WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000 - 15771] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 7. Basic Health Care [14000 - 14199.87] *(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

ARTICLE 3.8. Medi-Cal Long-Term Care Reimbursement Act [14126 - 14126.036] *(Article 3.8 repealed and added by Stats. 2004, Ch. 875, Sec. 5.)*

14126. This article shall be known as the Medi-Cal Long-Term Care Reimbursement Act.

(Repealed and added by Stats. 2004, Ch. 875, Sec. 5. Effective September 29, 2004. Conditionally inoperative as provided in subd. (a) of Section 14126.035. Inoperative after December 31, 2026, pursuant to Section 14126.036. Repealed as of January 1, 2028, pursuant to Section 14126.036.)

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

(b) The department shall implement a facility-specific ratesetting system, subject to federal approval and the availability of federal funds, that reflects the costs and staffing levels associated with quality of care for residents in nursing facilities, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, except that the ratesetting system shall not apply to a unit that provides pediatric subacute services in a skilled nursing facility, or to a skilled nursing facility that is designated as an institution for mental diseases, as defined in Section 1396d(i) of Title 42 of the United States Code. The facility-specific ratesetting system shall be effective commencing on August 1, 2005, and shall be implemented commencing on the first day of the month following federal approval. The department may retroactively increase and make payment of rates to facilities.

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

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

(Amended by Stats. 2005, Ch. 508, Sec. 8. Effective October 4, 2005. Conditionally inoperative as provided in subd. (a) of Section 14126.035. Inoperative after December 31, 2026, pursuant to Section 14126.036. Repealed as of January 1, 2028, pursuant to Section 14126.036.)

14126.021. The department shall develop and implement a cost-based reimbursement rate methodology using the cost categories as described in Section 14126.023, for freestanding nursing facilities pursuant to this article, excluding nursing facilities that are a distinct part of a facility that is licensed as a general acute care hospital as identified pursuant to subdivision (d) of Section 14126.02. The cost-based reimbursement rate methodology shall be effective on August 1, 2005, and shall be implemented on the first day of the month following federal approval.

(Added by Stats. 2004, Ch. 875, Sec. 5. Effective September 29, 2004. Conditionally inoperative as provided in subd. (a) of Section 14126.035. Inoperative after December 31, 2026, pursuant to Section 14126.036. Repealed as of January 1, 2028, pursuant to Section 14126.036.)

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 or calendar year, the administrative cost category shall exclude 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 or calendar 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 if 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 on any citation issued under subdivision (c), (d), or (e) of Section 1424 of the Health and Safety Code or on 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 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.

(i) Eligible caregiver training costs include any and all trainings that enhance the skills, education, or career advancement for nursing home workers.

(ii) Trainings provided through a joint labor-management Taft-Hartley fund are eligible for the direct pass through of proportional Medi-Cal costs.

(B) (i) Notwithstanding subparagraph (A), for the 2010–11 rate year and each rate or calendar 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 rate year, and each rate or calendar 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.

(3) Effective August 1, 2020, the department shall continue to establish the specific geographic peer groups on the basis of, but need not be limited to, similar or common facility characteristics as determined by the department in consultation with

stakeholders. The department may periodically review and change the number and assignment of peer groups and the peer group placement of an individual facility. Peer group assignments shall be effective for the duration of the rate or calendar year.

(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 or January 1 of each calendar year period, as applicable, 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 or January 1 of each calendar year period, as applicable, 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 or January 1 of each calendar year period, as applicable, 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 or January 1 of each calendar year period, as applicable, 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 or January 1 of each calendar year period, as applicable, 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 or January 1 of each calendar year period, as applicable, 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 or January 1 of each calendar year period, as applicable, 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 or January 1 of each calendar year period, as applicable, pursuant to Section 14126.021.

(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 through the

conclusion of the 2019–20 rate year. Beginning for the rate period of August 1, 2020, to December 31, 2020, inclusive, and each subsequent calendar year thereafter, these costs shall be limited to the 95th 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 through the conclusion of the 2019–20 rate year. Beginning for the rate period of August 1, 2020, to December 31, 2020, inclusive, and each subsequent calendar year thereafter for which this article is operative, these costs shall be limited to the 95th 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 or calendar 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 annually update each facility specific rate calculated under this methodology. 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 law, beginning with the 2010–11 rate year, and each rate or calendar 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 law, beginning with the 2010–11 rate year through December 31, 2022, 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.

(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 on 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.

(Amended by Stats. 2022, Ch. 46, Sec. 8. (AB 186) Effective June 30, 2022. Conditionally inoperative as provided in subd. (a) of Section 14126.035. Inoperative after December 31, 2026, pursuant to Section 14126.036. Repealed as of January 1, 2028, pursuant to Section 14126.036.)

14126.024. (a) For managed care rating periods that begin between January 1, 2023, and December 31, 2025, inclusive, the department, in consultation with representatives from the long-term care industry, organized labor, consumer advocates, and Medi-Cal managed care plans, shall establish and implement the Workforce and Quality Incentive Program under which a network provider furnishing skilled nursing facility services to a Medi-Cal managed care enrollee may earn performance-based directed payments from the Medi-Cal managed care plan they contract with in accordance with this section.

(b) Subject to appropriation by the Legislature in the annual Budget Act, the department shall do all of the following:

(1) Set the amount of performance-based directed payments to target an aggregate amount of two hundred eighty million dollars ($280,000,000) for the 2023 calendar year.

(2) For the 2024 through 2025 calendar years, the department shall set the amount of the performance-based directed payments to target the previous calendar year's target plus the annual increase specified by clause (ii) of subparagraph (A) of paragraphs (18), (19), and (20) of subdivision (c) of Section 14126.033.

(3) No sooner than December 31, 2023, the department shall make a one-time increase to the performance-based directed payment target amount by the amounts described in subdivision (f) of Section 14126.032. This one-time increase shall not be factored into the amount calculated for a subsequent calendar year pursuant to paragraph (2).

(c) The department, in consultation with stakeholders listed in subdivision (a), shall establish the methodology or methodologies, parameters, and eligibility criteria for the directed payments pursuant to this section. This shall include, but is not limited to, the milestones and metrics that network providers of skilled nursing facility services must meet in order to receive a directed payment from a Medi-Cal managed care plan pursuant to this section, with at least two of these milestones and metrics tied to workforce measures. Subject to subdivision (j), the department may implement the directed payment described in this section using one or more of the models authorized at Section 438.6(c)(1)(i)-(iii), inclusive, of Title 42 of the Code of Federal Regulations.

(d) A freestanding pediatric subacute care facility, as defined in Section 51215.8 of Title 22 of the California Code of Regulations, shall be exempt from the directed payments described in this section.

(e) Notwithstanding any other law, special program services for the mentally disordered that are entitled to receive the supplemental payment under Section 51511.1 of Title 22 of the California Code of Regulations shall be exempt from the directed payments described in this section.

(f) Directed payments made pursuant to this section shall be in addition to any other payments made by the a Medi-Cal managed care plan to applicable network providers of skilled nursing facility services and shall not supplant amounts that would otherwise be payable by a Medi-Cal managed care plan to a provider of skilled nursing facility services, including those payments made in accordance with paragraph (2) of subdivision (b) of Section 14184.201.

(g) For managed care rating periods during which this section is implemented, capitation rates paid by the department to a Medi-Cal managed care plan shall be actuarially sound and shall account for the directed payments described in this section.

(h) The department may require Medi-Cal managed care plans and network providers of skilled nursing facility services to submit information the department deems necessary to implement this section, at the times and in the form and manner specified by the department.

(i) Payments pursuant to this section shall be made in accordance with the requirements for directed payment arrangements described in Section 438.6(c) of Title 42 of the Code of Federal Regulations and any associated federal guidance.

(j) In implementing this section, the department may contract, as necessary, with California's Medicare Quality Improvement Organization, or other entities deemed qualified by the department, not associated with a skilled nursing facility, to assist with development, collection, analysis, and reporting of the performance data pursuant to this section. The department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis for purposes of implementing this subdivision. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and State Administrative Manual, and the State Contracting Manual, and shall be exempt from the review or approval of any division of the State Department of General Services.

(k) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(l) For purposes of this section, the following definitions apply:

(1) "Medi-Cal managed care plan" has the same meaning as set forth in subdivision (j) of Section 14184.101.

(2) "Network provider" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(3) "Skilled nursing facility" has the same meaning as set forth in subdivision (c) of Section 1250 of the Health and Safety Code, excluding a nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital as described in subdivision (a) of Section 1250 of the Health and Safety Code.

(m) (1) This section shall become inoperative on January 1, 2026. The department may conduct all necessary closeout activities applicable to any managed care rating period before January 1, 2026.

(2) This section shall be repealed on January 1, 2027, or on the date that the director certifies to the Secretary of State that all necessary closeout activities have been completed pursuant to paragraph (1), whichever is later.

(Amended by Stats. 2025, Ch. 21, Sec. 99. (AB 116) Effective June 30, 2025. Inoperative January 1, 2026, by its own provisions. Conditionally repealed on or after January 1, 2027, by its own provisions.)

14126.025. (a) The department shall seek approval of an amendment to the Medicaid state plan specifically outlining the reimbursement methodology developed pursuant to this article not later than February 1, 2005.

(b) The amendment to the Medicaid state plan pursuant to subdivision (a), and any regulations, provider bulletins, or other similar instructions, shall be prepared in consultation with representatives of the long-term care industry, organized labor, seniors, and consumers.

(Added by Stats. 2004, Ch. 875, Sec. 5. Effective September 29, 2004. Conditionally inoperative as provided in subd. (a) of Section 14126.035. Inoperative after December 31, 2026, pursuant to Section 14126.036. Repealed as of January 1, 2028, pursuant to Section 14126.036.)

14126.026. (a) Notwithstanding any other law, and in addition to any other remedial action available to the department, if a skilled nursing facility fails to meet or exceed one or more of the measures developed by the department, including, but not limited to, those developed pursuant to subdivision (b) of Section 14126.024, the department may assess sanctions as described in this section.

(b) (1) For each measure a skilled nursing facility fails to meet or exceed in a single rating period, the department may assess a sanction of five dollars ($5) for each Medi-Cal bed day within the rating period.

(2) For each measure a skilled nursing facility fails to meet or exceed, the department shall not assess an aggregate sanction that exceed one hundred fifty thousand dollars ($150,000) in a single rating period.

(c) The director may identify findings of noncompliance through any means, including, but not limited to, findings in audits, investigations, compliance reviews, quality improvement monitoring, routine monitoring, facility site surveys, encounter and provider data submissions, grievances and appeals, reviews of utilization data, fair hearing decisions, complaints from beneficiaries and other stakeholders, whistleblowers, and self-disclosures.

(d) Notwithstanding any other law, the amount of the assessed sanction, as calculated pursuant to subdivision (b), for a skilled nursing facility may be deducted by the department from any Medi-Cal payments to that facility until the sanction is paid in full. If the

department deducts the sanction from the Medi-Cal payments to the facility, the department shall provide prior written notice to the facility, and, in taking into account the financial condition of the facility, may apply that deduction over a period of time.

(e) Notwithstanding any other law, if there is a merger, acquisition, or change of ownership involving a skilled nursing facility that has an outstanding sanction pursuant to this section, the successor skilled nursing facility shall be responsible for paying to the department the full amount of the outstanding sanction attributable to the facility for which it was assessed, upon the effective date of that transaction.

(f) The department may waive all or a portion of the sanction assessed under this section if a facility petitions for a waiver and the department determines, in its sole discretion, that the petitioning facility meets both of the following:

(1) The facility has demonstrated to the department's satisfaction that sufficient corrective action has been taken to remediate the underlying deficiency.

(2) The facility has demonstrated to the department's satisfaction that imposing the full amount of the sanction under this section has a high likelihood of creating an undue financial hardship for that facility or creates a significant difficulty in providing services to Medi-Cal beneficiaries.

(g) Any sanction collected by the department pursuant to this section shall be deposited into the General Fund, and, upon appropriation by the Legislature, shall be used to improve the quality of skilled nursing facility services under the Medi-Cal program, and to fund the department's administrative costs associated with implementing the program described in this section.

(h) (1) If a facility disputes any sanction made pursuant to this section, the facility shall, within 30 days of the facility's receipt of the sanction assessment, submit a request for appeal to the department. The request shall include a detailed statement describing the reason for appeal and include all supporting documents the facility will present at the hearing.

(2) Within 30 days of the department's receipt of the facility's request for appeal, the department shall submit to the facility its responsive arguments and all supporting documents that the department will present at the hearing.

(3) The department shall hear a timely appeal and issue a decision as follows:

(A) The hearing shall commence within 60 days from the date of receipt by the department of the facility's timely request for appeal.

(B) 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.

(C) The decision of the department's hearing officer, when issued, shall be the final decision of the department.

(4) The appeals process set forth in this subdivision 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 Sections 100171 and 131071 of the Health and Safety Code do not apply to appeals under this subdivision.

(5) If a hearing decision issued pursuant to subparagraph (C) of paragraph (3) of this subdivision is in favor of the department, the skilled nursing facility shall pay the sanctions to the department within 30 days of the facility's receipt of the decision. The sanctions collected shall be deposited in accordance with subdivision (g).

(i) Any sanction issued pursuant to this section shall not prohibit any state or federal enforcement action, including, but not limited to, 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.

(j) In implementing this section, the department may contract, as necessary, with California's Medicare Quality Improvement Organization, or other entities deemed qualified by the department, not associated with a skilled nursing facility, to assist with development, collection, analysis, and reporting of the performance data pursuant to this section. The department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis for purposes of implementing this subdivision. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, the State Administrative Manual, and the State Contracting Manual, and shall be exempt from the review or approval of any division of the State Department of General Services.

(k) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(l) For purposes of this section, "skilled nursing facility" has the same meaning as set forth in subdivision (c) of Section 1250 of the Health and Safety Code, excluding a nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital as described in subdivision (a) of Section 1250 of the Health and Safety Code.

(Added by Stats. 2022, Ch. 46, Sec. 10. (AB 186) Effective June 30, 2022. Conditionally inoperative as provided in subd. (a) of Section 14126.035. Inoperative after December 31, 2026, pursuant to Section 14126.036. Repealed as of January 1, 2028, pursuant to Section 14126.036.)

14126.027. 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 provider bulletins or other similar instructions, without taking regulatory action. The department shall make use of appropriate processes to ensure that affected stakeholders are informed of, and have access to, applicable guidance issued pursuant to this authority in a timely manner, and that this guidance remains publicly available while this article remains operative.

(Amended by Stats. 2020, Ch. 13, Sec. 12. (AB 81) Effective June 29, 2020. Conditionally inoperative as provided in subd. (a) of Section 14126.035. Inoperative after December 31, 2026, pursuant to Section 14126.036. Repealed as of January 1, 2028, pursuant to Section 14126.036.)

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

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

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

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

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

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

(e) The State Department of Public Health and the State Department of Health Care Services shall regularly, and at least quarterly, meet with representatives from the long-term care industry, organized labor, consumers, and consumer advocates to provide updates and receive input on the planning for, implementation of, and progress of the skilled nursing facility quality improvement program. To facilitate decisionmaking, the State Department of Public Health and the State Department of Health Care Services shall promptly convene this workgroup and provide ongoing guidance to reach tangible outcomes for implementation by no later than January 2013.

(Added by Stats. 2012, Ch. 631, Sec. 7. (AB 1489) Effective September 27, 2012. Conditionally inoperative as provided in subd. (a) of Section 14126.035. Inoperative after December 31, 2026, pursuant to Section 14126.036. Repealed as of January 1, 2028, pursuant to Section 14126.036.)

14126.029. (a) For purposes of this section, the following definitions apply:

(1) "Long-term health care facility" means a skilled nursing facility or nursing facility as those terms are defined in paragraph (1) of subdivision (c) and subdivision (k) of Section 1250 of the Health and Safety Code, respectively.

(2) "Timely" means within three calendar days of a long-term health care facility being served a hearing decision.

(b) A long-term health care facility shall timely comply with a hearing decision, as issued by the department's Office of Administrative Hearings and Appeals pursuant to Section 1396r(e)(3) of Title 42 of the United States Code and Section 1599.1 of the Health and Safety Code, that finds that the long-term health care facility improperly transferred, discharged, or refused to readmit a resident.

(c) (1) Notwithstanding any other law, and in addition to any other remedial action available to the department, if a long-term health care facility fails to timely comply with a hearing decision issued by the department's Office of Administrative Hearings and Appeals, the department may assess penalties pursuant to this subdivision.

(2) Commencing on the fourth calendar day after the date of service of the hearing decision, the department may assess a penalty of seven hundred fifty dollars ($750) for each calendar day the facility fails to comply with the hearing decision.

(3) For each individual hearing decision, the department shall not assess aggregate penalties that exceed seventy-five thousand dollars ($75,000).

(d) To demonstrate compliance with a hearing decision, a long-term health care facility shall file a certification of compliance with the department within three calendar days of the date the hearing decision is served on that facility, in a form and manner as established by the department. The certification shall specify the date of service of the hearing decision and the date on which the resident was readmitted or the facility otherwise complied with the hearing decision. The department shall make a certificate of compliance available on its internet website.

(e) A long-term health care facility's failure to timely comply with the hearing decision, including, but not limited to, a failure to file the certification of compliance within three calendar days of service of the hearing decision, as described in subdivision (d), shall subject that facility to the issuance of penalties as specified in subdivision (c), except as provided in subdivision (g).

(f) (1) Notwithstanding any other law, the amount of the assessed penalties, as calculated pursuant to subdivision (c), for a long-term health care facility may be deducted by the department from any Medi-Cal payments to that facility until the penalties are paid in full. If the department deducts the penalties from the Medi-Cal payments to the facility, the department shall provide prior written notice to the facility, and, in taking into account the financial condition of the facility, may apply that deduction over a period of time.

(2) Notwithstanding any other law, if there is a merger, acquisition, or change of ownership involving a long-term health care facility that has outstanding penalties pursuant to this section, the successor long-term health care facility shall be responsible for paying to the department the full amount of outstanding penalties attributable to the facility for which it was assessed, upon the effective date of that transaction.

(g) The department may waive all or a portion of the penalties assessed under this section if a facility petitions for a waiver and the department determines, in its sole discretion, that the petitioning facility meets both of the following:

(1) The facility complied with the hearing decision or otherwise demonstrated to the department's satisfaction that sufficient corrective action has been taken to remediate the underlying improper conduct.

(2) The facility demonstrated to the department's satisfaction that imposing the full amount of penalties under this section has a high likelihood of creating an undue financial hardship for that facility or creates a significant difficulty in providing services to Medi-Cal beneficiaries.

(h) Any penalties collected by the department pursuant to this section shall be deposited into the General Fund, and, upon appropriation by the Legislature, shall be used to improve quality of long-term care services under the Medi-Cal program, and to fund the department's administrative costs associated with the hearings conducted pursuant to Section 1396r(e)(3) of Title 42 of the United States Code and Section 1599.1 of the Health and Safety Code for purposes of implementing this section.

(i) Any penalty the department assesses on a long-term health care facility pursuant to this section is appealable only to the superior court of the county where the facility is located.

(j) Any penalty issued pursuant to this section shall not prohibit any state or federal enforcement action, including, but not limited to, an enforcement action by the State Department of Public Health, for a violation of improper transfer or discharge or failure to readmit requirements.

(k) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of information notices, provider bulletins, or other similar instructions, without taking any further regulatory action.

(l) The department shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is not jeopardized.

(m) In the event that the long-term health care facility seeks judicial review of the hearing decision and the hearing decision is reversed through such review, the department, after being provided a copy of the final judicial order by the facility, shall refund to the facility any penalties paid by the facility associated with the reversed hearing decision.

(n) (1) A hearing decision for a hearing described in subdivision (b) shall be made by a hearing officer trained to consider and apply the procedural and substantive requirements of all applicable federal and state laws and regulations governing the transfer and discharge process.

(2) A hearing described in subdivision (b) shall afford the resident and facility due process, including, but not limited to, allowing the direct and cross-examination of witnesses under oath, allowing the presentation of documents as exhibits, and making a recording of all sessions of the proceedings of sufficient quality to allow for the preparation of a written transcript.

(Added by Stats. 2021, Ch. 143, Sec. 384. (AB 133) Effective July 27, 2021. Conditionally inoperative as provided in subd. (a) of Section 14126.035. Inoperative after December 31, 2026, pursuant to Section 14126.036. Repealed as of January 1, 2028, pursuant to Section 14126.036.)

14126.031. (a) In implementing this article, the department may use the process outlined in subdivision (c) of Section 14126.02 to obtain professional consulting services for the purpose of finalizing design of the system, procurement of required technical hardware and software, establishing operational parameters, implementation, and transitional management pending assumption of operational management by state staff.

(b) The ratesetting system described in subdivision (b) of Section 14126.02 shall be developed expeditiously in order to meet the implementation date required under Section 14126.02.

(c) To ensure compliance with the timeframes set forth in this article, it is the intent of the Legislature that the department be authorized to hire up to three full-time equivalents to support implementation and continuous operation of the system.

(Added by Stats. 2004, Ch. 875, Sec. 5. Effective September 29, 2004. Conditionally inoperative as provided in subd. (a) of Section 14126.035. Inoperative after December 31, 2026, pursuant to Section 14126.036. Repealed as of January 1, 2028, pursuant to Section 14126.036.)

14126.032. (a) (1) Notwithstanding any other law, the department shall audit the costs and revenues of skilled nursing facilities that are associated with the COVID-19 Public Health Emergency, as determined by the department, including, but not limited to, equivalent amounts paid pursuant to paragraph (15) of subdivision (c) of Section 14126.033, to determine whether a skilled nursing facility has adequately used increased Medicaid payments associated with the COVID-19 Public Health Emergency made pursuant to subdivision (a) of Section 14124.12 for only allowable costs. For purposes of this section, allowable costs shall include patient care, additional labor costs attributable to the COVID-19 Public Health Emergency including, but not limited to, increased wages or benefits, shift incentive payments, staff retention bonuses, pay differential for workers employed by more than one facility, and overtime payments to nonmanagerial workers, and other appropriate costs that support the delivery of patient care, including, but not limited to, personal protective equipment, COVID-19 testing for any workers regardless of whether they are symptomatic or asymptomatic, infection control measures and equipment, and additional staff training. The department shall conduct financial audits of facility costs and revenues under this section based on the categories defined in Section 14126.023, including, but not limited to, direct labor costs, indirect labor costs, and administrative costs, and in accordance with any terms of federal approval obtained pursuant to subdivision (d).

(2) For the costs and revenues associated with the time period of January 1, 2023, through December 31, 2023, the audit conducted pursuant to paragraph (1) shall include an audit of revenues received by a facility that were spent on additional labor costs attributable to the COVID-19 Public Health Emergency, including, but not limited to, increased wages or benefits, shift incentive payments, staff retention bonuses, pay differential for workers employed by more than one facility, and overtime payments to nonmanagerial workers. If a skilled nursing facility spent less than 85 percent of revenues associated with the COVID-19 Public Health Emergency on additional labor costs during this time period, the skilled nursing facility shall remit to the department the difference between that amount and 85 percent of revenues associated with the COVID-19 Public Health Emergency received by that facility. If the skilled nursing facility fails to remit this amount within 90 days, the department shall recoup that amount by withholding the remittance amount from any Medi-Cal payment made to the facility, or by any other means available by law.

(3) Such increased wages or benefits, shift incentive payments, staff retention bonuses, pay differential for workers employed by more than one facility, overtime payments to nonmanagerial workers or other additional labor costs shall qualify for the purposes of paragraph (2) if they were either of the following:

(A) Implemented prior to January 1, 2023, and continued during the 2023 calendar year.

(B) Implemented on or after January 1, 2023.

(b) For purposes of implementing this section, a skilled nursing facility that received increased Medicaid payments described in subdivision (a) shall disclose, at the time and in the form and manner specified by the department, any information requested by the department relating to costs and revenues associated with the COVID-19 Public Health Emergency. This may include, but is not limited to, documentation of any grant, loan, payment or other revenue received by the facility pursuant to any federal or state law related to the COVID-19 Public Health Emergency.

(c) To the extent permissible under federal law, and in addition to any other remedial actions available to the department, the department shall recoup any amounts of the increased Medicaid payments audited pursuant to paragraph (1) of subdivision (a) that were not used to support the delivery of patient care against any applicable Medicaid payments made to the facility.

(d) (1) The department shall seek any state plan amendments it deems necessary to audit the increased Medicaid payments described in subdivision (a) and recoup identified overpayments as described in this section.

(2) This section shall be implemented only to the extent any necessary federal approvals are obtained, and federal financial participation is available and is not otherwise jeopardized.

(e) For purposes of this section, “COVID-19 Public Health Emergency” means the federal Public Health Emergency declaration made pursuant to Section 247d of Title 42 of the United States Code on January 30, 2020, entitled “Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus,” and any renewal of that declaration.

(f) For any recoupment pursuant to paragraph (2) of subdivision (a) or subdivision (c) associated with the audit of costs and revenues for the time period of January 1, 2023, through December 31, 2023, the amounts associated with such recoupment shall be added on a one-time basis to the amount available for the Workforce and Quality Incentive Program described in Section 14126.024 in a subsequent rate year.

(Amended by Stats. 2022, Ch. 46, Sec. 11. (AB 186) Effective June 30, 2022. Conditionally inoperative as provided in subd. (a) of Section 14126.035. Inoperative after December 31, 2026, pursuant to Section 14126.036. Repealed as of January 1, 2028, pursuant to Section 14126.036.)

14126.033. (a) The Legislature finds and declares all of the following:

(1) Costs within the Medi-Cal program continue to grow due to the rising cost of providing health care throughout the state and also due to increases in enrollment, which are more pronounced during difficult economic times.

(2) In order to minimize the need for drastically cutting enrollment standards or benefits during times of economic crisis, it is crucial to find areas within the program where reimbursement levels are higher than required under the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and can be reduced in accordance with federal law.

(3) The Medi-Cal program delivers its services and benefits to Medi-Cal beneficiaries through a wide variety of health care providers, under multiple delivery systems, including managed care, other contract models, or 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 the Medicaid program 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 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) Subject to an appropriation by the Legislature in the annual Budget Act, this article shall be funded as follows:

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

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

(B) Beginning with the 2006–07 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not exceed 5 percent of the weighted average Medi-Cal reimbursement rate for the prior fiscal year, as adjusted for the projected cost of complying with new state or federal mandates.

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

(D) For the 2009–10 rate year, the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not be increased with respect to the weighted average Medi-Cal reimbursement rate for the 2008–09 rate year, as adjusted for the projected cost of complying with new state or federal mandates.

(3) (A) For the 2010–11 rate year, if the increase in the federal medical assistance percentage (FMAP) pursuant to the federal American Recovery and Reinvestment Act of 2009 (ARRA) (Public Law 111-5) is extended for the entire 2010–11 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate for the purposes of this article shall not exceed 3.93 percent, or 3.14 percent, if the increase in the FMAP pursuant to ARRA is not extended for that period of time, plus the projected cost of complying with new state or federal mandates. If the increase in the FMAP pursuant to ARRA is extended at a different rate, or for a different time period, the rate adjustment for facilities shall be adjusted accordingly.

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

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

(ii) If the federal Centers for Medicare and Medicaid Services does not approve any proposed modification to the methodology for calculation of the quality assurance fee.

(iii) To ensure that the state does not incur any additional General Fund expenses to pay for the 2010–11 weighted average Medi-Cal reimbursement rate increase.

(C) If the maximum annual increase in the weighted average Medi-Cal rate is reduced pursuant to subparagraph (B), the department shall recalculate and publish the final maximum annual increase in the weighted average Medi-Cal reimbursement rate.

(4) (A) Subject to the following provisions, for the 2011–12 rate year, the increase in the Medi-Cal reimbursement rate for the purpose of this article, for each skilled nursing facility as defined in subdivision (c) of Section 1250 of the Health and Safety Code, shall not exceed 2.4 percent of the rate on file that was applicable on May 31, 2011, plus the projected cost of complying with new state or federal mandates. The percentage increase shall be applied equally to each rate on file as of May 31, 2011.

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

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

(ii) If the federal Centers for Medicare and Medicaid Services does not approve any proposed modification to the methodology for calculation of the quality assurance fee.

(iii) To ensure that the state does not incur any additional General Fund expenses to pay for the 2011–12 weighted average Medi-Cal reimbursement rate increase.

(C) The department may recalculate and publish the weighted average Medi-Cal reimbursement rate increase for the 2011–12 rate year if the difference in the projected quality assurance fee collections from the 2011–12 rate year, compared to the projected quality assurance fee collections for the 2010–11 rate year, would result in any additional General Fund expense to pay for the 2011–12 rate year weighted average reimbursement rate increase.

(5) To the extent that rates are projected to exceed the adjusted limits calculated pursuant to subparagraphs (A) to (D), inclusive, of paragraph (2) and, as applicable, paragraphs (3) and (4), the department shall adjust each skilled nursing facility's projected rate for the applicable rate year by an equal percentage.

(6) (A) (i) Notwithstanding any other law, and except as provided in subparagraph (B), payments resulting from the application of paragraphs (3) and (4), the provisions of paragraph (5), and all other applicable adjustments and limits as required by this section, shall be reduced by 10 percent for dates of service on and after June 1, 2011, through July 31, 2012. This one-time reduction shall be evenly distributed across all facilities to ensure long-term stability of nursing homes serving the Medi-Cal population.

(ii) Notwithstanding any other law, the director may adjust the percentage reductions specified in clause (i), as long as the resulting reductions, in the aggregate, total no more than 10 percent.

(iii) The adjustments authorized under this subparagraph shall be implemented only if the director determines that the payments resulting from the adjustments comply with paragraph (7).

(B) Payments to facilities owned or operated by the state shall be exempt from the payment reduction required by this paragraph.

(7) (A) Notwithstanding 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) shall 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 unavailable with respect to any payment that is reduced pursuant to this section, the director retains the discretion to not implement the particular payment reduction or adjustment and may adjust the payment as necessary to comply with federal Medicaid requirements.

(8) For managed care health plans that contract with the department pursuant to this chapter and Chapter 8 (commencing with Section 14200), except for contracts with the Senior Care Action Network and AIDS Healthcare Foundation, and to the extent that these services are provided through any of those contracts, payments shall be reduced by the actuarial equivalent amount of the reduced provider reimbursements specified in paragraph (6) pursuant to contract amendments or change orders effective on July 1, 2011, or thereafter.

(9) (A) For the 2012–13 rate year, all of the following shall apply:

(i) The department shall determine the amounts of reduced payments for each skilled nursing facility, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, resulting from the 10-percent reduction imposed pursuant to clause (i) of subparagraph (A) of paragraph (6) for the period beginning on June 1, 2011, through July 31, 2012.

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

(iii) For managed care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), except contracts with Senior Care Action Network and AIDS Healthcare Foundation, and to the extent that skilled nursing services are provided through any of those contracts, payments shall be adjusted by the actuarial equivalent amount of the reimbursements calculated in clause (i) pursuant to contract amendments or change orders effective on July 1, 2012, or thereafter.

(B) Notwithstanding subparagraph (A), beginning on August 1, 2012, through July 31, 2013, the department shall pay the facility specific Medi-Cal reimbursement rate that was on file and applicable to the specific skilled nursing facility on August 1, 2011, prior to and excluding any rate reduction implemented pursuant to clause (i) of subparagraph (A) of paragraph (6) for the period beginning on June 1, 2011, to July 31, 2012, inclusive, and adjusted for the projected costs of complying with new state or federal mandates. These rates are deemed to be sufficient to meet operating expenses.

(C) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (B) shall be adjusted by the department if the federal Centers for Medicare and Medicaid Services does not approve any proposed modification to the methodology for calculation of the skilled nursing quality assurance fee pursuant to Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code.

(D) Notwithstanding any other law, beginning on January 1, 2013, Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code, which imposes a skilled nursing facility quality assurance fee, shall be unenforceable against any skilled nursing facility unless each skilled nursing facility is paid the rate provided for in subparagraphs (A) and (B). Any amount collected during the 2012–13 rate year by the department pursuant to Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code shall be refunded to each facility not later than February 1, 2013.

(E) The provisions of this paragraph shall also be included as part of a state plan amendment implementing the 2011–12 and 2012–13 Medi-Cal reimbursement rates authorized under this article.

(10) (A) Subject to the following provisions, for the 2013–14 and 2014–15 rate years, the annual increase in the weighted average Medi-Cal reimbursement rate for the purpose of this article, for each skilled nursing facility as defined in subdivision (c) of Section 1250 of the Health and Safety Code, shall be 3 percent for each rate year, respectively, plus the projected cost of complying with new state or federal mandates.

(B) (i) For the 2013–14 rate year, if there is a rate increase in the weighted average Medi-Cal reimbursement rate, the department shall set aside 1 percent of the increase in the weighted average Medi-Cal reimbursement rate, from which the department shall transfer the nonfederal portion into the Skilled Nursing Facility Quality and Accountability Special Fund, to be used for the supplemental rate pool.

(ii) For the 2014–15 rate year, if there is a rate increase in the weighted average Medi-Cal reimbursement rate, the department shall set aside at least one-third of the weighted average Medi-Cal reimbursement rate increase, up to a maximum of 1 percent, from which the department shall transfer the nonfederal portion of this amount into the Skilled Nursing Facility Quality and Accountability Special Fund.

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

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

(ii) If the federal Centers for Medicare and Medicaid Services does not approve any proposed modification to the methodology for calculation of the quality assurance fee.

(11) The director shall seek any necessary federal approvals for the implementation of this section. This section shall not be implemented until federal approval is obtained. When federal approval is obtained, the payments resulting from the application of paragraph (6) shall be implemented retroactively to June 1, 2011, or on any other date or dates as may be applicable.

(12) (A) (i) Beginning with the 2015–16 rate year, and through the conclusion of the rate period from August 1, 2020, to December 31, 2020, inclusive, the annual increase in the weighted average Medi-Cal reimbursement rate, required for the purposes of this article, shall be 3.62 percent, plus the projected cost of complying with new state or federal mandates.

(ii) The reimbursement rates established for the rate period of August 1, 2020, to December 31, 2020, inclusive, shall be no less than the amounts that would have been established under the reimbursement methodology pursuant to this section for the 2019–20 rate year, subject to subparagraph (B).

(B) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) may be adjusted by the department as it deems necessary to obtain any applicable federal approval and shall not exceed the applicable federal upper payment limit.

(C) (i) Only to the extent any necessary federal approvals are obtained for this subparagraph, the department may condition a facility's receipt of the annual increase in the weighted average Medi-Cal reimbursement rate pursuant to this paragraph for the rate period of August 1, 2020, to December 31, 2020, inclusive, upon that facility's good faith efforts to comply with any requirements related to the COVID-19 Public Health Emergency described in All Facility Letters issued by the State Department of Public Health. The department shall consult with the State Department of Public Health in determining a facility's compliance for purposes of this subparagraph.

(ii) For purposes of this subparagraph, "COVID-19 Public Health Emergency" means the federal Public Health Emergency declaration made pursuant to Section 247d of Title 42 of the United States Code on January 30, 2020, entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," and any renewal of that declaration.

(13) (A) For the 2021 calendar year, the annual aggregate increase in the weighted average Medi-Cal reimbursement rate that is required for the purposes of this article shall be 3.5 percent plus the projected cost of complying with new state or federal mandates.

(B) The aggregate, weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) may be adjusted by the department as it deems necessary to obtain any applicable federal approval, and shall not exceed the applicable federal upper payment limit.

(C) (i) Only to the extent any necessary federal approvals are obtained for this subparagraph, the department may condition a facility's receipt of the annual increase in the weighted average Medi-Cal reimbursement rate pursuant to this paragraph for the 2021 calendar year upon that facility's good faith efforts to comply with any requirements related to the COVID-19 Public Health Emergency described in All Facility Letters issued by the State Department of Public Health. The department shall consult with the State Department of Public Health in determining a facility's compliance for purposes of this subparagraph.

(ii) For purposes of this subparagraph, "COVID-19 Public Health Emergency" shall mean the federal Public Health Emergency declaration made pursuant to Section 247d of Title 42 of the United States Code on January 30, 2020, entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," and any renewal of that declaration.

(14) (A) For the 2022 calendar year, the annual aggregate increase in the weighted average Medi-Cal reimbursement rate that is required for the purposes of this article shall be 2.4 percent plus the projected cost of complying with new state or federal mandates.

(B) The aggregate, weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) may be adjusted by the department as it deems necessary to obtain any applicable federal approval, and shall not exceed the applicable federal upper payment limit.

(C) (i) Only to the extent any necessary federal approvals are obtained for this subparagraph, the department may condition a facility's receipt of the annual increase in the weighted average Medi-Cal reimbursement rate pursuant to this paragraph for the 2022 calendar year upon that facility's good faith efforts to comply with any requirements related to the COVID-19 Public Health Emergency described in All Facility Letters issued by the State Department of Public Health. The department shall consult with the State Department of Public Health in determining a facility's compliance for purposes of this subparagraph.

(ii) For purposes of this subparagraph, "COVID-19 Public Health Emergency" shall mean the federal Public Health Emergency declaration made pursuant to Section 247d of Title 42 of the United States Code on January 30, 2020, entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," and any renewal of such declaration.

(15) (A) For the 2022 and 2023 calendar years, inclusive, the reimbursement rate established for a skilled nursing facility pursuant to this section shall continue to be increased by the temporary Medicaid payments associated with the COVID-19 Public Health Emergency in effect for that facility on July 31, 2020, or an amount equivalent to those temporary increased Medicaid payments should the COVID-19 Public Health Emergency expire prior to December 31, 2023.

(B) For the 2023 calendar year, 85 percent of the amount of temporary Medicaid payments associated with the COVID-19 Public Health Emergency, or amounts equivalent to those temporary increased Medicaid payments should the COVID-19 Public Health Emergency expire prior to December 31, 2023, received by a facility shall be spent on additional labor costs, including, but not limited to, increased wages or benefits, shift incentive payments, staff retention bonuses, pay differential for workers employed by more than one facility, and overtime payments to nonmanagerial workers. Such increased wages or benefits, shift incentive payments, staff retention bonuses, pay differential for workers employed by more than one facility, overtime payments to nonmanagerial workers or other additional labor costs shall qualify for this purpose if they were either of the following:

(i) Implemented prior to January 1, 2023, and continued during the 2023 calendar year.

(ii) Implemented on or after January 1, 2023.

(C) If the COVID-19 Public Health Emergency is renewed past December 31, 2023, the temporary Medicaid payments for skilled nursing facilities associated with the COVID-19 Public Health Emergency, as authorized in the Medi-Cal State Plan, shall cease on December 31, 2023, subject to subdivision (h).

(D) For purposes of this subparagraph, "COVID-19 Public Health Emergency" shall mean the federal Public Health Emergency declaration made pursuant to Section 247d of Title 42 of the United States Code on January 30, 2020, entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," and any renewal of such declaration.

(16) (A) For the 2023 calendar year, the maximum annual aggregate increase in the weighted average Medi-Cal reimbursement rate required for the purposes of this article shall be the following, plus the projected cost of complying with new state or federal mandates:

(i) For the labor cost category as specified in paragraph (1) of subdivision (a) of Section 14126.023, the annual aggregate increase shall be 5 percent.

(ii) For each of the indirect care nonlabor cost, administrative cost, capital cost, and direct passthrough categories as specified in paragraphs (2) to (5), inclusive, of subdivision (a) of Section 14126.023, the annual aggregate increase shall be 2 percent.

(B) The aggregate, weighted average Medi-Cal reimbursement rate increases specified in subparagraph (A) may be adjusted by the department as it deems necessary to obtain any applicable federal approval, and shall not exceed the applicable federal upper payment limit.

(17) (A) Beginning in the 2024 calendar year, the department shall establish a workforce adjustment, as further described in paragraphs (18), (19) and (20), for a skilled nursing facility that meets workforce standards, as determined by the department in consultation with representatives from the long-term care industry, organized labor, and consumer advocates.

(B) The workforce standards may include, but need not be limited to, criteria such as maintaining a collective bargaining agreement or comparable, legally binding, written commitment with its direct and indirect care staff, payment of a prevailing wage for its direct and indirect care staff, payment of an average salary above minimum wage, participation in a statewide,

multiemployer joint labor-management committee of skilled nursing facility employers and workers, or other factors, as determined by the department in consultation with the stakeholders listed above. The criteria may vary for facilities based on facility demographics or other factors such as facility size, location or other factor, as determined by the department in consultation with the stakeholders listed above.

(18) (A) For the 2024 calendar year, the maximum annual increase in the Medi-Cal reimbursement rate required for the purposes of this article shall be the following, plus the projected cost of complying with new state or federal mandates:

(i) For the labor cost category specified in paragraph (1) of subdivision (a) of Section 14126.023, the annual increase shall be determined as follows:

(I) If the department determines the facility meets the criteria described in paragraph (17), the annual increase for the facility shall not have a percentage growth limit applied to the facility's audited costs within the labor cost category trended to the 2024 calendar year.

(II) If the facility does not meet the criteria described in paragraph (17), an annual increase of up to 5 percent shall be applied to the labor cost category rate included in the facility's 2023 calendar year rate based on audited cost reports trended to the calendar 2024 year.

(ii) For the 2024 calendar year, for each of the indirect care nonlabor cost, administrative cost, capital cost, and direct passthrough categories as specified in paragraphs (2) through (5), inclusive, of subdivision (a) of Section 14126.023, the annual aggregate increase in the weighted average Medi-Cal reimbursement rate for those categories shall be 1 percent. Additionally, for the 2024 calendar year, an amount equivalent to the annual aggregate increase of 1 percent calculated pursuant to this clause, as determined by the department, shall be used to supplement the funds available for payments made pursuant to subdivision (a) of Section 14126.024.

(B) The Medi-Cal reimbursement rate specified in subparagraph (A) may be adjusted by the department as it deems necessary to obtain any applicable federal approval, and shall not exceed the applicable federal upper payment limit.

(19) (A) For the 2025 calendar year, the Medi-Cal reimbursement rate required for the purposes of this article shall be the following, plus the projected cost of complying with new state or federal mandates:

(i) The rate for the labor cost category as specified in paragraph (1) of subdivision (a) of Section 14126.023 shall be determined as follows:

(I) If the department determines the facility meets the criteria described in paragraph (17), the facility's rate for the labor cost category shall equal the facility's audited costs for the labor cost category that would have been used for calculating the facility's 2024 calendar year rate had the facility met the criteria described in paragraph (17) in the 2024 calendar year increased by up to 5 percent for the 2025 calendar year based on audited cost reports trended to the 2025 calendar year.

(II) If the facility does not meet the criteria described in paragraph (17), the facility's rate for the labor cost category shall equal the labor cost category rate included in the facility's 2023 calendar year rate increased by up to 5 percent for each of the 2024 and 2025 calendar years based on audited cost reports trended to the applicable calendar year.

(ii) For the 2025 calendar year, for each of the indirect care nonlabor cost, administrative cost, capital cost, and direct passthrough categories as specified in paragraphs (2) through (5), inclusive, of subdivision (a) of Section 14126.023, the facility's rate for those categories shall equal the reimbursement included in the facility's 2024 calendar year rate for those categories increased by an aggregate of 1 percent in the weighted average Medi-Cal reimbursement rate for those categories. Additionally, for the 2025 calendar year, an amount equivalent to the annual aggregate increase of 1 percent calculated pursuant to this clause, as determined by the department, shall be used to supplement the funds available for payments made pursuant to subdivision (a) of Section 14126.024.

(B) The Medi-Cal reimbursement rate specified in subparagraph (A) may be adjusted by the department as it deems necessary to obtain any applicable federal approval, and shall not exceed the applicable federal upper payment limit.

(20) (A) For the 2026 calendar year, the Medi-Cal reimbursement rate required for the purposes of this article shall be the following, plus the projected cost of complying with new state or federal mandates:

(i) The rate for labor cost category as specified in paragraph (1) of subdivision (a) of Section 14126.023 shall be determined as follows:

(I) If the department determines the facility meets the criteria described in paragraph (17), the facility's rate for the labor cost category shall equal the facility's audited costs within the labor cost category that would have been used for

calculating the facility's 2024 calendar year rate had the facility met the criteria in the 2024 calendar year increased by up to 5 percent for each of the 2025 and 2026 calendar years based on audited cost reports trended to the applicable calendar year.

(II) If the facility does not meet the criteria described in paragraph (17), the facility's rate for the labor cost category shall equal the labor cost category rate included in the facility's 2023 calendar year rate increased by up to 5 percent for each of the 2024, 2025, and 2026 calendar years based on audited cost reports trended to the applicable calendar year.

(ii) For the 2026 calendar year, for each of the indirect care nonlabor cost, administrative cost, capital cost, and direct passthrough categories as specified in paragraphs (2) through (5), inclusive, of subdivision (a) of Section 14126.023, the facility's rate for those categories shall equal the reimbursement included in the facility's 2025 calendar year rate for those categories increased by an aggregate of 1 percent in the weighted average Medi-Cal reimbursement rate for those categories.

(B) The Medi-Cal reimbursement rate specified in subparagraph (A) may be adjusted by the department as it deems necessary to obtain any applicable federal approval, and shall not exceed the applicable federal upper payment limit.

(d) (1) The department may modify any methodology or other provision specified in this article to the extent it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or is not otherwise jeopardized, provided the modification does not violate the spirit, purposes, and intent of this article.

(2) If the department determines that a modification is necessary pursuant to paragraph (1), the department shall consult with affected providers and stakeholders to the extent practicable.

(3) In the event of a modification made pursuant to this subdivision, the department shall notify affected providers, the Joint Legislative Budget Committee, and the relevant policy and fiscal committees of the Legislature within 10 business days of the modification.

(e) The rate methodology shall cease to be implemented after December 31, 2026.

(f) (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 California State Auditor's Office 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 before the implementation of this article.

(C) The staffing retention rates before 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 before 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 before 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.

(g) (1) Beginning with the 2021 calendar year, and continuing each calendar year thereafter, a skilled nursing facility shall demonstrate its compliance with the following Medi-Cal funded requirements upon request by, and in the form and manner specified by, the department:

(A) Direct care service hours per patient day requirements pursuant to Section 1276.65 of the Health and Safety Code and as enforced pursuant to Section 14126.022.

(B) Applicable minimum wage laws.

(C) Wage passthrough requirements pursuant to Section 14110.6 of this code and Section 1338 of the Health and Safety Code.

(2) If the department determines that a skilled nursing facility has not demonstrated satisfactory compliance pursuant to subparagraphs (B) and (C) of paragraph (1), in consultation with State Department of Public Health or other applicable state agencies and departments if necessary, the department shall assess a monthly penalty up to fifty thousand dollars ($50,000) for that skilled nursing facility, except as provided in paragraph (3), until the facility demonstrates its compliance to the department. The penalty amounts assessed pursuant to this subdivision in any one calendar year shall be limited to 4 percent of the total Medi-Cal revenue received by the skilled nursing facility in the previous calendar year. If the department determines a facility is out of compliance for multiple calendar years, additional penalty amounts may be assessed for each respective calendar year.

(3) The department may waive a portion or all of the penalties assessed pursuant to this subdivision with respect to a petitioning skilled nursing facility in the event the department determines, in its sole discretion, that the facility has demonstrated that imposing the full penalty has a high likelihood of creating an undue financial hardship for the facility or creates a significant financial difficulty in providing services to Medi-Cal beneficiaries.

(h) In implementing this article, the department shall seek any federal approvals it deems necessary. This article shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(Amended by Stats. 2025, Ch. 21, Sec. 100. (AB 116) Effective June 30, 2025. Conditionally inoperative as provided in subd. (a) of Section 14126.035. Inoperative after December 31, 2026, pursuant to Section 14126.036. Repealed as of January 1, 2028, pursuant to Section 14126.036.)

14126.034. (a) (1) The department shall convene a workgroup of interested stakeholders to make recommendations to the department to ensure compliance with the intent of this article, as provided in subdivision (a) of Section 14126.02.

(2) (A) Interested stakeholders shall include consumers or their representatives, or both, including current or former skilled nursing facility residents, and family members of current or former skilled nursing facility residents, or both, seniors or their representatives, or both, skilled nursing facility representatives, labor representatives, and people with disabilities and disability rights advocates.

(B) A stakeholder workgroup of 18 members shall be convened representing interested stakeholders from the groups listed in subparagraph (A), with six members selected from each of the following areas of interest:

(i) Consumers.

(ii) Skilled nursing facility labor.

(iii) Skilled nursing facilities.

(C) Interested stakeholders within each of the areas of interest in subparagraph (B) shall nominate and select six members within their area of interest to serve on the stakeholder workgroup to represent their interests.

(D) The stakeholder workgroup shall also include representatives from the department, the Office of the State Long-Term Care Ombudsman, the State Department of Public Health, the Office of Statewide Health Planning and Development, with members appointed by their respective directors, or their designee, and may also include legislative staff, academics, and other state department representatives, including, but not limited to, representatives from the California Department of Aging and the State Department of Developmental Services.

(b) (1) Each stakeholder workgroup meeting shall be chaired by a facilitator from an organization independent of the department and any of the stakeholder groups, to the extent that foundation funding is made available for this purpose. If no funds are made available for this purpose, the department shall facilitate the stakeholder workgroup meetings.

(2) The consumers, skilled nursing facility labor, and skilled nursing facility stakeholder workgroup members shall each select one representative who will meet with the department and the facilitator to develop meeting agendas after having solicited input from each representative's respective stakeholder group.

(3) To the extent that foundation funding is made available, stakeholder workgroup members shall receive reimbursement for any actual, necessary, and reasonable expenses incurred in connection with their duties as members of the workgroup.

(c) The department shall assign staff as needed to assist the stakeholder workgroup in carrying out its responsibilities.

(d) In developing recommendations, the stakeholder workgroup shall consider the structure of, and potential changes to, the facility-specific ratesetting system, developed pursuant to Section 14126.023, that may improve the quality of resident care. The stakeholder workgroup members may take into consideration the following factors, or any other factors deemed relevant to ensure the quality of resident care:

(1) Skilled nursing facility staffing levels, including, but not limited to, compliance with existing staffing requirements.

(2) Skilled nursing facility staff wages and benefits, including, but not limited to, geographic disparities in wages and benefits.

(3) Skilled nursing facility staff turnover and retention.

(4) Deficiency reports issued as a result of both surveys and complaint investigations, to the extent that they may be disclosed as public records, and the enforcement actions taken under federal certification and state licensing laws and regulations.

(5) Skilled nursing facility compliance with assessments required to ascertain residents' preference for, and ability to return to, the community as required by Section 1418.81 of the Health and Safety Code, including necessary followthrough to assure care necessary for a resident to transition out of skilled nursing facility care and into the community.

(6) The extent to which this article encourages compliance with the United States Supreme Court decision in Olmstead v. L.C. ex rel. Zimring (1999) 527 U.S. 581, including using the ratesetting system to increase Olmstead compliance.

(7) Health care efficiency.

(8) Health care safety.

(9) The extent to which a pay-for-performance program may contribute to improving the quality of resident care and appropriate performance measures for a pay-for-performance program.

(10) Preventable emergency room visits and rehospitalizations.

(11) Resident and family satisfaction with care and resident's quality of life, including improvements on ways to measure satisfaction.

(12) Recommendations for methods to evaluate the effectiveness of the facility-specific ratesetting system, defined in Section 14126.023, in meeting the intent of this article, pursuant to Section 14126.02.

(13) Additional quality measures, including, but not limited to, adequate nutrition and ready availability of durable medical equipment.

(e) The department shall convene the stakeholder workgroup no later than one month following the effective date of this section. The stakeholder workgroup shall meet a minimum of six times through December 31, 2008. Subcommittees may be convened and meet as necessary.

(f) In addition to recommendations provided during stakeholder workgroup meetings, individual members of the stakeholder workgroup and any other interested stakeholders may provide to the department any additional written recommendations on the items considered in the stakeholder workgroup meetings.

(g) The department shall provide technical assistance to the stakeholder workgroup to evaluate the feasibility of its recommendations so that the stakeholder workgroup will have the benefit of the department's analysis when discussing and reviewing proposed recommendations.

(h) The department shall review and analyze all recommendations from the stakeholder workgroup, individual workgroup members, and any other interested stakeholders, and, no later than March 1, 2009, the department shall deliver to the Legislature, both of the following:

(1) The complete recommendations of the stakeholder workgroup, individual workgroup members, and any other interested stakeholders.

(2) The department's analysis of the feasibility to implement the proposed recommendations.

(i) (1) The stakeholder workgroup may continue to meet to carry out its responsibilities pursuant to subdivision (d) for an extension period of up to one year. During this extension period, the stakeholder workgroup shall meet at least quarterly as agreed by the department and those members selected pursuant to paragraph (2) of subdivision (a).

(2) During the extension period the stakeholder workgroup's activities may include assisting the department or Legislature, or both, to enact improvements to the ratesetting system.

(j) The department shall seek partnership with one or more independent, nonprofit groups or foundations, academic institutions, or governmental entities providing grants for health-related activities, to support stakeholder workgroup efforts.

(k) The department shall seek necessary legislative changes to implement the stakeholder workgroup's recommendations that the department determines are feasible to implement as part of the reauthorization of this section.

(l) The department may meet the intent of this article, as stated in subdivision (a) of Section 14126.02, by using the stakeholder workgroup's recommendations in order to design an evaluation of the effectiveness of the facility-specific ratesetting system established pursuant to Section 14126.023.

(m) Implementation and administration of this section is not dependent on the availability of foundation funding.

(Amended by Stats. 2009, Ch. 140, Sec. 208. (AB 1164) Effective January 1, 2010. Conditionally inoperative as provided in subd. (a) of Section 14126.035. Inoperative after December 31, 2026, pursuant to Section 14126.036. Repealed as of January 1, 2028, pursuant to Section 14126.036.)

14126.035. (a) This article shall remain operative only as long as Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code, which imposes a skilled nursing facility quality assurance fee continues as approved by the federal Centers for Medicare and Medicaid Services pursuant to Section 1324.27 of the Health and Safety Code.

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

(Added by Stats. 2004, Ch. 875, Sec. 5. Effective September 29, 2004. Inoperative after December 31, 2026, pursuant to Section 14126.036. Repealed as of January 1, 2028, pursuant to Section 14126.036. Note: Termination clause in subd. (a) affects Article 3.8, commencing with Section 14126.)

14126.036. This article shall become inoperative after December 31, 2026, except that the department shall be authorized to conduct all necessary closeout activities after this date and to continue implementing this article for any rate period before December 31, 2026, and as of January 1, 2028, this article is repealed, unless a later enacted statute that is enacted before, January 1, 2028, deletes or extends that date.

(Amended by Stats. 2022, Ch. 46, Sec. 13. (AB 186) Effective June 30, 2022. Repealed as of January 1, 2028, by its own provisions. Note: Termination clause affects Article 3.8, commencing with Section 14126 (except Section 14126.022).)