An act to amend Sections 1324.20, 1324.22, 1324.23, 1324.24, 1324.27, 1324.29, and 1324.30 of the Health and Safety Code, and to amend Sections 14126.022, 14126.023, 14126.027, 14126.033, and 14126.036 of the Welfare and Institutions Code, relating to public health, and making an appropriation therefor.

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

SECTION 1. 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 (d) of Section 1771.3.

(2) Notwithstanding paragraph (1), beginning with the 2010–11 rate year and for every rate or calendar year thereafter, the term "continuing care retirement community" shall have the ~~definition contained in paragraph (11)~~ same meaning as defined in paragraph (10) of subdivision (c) of Section 1771.

(b) "Department," unless otherwise specified, means the State Department of Health Care Services.

(c) (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 department 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) Notwithstanding paragraph (1), beginning with the 2010–11 rate year and for every rate or calendar year thereafter, the term "exempt facility" shall mean a skilled nursing facility that is part of a continuing care retirement community, as defined in paragraph (2) of subdivision (a), 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 department 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) Notwithstanding paragraph (1), beginning with the 2010–11 rate year and every rate or calendar year thereafter, a multilevel facility, as described in paragraph (1) of subdivision (a), shall not be exempt from the quality assurance fee requirements pursuant to this article, unless it meets the definition of a continuing care retirement community in paragraph ~~(11)~~ (10) of subdivision (c) of Section 1771.

(4) (A) Notwithstanding paragraph (1), beginning with the 2011–12 rate year, and every rate or calendar year thereafter, a unit that provides freestanding pediatric subacute care services in a skilled nursing facility, as described in paragraph ~~(1) of subdivision (c),~~ (1), shall not be exempt from the quality assurance fee requirements pursuant to this article.

(B) Notwithstanding paragraph (1) and subparagraph (A), for the rate period from August 1, 2020, to December 31, 2020, and every subsequent calendar year thereafter, a unit that provides freestanding pediatric subacute care services in a skilled

nursing facility, as described in paragraph (1), shall be exempt from the quality assurance fee requirements pursuant to this article.

~~(B)~~

(C) For the purposes of this article, "freestanding pediatric subacute care unit" has the same meaning as defined in subdivision (a) of Section 51215.8 of Title 22 of the California Code of Regulations.

(d) (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, 2010–11, and 2011–12 rate years, and each rate or calendar year thereafter, "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.

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

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

SEC. 2. 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,~~ month or quarter, as determined by the department, 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 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 calendar month or quarter in which it commences operations.

(2) For purposes of this subdivision, "newly licensed skilled nursing facility" means a location that has not been previously licensed as a skilled nursing facility.

(e) (1) If 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 shall assess interest at the rate of 7 percent per annum on any unpaid amount due, beginning on the 61st calendar day from the date the payment is due, until the unpaid amount due, plus any interest, is paid in full.

~~(e) (1)~~

(2) (A) 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~~ any unpaid assessment, including any interest and penalties 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.

(B) Notwithstanding any other law, for the rate period from August 1, 2020, to December 31, 2020, and every subsequent calendar year thereafter, the department may deduct any unpaid assessments, including any interest and penalties owed, attributable to a debtor facility from any Medi-Cal payments made to a related facility or entity by common ownership or control to the debtor facility within the meaning of Section 413.17(b) of Title 42 of the Code of Federal Regulations. If the department deducts any unpaid assessments from the Medi-Cal payments to a related facility or entity, the department shall provide prior written notice to both the debtor facility and the related facility or entity, and, in taking into account the financial condition of the related facility, may apply that deduction over a period of time.

~~(2)~~

(3) In addition to the ~~provisions of paragraph (1),~~ requirements specified in this subdivision and subdivision (h), any unpaid quality assurance ~~fee~~ fee, including any interest and penalties owed, assessed by this article shall constitute a debt due to the state 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 collect the quality assurance fee, including any previously unpaid quality assurance fee, and any interest or penalties owed, from each skilled nursing facility, irrespective of any changes in ownership or ownership interest or control or the transfer of any portion of the assets of the facility to another owner.

(2) Notwithstanding any other law, in the event of a merger, acquisition, or change of ownership involving a skilled nursing facility that has outstanding quality assurance fee payment obligations pursuant to this article, including any interest and penalty amounts owed, the successor skilled nursing facility shall be responsible for paying to the department the full amount of outstanding quality assurance fee payments, including any interest and penalties, attributable to the skilled nursing facility for which it was assessed, upon the effective date of that transaction. An entity considering a merger, acquisition, or similar transaction involving a skilled nursing facility may submit a request to the department pursuant to Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code to ascertain the outstanding

quality assurance fee payment obligations of the skilled nursing facility pursuant to this article as of the date of the department's response to that request.

(g) During the time period 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 State Department of Public Health shall not be responsible for any unpaid quality assurance fee assessed ~~prior to~~ before the time period of the temporary manager or receiver. ~~Nothing in this subdivision shall~~ This subdivision shall not affect the responsibility of the facility to make all payments of unpaid or current quality assurance fees, including any interest and penalty amounts, as required by this section and Section 1324.21.

(h) If all or any part of the quality assurance fee remains unpaid, the department may take ~~either or both of the following actions:~~ any or all of the following actions against the debtor facility, in addition to assessing interest pursuant to paragraph (1) of subdivision (e):

(1) Assess a penalty ~~equal~~ of up to 50 percent of the total unpaid fee ~~amount for unpaid fees assessed during the 2004–05 to 2009–10, inclusive, rate years, and up to 50 percent of the unpaid fee amount for unpaid fees assessed during the 2010–11 rate year and any subsequent rate year.~~ amounts, and any interest assessed pursuant to paragraph (1) of subdivision (e) in each applicable rate or calendar year.

~~(2) (A) Delay license renewal.~~

~~(B) Beginning with the 2010–11 rate year, the department may recommend~~

(2) Recommend to the State Department of Public Health that license ~~renewal~~ or Medi-Cal certification renewal or approval of a change of ownership application be delayed until the full amount of the quality assurance fee, penalties, and interest is recovered.

(3) (A) In the event of a merger, acquisition, or change of ownership involving a skilled nursing facility as described in paragraph (2) of subdivision (f), the department may delay approval of a new Medi-Cal provider agreement or a transfer of an existing Medi-Cal provider agreement to a successor skilled nursing facility until the full amount of the quality assurance fees, penalties, and interest owed by the successor or previous facility owner is recovered in full, or until the successor skilled nursing facility has entered into an alternative payment agreement with the department for the outstanding quality assurance fees, penalties, and interest owed that takes into account the financial situation of the facility and the potential impact on delivery of services to Medi-Cal beneficiaries.

(B) In addition to subparagraph (A), as a condition of approving a new Medi-Cal provider agreement or a transfer of an existing Medi-Cal provider agreement to a successor skilled nursing facility, the department may require either or both of the following:

(i) The successor skilled nursing facility to enter into an agreement with the department to be financially responsible to the department for the outstanding quality assurance fees, penalties, and interest owed by the previous facility owner.

(ii) The successor facility owner to enter into an agreement with the department to pay outstanding quality assurance fees, penalties, and interest owed by the successor facility owner on an alternative payment schedule developed by the department that takes into account the financial situation of the facility and the potential impact on delivery of services to Medi-Cal beneficiaries.

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

(j) 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.

(k) The amendments made to subdivision (d) and the addition of subdivision (f) by the act that added this subdivision ~~shall not be construed as~~ are not substantive changes, but are merely clarifying existing law.

(*l*) (1) Notwithstanding any other ~~provision of~~ law, for the 2011–12 rate year, the department may waive the actions provided under subdivision (h), or may allow a freestanding pediatric subacute care facility to delay payments for up to six months, to ensure the facility has the financial stability required to pay the fee.

(2) For the purposes of this article, "freestanding pediatric subacute care facility" has the same meaning as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(m) (1) Subject to paragraph (2), the department may waive a portion or all of either the interest or penalties, or both, assessed under this article with respect to a petitioning skilled nursing facility if the department determines, in its sole discretion, that the facility has demonstrated that imposing the full amount of fees under this article has a high likelihood of creating an undue financial hardship for the facility or creates a significant financial difficulty in providing services to Medi-Cal beneficiaries. A waiver pursuant to this subdivision may include, but need not be limited to, interest or penalties, or both, that accrue or are assessed with respect to a facility during the time period for which a change of ownership is pending, or for which a change of ownership is being contemplated, as determined by the department in its sole discretion.

(2) The department's waiver of some or all of the interest or penalties shall be conditioned on the skilled nursing facility's agreement to pay outstanding fee amounts on an alternative schedule developed by the department that takes into account the financial situation of the facility and the potential impact on delivery of services to Medi-Cal beneficiaries.

SEC. 3. 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~~ their 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~~

(b) 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 and administer this article, in whole or in part, by means of ~~a provider bulletin~~ provider bulletins or other similar instructions, without taking regulatory ~~action, provided that no such bulletin or other similar instructions shall remain in effect after July 31, 2020. It is the intent of the Legislature that the regulations adopted pursuant to subdivision (b) shall be adopted on or before July 31, 2020.~~ action. The department shall make use of appropriate processes to ensure that affected stakeholders are timely informed of, and have access to, applicable guidance issued pursuant to this authority in a timely manner, and that this guidance remains publicly available while this article remains operative.

SEC. 4. Section 1324.24 of the Health and Safety Code is amended to read:

1324.24. (a) The quality assurance fee assessed and collected pursuant to this article shall be deposited in the State Treasury.

(b) Notwithstanding subdivision (a), commencing August 1, 2013, the quality assurance ~~fee~~ fees, including any associated interest or penalties, assessed and collected pursuant to this article shall be deposited in the Long-Term Care Quality Assurance Fund established pursuant to Section 1324.9.

SEC. 5. Section 1324.27 of the Health and Safety Code is amended to read:

~~1324.27. (a) (1) 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 facilities identified in subdivision (c) of Section 1324.20, including the submission of a request for waiver of broad-based requirement, waiver of 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.~~

~~(2) The director may alter the methodology specified in this article, to the extent necessary to meet the requirements of federal law or regulations or to obtain federal approval. The Director of Health Care Services may also add new categories of exempt facilities or apply a nonuniform fee to the skilled nursing facilities subject to the fee in order to meet requirements of federal law or regulations. The Director of Health Care Services may apply a zero fee to one or more exempt categories of facilities, if necessary to obtain federal approval.~~

~~(3) If after seeking federal approval, federal approval is not obtained, this article shall not be implemented.~~

1324.27. (a) In implementing this article, the department shall seek any federal approvals it deems necessary. This article 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.

(b) The department shall make retrospective adjustments, as necessary, to the amounts calculated pursuant to Section 1324.21 in order to assure that the aggregate

quality assurance fee for any particular state fiscal or calendar year does not exceed 6 percent of the aggregate annual net revenue of facilities subject to the fee.

(c) (1) The department may modify any methodology or other provision specified in this article to the extent it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or is not otherwise jeopardized, provided the modification does not violate the spirit, purposes, and intent of this article.

(2) If the department determines that a modification is necessary pursuant to paragraph (1), the department shall consult with affected providers and stakeholders to the extent practicable.

(3) If a modification is made pursuant to this subdivision, the department shall notify affected providers, the Joint Legislative Budget Committee, and the relevant policy and fiscal committees of the Legislature within 10 business days of that modification.

SEC. 6. Section 1324.29 of the Health and Safety Code is amended to read:

1324.29. (a) The quality assurance fee shall cease to be assessed after ~~July 31, 2020.~~ December 31, 2024.

(b) Notwithstanding subdivision (a) and Section 1324.30, the department's authority and obligation to collect all quality assurance fees and penalties, including interest, shall continue in effect and shall not cease until the date that all amounts are paid or recovered in full.

(c) This section shall remain operative until the date that all fees and penalties, including interest, have been recovered pursuant to subdivision (b), and as of that date is repealed.

SEC. 7. Section 1324.30 of the Health and Safety Code is amended to read:

1324.30. This article shall become inoperative after ~~July 31, 2020, and, as of January 1, 2021,~~ December 31, 2024, and as of January 1, 2026, is repealed, unless a later enacted statute, that becomes operative on or before January 1, ~~2021,~~ 2026, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 8. Section 14126.022 of the Welfare and Institutions Code is amended to read:

14126.022. (a) (1) By August 1, 2011, the department shall develop the Skilled Nursing Facility Quality and Accountability Supplemental Payment System, subject to approval by the federal Centers for Medicare and Medicaid Services, and the availability of federal, state, or other funds.

(2) (A) The system shall be utilized to provide 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 to penalize those facilities that do not meet measurable standards.

(B) A freestanding pediatric subacute care facility, as defined in Section 51215.8 of Title 22 of the California Code of Regulations, shall be exempt from the Skilled Nursing Facility Quality and Accountability Supplemental Payment System. A freestanding pediatric subacute care facility, as defined in Section 51215.8 of Title 22 of the California Code of Regulations, shall be ineligible to receive the quality-based, per diem rate increase described in subdivision (v) effective January 1, 2022.

(C) Notwithstanding any other law, special program services for the mentally disordered that are entitled to receive the supplemental payment under Section 51511.1

of Title 22 of the California Code of Regulations shall continue to be exempt from the Skilled Nursing Facility Quality and Accountability Supplemental Payment System.

(3) The system shall be phased in, beginning with the 2010–11 rate year.

(4) The department may utilize the system to do all of the following:

(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 (i).

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

(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 determined by the director, or ~~his or her~~ their designee.

(E) Beginning with the 2011–12 fiscal year, establish a base year to collect performance measures described in subdivision (i).

(F) Beginning with the 2011–12 fiscal year, in coordination with the State Department of Public Health, publish the direct care staffing level data and the performance measures required pursuant to subdivision (i).

(5) The department, in coordination with the State Department of Public Health, shall report to the relevant Assembly and Senate budget subcommittees by May 1, 2016, information ~~regarding~~ on the quality and accountability supplemental payments, including, but not limited to, its assessment of whether the payments are adequate to incentivize quality care and to sustain the program.

(b) (1) There is hereby created in the State Treasury, the Skilled Nursing Facility Quality and Accountability Special Fund. The fund shall contain moneys deposited pursuant to subdivisions (g) and (j) to (m), inclusive. Notwithstanding Section 16305.7 of the Government Code, the fund shall contain all interest and dividends earned on moneys in the fund.

(2) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated without regard to fiscal year to the department for making quality and accountability payments, in accordance with subdivision (n), to facilities that meet or exceed predefined measures as established by this ~~section.~~ section through December 31, 2021, or for making quality-based, per diem rate increases to qualified facilities that meet or exceed predefined measures developed by the department pursuant to subdivision (v) beginning in the 2022 calendar year.

(3) Upon appropriation by the Legislature, moneys in the fund may also be used for any of the following purposes:

(A) To cover the administrative costs incurred by the State Department of Public Health for positions and contract funding required to implement this section.

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

(C) To provide funding assistance for the Long-Term Care Ombudsman Program activities pursuant to Chapter 11 (commencing with Section 9700) of Division 8.5.

(c) ~~No~~ Any appropriation associated with Chapter 717 of the Statutes of 2010 is not intended to implement ~~the provisions of~~ Section 1276.65 of the Health and Safety Code.

(d) (1) There is hereby appropriated for the 2010–11 fiscal year, one million nine hundred thousand dollars ($1,900,000) from the Skilled Nursing Facility Quality and Accountability Special Fund to the California Department of Aging for the Long-Term Care Ombudsman Program activities pursuant to Chapter 11 (commencing with Section 9700) of Division 8.5. It is the intent of the Legislature for the one million nine hundred thousand dollars ($1,900,000) from the fund to be in addition to the four million one hundred sixty-eight thousand dollars ($4,168,000) proposed in the Governor's May Revision for the 2010–11 Budget. It is further 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 Chapter 11 (commencing with Section 9700) of Division 8.5.

(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 reimbursement for activities conducted by the Long-Term Care Ombudsman Program. 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.

(e) There is hereby created in the Special Deposit Fund established pursuant to Section 16370 of the Government Code, the Skilled Nursing Facility Minimum Staffing Penalty Account. The account shall contain all moneys deposited pursuant to subdivision (f).

(f) (1) Beginning with the 2010–11 fiscal year, the State Department of Public Health shall use the direct care staffing level data it collects to determine whether a skilled nursing facility has met the nursing hours or direct care service hours per patient per day requirements pursuant to Section 1276.5 or 1276.65, as applicable, of the Health and Safety Code.

(2) (A) Beginning with the 2010–11 fiscal year, the State 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 State Department of Public Health determines that the skilled nursing facility fails to meet the nursing hours or direct care service hours per patient per day requirements pursuant to Section 1276.5 or 1276.65, as applicable, of the Health and Safety Code, as follows:

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

(ii) Thirty thousand dollars ($30,000) if the facility fails to meet the requirements for over 49 percent or more of the audited days.

(B) (i) If the skilled nursing facility does not dispute the determination or assessment, the penalties shall be paid in full by the licensee to the State Department of Public Health within 30 days of the facility's receipt of the notice of penalty and deposited into the Skilled Nursing Facility Minimum Staffing Penalty Account.

(ii) The State 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 to recoup the penalty provided for in this section.

(C) (i) If a facility disputes the determination or assessment made pursuant to this paragraph, the facility shall, within 15 days of the facility's receipt of the determination and assessment, simultaneously submit a request for appeal to both the

department and the State Department of Public Health. A request for an appeal may be made by a facility based upon a determination that does not result in an assessment. The request shall include a detailed statement describing the reason for appeal and include all supporting documents the facility will present at the hearing.

(ii) Within 10 days of the State Department of Public Health's receipt of the facility's request for appeal, the State Department of Public Health shall submit, to both the facility and the department, all supporting documents that will be presented at the hearing.

(D) The department shall hear a timely appeal and issue a decision as follows:

(i) The hearing shall commence within 60 days from the date of receipt by the department of the facility's timely request for appeal.

(ii) The department shall issue a decision within 120 days from the date of receipt by the department of the facility's timely request for appeal.

(iii) The decision of the department's hearing officer, when issued, shall be the final decision of the State Department of Public Health.

(E) The appeals process set forth in this paragraph shall be exempt from Chapter 4.5 (commencing with Section 11400) and Chapter 5 (commencing with Section 11500), of Part 1 of Division 3 of Title 2 of the Government Code. ~~The provisions of Sections~~ Sections 100171 and 131071 of the Health and Safety Code do not apply to appeals under this paragraph.

(F) If a hearing decision issued pursuant to subparagraph (D) is in favor of the State Department of Public Health, the skilled nursing facility shall pay the penalties to the State Department of Public Health within 30 days of the facility's receipt of the decision. The penalties collected shall be deposited into the Skilled Nursing Facility Minimum Staffing Penalty Account.

(G) The assessment of a penalty under this subdivision does not supplant the State Department of Public Health's investigation process or issuance of deficiencies or citations under Chapter 2.4 (commencing with Section 1417) of Division 2 of the Health and Safety Code.

(g) The State Department of Public Health shall transfer, on a monthly basis, all penalty payments collected pursuant to subdivision (f) into the Skilled Nursing Facility Quality and Accountability Special Fund.

(h) This section does not impact the effectiveness or utilization of Section 1278.5 or 1432 of the Health and Safety Code relating to whistleblower protections, or Section 1420 of the Health and Safety Code relating to complaints.

(i) (1) Beginning in the 2010–11 fiscal year, the department, in consultation with representatives from the 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.

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

(A) Beginning in the 2011–12 fiscal year:

(i) Immunization rates.

(ii) Facility acquired pressure ulcer incidence.

(iii) The use of physical restraints.

(iv) Compliance with the nursing hours or direct care service hours per patient per day requirements pursuant to Section 1276.5 or 1276.65, as applicable, of the Health and Safety Code.

(v) Resident and family satisfaction.

(vi) Direct care staff retention, if sufficient data is available.

(B) If this act is extended beyond the dates on which it becomes inoperative and is repealed, in accordance with Section 14126.033, the department, in consultation with representatives from the long-term care industry, organized labor, and consumers, beginning in the 2013–14 rate year, shall incorporate additional measures into the system, including, but not limited to, quality and accountability measures required by federal health care reform that are identified by the federal Centers for Medicare and Medicaid Services.

(C) 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, the following:

(i) Compliance with state policy associated with the United States Supreme Court decision in Olmstead v. L.C. ex rel. Zimring (1999) 527 U.S. 581.

(ii) Direct care staff retention, if not addressed in the 2012–13 rate year.

(iii) The use of chemical restraints.

(D) Beginning with the 2015–16 fiscal year, the department, in consultation with representatives from the long-term care industry, organized labor, and consumers, shall incorporate direct care staff retention as a performance measure in the methodology developed pursuant to this section.

(E) (i) Beginning with the 2020–21 fiscal year, and only to the extent any necessary federal approvals are obtained, the department may incorporate an additional performance measure based upon a facility's compliance with any requirements related to the COVID-19 Public Health Emergency described in All Facility Letters issued by the State Department of Public Health. The department shall consult with the State Department of Public Health in determining a facility's compliance for purposes of this subparagraph.

(ii) For purposes of this subparagraph, "COVID-19 Public Health Emergency" shall mean the federal Public Health Emergency declaration made pursuant to Section 247d of Title 42 of the United States Code on January 30, 2020 entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," and any renewal of that declaration.

(j) (1) Beginning with the 2010–11 rate year, and pursuant to subparagraph (B) of paragraph (5) of subdivision (a) 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. A skilled nursing facility shall provide supplemental data on insurance deductible costs to facilitate this adjustment, in the format and by the deadlines determined by the department. If this data is not provided, a facility's insurance deductible costs will remain in the administrative costs category.

(2) Notwithstanding paragraph (1), for the 2012–13 rate year only, savings from capping the professional liability insurance cost category pursuant to paragraph (1)

shall remain in the General Fund and shall not be transferred to the Skilled Nursing Facility Quality and Accountability Special Fund.

(k) For the 2013–14 rate year, if there is a rate increase in the weighted average Medi-Cal reimbursement rate, the department shall set aside the first 1 percent of the weighted average Medi-Cal reimbursement rate increase for the Skilled Nursing Facility Quality and Accountability Special Fund.

(*l*) If this act is extended beyond the dates on which it becomes inoperative and is repealed, for the 2014–15 rate year, in addition to the amount set aside pursuant to subdivision (k), if there is a rate increase in the weighted average Medi-Cal reimbursement rate, the department shall set aside at least one-third of the weighted average Medi-Cal reimbursement rate increase, up to a maximum of 1 percent, from which the department shall transfer the General Fund portion of this amount into the Skilled Nursing Facility Quality and Accountability Special Fund.

(m) Beginning with the 2015–16 rate year, and each subsequent rate or calendar year thereafter for which this article is operative, an amount equal to the amount deposited in the fund pursuant to subdivisions (k) and (*l*) for the 2014–15 rate year shall be deposited into the Skilled Nursing Facility Quality and Accountability Special Fund, for the purposes specified in this section.

(n) (1) (A) Beginning with the 2013–14 rate year, and through the conclusion of the rate period from August 1, 2020, to December 31, 2020, inclusive, the department shall pay a supplemental payment, by April ~~30, 2014,~~ 30 of each applicable rate year, to skilled nursing facilities based on all of the criteria in subdivision (i), as published by the department, and according to performance measure benchmarks determined by the department in consultation with stakeholders.

(B) For the 2021 calendar year, the department shall pay a supplemental payment, by April 30, 2021, to qualified skilled nursing facilities based on the criteria in subdivision (i), as published by the department, and according to performance measure benchmarks determined by the department in consultation with stakeholders.

~~(B)~~

(C) (i) The department may convene a diverse stakeholder group, including, but not limited to, representatives from consumer groups and organizations, labor, nursing home providers, advocacy organizations involved with the aging community, staff from the Legislature, and other interested parties, to discuss and analyze alternative mechanisms to implement the quality and accountability payments provided to nursing homes for reimbursement.

(ii) The department shall articulate in a report to the fiscal and appropriate policy committees of the Legislature the implementation of an alternative mechanism as described in clause (i) at least 90 days prior to any policy or budgetary changes, and seek subsequent legislation in order to enact the proposed changes.

(2) Skilled nursing facilities that do not submit required performance data by the department's specified data submission deadlines pursuant to subdivision (i) are ~~not eligible~~ ineligible to receive supplemental payments.

(3) Notwithstanding paragraph (1), if a facility appeals the performance measure of compliance with the nursing hours or direct care service hours per patient per day requirements, pursuant to Section 1276.5 or 1276.65, as applicable, of the Health and Safety Code, to the State 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, 2014, then on May 1, 2014, 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 subparagraphs (A) and (B) of paragraph (3) of subdivision (b), in addition to any Medicaid funds that are available as of December 31, 2013, to increase provider rates retroactively to August 1, 2013.

(o) 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 approval is obtained from the federal Centers for Medicare and Medicaid Services and federal financial participation is ~~available.~~ available and not otherwise jeopardized.

(p) In implementing this section, the department and the State Department of Public Health may contract as necessary, with California's Medicare Quality Improvement Organization, or other entities deemed qualified by the department or the State 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 (i), and with demonstrated expertise in long-term care quality, data collection or analysis, and accountability performance measurement models pursuant to subdivision (i). This subdivision establishes an accelerated process for issuing any contract pursuant to this section. Any contract entered into pursuant to this subdivision is exempt from the requirements of the Public Contract ~~Code, through December 31, 2020.~~ Code.

(q) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the following apply:

(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 State Public Health Officer may implement this section by means of all-facility letters, or other similar instructions without taking regulatory action.

(r) Notwithstanding paragraph (1) of subdivision (n), if a final judicial determination is made by any state or federal court that is not appealed, in any action by any party, or a final determination is made by the administrator of the federal Centers for Medicare and Medicaid Services, that any payments pursuant to subdivisions (a) and (n), are invalid, unlawful, or contrary to ~~any provision of~~ federal law or regulations, or of state law, these subdivisions shall become inoperative, and for the 2011–12 rate year, the rate increase provided under subparagraph (A) of paragraph (4) of subdivision (c) of Section 14126.033 shall be reduced by the amounts described in subdivision (j). For the 2013–14 and 2014–15 rate years, any rate increase shall be reduced by the amounts described in subdivisions (j) to (*l*), inclusive.

(s) Notwithstanding any other provision of this section, but only to the extent the department determines federal financial participation is available and not otherwise jeopardized, for performance periods in the 2017–18 and 2018–19 fiscal years, a skilled nursing facility shall remain eligible to participate in the supplemental payment program

pursuant to this section ~~so long as~~ if the facility meets the applicable nursing hours per patient per day requirements pursuant to Section 1276.5 of the Health and Safety Code.

(t) Notwithstanding any provision of this section, but only to the extent the department determines federal financial participation is available and not otherwise jeopardized, compliance with ~~the provisions of~~ subdivision (c) of Section 1276.65 of the Health and Safety Code, as amended by Chapter 52 of the Statutes of 2017, shall not be used to determine facility qualification for the supplemental payments provided for in this section until the performance period beginning in the 2019–20 fiscal year. This limitation shall also apply to the issuance of citations pursuant to subdivisions (c) and (d) of Section 1424 of the Health and Safety Code based upon the failure to comply with ~~the provisions of~~ subdivision (c) of Section 1276.65 of the Health and Safety Code as amended by Chapter 52 of the Statutes of 2017. Until the performance period beginning in the 2019–20 fiscal year, the department shall apply ~~the provisions of~~ Section 1276.5 of the Health and Safety Code for purposes of administering the supplemental payments pursuant to this section. For performance periods beginning in the 2019–20 fiscal year and each fiscal year thereafter, a skilled nursing facility that is granted a waiver pursuant to subdivision (*l*) of Section 1276.65 of the Health and Safety Code shall remain eligible to participate in the supplemental payment program pursuant to this section so long as the facility meets the applicable nursing hours per patient per day requirement pursuant to Section 1276.5 of the Health and Safety Code that would have applied in the absence of Chapter 52 of the Statutes of 2017 for the duration of the time for which the waiver is granted.

(u) Effective January 1, 2022, the department shall cease to make supplemental payments pursuant to subdivision (n). The department shall be authorized to conduct all necessary closeout activities after this date and to continue implementing this section for supplemental payments applicable to any rate period before January 1, 2022.

(v) (1) Beginning with the 2022 calendar year, and every subsequent calendar year thereafter, the department shall make quality-based, per diem rate increases to qualified facilities that meet or exceed predefined benchmarks within quality measures developed by the department, in consultation with stakeholders, and in accordance with this subdivision. To the extent practicable, the department shall seek federal approval to select only those short-stay and long-stay quality measures that rely on data for which skilled nursing facilities are already required to report under applicable federal or state law for the relevant reporting period.

(2) The department shall develop and implement, in consultation with stakeholders, a benchmark- and threshold- based methodology that allows any applicable facility to earn a quality-based, per diem rate increase if the facility meets or exceeds benchmarks within a given measure in the applicable performance year. Any subsequent adjustment to a benchmark or threshold the department has established for an applicable reporting period shall be limited to adjustments to the national median rate of performance for the applicable quality measure or adjustments otherwise required pursuant to any applicable terms of federal approval obtained pursuant to subdivision (o).

(3) The department shall publish on its internet website the predefined quality measures and benchmarks, and any associated performance data required of facilities, to be used for determining a facility's eligibility for quality-based, per diem rate

increases in each applicable calendar year by November 1 of the preceding calendar year.

(4) Beginning with the 2022 calendar year, the department shall allocate the total pool of funds appropriated for quality-based, per diem rate increases as follows:

(A) Seventy-five percent of funds in a calendar year shall be available for facility-specific per diem rate increases based on achievement of department-published benchmarks by applicable facilities.

(B) Fifteen percent of funds in a calendar year shall be available for high-performance improvement per diem rate increases for qualified facilities that achieve a predefined level of improvement, as determined by the department, in their benchmark scores achieved pursuant to subparagraph (A) from one calendar year to the next.

(C) Ten percent of funds in a calendar year shall be available for high-performing facilities, as determined by the department, that rank in the 90th percentile or higher in the applicable benchmark scores pursuant to subparagraph (A).

(5) For any funds allocated in a given calendar year pursuant to subparagraph (A) of paragraph (4) that are not earned by an applicable facility, as determined by the department, those funds shall not be redistributed in the same calendar year.

(6) Any facility that does not comply with the nursing hours or direct care service hours per patient per day requirements pursuant to Section 1276.5 or 1276.65, as applicable, of the Health and Safety Code for more than two sampled days in a given calendar year shall be ineligible to receive the quality-based, per diem rate increase for periods when that same calendar year is used by the department to measure performance for purposes of this subdivision.

(7) If a facility qualifies for a quality-based, per diem rate increase or increases in a given calendar year, as determined by the department, that increase shall be incorporated into the applicable facility-specific rate developed pursuant to Section 14126.023.

(8) (A) To the extent any necessary federal approvals are obtained, for purposes of a facility's receipt of the quality-based, per-diem-rate increase described in this subdivision, the department may incorporate a performance measure based upon a facility's compliance with any requirements related to the COVID-19 Public Health Emergency described in All Facility Letters issued by the State Department of Public Health. The department shall consult with the State Department of Public Health in determining a facility's compliance for purposes of this paragraph.

(B) For purposes of this paragraph, "COVID-19 Public Health Emergency" shall mean the federal Public Health Emergency declaration made pursuant to Section 247d of Title 42 of the United States Code on January 30, 2020 entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," and any renewal of that declaration.

(w) Any outstanding amount of the quality assurance fee, as calculated pursuant to Section 1324.21 of the Health and Safety Code, or interest assessed pursuant to subdivision (e) of Section 1324.22 of the Health and Safety Code, or penalties assessed pursuant to paragraph (1) of subdivision (h) of Section 1324.22 of the Health and Safety Code for a facility may be deducted by the department from any Medi-Cal payments to the facility, including, but not limited to, supplemental payments pursuant to

subdivision (n) or quality-based, per diem rate increases pursuant to subdivision (v), until the outstanding amount is paid in full.

SEC. 9. 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 subdivisions (d) and (e).

(2) Indirect care nonlabor costs limited to the 75th percentile.

(3) (A) Administrative costs limited to the 50th percentile.

(B) Notwithstanding subparagraph (A), beginning with the 2010–11 rate year and in each subsequent rate or calendar year, the administrative cost category shall ~~not include~~ exclude any legal and consultant fees in connection with a fair hearing or other litigation against or involving any governmental agency or department until all issues related to the fair hearing or litigation issues are ultimately decided or resolved.

(C) Notwithstanding subparagraph (A), beginning with the 2010–11 rate year and in each subsequent rate or calendar 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 governmental agency or department ~~where~~ if any of the following apply:

(i) A decision has been rendered in favor of the governmental agency or department.

(ii) The determination of the governmental agency or department otherwise stands.

(iii) A settlement or similar resolution has been reached ~~regarding~~ on any citation issued under subdivision (c), (d), or (e) of Section 1424 of the Health and Safety Code or ~~regarding~~ on any remedy imposed under Subpart F of Part 489 of Title 42 of the Code of Federal Regulations.

(iv) A settlement or similar resolution has been reached under ~~the provisions of~~ Section 14123 or 14171.

(D) Facilities shall report supplemental data required to disallow costs described in subparagraph (C) in a format and by the deadline determined by the department.

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

(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 subparagraph (A), for the 2010–11 rate year and each rate or calendar 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 this subparagraph 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 (1), for the 2010–11 rate year, and each rate or calendar year thereafter, the percentiles in paragraphs (1) to (5), inclusive, 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.

(3) Effective August 1, 2020, the department shall continue to establish the specific geographic peer groups on the basis of, but need not be limited to, similar or common facility characteristics as determined by the department in consultation with stakeholders. The department may periodically review and change the number and assignment of peer groups and the peer group placement of an individual facility. Peer group assignments shall be effective for the duration of the rate or calendar year.

(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 either of the following conditions is 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,~~ year or January 1 of each calendar year period, as applicable, 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,~~ year or January 1 of each calendar year period, as applicable, pursuant to Section 14126.021.

(2) Facilities that have been decertified 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 either of the following conditions is 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,~~ year or January 1 of each calendar year period, as applicable, 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,~~ year or January 1 of each calendar year period, as applicable, pursuant to Section 14126.021.

(3) Facilities that have been decertified 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 either of the following conditions is 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,~~ year or January 1 of each calendar year period, as applicable, 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,~~ year or January 1 of each calendar year period, as applicable, pursuant to Section 14126.021.

(4) Facilities that have a change of ownership or change 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 either of the following conditions is 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,~~ year or January 1 of each calendar year period, as applicable, 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,~~ year or January 1 of each calendar year period, as applicable, pursuant to Section 14126.021.

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

(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~~ 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.~~ percentile through the conclusion of the 2019–20 rate year. Beginning for the rate period of August 1, 2020, to December 31, 2020, inclusive, and each subsequent calendar year thereafter, these costs shall be limited to the 95th percentile.

(2) Indirect care labor cost ~~category which~~ 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 through the conclusion of the 2019–20 rate year. Beginning for the rate period of August 1, 2020, to December 31, 2020, inclusive, and each subsequent calendar year thereafter for which this article is operative, these costs shall be limited to the 95th percentile.

(3) 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 subdivision (d), beginning with the 2010–11 rate year and each rate or calendar 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.

(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).

(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.

(h) The department shall annually update each facility specific rate calculated under this ~~methodology annually.~~ methodology. 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 (i), (j), and (k).

(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 the 2010–11 rate year, and each rate or calendar year thereafter, the department shall establish rates pursuant to this article on the basis of facility audited cost data pursuant to subdivision (c), reported in the integrated long-term care disclosure and Medi-Cal cost report described in 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 the 2010–11 rate year and each rate or calendar 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. Effective for the 2022 calendar year, and each calendar year thereafter, the department may determine a facility ineligible to receive the quality-based, per diem rate increase pursuant to subdivision (v) of Section 14126.022 for an applicable calendar year if a facility fails to provide the requisite performance data in the form and manner requested by the department.

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

(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.

(k) (1) On an annual basis, the department shall use the results of audits performed pursuant to subdivisions (i) and (j), 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.

(*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.

(m) Except as provided in Section 14126.022, compliance by each facility with state laws and regulations ~~regarding~~ on 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.

SEC. 10. Section 14126.027 of the Welfare and Institutions Code is amended to read:

~~14126.027. (a) (1) The Director of Health Care Services, or his or her designee, shall administer this article.~~

~~(2) The regulations and other similar instructions adopted pursuant to this article shall be developed in consultation with representatives of the long-term care industry, organized labor, seniors, and consumers.~~

~~(b) (1) The director may adopt regulations as are necessary to implement this article. The adoption, amendment, repeal, or readoption of a regulation authorized by this section is deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe specific facts showing the need for immediate action.~~

~~(2) The regulations adopted pursuant to this section may include, but need not be limited to, any regulations necessary for any of the following purposes:~~

~~(A) The administration of this article, including the specific analytical process for the proper determination of long-term care rates.~~

~~(B) The development of any forms necessary to obtain required cost data and other information from facilities subject to the ratesetting methodology.~~

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

~~(c) As an alternative to the adoption of regulations pursuant to subdivision (b), and notwithstanding~~

14126.027. 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~~ provider bulletins or other similar instructions, without taking regulatory ~~action, provided that no such bulletin or other similar instructions shall remain in effect after July 31, 2020. It is the intent of the Legislature that regulations adopted pursuant to subdivision (b) shall be in place on or before July 31, 2020.~~ action. The department shall make use of appropriate processes to ensure that affected stakeholders are informed of, and have access to, applicable guidance issued pursuant to this authority in a timely manner, and that this guidance remains publicly available while this article remains operative.

SEC. 11. Section 14126.033 of the Welfare and Institutions Code is amended to read:

14126.033. (a) The Legislature finds and declares all of the following:

(1) Costs within the Medi-Cal program continue to grow due to the rising cost of providing health care throughout the state and ~~also due to~~ increases in enrollment, which are more pronounced during difficult economic times.

(2) In order to minimize the need for drastically cutting enrollment standards or benefits during times of economic crisis, it is crucial to find areas within the program where reimbursement levels are higher than required under the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and can be reduced in accordance with federal law.

(3) The Medi-Cal program delivers its services and benefits to Medi-Cal beneficiaries through a wide variety of health care providers, ~~some of which deliver care via managed care or other contract models while others do so through~~ under

multiple delivery systems, including managed care, other contract models, or fee-for-service arrangements.

(4) The setting of rates within the Medi-Cal program is complex and is subject to close supervision by the United States Department of Health and Human Services.

(5) As the single state agency for ~~Medicaid~~ the Medicaid program in California, the State Department of Health Care Services has unique expertise that can inform decisions that set or adjust reimbursement methodologies and levels consistent with the requirements of federal law.

(b) Therefore, it is the intent of the Legislature for the department to analyze and identify where reimbursement levels can be reduced consistent with the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and ~~also consistent with~~ federal and state law and policies, including any exemptions contained in the act that added this section, provided that the reductions in reimbursement shall not exceed 10 percent on an aggregate basis for all providers, services, and products.

(c) This ~~article, including Section 14126.031,~~ article 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 rate year, 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.

(3) (A) For the 2010–11 rate year, if the increase in the federal medical assistance percentage (FMAP) pursuant to the federal American Recovery and Reinvestment Act of 2009 (ARRA) (Public Law 111-5) is extended for the entire 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, or 3.14 percent, if the increase in the FMAP pursuant to ARRA is not extended for that period of time, plus the projected cost of complying with new state or federal mandates. If the increase in the FMAP pursuant to ARRA 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 adjusted by the department for the following reasons:

(i) If the federal Centers for Medicare and Medicaid Services does not approve exemption changes to the facilities subject to the quality assurance fee.

(ii) If the federal Centers for Medicare and Medicaid Services does not approve any proposed modification to the methodology for calculation of the quality assurance fee.

(iii) To ensure that the state does not incur any additional General Fund expenses to pay for the 2010–11 weighted average Medi-Cal 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) Subject to the following provisions, for the 2011–12 rate year, the increase in the Medi-Cal reimbursement rate for the purpose of this article, for each skilled nursing facility as defined in subdivision (c) of Section 1250 of the Health and Safety Code, shall not exceed 2.4 percent of the rate on file that was applicable on May 31, 2011, plus the projected cost of complying with new state or federal mandates. The percentage increase shall be applied equally to each rate on file as of May 31, 2011.

(B) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) shall be adjusted by the department for the following reasons:

(i) If the federal Centers for Medicare and Medicaid Services does not approve exemption changes to the facilities subject to the quality assurance fee.

(ii) If the federal Centers for Medicare and Medicaid Services does not approve any proposed modification to the methodology for calculation of the quality assurance fee.

(iii) To ensure that the state does not incur any additional General Fund expenses to pay for the 2011–12 weighted average Medi-Cal reimbursement rate increase.

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

(6) (A) (i) Notwithstanding any other ~~provision of~~ law, and except as provided in subparagraph (B), payments resulting from the application of paragraphs (3) and (4), the provisions of paragraph (5), and all other applicable adjustments and limits as required by this section, shall be reduced by 10 percent for dates of service on and after June 1, 2011, through July 31, 2012. This ~~is a~~ one-time reduction shall be evenly

distributed across all facilities to ensure long-term stability of nursing homes serving the Medi-Cal population.

(ii) Notwithstanding any other ~~provision of~~ law, the director may adjust the percentage reductions specified in clause (i), as long as the resulting reductions, in the aggregate, total no more than 10 percent.

(iii) The adjustments authorized under this subparagraph shall be implemented only if the director determines that the payments resulting from the adjustments comply with paragraph (7).

(B) Payments to facilities owned or operated by the state shall be exempt from the payment reduction required by this paragraph.

(7) (A) Notwithstanding ~~any other provision of~~ this section, the payment reductions and adjustments required by paragraph (6) shall be implemented only if the director determines that the payments that result from the application of paragraph (6) ~~will~~ shall comply with applicable federal Medicaid requirements and that federal financial participation will be available.

(B) In determining whether federal financial participation is available, the director shall determine whether the payments comply with applicable federal Medicaid requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(C) To the extent that the director determines that the payments do not comply with applicable federal Medicaid requirements or that federal financial participation is ~~not available~~ unavailable with respect to any payment that is reduced pursuant to this section, the director retains the discretion to not implement the particular payment reduction or adjustment and may adjust the payment as necessary to comply with federal Medicaid requirements.

(8) For managed care health plans that contract with the department pursuant to this chapter and Chapter 8 (commencing with Section 14200), except for contracts with the Senior Care Action Network and AIDS Healthcare Foundation, and to the extent that these services are provided through any of those contracts, payments shall be reduced by the actuarial equivalent amount of the reduced provider reimbursements specified in paragraph (6) pursuant to contract amendments or change orders effective on July 1, 2011, or thereafter.

(9) (A) For the 2012–13 rate year, all of the following shall apply:

(i) The department shall determine the amounts of reduced payments for each skilled nursing facility, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, resulting from the 10-percent reduction imposed pursuant to clause (i) of subparagraph (A) of paragraph (6) for the period beginning on June 1, 2011, through July 31, 2012.

(ii) For claims adjudicated through October 1, 2012, each skilled nursing facility as defined in subdivision (c) of Section 1250 of the Health and Safety Code that is reimbursed under the Medi-Cal fee-for-service program, shall receive the total payments calculated by the department in clause (i), not later than December 31, 2012.

(iii) For managed care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), except contracts with Senior Care Action Network and AIDS Healthcare Foundation, and to the extent that skilled nursing services are provided through any of those contracts, payments shall be adjusted by the actuarial equivalent amount of the reimbursements calculated in clause (i)

pursuant to contract amendments or change orders effective on July 1, 2012, or thereafter.

(B) Notwithstanding subparagraph (A), beginning on August 1, 2012, through July 31, 2013, the department shall pay the facility specific Medi-Cal reimbursement rate that was on file and applicable to the specific skilled nursing facility on August 1, 2011, prior to and excluding any rate reduction implemented pursuant to clause (i) of subparagraph (A) of paragraph (6) for the period beginning on June 1, 2011, to July 31, 2012, inclusive, and adjusted for the projected costs of complying with new state or federal mandates. These rates are deemed to be sufficient to meet operating expenses.

(C) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (B) shall be adjusted by the department if the federal Centers for Medicare and Medicaid Services does not approve any proposed modification to the methodology for calculation of the skilled nursing quality assurance fee pursuant to Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code.

(D) Notwithstanding any other ~~provision of~~ law, beginning on January 1, 2013, Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code, which imposes a skilled nursing facility quality assurance fee, shall ~~not be enforceable~~ be unenforceable against any skilled nursing facility unless each skilled nursing facility is paid the rate provided for in subparagraphs (A) and (B). Any amount collected during the 2012–13 rate year by the department pursuant to Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code shall be refunded to each facility not later than February 1, 2013.

(E) The provisions of this paragraph shall also be included as part of a state plan amendment implementing the 2011–12 and 2012–13 Medi-Cal reimbursement rates authorized under this article.

(10) (A) Subject to the following provisions, for the 2013–14 and 2014–15 rate years, the annual increase in the weighted average Medi-Cal reimbursement rate for the purpose of this article, for each skilled nursing facility as defined in subdivision (c) of Section 1250 of the Health and Safety Code, shall be 3 percent for each rate year, respectively, plus the projected cost of complying with new state or federal mandates.

(B) (i) For the 2013–14 rate year, if there is a rate increase in the weighted average Medi-Cal reimbursement rate, the department shall set aside 1 percent of the increase in the weighted average Medi-Cal reimbursement rate, from which the department shall transfer the nonfederal portion into the Skilled Nursing Facility Quality and Accountability Special Fund, to be used for the supplemental rate pool.

(ii) For the 2014–15 rate year, if there is a rate increase in the weighted average Medi-Cal reimbursement rate, the department shall set aside at least one-third of the weighted average Medi-Cal reimbursement rate increase, up to a maximum of 1 percent, from which the department shall transfer the nonfederal portion of this amount into the Skilled Nursing Facility Quality and Accountability Special Fund.

(C) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) shall be adjusted by the department for the following reasons:

(i) If the federal Centers for Medicare and Medicaid Services does not approve exemption changes to the facilities subject to the quality assurance fee.

(ii) If the federal Centers for Medicare and Medicaid Services does not approve any proposed modification to the methodology for calculation of the quality assurance fee.

(11) The director shall seek any necessary federal approvals for the implementation of this section. This section shall not be implemented until federal approval is obtained. When federal approval is obtained, the payments resulting from the application of paragraph (6) shall be implemented retroactively to June 1, 2011, or on any other date or dates as may be applicable.

(12) (A) (i) Beginning with the 2015–16 rate year, and through the conclusion of the rate period from August 1, 2020, to December 31, 2020, inclusive, the annual increase in the weighted average Medi-Cal reimbursement rate, required for the purposes of this article, shall be 3.62 percent, plus the projected cost of complying with new state or federal mandates.

(ii) The reimbursement rates established for the rate period of August 1, 2020, to December 31, 2020, inclusive, shall be no less than the amounts that would have been established under the reimbursement methodology pursuant to this section for the 2019–20 rate year, subject to subparagraph (B).

(B) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) may be adjusted by the department as it deems necessary to obtain any applicable federal ~~approval.~~ approval and shall not exceed the applicable federal upper payment limit.

(C) (i) Only to the extent any necessary federal approvals are obtained for this subparagraph, the department may condition a facility's receipt of the annual increase in the weighted average Medi-Cal reimbursement rate pursuant to this paragraph for the rate period of August 1, 2020, to December 31, 2020, inclusive, upon that facility's compliance with any requirements related to the COVID-19 Public Health Emergency described in All Facility Letters issued by the State Department of Public Health. The department shall consult with the State Department of Public Health in determining a facility's compliance for purposes of this subparagraph.

(ii) For purposes of this subparagraph, "COVID-19 Public Health Emergency" shall mean the federal Public Health Emergency declaration made pursuant to Section 247d of Title 42 of the United States Code on January 30, 2020, entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," and any renewal of that declaration.

(13) (A) For the 2021 calendar year, the annual aggregate increase in the weighted average Medi-Cal reimbursement rate that is required for the purposes of this article shall be 3.5 percent plus the projected cost of complying with new state or federal mandates.

(B) The aggregate, weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) may be adjusted by the department as it deems necessary to obtain any applicable federal approval, and shall not exceed the applicable federal upper payment limit.

(C) (i) Only to the extent any necessary federal approvals are obtained for this subparagraph, the department may condition a facility's receipt of the annual increase in the weighted average Medi-Cal reimbursement rate pursuant to this paragraph for the 2021 calendar year upon that facility's compliance with any requirements related to the COVID-19 Public Health Emergency described in All Facility Letters issued by

the State Department of Public Health. The department shall consult with the State Department of Public Health in determining a facility's compliance for purposes of this subparagraph.

(ii) For purposes of this subparagraph, "COVID-19 Public Health Emergency" shall mean the federal Public Health Emergency declaration made pursuant to Section 247d of Title 42 of the United States Code on January 30, 2020, entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," and any renewal of that declaration.

(14) (A) For the 2022 calendar year, the maximum annual aggregate increase in the weighted average Medi-Cal reimbursement rate that is required for the purposes of this article shall be 4 percent plus the projected cost of complying with new state or federal mandates. For this aggregate increase, 60 percent shall be derived from adjustments to the cost-based facility-specific rates developed pursuant to the methodology described in this section, and 40 percent shall be derived from the total pool of funds appropriated for quality-based, per diem rate increases awarded by the department pursuant to subdivision (v) of Section 14126.022.

(B) The aggregate, weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) may be adjusted by the department as it deems necessary to obtain any applicable federal approval, and shall not exceed the applicable federal upper payment limit.

(C) (i) Only to the extent any necessary federal approvals are obtained for this subparagraph, the department may condition a facility's receipt of the annual increase in the weighted average Medi-Cal reimbursement rate pursuant to this paragraph for the 2022 calendar year upon that facility's compliance with any requirements related to the COVID-19 Public Health Emergency described in All Facility Letters issued by the State Department of Public Health. The department shall consult with the State Department of Public Health in determining a facility's compliance for purposes of this subparagraph.

(ii) For purposes of this subparagraph, "COVID-19 Public Health Emergency" shall mean the federal Public Health Emergency declaration made pursuant to Section 247d of Title 42 of the United States Code on January 30, 2020, entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," and any renewal of that declaration.

(15) (A) For the 2023 and 2024 calendar years, the maximum annual aggregate increase in the weighted average Medi-Cal reimbursement rate, required for the purposes of this article, shall be 4 percent plus the projected cost of complying with new state or federal mandates. For this aggregate increase, 55 percent shall be derived from adjustments to the cost-based facility-specific rates developed pursuant to the methodology described in this section, and 45 percent shall be derived from the total pool of funds appropriated for quality-based, per diem rate increases awarded by the department pursuant to subdivision (v) of Section 14126.022.

(B) The aggregate, weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) may be adjusted by the department as it deems necessary to obtain any applicable federal approval, and shall not exceed the applicable federal upper payment limit.

(C) (i) Only to the extent any necessary federal approvals are obtained for this subparagraph, the department may condition a facility's receipt of the annual increase

in the weighted average Medi-Cal reimbursement rate pursuant to this paragraph for the 2023 and 2024 calendar year rates upon that facility's compliance with any requirements related to the COVID-19 Public Health Emergency described in All Facility Letters issued by the State Department of Public Health. The department shall consult with the State Department of Public Health in determining a facility's compliance for purposes of this subparagraph.

(ii) For purposes of this subparagraph, "COVID-19 Public Health Emergency" shall mean the federal Public Health Emergency declaration made pursuant to Section 247d of Title 42 of the United States Code on January 30, 2020, entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," and any renewal of that declaration.

(d) (1) The department may modify any methodology or other provision specified in this article to the extent it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or is not otherwise jeopardized, provided the modification does not violate the spirit, purposes, and intent of this article.

(2) If the department determines that a modification is necessary pursuant to paragraph (1), the department shall consult with affected providers and stakeholders to the extent practicable.

(3) In the event of a modification made pursuant to this subdivision, the department shall notify affected providers, the Joint Legislative Budget Committee, and the relevant policy and fiscal committees of the Legislature within 10 business days of that modification.

~~(d)~~

(e) The rate methodology shall cease to be implemented after ~~July 31, 2020.~~ December 31, 2024.

~~(e)~~

(f) (1) It is the intent of the Legislature that the implementation of this article result in individual access to appropriate long-term care services, quality resident care, decent wages and benefits for nursing home workers, a stable workforce, provider compliance with all applicable state and federal requirements, and administrative efficiency.

(2) Not later than December 1, 2006, the Bureau of State Audits shall conduct an accountability evaluation of the department's progress toward implementing a facility-specific reimbursement system, including a review of data to ensure that the new system is appropriately reimbursing facilities within specified cost categories and a review of the fiscal impact of the new system on the General Fund.

(3) Not later than January 1, 2007, to the extent information is available for the three years immediately preceding the implementation of this article, the department shall provide baseline information in a report to the Legislature on all of the following:

(A) The number and percent of freestanding skilled nursing facilities that complied with minimum staffing requirements.

(B) The staffing levels ~~prior to~~ before the implementation of this article.

(C) The staffing retention rates ~~prior to~~ before the implementation of this article.

(D) The numbers and percentage of freestanding skilled nursing facilities with findings of immediate jeopardy, substandard quality of care, or actual harm, as

determined by the certification survey of each freestanding skilled nursing facility conducted ~~prior to~~ before the implementation of this article.

(E) The number of freestanding skilled nursing facilities that received state citations and the number and class of citations issued during calendar year 2004.

(F) The average wage and benefits for employees ~~prior to~~ before the implementation of this article.

(4) Not later than January 1, 2009, the department shall provide a report to the Legislature that does both of the following:

(A) Compares the information required in paragraph (2) to that same information two years after the implementation of this article.

(B) Reports on the extent to which residents who had expressed a preference to return to the community, as provided in Section 1418.81 of the Health and Safety Code, were able to return to the community.

(5) The department may contract for the reports required under this subdivision.

(g) In implementing this article, the department shall seek any federal approvals it deems necessary. This article 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.

SEC. 12. Section 14126.036 of the Welfare and Institutions Code is amended to read:

14126.036. This article shall become inoperative on ~~August 1, 2020,~~ December 31, 2024, and as of January 1, ~~2021,~~ 2026, is repealed, unless a later enacted statute that is enacted before, January 1, ~~2021~~ 2026, deletes or extends that date.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.
as introduced, _____.
General Subject: Public health: Medi-Cal: nursing facilities.

(1) 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 requires the department to impose a uniform quality assurance fee on each skilled nursing facility, with certain exceptions, in accordance with a prescribed formula. Existing law requires that the fee be based on the entire net revenue of all skilled nursing facilities subject to the fee. Existing law prohibits the fee from being assessed after July 31, 2020, and repeals these provisions on January 1, 2021. Existing law authorizes the Director of Health Care Services to promulgate regulations on these provisions, and to implement these provisions by provider bulletin or similar instruction so long as that guidance remains in effect only until July 31, 2020, and that regulations are adopted by that date. Existing law requires the department to request approval from the federal Centers for Medicare and Medicaid Services to implement these provisions, and authorizes the director to alter the methodology, to the extent necessary to meet the requirements of federal law or regulations or to obtain federal approval.

With respect to the uniform quality assurance fee, this bill would exempt a unit that provides freestanding pediatric subacute care services in a skilled nursing facility from that fee for the rate period from August 1, 2020, to December 31, 2020, inclusive, and every subsequent calendar year thereafter. The bill would establish various enforcement mechanisms for the department to collect delinquent quality assurance fees, such as requiring the department to assess interest on a skilled nursing facility that fails to pay all or part of the quality assurance fee within 60 days of the date that payment is due, beginning on the 61st calendar day from the date the payment is due, until the unpaid amount due and any interest is paid in full, and authorizing the department to deduct unpaid assessments, including any interest and penalties owed, attributable to a debtor facility from any Medi-Cal payments made to a related facility or entity by common ownership or control to the debtor facility.

In the event of a merger, acquisition, or change of ownership involving a skilled nursing facility, this bill would authorize the department to delay approval of a new Medi-Cal provider agreement or a transfer of an existing Medi-Cal provider agreement to a successor skilled nursing facility until the full amount of the quality assurance fees, penalties, and interest owed by the successor or previous facility owner is recovered in full, to take specified action as a condition of approving a new Medi-Cal provider agreement or a transfer of an existing Medi-Cal provider agreement to a successor skilled nursing facility, and to waive a portion or all of the interest or penalties, or interest or penalties assessed if the department determines that the facility has demonstrated that imposing the full amount of fees has a high likelihood of creating

an undue financial hardship for the facility or creates a significant financial difficulty in providing services to Medi-Cal beneficiaries.

This bill would delete the provisions on the director's authority to promulgate regulations, would instead authorize the director to solely implement provisions by provider bulletin or similar instruction, and would require the department to make use of appropriate processes to ensure that affected stakeholders are informed of, and have access to, applicable issued guidance in a timely manner. The bill would clarify that quality assurance fees, including any associated interest or penalties, assessed and collected are to be deposited in Long-Term Care Quality Assurance Fund. The bill would instead authorize the department to modify any methodology or other provision on the uniform quality assurance fee, to the extent it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or is not otherwise jeopardized. Before implementing a modification, the bill would require the department to consult with affected providers and stakeholders to the extent practicable, and to notify affected providers, the Joint Legislative Budget Committee, and the relevant policy and fiscal committees of the Legislature within 10 business days of that modification.

The bill would extend the department's imposition of a uniform quality assurance fee to December 31, 2024, and would repeal those provisions on January 1, 2026.

(2) Existing law, the Medi-Cal Long-Term Care Reimbursement Act, requires the department to implement a facility-specific reimbursement ratesetting system for certain skilled nursing facilities. Reimbursement rates for freestanding skilled nursing facilities are funded by a combination of federal funds and moneys collected pursuant to the skilled nursing uniform quality assurance fee. Existing law also establishes the Skilled Nursing Facility Quality and Accountability Special Fund in the State Treasury, which is a continuously appropriated fund that contains moneys from the assessment of specified administrative penalties and set asides of General Fund moneys, for the purposes of making quality and accountability payments, including supplemental payments. Under the act, the department is required to develop the Skilled Nursing Facility Quality and Accountability Supplemental Payment System (system), which is utilized to provide supplemental payments to skilled nursing facilities that improve the quality and accountability of care rendered to residents in skilled nursing facilities, and to penalize those facilities that do not meet measurable standards. Under existing law, the rate methodology becomes inoperative after July 31, 2020, and these provisions will be repealed on January 1, 2021. Existing law authorizes the director to promulgate regulations on these provisions, and to implement these provisions by provider bulletin or similar instruction so long as that guidance remains in effect only until July 31, 2020, and that regulations are adopted by that date.

This bill would make various changes to the act, including providing that a freestanding pediatric subacute care facility is ineligible to receive the quality-based, per diem rate increase, and that special program services for the mentally disordered that are entitled to receive supplemental payment are exempt from the system. The bill would extend the department's use of the Skilled Nursing Facility Quality and Accountability Special Fund to December 31, 2021, for making quality and accountability payments, and would expand the use of that fund to be used to make per diem rate increases to qualified facilities that meet or exceed predefined measures developed by the department commencing in the 2022 calendar year.

The bill would modify parameters of the supplemental payment, and would cease the availability of those payments on January 1, 2022. Commencing on January 1, 2022, the bill would require the department to make quality-based, per diem rate increases to qualified facilities that meet or exceed predefined benchmarks within quality measures developed by the department, in consultation with stakeholders, and to allocate the total pool of funds appropriated for quality-based, per diem rate increases, as prescribed. The bill would require the department to publish the quality measures and benchmarks on its internet website. The bill would establish various requirements on the quality-based, per diem rate increases, such as providing that any facility that does not comply with nursing hours or direct care service hours per patient per day requirements as set forth in law is ineligible to receive the quality-based, per diem rate increase, and that any outstanding amount of the uniform quality assurance fee may be deducted by the department from any Medi-Cal payments to the facility, including supplemental payments or the quality-based, per diem rate increases. The bill would delete the provisions on the director's authority to promulgate regulations, would instead authorize the director to solely implement provisions by provider bulletin or similar instruction, and would require the department to make use of appropriate processes to ensure that affected stakeholders are informed of, and have access to, applicable issued guidance that remains publicly available in a timely manner.

The bill would make various changes to the Medi-Cal rate reimbursement methodology, including that the reimbursement rates established for the rate period of August 1, 2020, to December 31, 2020, inclusive, be no less than the amounts that would otherwise have been established under the reimbursement methodology for the 2019–20 rate year, and that the weighted average Medi-Cal reimbursement rate increase not exceed the applicable federal upper payment limit. The bill would establish annual aggregate rate increases for the 2020 to 2024, inclusive, calendar years, as prescribed, and set forth the annual rate methodologies. The bill would authorize the department to modify any methodology or other provision on the reimbursement methodology, to the extent it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or is not otherwise jeopardized. Before implementing a modification, the bill would require the department to consult with affected providers and stakeholders to the extent practicable, and to notify affected providers, the Joint Legislative Budget Committee, and the relevant policy and fiscal committees of the Legislature within 10 business days of that modification.

The bill would extend the operative date of the act to December 31, 2024, and would repeal those provisions on January 1, 2026.

By extending the period of time during which moneys are deposited in the Skilled Nursing Facility Quality and Accountability Special Fund, the bill would make an appropriation.

(3) This bill would include a change in state statute that would result in a taxpayer paying a higher tax within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of ⅔ of the membership of each house of the Legislature.

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