AMENDED IN SENATE AUGUST 31, 2012

AMENDED IN SENATE AUGUST 22, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1489

Introduced by Committee on Budget (Blumenfield (Chair), Alejo, Bonilla, Brownley, Buchanan, Butler, Cedillo, Chesbro, Dickinson, Feuer, Gordon, Huffman, Mitchell, Monning, and Swanson)

January 10, 2012

~~An act to amend Sections 5092, 5093, and 5094.6 of, and to repeal Sections 3628 and 5094.5 of, the Business and Professions Code, to repeal Section 11535 of, and to repeal Article 3 (commencing with Section 11675) of Chapter 6 of Part 1 of Division 3 of Title 2 of, the Government Code, to amend Section 110552 of the Health and Safety Code, to repeal Section 1872.1 of the Insurance Code, to repeal Section 11062 of the Penal Code, and to amend Section 10605.2 of the Welfare and Institutions Code, relating to state government, and making an appropriation therefor, to take effect immediately, bill related to the budget.~~ *An act to amend Sections 1324.23, 1324.27, 1324.29, and 1324.30 of the Health and Safety Code, and to amend Sections 14126.022, 14126.027, 14126.033, and 14126.036 of, and to add Section 14126.028 to, the Welfare and Institutions Code, relating to public health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1489, as amended, Committee on Budget. ~~State boards and commissions.~~ *Public health: Medi-Cal: nursing facilities.*

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. The formula is based on the determination of the projected net revenues, as defined, of skilled nursing facilities. Under existing law, the charge will cease to be assessed after July 31, 2013, and these provisions will be repealed on January 1, 2014. 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. Existing law provides that this rate methodology shall cease to be implemented after July 31, 2013, and that these provisions shall be repealed on January 1, 2014.

This bill would modify the calculation of rates under the above-referenced rate methodology, and would extend the assessment of the charge, implementation of the rate methodology, and implementation of related provisions until July 31, 2015. By extending the period of time during which transfers are made to the Skilled Nursing Facility Quality and Accountability Special Fund, this bill would make an appropriation. This bill would also modify the amount of moneys to be deposited into the Skilled Nursing Facility Quality and Accountability Special Fund, by, among other things, requiring that specified set-asides under the rate methodology remain in the General Fund instead of transferring to the Skilled Nursing Facility Quality and Accountability Special Fund and increasing the amount of certain set-asides to be transferred to the fund. This bill would instead require that the quality and accountability payments be made beginning with the 2013–14 rate year.

Existing federal Medicaid law requires nursing facilities, as defined, to perform an assessment of each resident's functional capacity that is based on a uniform minimum data set, as specified.

This bill would require nursing facilities, the State Department of Health Care Services, and the State Department of Public Health to perform various duties with respect to the federal government's nursing home quality initiative and this assessment.

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

~~(1) Existing law, the Naturopathic Doctors Act, provides for the licensure and regulation of naturopathic doctors by the Naturopathic Medicine Committee within the Osteopathic Medical Board of California. Existing law also requires the committee to establish a naturopathic childbirth attendance advisory subcommittee to issue recommendations concerning the practice of naturopathic childbirth attendance based upon a review of naturopathic medical education and training, as specified.~~

~~This bill would repeal the provisions providing for the establishment of this subcommittee.~~

~~(2) Existing law provides for the licensure and regulation of accountants by the California Board of Accountancy. Existing law requires an applicant for an accountancy license to complete a minimum of 24 semester units in accounting subjects and a minimum of 24 semester units in business-related subjects. Existing law, on and after January 1, 2014, requires an applicant for an accountancy license to complete an additional 10 semester units or 15 quarter units in ethics study and 20 units in accounting study. Existing law establishes the Advisory Committee on Accounting Ethics Curriculum within the jurisdiction of the board to, by January 1, 2012, recommend guidelines for the ethics study requirement to the board.~~

~~This bill would repeal the provisions establishing the Advisory Committee on Accounting Ethics Curriculum and would make related conforming and technical changes.~~

~~(3) Existing law establishes the Committee of Executive Salaries, and requires the committee to study issues relating to executive salaries in the private and public sector, and to report to the Legislature on a biannual basis on its findings and recommended changes.~~

~~This bill would repeal the provisions establishing the committee.~~

~~(4) Existing law requires the State Department of Public Health to regulate certain types of candy, as defined, and requires the department~~

~~to convene an interagency collaborative to serve as an oversight committee for the implementation of those provisions and to work with the department in establishing and revising the required standards.~~

~~This bill would repeal those provisions establishing the interagency collaborative and would make technical and conforming changes.~~

~~(5) Existing law creates the Fraud Division within the Department of Insurance to enforce specific provisions of law regarding crimes against insured property and insurance fraud reporting. Existing law creates the advisory committee on automobile insurance fraud and economic automobile theft prevention within the division to recommend ways to coordinate the investigation, prosecution, and prevention of automobile insurance claims fraud, and to provide assistance to the division towards implementing the goal of reducing the frequency and severity of fraudulent automobile insurance claims, among other things.~~

~~This bill would repeal the provisions establishing the advisory committee.~~

~~(6) Existing law requires the Department of Justice to establish and chair a task force known as the Crime Laboratory Review Task Force to review and make recommendations as to how best to configure, fund, and improve the delivery of state and local crime laboratory services in the future and to report its findings to the Department of Finance and specified legislative committees by July 1, 2009.~~

~~This bill would repeal the provision establishing the task force.~~

~~(7) This bill would make various technical and conforming changes.~~

~~(8) This bill would appropriate $1,000 from the General Fund to the Department of Finance for administrative costs related to this bill.~~

~~This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.~~

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

The people of the State of California do enact as follows:

SECTION 1. Section 1324.23 of the Health and Safety Code is amended to read:

1324.23. (a) The Director of Health Care Services, or his or her designee, shall administer this article.

(b) The director may adopt regulations as are necessary to implement this article. These regulations may be adopted as emergency regulations in accordance with the rulemaking

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

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

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

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

(c) As an alternative to subdivision (b), and notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement this article, in whole or in part, by means of a provider bulletin or other similar instructions, without taking regulatory action, provided that no such bulletin or other similar instructions shall remain in effect after July 31, ~~2013.~~ *2015.* It is the intent of the Legislature that the regulations adopted pursuant to subdivision (b) shall be adopted on or before July 31, ~~2013.~~ *2015.*

SEC. 2. 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.

(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. 3. 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, ~~2013.~~ *2015.*

(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. 4. Section 1324.30 of the Health and Safety Code is amended to read:

1324.30. This article shall become inoperative after July 31, ~~2013,~~ *2015,* and, as of January 1, ~~2014,~~ *2016,* is repealed, unless a later enacted statute, that becomes operative on or before January 1, ~~2014,~~ *2016,* deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 5. 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.

(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 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).

(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 (*l*), 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 (m), to facilities that meet or exceed predefined measures as established by this section.

(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 appropriation associated with this bill is 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~~ *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 per patient per day requirements pursuant to Section 1276.5 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 per patient per day requirements pursuant to Section 1276.5 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. 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 Section 100171 and 131071 of the Health and Safety Code shall 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) Nothing in this section shall 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 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 per patient per day requirements pursuant to Section 1276.5 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.

(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) Beginning with the ~~2012–13~~ *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, from which~~ *rate increase for* the ~~department shall transfer the General Fund portion into the~~ Skilled Nursing Facility Quality and Accountability Special Fund.

(*l*) If this act is extended beyond the dates on which it becomes inoperative and is repealed, in accordance with Section 14126.033, beginning with the ~~2013–14~~ *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) (1) *(A)* Beginning with the ~~2012–13~~ *2013–14* rate year, the department shall pay a supplemental payment, by April 30, ~~2013,~~ *2014*, 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) (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) shall not be eligible to receive supplemental payments.

(3) Notwithstanding paragraph (1), if a facility appeals the performance measure of compliance with the nursing hours per patient per day requirements, pursuant to Section 1276.5 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, ~~2013,~~ *2014,* then on May 1, ~~2013,~~ *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, ~~2012,~~ *2013,* to increase provider rates retroactively to August 1, ~~2012.~~ *2013.*

(n) 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.

(o) 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 shall be exempt from the requirements of the Public Contract Code, through December 31, 2013.

(p) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the following shall 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.

(q) Notwithstanding paragraph (1) of subdivision (m), 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 (m), 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 ~~2012–13 rate year, any rate increase shall be reduced by the amounts described in subdivisions (j) and (k). For the~~ 2013–14 rate year, and for each subsequent rate year, any rate increase shall be reduced by the amounts described in subdivisions (j) ~~and (*l*).~~ *to (l), inclusive.*

SEC. 6. 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 Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement this article, in whole or in part, by means of a provider bulletin or other similar instructions, without taking regulatory action, provided that no such bulletin or other similar instructions shall remain in effect after July 31, ~~2013.~~ *2015*. It is the intent of the Legislature that regulations adopted pursuant to subdivision (b) shall be in place on or before July 31, ~~2013.~~ *2015*.

SEC. 7. Section 14126.028 is added to the Welfare and Institutions Code, to read:

14126.028. (a) The Legislature finds and declares both of the following:

(1) Section Q of the Minimum Data Set, Version 3.0, developed as part of the federal government's nursing home quality initiative, uses a person-centered approach to ensure that all individuals have the opportunity to learn about home- and community-based services and have the opportunity to receive long-term care services in the least restrictive setting possible.

(2) More community care services and support options and choices are now available to meet the care preferences and needs in the least restrictive setting possible.

(b) Nursing facilities shall either meet the residents' discharge planning and referral needs, or make referrals to a designated local contact agency (LCA) as determined by the State Department of Health Care Services. The LCA is responsible for contacting referred residents, and for providing information and counseling on available home- and community-based services. The LCA shall also either assist directly with transition services or make referrals to organizations that assist with transition services, as appropriate.

(c) It is the intent of the Legislature to ensure that nursing home residents who, during the Minimum Data Set, Version 3.0, Section Q assessment, express interest in the possibility of receiving care and services in the community are appropriately referred by nursing facilities to the LCA, as appropriate.

(d) The State Department of Health Care Services, in collaboration with the State Department of Public Health, shall, by April 1, 2013, provide the Legislature an analysis of the appropriate sections of the Minimum Data Set, Version 3.0, Section Q and nursing facilities referrals made to the LCA. This analysis shall also document the LCA's response to referrals from nursing facilities and the outcomes of those referrals.

(e) The State Department of Public Health and the State Department of Health Care Services shall regularly, and at least quarterly, meet with representatives from the long-term care industry, organized labor, consumers, and consumer advocates to provide updates and receive input on the planning for, implementation of, and progress of the skilled nursing facility quality improvement program. To facilitate decisionmaking, the State Department of Public Health and the State Department of Health Care Services shall promptly convene this workgroup and

provide ongoing guidance to reach tangible outcomes for implementation by no later than January 2013.

SEC. 8. 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 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 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, 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 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

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 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 ~~calculate rates pursuant to~~ *pay* the ~~reimbursement methodology provided in Section 14126.023, except that the~~ facility specific Medi-Cal reimbursement rate ~~calculated under this subparagraph shall not be less than the Medi-Cal rate~~ that was on file and applicable to the specific skilled nursing facility on ~~May 31,~~ *August 1*, 2011, ~~plus the projected cost of complying with new state or federal mandates. If the department was not able to increase the Medi-Cal reimbursement rates by the maximum 2.4 percent as provided under subparagraph (A) of paragraph (4) for the 2011–12 rate year, then the department may increase the rates for the 2012–13 rate year by an amount equal~~ *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 ~~the difference between the actual percentage increase in the 2011–12 rates and the maximum amount that would have been received if the maximum 2.4 percent increase had been implemented.~~ *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) The department shall set aside 1 percent of the weighted average Medi-Cal reimbursement rate, from which the department shall transfer the General Fund portion into the Skilled Nursing Facility Quality and Accountability Special Fund, to be used for the supplemental rate pool.~~

~~(E)~~

(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 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.

~~(F)~~

(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.

~~(10)~~

(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.

(d) The rate methodology shall cease to be implemented after July 31, ~~2013.~~ *2015*.

(e) (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.

SEC. 9. Section 14126.036 of the Welfare and Institutions Code is amended to read:

14126.036. This article shall become inoperative on August 1, ~~2013,~~ *2015,* and as of January 1, ~~2014,~~ *2016,* is repealed, unless a later enacted statute that is enacted before January 1, ~~2014,~~ *2016,* deletes or extends that date.

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 to make statutory changes necessary for implementation of the Budget Act of 2012, it is necessary that this act take effect immediately.

All matter omitted in this version of the bill appears in the bill as amended in the Senate, August 22, 2012. (JR11)

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