and audited facility expenditures in the rate year.
(2) If the department determines that there is a difference between reported costs and audited facility expenditures pursuant to paragraph (1), the department shall adjust a facility's reimbursement prospectively over the intervening years between audits by an amount that reflects the difference, consistent with the methodology specified in this article.

(~~j~~) (l) For nursing facilities that obtain an audit appeal decision that results in revision of the facility's allowable costs, the facility shall be entitled to seek a retroactive adjustment in its facility specific reimbursement rate.

~~(k)~~ (m) Except as provided in Section 14126.022, ~~C~~compliance by each facility with state laws and regulations regarding staffing levels shall be documented annually either through facility cost reports, including supplemental reports, or through the annual licensing inspection process specified in Section 1422 of the Health and Safety Code**.**

Section 14126.027 of the Welfare and Institutions Code is amended to read:
14126.027. (a) – (b) No change.

(c) As an alternative to the adoption of regulations pursuant to subdivision (b), and notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code**,** the director may implement this article, in whole or in part, by means of a provider bulletin or other similar instructions, without taking regulatory action, provided that no such bulletin or other similar instructions shall remain in effect after July 31, ~~2010~~.2012. It is the intent that regulations adopted pursuant to subdivision (b) shall be in place on or before July 31, ~~2010~~ 2012 .

Section 14126.033 of the Welfare and Institutions Code is amended to read:
14126**.**033. (a) This article, including Section 14126.031, shall be funded as follows:

(1) General Fund moneys appropriated for purposes of this article pursuant to Section 6 of the act adding this section shall be used for increasing rates, except as provided in Section 14126.031, for freestanding skilled nursing facilities, and shall be consistent with the approved methodology required to be submitted to the federal Centers for Medicare and Medicaid Services pursuant to Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code**.**

(2) (A) Notwithstanding Section 14126.023, for the 2005-06 rate year, the maximum annual increase in the weighted average Medi-Cal rate required for purposes of this article shall not exceed 8 percent of the weighted average Medi-Cal reimbursement rate for the 2004-05 rate year as adjusted for the change in the cost to the facility to comply with the nursing facility quality assurance fee for the 2005-06 rate year, as required under subdivision (b) of Section 1324.21 of the Health and Safety Code, plus the total projected Medi-Cal cost to the facility of complying with new state or federal mandates.

(B) Beginning with the 2006-07 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not exceed 5 percent of the weighted average Medi-Cal reimbursement rate for the prior fiscal year, as adjusted for the projected cost of complying with new state or federal mandates.

(C) Beginning with the 2007-08 rate year and continuing through the 2008-09 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not exceed 5.5 percent of the weighted

average Medi-Cal reimbursement rate for the prior fiscal year, as adjusted for the projected cost of complying with new state or federal mandates.

(D) For the 2009-10 ~~and 2010-11~~ rate year~~s~~, the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not be increased with respect to the weighted average Medi-Cal reimbursement rate for the 2008-09 rate year, as adjusted for the projected cost of complying with new state or federal mandates.

~~(E) To the extent that new rates are projected to exceed the adjusted limits calculated pursuant to subparagraphs (A) to (D), inclusive, as applicable, the department shall adjust each skilled nursing facility's projected rate for the applicable rate year by an equal percentage.~~

(3)(A) For the 2010-11 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate for the purposes of this article shall not exceed 3.93 percent, if the federal American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) is extended for the entire 2010-11 fiscal year, or 3.14 percent, if the federal American Recovery and Reimbursement Act of 2009 (Pub. L. No. 111-5) is not extended for that period of time, plus the projected cost of complying with new state or federal mandates. If the federal American Recovery and Reinvestment Act of 2009 is extended at a different rate or for a different time period, the rate adjustment for facilities shall be adjusted accordingly.

(B) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) shall be reduced if any of the following occur:

(i) The federal Centers for Medicare and Medicaid Services does not approve exemption changes to the facilities subject to the Quality Assurance Fee, or any proposed modification to the methodology for calculation of the Quality Assurance Fee.

(ii) The state would incur any additional General Fund expense to pay for the 2010-11 weighted average reimbursement rate increase.

(C) If the maximum annual increase in the weighted average Medi-Cal rate is reduced pursuant to subparagraph (B), the Department shall recalculate and publish the final maximum annual increase in the weighted average Medi-Cal reimbursement rate.

(4)(A) For the rate 2011-12 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate for the purpose of this article shall not exceed 2.4 percent, plus the projected cost of complying with new state or federal mandates.

The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) shall be subject to the following provisions:

(i) For the 2011-12 rate year, the department shall set aside 1 percent of the weighted average Medi-Cal reimbursement rate. From this amount, the department shall transfer the General Fund portion into the Skilled Nursing Facility Quality and Accountability Special Fund, to be used for the supplemental rate pool.

(ii) The state shall not incur any additional General Fund expense to pay for the 2011-12 weighted average reimbursement rate increase.

(B) The department may recalculate and publish the weighted average Medi-Cal reimbursement rate increase for the 2011-12 rate year if the difference in the projected Quality Assurance Fee collections from the 2011-12 rate year, compared to the projected Quality Assurance Fee collections for the 2010-11 rate year, would result in any additional General Fund expense to pay for the 2011-12 rate year weighted average reimbursement rate increase.

(5) To the extent that new rates are projected to exceed the adjusted limits calculated pursuant to subparagraphs (a) (1) (A) to (D), inclusive, of paragraphs (2), (3) and (4), as applicable, the department shall adjust each skilled nursing facility's projected rate for the applicable rate year by an equal percentage.

(b) The rate methodology shall cease to be implemented ~~on and~~ after July 31, ~~2011~~ 2012.

(c) No change.

(d) This section shall become inoperative ~~on~~ after July 31, ~~2011~~, 2012 and as of January 1, ~~2012~~, 2013 is repealed, unless a later enacted statute, that is enacted before January 1, ~~2012~~, 2013 deletes or extends the dates on which it becomes inoperative and is repealed.