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CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 411

Introduced by Assembly ~~Members Garrick and Harkey~~ *Member De La Torre*
(Coauthor: Assembly Member Jones)
(Coauthors: Senators Alquist and Strickland)

February 23, 2009

~~An act relating to health facilities.~~ *An act to amend Sections 1324.20, 1324.21, and 1324.27 of the Health and Safety Code, and to amend Section 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 411, as amended, ~~Garrick~~ *De La Torre*. ~~Health facilities: seismic safety.~~ *Skilled nursing facilities: quality assurance fee: Medi-Cal reimbursement.*

Existing law, as long as prescribed conditions are met, provides for the imposition of a uniform quality assurance fee on skilled nursing facilities, subject to prescribed exemptions, to be administered by the Director of Health Care 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 provides that the quality assurance fee shall be based upon the entire net revenue of all skilled nursing facilities subject to the fee, except an exempt facility, as defined to include, among other facilities, a skilled nursing facility that is part of a continuing care retirement community. Violation of these provisions is a misdemeanor.

This bill would eliminate the exemption for a skilled nursing facility that is part of a continuing care retirement community. By changing the definition of a crime, this bill would impose a state-mandated local program.

Existing law provides that for the 2005–06 rate year and subsequent rate years through and including the 2010–11 rate year, the net revenue projected for all skilled nursing facilities subject to the fee shall be based on the prior rate year's data.

This bill would require the prior rate year's data to be updated to the midpoint of the upcoming rate year.

Existing law, the Medi-Cal Long-Term Reimbursement Act, requires the department to implement a cost-based reimbursement rate methodology for freestanding skilled nursing facilities, excluding skilled nursing facilities that are a distinct part of a facility that is licensed as a general acute care hospital. Reimbursement rates for these facilities are funded by a combination of federal funds and moneys collected pursuant to the above-described uniform quality assurance fees. Existing law provides that this rate methodology shall cease to be implemented on July 31, 2011, with these provisions to be repealed on January 1, 2012. Existing law provides, for the 2009–10 and 2010–11 rate years, that the weighted average Medi-Cal reimbursement rate required for purposes of the above-described provisions shall not be increased with respect to the weighted average Medi-Cal reimbursement rate for the 2008–09 rate year.

This bill would, instead, provide that for the 2009–10 rate year, the weighted average Medi-Cal reimbursement rate required for purposes of the above-described provisions shall not exceed 2.5% of the weighted average Medi-Cal reimbursement rate for the prior fiscal year.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

~~Existing law, the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, establishes, under the jurisdiction of the Office of Statewide Health Planning and Development, a program of seismic safety building standards for certain hospitals constructed on and after March 7, 1973. Existing law authorizes the office to assess an application fee for the review of facilities' design and construction, and requires that full and complete plans be submitted to the office for review and approval.~~

~~Existing law requires that, after January 1, 2008, any general acute care hospital building that is determined to be a potential risk of collapse or pose significant loss of life be used only for nonacute care hospital purposes, except that the office may grant an extension under prescribed circumstances. Existing law allows certain hospital owners who do not have the financial capacity to bring certain buildings into compliance by 2013 to, instead, replace those buildings by January 1, 2020.~~

~~This bill would require a health care district that has been denied an extension of the seismic retrofit and replacement deadlines to make a specified report to the office.~~

~~Because this bill would impose additional duties upon local officials, this bill would create a state-mandated local program.~~

~~The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.~~

~~This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.~~

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

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)~~

(a) "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)~~

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

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

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

~~(d)~~

(c) "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)~~

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

SEC. 2. Section 1324.21 of the Health and Safety Code is amended to read:

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

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

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

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

(2) For the ~~rate year~~ 2005–06 *rate year* and subsequent rate years through and including the 2010–11 rate year, the net revenue shall be projected for all skilled nursing facilities subject to the uniform quality assurance fee. The projection of net revenue shall be based on the prior rate year's data *updated to the midpoint of the upcoming rate year*. Once determined, the aggregate projected net revenue for all facilities shall be multiplied by 6 percent, as determined under the approved methodology, and then divided by the projected total resident days of all providers subject to the fee.

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

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

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

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

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

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

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

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

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)~~ *(a)* 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.

(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 14126.033 of the Welfare and Institutions Code is amended to read:

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

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

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

(B) Beginning with the 2006–07 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate

required for purposes of this article shall not exceed 5 percent of the weighted average Medi-Cal reimbursement rate for the prior fiscal year, as adjusted for the projected cost of complying with new state or federal mandates.

(C) Beginning with the 2007–08 rate year and continuing through the 2008–09 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not exceed 5.5 percent of the weighted average Medi-Cal reimbursement rate for the prior fiscal year, as adjusted for the projected cost of complying with new state or federal mandates.

(D) For the 2009–10 ~~and 2010–11 rate years~~ *rate year*, the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not ~~be increased with respect to~~ *exceed 2.5 percent of* the weighted average Medi-Cal reimbursement rate for the ~~2008–09 rate~~ *prior fiscal* year, as adjusted for the projected cost of complying with new state or federal mandates.

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

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

(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, 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.

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

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

SEC. 6. 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 to ensure that skilled nursing facility services are adequately available at the earliest possible time, it is necessary that this act take effect immediately.

~~SECTION 1. On or before March 1, 2010, a health care district established pursuant to Division 23 (commencing with Section 32000) that owns or operates a general acute care hospital building and has been denied a request for an extension of the seismic retrofit and replacement deadlines shall report to the office both of the following:~~

~~(a) The health care district's efforts to comply with the seismic retrofit and replacement deadlines, including, but not limited to, the reassessment of the structural performance level of a general acute care hospital building owned by the health care district.~~

~~(b) The health care district's efforts to secure passage of a local bond measure to fund seismic safety compliance, including the failure or passage of a ballot measure to approve the issuance of these bonds, the extent to which the number of voters who voted in favor the ballot measure exceeded 50 percent of the votes cast but failed to reach the percentage of votes required for passage and the extent to which the vote requirement is a barrier to the ability of the health care district to obtain necessary revenues to comply with the seismic safety deadlines and standards.~~

~~SEC. 2. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.~~

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