

Assembly Bill No. 360

Passed the Assembly September 7, 2005

Chief Clerk of the Assembly

Passed the Senate September 6, 2005

Secretary of the Senate

This bill was received by the Governor this _____ day
of _____, 2005, at _____ o'clock ____M.

Private Secretary of the Governor

CHAPTER _____

An act to amend Sections 1324.20, 1324.22, 1324.27, and 1324.28 of the Health and Safety Code, and to amend Sections 5902, 5912, 14105.06, 14126.02, and 14126.033 of the Welfare and Institutions Code, relating to skilled nursing facilities, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 360, Frommer. Skilled nursing facilities.

Existing law provides for the licensure and regulation of health facilities by the State Department of Health Services. Existing law provides for the imposition each state fiscal year upon the entire gross receipts of certain intermediate care facilities a quality assurance fee, as a condition of participation in the Medi-Cal program.

Existing law, as long as prescribed conditions are met, provides for the imposition of a quality assurance fee on each skilled nursing facility, with some exemptions, to be administered by the Director of Health Services and deposited in the State Treasury to be available to enhance federal financial participation in the Medi-Cal program or to provide additional reimbursement to, and support facility quality improvement efforts in, licensed skilled nursing facilities.

Existing law requires the department to request federal approval for implementation of these quality assurance fee provisions and authorizes imposition of a nonuniform fee in order to meet federal requirements.

This bill would exclude a unit that provides pediatric subacute services in a skilled nursing facility and a skilled nursing facility that is certified by the State Department of Mental Health for a special treatment program and is an institution for mental disease as defined under federal law from the fee requirements, and would make a conforming change to provisions setting forth the department's Medi-Cal ratesetting authority. The bill would revise erroneous cross-references contained in related provisions.

This bill would require reimbursement rates for services in institutions for mental disease that are required to be licensed and certified as skilled nursing facilities to be the same as the rates in

effect on July 31, 2004. The bill would require these reimbursement rates to be increased by 6.5% annually from July 1, 2005, to June 30, 2008, and by 4.7% annually, commencing July 1, 2008.

This bill would declare that it is to take effect immediately as an urgency statute.

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) “Continuing care retirement community” means a provider of a continuum of services, including independent living services, assisted living services as defined in paragraph (5) of subdivision (a) of Section 1771, and skilled nursing care, on a single campus, that is subject to Section 1791, or a provider of such a continuum of services on a single campus that has not received a Letter of Exemption pursuant to subdivision (b) of Section 1771.3.

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

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

(2) “Net revenue” does not mean charitable contributions and bad debt.

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

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

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, 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) A newly licensed skilled nursing facility, as defined by the department, shall complete all requirements of subdivision (a) for any portion of the year in which it commences operations and of subdivision (b) for any portion of the quarter in which it commences operations.

(e) When a skilled nursing facility fails to pay all or part of the quality assurance fee within 60 days of the date that payment is due, the department may deduct the unpaid assessment and interest owed from any Medi-Cal reimbursement payments to the

facility until the full amount is recovered. Any deduction shall be made only after written notice to the facility and may be taken over a period of time taking into account the financial condition of the facility.

(f) Should all or any part of the quality assurance fee remain unpaid, the department may take either or both of the following actions:

(1) Assess a penalty equal to 50 percent of the unpaid fee amount.

(2) Delay license renewal.

(g) 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.

(h) 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.

SEC. 3. 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 (b) 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 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 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.

(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 year does not exceed 6 percent of the aggregate annual net revenue of facilities subject to the fee.

SEC. 4. Section 1324.28 of the Health and Safety Code is amended to read:

1324.28. (a) This article shall be implemented as long as both of the following conditions are met:

(1) The state receives federal approval of the quality assurance fee from the federal Centers for Medicare and Medicaid Services.

(2) Legislation is enacted in the 2004 legislative session making an appropriation from the General Fund and from the Federal Trust Fund to fund a rate increase for skilled nursing facilities, as defined under subdivision (c) of Section 1250, for the 2004–05 rate year in an amount consistent with the Medi-Cal rates that specific facilities would have received under the rate methodology in effect as of July 31, 2004, plus the proportional costs as projected by Medi-Cal for new state or federal mandates.

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

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

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

(3) The state has continued its maintenance of effort for the level of state funding of nursing facility reimbursement for rate year 2005–06, and for every subsequent rate year continuing through the 2007–08 rate year, in an amount not less than the amount that specific facilities would have received under the rate

methodology in effect on July 31, 2004, plus Medi-Cal's projected proportional costs for new state or federal mandates, not including the quality assurance fee.

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

(c) If all of the conditions in subdivision (a) are met, this article is implemented, and subsequently, any one of the conditions in subdivision (b) is not met, on and after the date that the department makes that determination, this article shall not be implemented, notwithstanding that the condition or conditions subsequently may be met.

(d) Notwithstanding subdivisions (a), (b), and (c), in the event of a final judicial determination made by any state or federal court that is not appealed, or by a court of appellate jurisdiction that is not further appealed, in any action by any party, or a final determination by the administrator of the federal Centers for Medicare and Medicaid Services, that federal financial participation is not available with respect to any payment made under the methodology implemented pursuant to this article because the methodology is invalid, unlawful, or contrary to any provision of federal law or regulations, or of state law, this section shall become inoperative.

SEC. 5. Section 5902 of the Welfare and Institutions Code is amended to read:

5902. (a) In the 1991–92 fiscal year, funding sufficient to cover the cost of the basic level of care in institutions for mental disease at the rate established by the State Department of Health Services shall be made available to the department for skilled nursing facilities, plus the rate established for special treatment programs. The department may authorize a county to administer institutions for mental disease services if the county with the consent of the affected providers makes a request to administer services and an allocation is made to the county for these services. The department shall continue to contract with these providers for the services necessary for the operation of the institutions for mental disease.

(b) In the 1992–93 fiscal year, the department shall consider county-specific requests to continue to provide administrative

services relative to institutions for mental disease facilities when no viable alternatives are found to exist.

(c) (1) By October 1, 1991, the department, in consultation with the California Conference of Local Mental Health Directors and the California Association of Health Facilities, shall develop and publish a county-specific allocation of institutions for mental disease funds which will take effect on July 1, 1992.

(2) By November 1, 1991, counties shall notify the providers of any intended change in service levels to be effective on July 1, 1992.

(3) By April 1, 1992, counties and providers shall have entered into contracts for basic institutions for mental disease services at the rate described in subdivision (e) for the 1992–93 fiscal year at the level expressed on or before November 1, 1991, except that a county shall be permitted additional time, until June 1, 1992, to complete the processing of the contract, when any of the following conditions are met:

(A) The county and the affected provider have agreed on all substantive institutions for mental disease contract issues by April 1, 1992.

(B) Negotiations are in process with the county on April 1, 1992, and the affected provider has agreed in writing to the extension.

(C) The service level committed to on November 1, 1991, exceeds the affected provider's bed capacity.

(D) The county can document that the affected provider has refused to enter into negotiations by April 1, 1992, or has substantially delayed negotiations.

(4) If a county and a provider are unable to reach agreement on substantive contract issues by June 1, 1992, the department may, upon request of either the affected county or the provider, mediate the disputed issues.

(5) Where contracts for service at the level committed to on November 1, 1991, have not been completed by April 1, 1992, and additional time is not permitted pursuant to the exceptions specified in paragraph (3) the funds allocated to those counties shall revert for reallocation in a manner that shall promote equity of funding among counties. With respect to counties with exceptions permitted pursuant to paragraph (3), funds shall not revert unless contracts are not completed by June 1, 1992. In no

event shall funds revert under this section if there is no harm to the provider as a result of the county contract not being completed. During the 1992–93 fiscal year, funds reverted under this paragraph shall be used to purchase institution for mental disease/skilled nursing/special treatment program services in existing facilities.

(6) Nothing in this section shall apply to negotiations regarding supplemental payments beyond the rate specified in subdivision (e).

(d) On or before April 1, 1992, counties may complete contracts with facilities for the direct purchase of services in the 1992–93 fiscal year. Those counties for which facility contracts have not been completed by that date shall be deemed to continue to accept financial responsibility for those patients during the subsequent fiscal year at the rate specified in subdivision (a).

(e) As long as contracts with institutions for mental disease providers require the facilities to maintain skilled nursing facility licensure and certification, reimbursement for basic services shall be at the rate established by the State Department of Health Services. Except as provided in this section, reimbursement rates for services in institutions for mental diseases shall be the same as the rates in effect on July 31, 2004. Effective July 1, 2005, through June 30, 2008, the reimbursement rate for institutions for mental disease shall increase by 6.5 percent annually. Effective July 1, 2008, the reimbursement rate for institutions for mental disease shall increase by 4.7 percent annually.

(f) (1) Providers that agree to contract with the county for services under an alternative mental health program pursuant to Section 5768 that does not require skilled nursing facility licensure shall retain return rights to licensure as skilled nursing facilities.

(2) Providers participating in an alternative program that elect to return to skilled nursing facility licensure shall only be required to meet those requirements under which they previously operated as a skilled nursing facility.

(g) In the 1993–94 fiscal year and thereafter, the department shall consider requests to continue administrative services related to institutions for mental disease facilities from counties with a population of 150,000 or less based on the most recent available

estimates of population data as determined by the Population Research Unit of the Department of Finance.

SEC. 6. Section 5912 of the Welfare and Institutions Code is amended to read:

5912. As long as contracts require institutions for mental disease to continue to be licensed and certified as skilled nursing facilities by the State Department of Health Services, they shall be reimbursed for basic services at the rate established by the State Department of Health Services. Except as provided in this section, reimbursement rates for services in institutions for mental diseases shall be the same as the rates in effect on July 31, 2004. Effective July 1, 2005, through June 30, 2008, the reimbursement rate for institutions for mental disease shall increase by 6.5 percent annually. Effective July 1, 2008, the reimbursement rate for institutions for mental disease shall increase by 4.7 percent annually.

SEC. 7. Section 14105.06 of the Welfare and Institutions Code is amended to read:

14105.06. (a) Notwithstanding Section 14105 and any other provision of law, the Medi-Cal reimbursement rates in effect on August 1, 2003, shall remain in effect through July 31, 2005, for the following providers:

(1) Freestanding nursing facilities licensed as either of the following:

(A) An intermediate care facility pursuant to subdivision (d) of Section 1250 of the Health and Safety Code.

(B) An intermediate care facility for the developmentally disabled pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code.

(2) A skilled nursing facility that is a distinct part of a general acute care hospital. For purposes of this paragraph, "distinct part" shall have the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(3) A subacute care program, as described in Section 14132.25 or subacute care unit, as described in Sections 51215.5 and 51215.8 of Title 22 of the California Code of Regulations.

(4) An adult day health care center.

(b) (1) The director may adopt regulations as are necessary to implement subdivision (a). These regulations shall 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 section, 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.

(2) As an alternative to paragraph (1), and 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 by means of a provider bulletin, or similar instructions, without taking regulatory action.

(c) The director shall implement subdivision (a) in a manner that is consistent with federal medicaid law and regulations. The director shall seek any necessary federal approvals for the implementation of this section. This section shall be implemented only to the extent that federal approval is obtained.

(d) The provisions of subdivision (a) shall apply to a skilled nursing facility, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, only until the first day of the month following federal approval to implement both the skilled nursing quality assurance fee imposed by Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code and the rate methodology developed pursuant to Article 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of Division 9.

SEC. 8. Section 14126.02 of the Welfare and Institutions Code is amended to read:

14126.02. (a) It is the intent of the Legislature to devise a Medi-Cal long-term care reimbursement methodology that more effectively ensures individual access to appropriate long-term care services, promotes quality resident care, advances decent wages and benefits for nursing home workers, supports provider compliance with all applicable state and federal requirements, and encourages administrative efficiency.

(b) The department shall implement a facility-specific ratesetting system, subject to federal approval and the availability of federal funds, that reflects the costs and staffing levels associated with quality of care for residents in nursing facilities, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, except that the ratesetting system shall not apply to

a unit that provides pediatric subacute services in a skilled nursing facility, or to a skilled nursing facility that is designated as an institution for mental diseases, as defined in Section 1396d(i) of Title 42 of the United States Code. The facility-specific ratesetting system shall be effective commencing on August 1, 2005, and shall be implemented commencing on the first day of the month following federal approval. The department may retroactively increase and make payment of rates to facilities.

(c) In implementing this section, the department may contract as necessary, on a bid or nonbid basis, for professional consulting services from nationally recognized higher education and research institutions, or other qualified individuals and entities not associated with a skilled nursing facility, with demonstrated expertise in long-term care reimbursement systems. The ratesetting system specified in subdivision (b) shall be developed with all possible expedience. This subdivision establishes an accelerated process for issuing contracts pursuant to this section and contracts entered into pursuant to this subdivision shall be exempt from the requirements of Chapter 1 (commencing with Section 10100) and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(d) The department shall implement a facility-specific ratesetting system by August 1, 2004, subject to federal approval and availability of federal or other funds, that reflects the costs and staffing levels associated with quality of care for residents in hospital-based nursing facilities.

SEC. 9. Section 14126.033 of the Welfare and Institutions Code is amended to read:

14126.033. (a) This article, including Section 14126.031, shall be funded as follows:

(1) General Fund moneys appropriated for purposes of this article pursuant to Section 6 of the act adding this section shall be used for increasing rates, except as provided in Section 14126.031, for freestanding skilled nursing facilities, and shall be consistent with the approved methodology required to be submitted to the 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, 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) To the extent that new rates are projected to exceed the adjusted limits calculated pursuant to subparagraph (A) or (B), the department shall adjust the increase to each skilled nursing facility’s projected rate for the applicable rate year by an equal percentage.

(b) The rate methodology shall cease to be implemented on and after July 31, 2008.

(c) (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 the implementation of this article.

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

(4) Not later than January 1, 2008, 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.

(d) This section shall become inoperative on July 31, 2008, and as of January 1, 2009, is repealed, unless a later enacted statute, that is enacted before January 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 10. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order for the provisions of this act to take effect at the same time that the quality assurance fee and facility-specific ratesetting system required by AB 1629 (Chapter 875, of the Statutes of 2004) are approved by the federal government and implemented by the Department of Health Services, it is necessary for this act to take effect immediately.

Approved _____, 2005

Governor