Department of Health Care Services
Proposed Trailer Bill Language

AB 1629 – QAF and Rate Methodology Extension

Pediatric and Freestanding Subacute Units – Assess QAF with Rate Changes 2011-12

Suspend Quality and Accountability Supplemental Payment System to 2012-13

Health and Safety (H&S) Code Section 1324.20 is amended to read:

For purposes of this article, the following definitions shall apply:

(a) (1) "Continuing care retirement community" means a provider of a continuum of services, including independent living services, assisted living services as defined in paragraph (5) of subdivision (a) of Section 1771, and skilled nursing care, on a single campus, that is subject to Section 1791, or a provider of such a continuum of services on a single campus that has not received a Letter of Exemption pursuant to subdivision (d) of Section 1771.3.

(2) Notwithstanding paragraph (1), beginning with the 2010-11 rate year and for every rate year thereafter, the term "continuing care retirement community" shall have the definition contained in paragraph (11) of subdivision (c) of Section 1771.

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

(c) (1) "Exempt facility" means a skilled nursing facility that is part of a continuing care retirement community, a skilled nursing facility operated by the state or another public entity, a unit that provides pediatric subacute services in a skilled nursing facility, a skilled nursing facility that is certified by the 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.

(2) Notwithstanding paragraph (1), beginning with the 2010-11 rate year and for every rate year thereafter, the term "exempt facility" shall mean a skilled nursing facility that is part of a continuing care retirement community, as defined in paragraph (2) of subdivision (a), a skilled nursing facility operated by the state or another public entity, a unit that provides pediatric subacute services in a skilled nursing facility, a skilled nursing facility that is certified by the 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.

(3) Notwithstanding paragraph (1), beginning with the 2010-11 rate year and every rate year thereafter, a multilevel facility, as described in paragraph (1) of subdivision (a), shall not be exempt from the quality assurance fee requirements pursuant to this article, unless it meets the definition of a continuing care retirement community in paragraph (11) of subdivision (c) of Section 1771.

(4) (A) Notwithstanding paragraph (1), beginning with the 2011-12 rate year and every rate year thereafter, a unit that provides pediatric subacute services in a skilled nursing facility, as described in paragraph (1) of subdivision (c), shall not be exempt from the quality assurance fee requirements pursuant to this article. (B) For purposes of this article, "pediatric subacute care unit" has the same meaning as defined in Section 51215.5 and 51215.8 of Title 22 of the California Code of Regulations.

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

(2) Notwithstanding paragraph (1), for the 2009-10, ~~to~~ **2010-11 and** 2011-12~~, inclusive,~~ rate years, **and each rate year thereafter,** "net revenue" means gross resident revenue for routine nursing services and ancillary services provided to all residents by a skilled nursing facility, including Medicare revenue for routine and ancillary services and Medicare revenue for services provided to residents covered under a Medicare managed care plan, less payer discounts and applicable contractual allowances as permitted under federal law and regulation. To implement this paragraph, the department shall request federal approval pursuant to Section 1324.27.

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

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

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

Health and Safety (H&S) Code Section 1324.22 is amended to read:

(a) The quality assurance fee, as calculated pursuant to Section 1324.21, shall be paid by the provider to the department for deposit in the State Treasury on a monthly basis on or before the last day of the month following the month for which the fee is imposed, except as provided in subdivision (e) of Section 1324.21.

(b) On or before the last day of each calendar quarter, each skilled nursing facility shall file a report with the department, in a prescribed form, showing the facility's total resident days for the preceding quarter and payments made. If it is determined that a lesser amount was paid to the department, the facility shall pay the amount owed in the preceding quarter to the department with the report. Any amount determined to have been paid in excess to the department during the previous quarter shall be credited to the amount owed in the following quarter.

(c) On or before August 31 of each year, each skilled nursing facility subject to an assessment pursuant to Section 1324.21 shall report to the department, in a prescribed form, the facility's total resident days and total payments made for the preceding state fiscal year. If it is determined that a lesser amount was paid to the department during the previous year, the facility shall pay the amount owed to the department with the report.

(d) (1) A newly licensed skilled nursing facility shall complete all requirements of subdivision (a) for any portion of the year in which it commences operations and of subdivision (b) for any portion of the quarter in which it commences operations.

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

(e) (1) When a skilled nursing facility fails to pay all or part of the quality assurance fee within 60 days of the date that payment is due, the department may deduct the unpaid assessment and interest owed from any Medi-Cal reimbursement payments to the facility until the full amount is recovered. Any deduction shall be made only after written notice to the facility and may be taken over a period of time taking into account the financial condition of the facility.

(2) In addition to the provisions of paragraph (1), any unpaid quality assurance fee assessed by this article shall constitute a debt due to the state and may be collected pursuant to Section 12419.5 of the Government Code.

(f) Notwithstanding any other provision of law, the department shall continue to assess and collect the quality assurance fee, including any previously unpaid quality assurance fee, from each skilled nursing facility, irrespective of any changes in ownership or ownership interest or control or the transfer of any portion of the assets of the facility to another owner.

(g) During the time period in which a temporary manager is appointed to a facility pursuant to Section 1325.5 or during which a receiver is appointed by a court pursuant to Section 1327, the State Department of Public Health shall not be responsible for any unpaid quality assurance fee assessed prior to the time period of the temporary manager or receiver. Nothing in this subdivision shall affect the responsibility of the facility to make all payments of unpaid or current quality assurance fees, as required by this section and Section 1324.21.

(h) If all or any part of the quality assurance fee remains unpaid, the department may take either or both of the following actions:

(1) Assess a penalty equal to 50 percent of the unpaid fee amount for unpaid fees assessed during the 2004-05 to 2009-10, inclusive, rate years, and up to 50 percent of the unpaid fee amount for unpaid fees assessed during the 2010-11 rate year and any subsequent rate year.

(2) (A) Delay license renewal.

(B) Beginning with the 2010-11 rate year, the department may recommend to the State Department of Public Health that license renewal be delayed until the full amount of the quality assurance fee, penalties, and interest is recovered.

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

(j) The assessment process pursuant to this section shall become operative not later than 60 days from receipt of federal approval of the quality assurance fee, unless extended by the department. The department may assess fees and collect payment in accordance with subdivision (e) of Section 1324.21 in order to provide retroactive payments for any rate increase authorized under this article.

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

(l) (1) Not withstanding any other provision of law, for the 2011-12 rate year, the department may waive the provisions provided under subdivision (h), or allow pediatric subacute care facilities to delay payments up to six months, to ensure financial stability required to pay the fee.

(2) For purposes of this paragraph, "pediatric subacute care facilities" has the same meaning as defined in Section 51215.5 and 51215.8 of Title 22 of the California Code of Regulations.

Health and Safety (H&S) Code Section 1324.23 is amended to read:

(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, ~~**2012**~~ **2013**. It is the intent of the Legislature that the regulations adopted pursuant to subdivision (b) shall be adopted on or before July 31, ~~**2012**~~ **2013**.

Health and Safety (H&S) Code Section 1324.29 is amended to read:

(a) The quality assurance fee shall cease to be assessed after July 31, ~~**2012**~~ **2013**.

(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.

Health and Safety (H&S) Code Section 1324.30 is amended to read:
This article shall become inoperative after July 31, ~~**2012**~~ **2013**, and, as of January 1, ~~**2013**~~ **2014**, is repealed, unless a later enacted statute, that becomes operative on or before January 1, ~~**2013**~~ **2014**, deletes or extends the dates on which it becomes inoperative and is repealed.

Welfare and Institutions (W&I) Code Section 14105.192 is amended to read:
(a) The Legislature finds and declares 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 department 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 consistent with federal and state law and policies, including any exemptions contained in the provisions of 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) Notwithstanding any other provision of law, the director shall adjust provider payments, as specified in this section.
(d) (1) Except as otherwise provided in this section, payments shall be reduced by 10 percent for Medi-Cal fee-for-service benefits for dates of service on and after June 1, 2011.
(2) For managed health 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, payments shall be reduced by the actuarial equivalent amount of the payment reductions specified in this section pursuant to contract amendments or change orders effective on July 1, 2011, or thereafter.
(3) Payments shall be reduced by 10 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after June 1, 2011. This paragraph shall not apply to inpatient hospital services provided in a

hospital that is paid under contract pursuant to Article 2.6 (commencing with Section 14081).

(4) (A) Notwithstanding any other provision of law, the director may adjust the payments specified in paragraphs (1) and (3) of this subdivision with respect to one or more categories of Medi-Cal providers, or for one or more products or services rendered, or any combination thereof, so long as the resulting reductions to any category of Medi-Cal providers, in the aggregate, total no more than 10 percent.

(B) The adjustments authorized in subparagraph (A) shall be implemented only if the director determines that, for each affected product, service or provider category, the payments resulting from the adjustment comply with subdivision (m).

(e) Notwithstanding any other provision of this section, payments to hospitals that are not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) for inpatient hospital services provided to Medi-Cal beneficiaries and that are subject to Section 14166.245 shall be governed by that section.

(f) Notwithstanding any other provision of this section, the following shall apply:

(1) Payments to providers that are paid pursuant to Article 3.8 (commencing with Section 14126) shall be governed by that article.

(2) (A) Subject to subparagraph (B), for dates of service on and after June 1, 2011, Medi-Cal reimbursement rates for intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, as determined by the applicable methodology for setting reimbursement rates for these facilities, shall not exceed the reimbursement rates that were applicable to providers in the 2008-09 rate year.

(B) (i) If Section 14105.07 is added to the Welfare and Institutions Code during the 2011-12 Regular Session of the Legislature, subparagraph (A) shall become inoperative.

(ii) If Section 14105.07 is added to the Welfare and Institutions Code during the 2011-12 Regular Session of the Legislature, then for dates of service on and after June 1, 2011, payments to intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, shall be governed by the applicable methodology for setting reimbursement rates for these facilities and by Section 14105.07.

(g) The department may enter into contracts with a vendor for the purposes of implementing this section on a bid or nonbid basis. In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this subdivision is necessary. Therefore, contracts entered into to implement this section and all contract amendments and change orders shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 Division 2 of the Public Contract Code.

(h) To the extent applicable, the services, facilities, and payments listed in this subdivision shall be exempt from the payment reductions specified in subdivision (d) as follows:

(1) Acute hospital inpatient services that are paid under contracts pursuant to Article 2.6 (commencing with Section 14081).

(2) Federally qualified health center services, including those facilities deemed to have federally qualified health center status pursuant to a waiver pursuant to subsection (a) of Section 1115 of the federal Social Security Act (42 U.S.C. Sec. 1315(a)).

(3) Rural health clinic services.

(4) Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services.

(5) Hospice services.

(6) Contract services, as designated by the director pursuant to subdivision (k).

(7) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations. This paragraph shall apply to payments described in paragraph (3) of subdivision (d) only to the extent that they are also exempt from reduction pursuant to subdivision (l).

(8) Services pursuant to local assistance contracts and interagency agreements to the extent the funding is not included in the funds appropriated to the department in the annual Budget Act.

(9) Breast and cervical cancer treatment provided pursuant to Section 14007.71 and as described in paragraph (3) of subdivision (a) of Section 14105.18 or Article 1.5 (commencing with Section 104160) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code.

(10) The Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to subdivision (aa) of Section 14132.

(i) Subject to the exception for services listed in subdivision (h), the payment reductions required by subdivision (d) shall apply to the benefits rendered by any provider who may be authorized to bill for the service, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse-midwives, nurse anesthetists, and organized outpatient clinics.

(j)**(1)** Notwithstanding any other provision of law, for dates of service on and after June 1, 2011, Medi-Cal reimbursement rates applicable to the following classes of providers shall not exceed the reimbursement rates that were applicable to those classes of providers in the 2008-09 rate year, as described in subdivision (f) of Section **~~14105.91~~ 14105.191**, reduced by 10 percent:

~~(1)~~ **(A)** Intermediate care facilities, excluding those facilities identified in paragraph (2) of subdivision (f). For purposes of this section, "intermediate care facility" has the same meaning as defined in Section 51118 of Title 22 of the California Code of Regulations.

~~(2)~~ **(B)** Skilled nursing facilities that are distinct parts of general acute care hospitals. For purposes of this section, "distinct part" has the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

~~(3)~~ **(C)** Rural swing-bed facilities.

~~(4)~~ **(D)** Subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this subparagraph, "subacute care unit" has the same meaning as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

~~(5) Pediatric subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this subparagraph, "pediatric~~

~~subacute care unit" has the same meaning as defined in Section 51215.8 of Title 22 of the California Code of Regulations.~~

~~(6)~~ **(E)** Adult day health care centers.

~~(7) Freestanding pediatric subacute care units, as defined in Section 51215.8 of Title 22 of the California Code of Regulations.~~

(2) (A) Beginning June 1, 2011, reimbursement rates for pediatric subacute care units that are, or are parts of distinct parts of general acute care hospitals shall be based on the reimbursement rates that were applicable in the 2008-09 rate year increased by 1.5 percent. For purposes of this subparagraph, "pediatric subacute care unit" has the same meaning as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

(B) Beginning June 1, 2011, reimbursement rates for freestanding pediatric subacute care units, as defined in Section 51215.8 of Title 22 of the California Code of Regulations, shall be the applicable rate for the 2008-09 rate year reduced by 5.75 percent.

(C) The department shall recalculate the reimbursement rates specified in subparagraphs (A) and (B) and publish the Medi-Cal reimbursement rates 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 pursuant to paragraph (2).

(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 June 1, 2011 pediatric subacute care units Medi-Cal reimbursement rate .

(iv) If the difference in the projected quality assurance fee collections from the 2011-12 rate year, would result in any additional General Fund expense to pay for the 2011-12 rate year reimbursement rate.

(k) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer this section by means of provider bulletins, or similar instructions, without taking regulatory action.

(l) The reductions described in this section shall apply only to payments for services when the General Fund share of the payment is paid with funds directly appropriated to the department in the annual Budget Act and shall not apply to payments for services paid with funds appropriated to other departments or agencies.

(m) Notwithstanding any other provision of this section, the payment reductions and adjustments provided for in subdivision (d) shall be implemented only if the director determines that the payments that result from the application of this section will comply with applicable federal Medicaid requirements and that federal financial participation will be available.

(1) 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.

(2) To the extent that the director determines that the payments do not comply with the 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.

(n) The department shall seek any necessary federal approvals for the implementation of this section.

(o) This section shall not be implemented until federal approval is obtained. When federal approval is obtained, the payments resulting from the application of subdivision (d) shall be implemented retroactively to June 1, 2011, or on such other date or dates as may be applicable.

Welfare and Institutions (W&I) Code Section 14126.022 is amended to read:

(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) 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.

(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.

(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 for 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 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 rate 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 2012-13 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 2011-12 rate year.

(iii) The use of chemical restraints.

(j) 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.

(k) Beginning with the ~~**2011-12**~~ **2012-13** rate year, 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.

(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 ~~**2012-13**~~ **2013-14** 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) Beginning with the ~~2011-12~~ **2012-13** rate year, the department shall pay a supplemental payment, by April 30, ~~2012~~ **2013**, 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.

(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, ~~2012~~ **2013**, then on May 1, ~~2012~~ **2013**, 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, ~~2011~~ **2012**, to increase provider rates retroactively to August 1, ~~2011~~ **2012**.

(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, 2012.

(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 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 provisions 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) ~~**or**~~ **of** paragraph (4) of subdivision ~~**(a)**~~ **(c)** of Section 14126.033 shall be reduced by the amounts described in subdivisions (j) ~~**and (k)**~~. For the 2012-13 rate year ~~**and for each subsequent rate year**~~, any rate increase shall be reduced by the amounts described in subdivisions (j) and ~~**(l)**~~ **(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).**

Welfare and Institutions (W&I) Code Section 14126.023 is amended to read:

(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 year, **and each rate year thereafter,** the percentiles in paragraphs (1) to (5), inclusive, of subdivision (a) shall be based on annualized audited costs divided by total resident days and computed on a specific geographic peer group basis. Costs within a specific category shall not be shifted to any other cost category.

(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 year**~~s~~**, **and each rate year thereafter,** the department shall establish rates pursuant to this article on the basis of facility audited cost data **pursuant to subdivision (c),** reported in the integrated long-term care disclosure and Medi-Cal cost report described in Section 128730 of the Health and Safety Code and audited cost data reported in other
facility financial disclosure reports or audited supplemental information required by the department in order to implement this article.

(3) Notwithstanding paragraph (1), or any other provision of law, beginning with the 2010-11 rate year and each rate 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.

Welfare and Institutions (W&I) Code Section 14126.027 is amended to read:

(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, ~~**2012**~~ **2013**. It is the intent that regulations adopted pursuant to subdivision (b) shall be in place on or before July 31, ~~**2012**~~ **2013**.

Welfare and Institutions (W&I) Code Section 14126.033 is amended to read:

(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** ~~**maximum annual increase in the weighted average**~~ Medi-Cal reimbursement rate for the purpose of this article**, for each skilled nursing facilities as defined in subdivision (c) of Section 1250 of the Health and Safety Code,** shall not exceed 2.4 percent **from the rate on file that was applicable on August 1, 2010 and the percentage increase shall be applied equally to each rate on file as of August 1, 2010**, plus the projected cost of complying with new state or federal mandates.

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

~~**(i) For the 2011-12 rate year, 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.**~~

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

~~**(iii)**~~ **(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.

~~**(iv)**~~ **(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~~**s**~~ (B)~~**, (C), and (D)**~~, 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**.

(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) Notwithstanding any other provision of law, the 1 percent set aside of the weighted average Medi-Cal reimbursement rate as required by clause (i) of subparagraph (B) of paragraph (4) shall be exempt from the payment reduction required by this paragraph.**~~

~~**(C) Notwithstanding any other provision of law, payments to**~~

~~skilled nursing facilities pursuant to subdivision (m) of Section 14126.022 shall be exempt from the payment reduction required by this paragraph.~~

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

(iii) For managed care health plans that contract with the department pursuant to this chapter, and Chapter 8 (commencing with Section 14200), 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 specified 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, each skilled nursing facility shall be paid the rate provided for in subparagraph (A) of paragraph (4) for such facility, plus the projected cost of complying with new state or federal mandates.

(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 quality assurance fee.

(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.

~~(9)~~ **(10)** 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, ~~2012~~ **2013**.

(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.

Welfare and Institutions (W&I) Code Section 14126.036 is amended to read:

This article shall become inoperative on August 1, ~~**2012**~~ **2013**, and as of January 1, ~~**2013**~~ **2014**, is repealed, unless a later enacted statute that is enacted before January 1, ~~**2013**~~ **2014**, deletes or extends that date.