SENATE BILL No. 895

Introduced by Senator Alquist

February 18, 2011

An act to amend Sections 1279 and 1422 of the Health and Safety Code, and to amend Section 14126.023 of the Welfare and Institutions Code, relating to health facilities.

LEGISLATIVE COUNSEL'S DIGEST

SB 895, as introduced, Alquist. Health facilities: inspections.

(1) Under existing law, the State Department of Public Health regulates the licensure and operation of various health facilities, including long-term health care facilities, some of which are collectively classified as nursing homes. Existing law requires the department to conduct periodic inspections of health facilities for which a license or special permit has been issued, to ensure the quality of care. Existing law requires inspection of general acute care hospitals, acute psychiatric hospitals, and special hospitals, no less than once every 3 years and, for other health facilities, inspections no less than once every 2 years.

This bill would revise these inspection requirements, as specified.

(2) Existing law, the Long-Term Care, Health, Safety and Security Act of 1973, requires the State Department of Public Health to conduct annual inspections, without notice, of long-term health care facilities that have not had serious violations of the act within the last 12 months. The act requires every facility to be inspected at least once every 2 years, and further requires the department to vary the cycle for conducting these inspections to reduce the predictability of the inspections.

This bill would delete these inspection requirements.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 1279 of the Health and Safety Code is amended to read:

1279. (a) Every health facility for which a license or special permit has been issued shall be periodically inspected by the department, or by another governmental entity under contract with the department. The frequency of inspections shall vary, depending upon the type and complexity of the health facility or special service to be inspected, unless otherwise specified by state or federal law or regulation. The inspection shall include participation by the California Medical Association consistent with the manner in which it participated in inspections, as provided in Section 1282 prior to September 15, 1992.

(b) Except as provided in subdivision (c), inspections shall be conducted no less than once every ~~two years~~ *other survey that the department conducts to determine compliance for the Medicare program, the Medicaid program, or both,* and as often as necessary to ensure the quality of care being provided.

(c) *(1)* For a health facility specified in subdivision (a), (b), or (f) of Section 1250, inspections shall be conducted no less than once every three years, and as often as necessary to ensure the quality of care being provided.

(2) For a health facility not certified for either the Medicare program or Medicaid program, inspections shall be conducted no less than once every two years, and as often as necessary to ensure the quality of care being provided.

(d) During the inspection, the representative or representatives shall offer such advice and assistance to the health facility as they deem appropriate.

(e) For acute care hospitals of 100 beds or more, the inspection team shall include at least a physician, registered nurse, and persons experienced in hospital administration and sanitary inspections. During the inspection, the team shall offer advice and assistance to the hospital as it deems appropriate.

(f) The department shall ensure that a periodic inspection conducted pursuant to this section is not announced in advance of the date of inspection. An inspection may be conducted jointly with inspections by entities specified in Section 1282. However, if the department conducts an inspection jointly with an entity

specified in Section 1282 that provides notice in advance of the periodic inspection, the department shall conduct an additional periodic inspection that is not announced or noticed to the health facility.

(g) Notwithstanding any other provision of law, the department shall inspect for compliance with provisions of state law and regulations during a state periodic inspection or at the same time as a federal periodic inspection, including, but not limited to, an inspection required under this section. If the department inspects for compliance with state law and regulations at the same time as a federal periodic inspection, the inspection shall be done consistent with the guidance of the federal Centers for Medicare and Medicaid Services for the federal portion of the inspection.

(h) The department shall emphasize consistency across the state and its district offices when conducting licensing and certification surveys and complaint investigations, including the selection of state or federal enforcement remedies in accordance with Section 1423. The department may issue federal deficiencies and recommend federal enforcement actions in those circumstances where they provide more rigorous enforcement action.

SEC. 2. Section 1422 of the Health and Safety Code is amended to read:

1422. (a) The Legislature finds and declares that it is the public policy of this state to ensure that long-term health care facilities provide the highest level of care possible. The Legislature further finds that inspections are the most effective means of furthering this policy. It is not the intent of the Legislature by the amendment of subdivision (b) enacted by Chapter 1595 of the Statutes of 1982 to reduce in any way the resources available to the state department for inspections, but rather to provide the state department with the greatest flexibility to concentrate its resources where they can be most effective. It is the intent of the Legislature to create a survey process that includes state-based survey components and that determines compliance with federal and California requirements for certified long-term health care facilities. It is the further intent of the Legislature to execute this inspection in the form of a single survey process, to the extent that this is possible and permitted under federal law. The inability of the state to conduct a single survey in no way exempts the state from the requirement under

this section that state-based components be inspected in long-term health care facilities as required by law.

~~(b) (1) (A) Notwithstanding Section 1279 or any other provision of law, without providing notice of these inspections, the department, in addition to any inspections conducted pursuant to complaints filed pursuant to Section 1419, shall conduct inspections annually, except with regard to those facilities which have no class "AA," class "A," or class "B" violations in the past 12 months. The state department shall also conduct inspections as may be necessary to ensure the health, safety, and security of patients in long-term health care facilities. Every facility shall be inspected at least once every two years. The department shall vary the cycle in which inspections of long-term health care facilities are conducted to reduce the predictability of the inspections.~~

~~(B)~~

(b) (1) Inspections and investigations of long-term health care facilities that are certified by the Medicare Program or the Medicaid Program shall determine compliance with federal standards and California statutes and regulations to the extent that California statutes and regulations provide greater protection to residents, or are more precise than federal standards, as determined by the department. Notwithstanding any other provision of law, the department may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific this paragraph by means of an All Facilities Letter (AFL) or similar instruction. Prior to issuing an AFL or similar instruction, the department shall consult with interested parties and shall inform the appropriate committees of the Legislature. The department shall also post the AFL or similar instruction on its *Internet* Web site so that any person may observe which California laws and regulations provide greater protection to its residents or are more precise than federal standards. Nothing in this subdivision is intended to change existing statutory or regulatory requirements governing the care provided to long-term health care facility residents.

~~(C)~~

(2) In order to ensure maximum effectiveness of inspections conducted pursuant to this article, the department shall identify all state law standards for the staffing and operation of long-term

health care facilities. Costs of the additional survey and inspection activities required by Chapter 895 of the Statutes of 2006 shall be included as Licensing and Certification Program activities for the purposes of calculating fees in accordance with Section 1266.

~~(2)~~

(3) The state department shall submit to the federal Department of Health and Human Services on or before July 1, 1985, for review and approval, a request to implement a three-year pilot program designed to lessen the predictability of the long-term health care facility inspection process. Two components of the pilot program shall be (A) the elimination of the present practice of entering into a one-year certification agreement, and (B) the conduct of segmented inspections of a sample of facilities with poor inspection records, as defined by the state department. At the conclusion of the pilot project, an analysis of both components shall be conducted by the state department to determine effectiveness in reducing inspection predictability and the respective cost benefits. Implementation of this pilot project is contingent upon federal approval.

~~(c) Except as otherwise provided in subdivision (b), the state department shall conduct unannounced direct patient care inspections at least annually to inspect physician and surgeon services, nursing services, pharmacy services, dietary services, and activity programs of all the long-term health care facilities. Facilities evidencing repeated serious problems in complying with this chapter or a history of poor performance, or both, shall be subject to periodic unannounced direct patient care inspections during the inspection year. The direct patient care inspections shall assist the state department in the prioritization of its efforts to correct facility deficiencies.~~

~~(d)~~

(c) All long-term health care facilities shall report to the state department any changes in the nursing home administrator or the director of nursing services within 10 calendar days of the changes.

~~(e)~~

(d) Within 90 days after the receipt of notice of a change in the nursing home administrator or the director of nursing services, the state department may conduct an abbreviated inspection of the long-term health care facilities.

~~(f)~~

(e) If a change in a nursing home administrator occurs and the Board of Nursing Home Administrators notifies the ~~state~~ department that the new administrator is on probation or has had his or her license suspended within the previous three years, the ~~state~~ department shall conduct an abbreviated survey of the long-term health care facility employing that administrator within 90 days of notification.

SEC. 3. Section 14126.023 of the Welfare and Institutions Code is amended to read:

14126.023. (a) The methodology developed pursuant to this article shall be facility specific and reflect the sum of the projected cost of each cost category and passthrough costs, as follows:

(1) Labor costs limited as specified in subdivisions (d) and (e).

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

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

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

(C) Notwithstanding subparagraph (A), beginning with the 2010–11 rate year and in each subsequent rate year, the department shall not allow any cost associated with legal or consultant fees in connection with a fair hearing or other litigation against any governmental agency or department where any of the following apply:

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

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

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

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

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

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

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

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

(ii) Facilities shall report supplemental data described in this subparagraph in a format and by the deadline determined by the department, or the insurance deductible costs shall continue to be reimbursed in the administrative cost category.

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

(2) Notwithstanding paragraph (1), for the 2010–11 and 2011–12 rate years, the percentiles in paragraphs (1) to (5), inclusive, of subdivision (a) shall be based on annualized audited costs divided by total resident days and computed on a specific geographic peer group basis. Costs within a specific category shall not be shifted to any other cost category.

(c) (1) Facilities newly certified to participate in the Medi-Cal program shall receive a reimbursement rate based on the peer group weighted average Medi-Cal reimbursement rate. Facilities shall continue to receive the peer group weighted average Medi-Cal reimbursement rate until either of the following conditions is met:

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

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

(2) Facilities that have been decertified for less than six months and upon recertification shall continue to receive the facility per diem reimbursement rate in effect prior to decertification. Facilities shall continue to receive the facility per diem reimbursement rate until either of the following conditions is met:

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

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

(3) Facilities that have been decertified for six months or longer and upon recertification shall receive a reimbursement rate based on the peer group weighted average Medi-Cal reimbursement rate. Facilities shall continue to receive the peer group weighted average Medi-Cal reimbursement rate until either of the following conditions is met:

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

(B) The department shall calculate the Freestanding Subacute Skilled Nursing Facility-B facility specific rate when a cost report with a minimum of 12 months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively

and shall be effective on August 1 of each rate year, pursuant to Section 14126.021.

(4) Facilities that have a change of ownership or change of the licensed operator shall continue to receive the facility per diem reimbursement rate in effect with the previous owner. Facilities shall continue to receive the facility per diem reimbursement rate until either of the following conditions is met:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Notwithstanding paragraph (1), or any other provision of law, beginning with the 2010–11 and 2011–12 rate years, the department shall establish rates pursuant to this article on the basis of facility audited cost data reported in the integrated long-term care disclosure and Medi-Cal cost report described in Section 128730 of the Health and Safety Code and audited cost data reported in other facility financial disclosure reports or audited supplemental information required by the department in order to implement this article.

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

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

(j) The department shall conduct financial audits of facility and home office cost data as follows:

(1) The department shall audit facilities a minimum of once every three years to ensure accuracy of reported costs.

(2) It is the intent of the Legislature that the department develop and implement limited scope audits of key cost centers or categories to assure that the rate paid in the years between each

full scope audit required in paragraph (1) accurately reflects actual costs.

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

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

(k) (1) On an annual basis, the department shall use the results of audits performed pursuant to subdivisions (i) and (j), the results of any federal audits, and facility cost reports, including supplemental reports of actual costs incurred in specific cost centers or categories as required by the department, to determine any difference between reported costs used to calculate a facility's rate and audited facility expenditures in the rate year.

(2) If the department determines that there is a difference between reported costs and audited facility expenditures pursuant to paragraph (1), the department shall adjust a facility's reimbursement prospectively over the intervening years between audits by an amount that reflects the difference, consistent with the methodology specified in this article.

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

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

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