HEALTH AND SAFETY CODE - HSC

DIVISION 2. LICENSING PROVISIONS [1200 - 1796.70] *(Division 2 enacted by Stats. 1939, Ch. 60.)*

CHAPTER 2. Health Facilities [1250 - 1339.59] *(Chapter 2 repealed and added by Stats. 1973, Ch. 1202.)*

ARTICLE 7.6. Skilled Nursing Facility Quality Assurance Fee [1324.20 - 1324.30] *(Article 7.6 added by Stats. 2004, Ch. 875, Sec. 1.)*

1324.20. For purposes of this article, the following definitions shall apply:

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

(2) Notwithstanding paragraph (1), beginning with the 2010–11 rate year and for every rate or calendar year thereafter, the term “continuing care retirement community” shall have the same meaning as defined in paragraph (10) of subdivision (c) of Section 1771.

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

(c) (1) “Exempt facility” means a skilled nursing facility that is part of a continuing care retirement community, a skilled nursing facility operated by the state or another public entity, a unit that provides pediatric subacute services in a skilled nursing facility, a skilled nursing facility that is certified by the department for a special treatment program and is an institution for mental disease as defined in Section 1396d(i) of Title 42 of the United States Code, or a skilled nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital.

(2) Notwithstanding paragraph (1), beginning with the 2010–11 rate year and for every rate or calendar year thereafter, the term “exempt facility” shall mean a skilled nursing facility that is part of a continuing care retirement community, as defined in paragraph (2) of subdivision (a), a skilled nursing facility operated by the state or another public entity, a unit that provides pediatric subacute services in a skilled nursing facility, a skilled nursing facility that is certified by the department for a special treatment program and is an institution for mental disease as defined in Section 1396d(i) of Title 42 of the United States Code, or a skilled nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital.

(3) Notwithstanding paragraph (1), beginning with the 2010–11 rate year and every rate or calendar year thereafter, a multilevel facility, as described in paragraph (1) of subdivision (a), shall not be exempt from the quality assurance fee requirements pursuant to this article, unless it meets the definition of a continuing care retirement community in paragraph (10) of subdivision (c) of Section 1771.

(4) (A) Notwithstanding paragraph (1), beginning with the 2011–12 rate year, and every rate or calendar year thereafter, a unit that provides freestanding pediatric subacute care services in a skilled nursing facility, as described in paragraph (1), shall not be exempt from the quality assurance fee requirements pursuant to this article.

(B) Notwithstanding paragraph (1) and subparagraph (A), for the rate period from August 1, 2020, to December 31, 2020, and every subsequent calendar year thereafter, a unit that provides freestanding pediatric subacute care services in a skilled nursing facility, as described in paragraph (1), shall be exempt from the quality assurance fee requirements pursuant to this article.

(C) For the purposes of this article, “freestanding pediatric subacute care unit” has the same meaning as defined in subdivision (a) of Section 51215.8 of Title 22 of the California Code of Regulations.

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

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

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

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

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

(Amended by Stats. 2020, Ch. 13, Sec. 1. (AB 81) Effective June 29, 2020. See operational conditions in Section 1324.28. Inoperative after December 31, 2026. Repealed as of January 1, 2028, pursuant to Section 1324.30.)

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

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

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

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

(2) (A) For the rate year 2005–06 and subsequent rate years through and including the 2009–10 rate year, the net revenue shall be projected for all skilled nursing facilities subject to the uniform quality assurance fee. The projection of net revenue shall be based on the prior rate year’s data. Once determined, the aggregate projected net revenue for all facilities shall be multiplied by 6 percent, as determined under the approved methodology, and then divided by the projected total resident days of all providers subject to the fee. The amounts so determined shall be subject to the provisions of subdivision (d).

(B) For the 2010–11 rate year and subsequent rate years, the net revenue shall be projected for all skilled nursing facilities subject to the uniform quality assurance fee. The projection of net revenue shall be based on the prior year’s data trended forward, using historical increases in net revenues. Once determined, the aggregate projected net revenue for all facilities shall be multiplied by 6 percent, as determined under the approved methodology, and then divided by the projected total resident days of all providers subject to the fee. The amounts so determined shall be subject to subdivision (d).

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

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

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

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

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

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

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

(Amended by Stats. 2010, Ch. 717, Sec. 4. (SB 853) Effective October 19, 2010. See operational conditions in Section 1324.28. Inoperative after December 31, 2026. Repealed as of January 1, 2028, pursuant to Section 1324.30.)

1324.22. (a) The quality assurance fee, as calculated pursuant to Section 1324.21, shall be paid by the provider to the department for deposit in the State Treasury on a monthly basis on or before the last day of the month following the month for which the fee is imposed, except as provided in subdivision (e) of Section 1324.21.

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

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

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

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

(e) (1) If a skilled nursing facility fails to pay all or part of the quality assurance fee within 60 days of the date that payment is due, the department shall assess interest at the rate of 7 percent per annum on any unpaid amount due, beginning on the 61st calendar day from the date the payment is due, until the unpaid amount due, plus any interest, is paid in full.

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

(B) Notwithstanding any other law, for the rate period from August 1, 2020, to December 31, 2020, and every subsequent calendar year thereafter, the department may deduct any unpaid assessments, including any interest and penalties owed, attributable to a debtor facility from any Medi-Cal payments made to a related facility or entity by common ownership or control to the debtor facility within the meaning of Section 413.17(b) of Title 42 of the Code of Federal Regulations. If the department deducts any unpaid assessments from the Medi-Cal payments to a related facility or entity, the department shall provide prior written notice to both the debtor facility and the related facility or entity, and, in taking into account the financial condition of the related facility, may apply that deduction over a period of time.

(3) In addition to the requirements specified in this subdivision and subdivision (h), any unpaid quality assurance fee, including any interest and penalties owed, assessed by this article shall constitute a debt due to the state and may be collected pursuant to Section 12419.5 of the Government Code.

(4) In addition to the requirements specified in this subdivision and subdivision (h), the department may take appropriate legal action in state or federal court to recover the unpaid quality assurance fee amount, including any interest and penalties owed, from the licensee's financial interest in the related party, as defined in subdivision (b) of Section 1424.3. Before taking any action pursuant to this paragraph, the department shall give written notice to the licensee and the related party.

(f) (1) Notwithstanding any other law, the department shall continue to assess and collect the quality assurance fee, including any previously unpaid quality assurance fee, and any interest or penalties owed, from each skilled nursing facility, irrespective of any changes in ownership or ownership interest or control or the transfer of any portion of the assets of the facility to another owner.

(2) Notwithstanding any other law, in the event of a merger, acquisition, or change of ownership involving a skilled nursing facility that has outstanding quality assurance fee payment obligations pursuant to this article, including any interest and penalty amounts

owed, the successor skilled nursing facility shall be responsible for paying to the department the full amount of outstanding quality assurance fee payments, including any interest and penalties, attributable to the skilled nursing facility for which it was assessed, upon the effective date of that transaction. An entity considering a merger, acquisition, or similar transaction involving a skilled nursing facility may submit a request to the department pursuant to Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code to ascertain the outstanding quality assurance fee payment obligations of the skilled nursing facility pursuant to this article as of the date of the department's response to that request.

(g) During the time period in which a temporary manager is appointed to a facility pursuant to Section 1325.5 or during which a receiver is appointed by a court pursuant to Section 1327, the State Department of Public Health shall not be responsible for any unpaid quality assurance fee assessed before the time period of the temporary manager or receiver. This subdivision shall not affect the responsibility of the facility to make all payments of unpaid or current quality assurance fees, including any interest and penalty amounts, as required by this section and Section 1324.21.

(h) If all or any part of the quality assurance fee remains unpaid, the department may take any or all of the following actions against the debtor facility, in addition to assessing interest pursuant to paragraph (1) of subdivision (e):

(1) Assess a penalty of up to 50 percent of the total unpaid fee amounts, and any interest assessed pursuant to paragraph (1) of subdivision (e) in each applicable rate or calendar year.

(2) Recommend to the State Department of Public Health that license or Medi-Cal certification renewal or approval of a change of ownership application be delayed until the full amount of the quality assurance fee, penalties, and interest is recovered.

(3) (A) In the event of a merger, acquisition, or change of ownership involving a skilled nursing facility as described in paragraph (2) of subdivision (f), the department may delay approval of a new Medi-Cal provider agreement or a transfer of an existing Medi-Cal provider agreement to a successor skilled nursing facility until the full amount of the quality assurance fees, penalties, and interest owed by the successor or previous facility owner is recovered in full, or until the successor skilled nursing facility has entered into an alternative payment agreement with the department for the outstanding quality assurance fees, penalties, and interest owed that takes into account the financial situation of the facility and the potential impact on delivery of services to Medi-Cal beneficiaries.

(B) In addition to subparagraph (A), as a condition of approving a new Medi-Cal provider agreement or a transfer of an existing Medi-Cal provider agreement to a successor skilled nursing facility, the department may require either or both of the following:

(i) The successor skilled nursing facility to enter into an agreement with the department to be financially responsible to the department for the outstanding quality assurance fees, penalties, and interest owed by the previous facility owner.

(ii) The successor facility owner to enter into an agreement with the department to pay outstanding quality assurance fees, penalties, and interest owed by the successor facility owner on an alternative payment schedule developed by the department that takes into account the financial situation of the facility and the potential impact on delivery of services to Medi-Cal beneficiaries.

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

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

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

(l) (1) Notwithstanding any other law, for the 2011–12 rate year, the department may waive the actions provided under subdivision (h), or may allow a freestanding pediatric subacute care facility to delay payments for up to six months, to ensure the facility has the financial stability required to pay the fee.

(2) For the purposes of this article, "freestanding pediatric subacute care facility" has the same meaning as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(m) (1) Subject to paragraph (2), the department may waive a portion or all of either the interest or penalties, or both, assessed under this article with respect to a petitioning skilled nursing facility if the department determines, in its sole discretion, that the facility has demonstrated that imposing the full amount of fees under this article 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. A waiver pursuant to this subdivision may include, but need not be limited to, interest or penalties, or both, that accrue or are assessed with respect to a facility during the time period for which a change of ownership is pending, or for which a change of ownership is being contemplated, as determined by the department in its sole discretion.

(2) The department's waiver of some or all of the interest or penalties shall be conditioned on the skilled nursing facility's agreement to pay outstanding fee amounts on an alternative schedule developed by the department that takes into account the financial situation of the facility and the potential impact on delivery of services to Medi-Cal beneficiaries.

(3) The department shall post on its internet website a list of all skilled nursing facilities that received a waiver for payment of interest or penalties, including the amount of interest or penalty that was waived.

(Amended by Stats. 2022, Ch. 28, Sec. 81. (SB 1380) Effective January 1, 2023. See operational conditions in Section 1324.28. Inoperative after December 31, 2026. Repealed as of January 1, 2028, pursuant to Section 1324.30.)

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

(b) 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 and administer 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 timely 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. 3. (AB 81) Effective June 29, 2020. See operational conditions in Section 1324.28. Inoperative after December 31, 2026. Repealed as of January 1, 2028, pursuant to Section 1324.30.)

1324.24. (a) The quality assurance fee assessed and collected pursuant to this article shall be deposited in the State Treasury.

(b) Notwithstanding subdivision (a), commencing August 1, 2013, the quality assurance fees, including any associated interest or penalties, assessed and collected pursuant to this article shall be deposited in the Long-Term Care Quality Assurance Fund established pursuant to Section 1324.9.

(Amended by Stats. 2020, Ch. 13, Sec. 4. (AB 81) Effective June 29, 2020. See operational conditions in Section 1324.28. Inoperative after December 31, 2026. Repealed as of January 1, 2028, pursuant to Section 1324.30.)

1324.25. The funds assessed pursuant to this article shall be available to enhance federal financial participation in the Medi-Cal program or to provide additional reimbursement to, and to support facility quality improvement efforts in, licensed skilled nursing facilities.

(Added by Stats. 2004, Ch. 875, Sec. 1. Effective September 29, 2004. See operational conditions in Section 1324.28. Inoperative after December 31, 2026. Repealed as of January 1, 2028, pursuant to Section 1324.30.)

1324.26. In implementing this article, the department may utilize the services of the Medi-Cal fiscal intermediary through a change order to the fiscal intermediary contract to administer this program, consistent with the requirements of Sections 14104.6, 14104.7, 14104.8, and 14104.9 of the Welfare and Institutions Code.

(Added by Stats. 2004, Ch. 875, Sec. 1. Effective September 29, 2004. See operational conditions in Section 1324.28. Inoperative after December 31, 2026. Repealed as of January 1, 2028, pursuant to Section 1324.30.)

1324.27. (a) 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.

(b) The department shall make retrospective adjustments, as necessary, to the amounts calculated pursuant to Section 1324.21 in order to assure that the aggregate quality assurance fee for any particular state fiscal or calendar year does not exceed 6 percent of the aggregate annual net revenue of facilities subject to the fee.

(c) (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) If a modification is 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 that modification.

(Amended by Stats. 2020, Ch. 13, Sec. 5. (AB 81) Effective June 29, 2020. See operational conditions in Section 1324.28. Inoperative after December 31, 2026. Repealed as of January 1, 2028, pursuant to Section 1324.30.)

1324.28. (a) This article shall be implemented as long as both of the following conditions are met:

(1) The state receives federal approval of the quality assurance fee from the federal Centers for Medicare and Medicaid Services.

(2) Legislation is enacted in the 2004 legislative session making an appropriation from the General Fund and from the Federal Trust Fund to fund a rate increase for skilled nursing facilities, as defined under subdivision (c) of Section 1250, for the 2004–05 rate year in an amount consistent with the Medi-Cal rates that specific facilities would have received under the rate methodology in effect as of July 31, 2004, plus the proportional costs as projected by Medi-Cal for new state or federal mandates.

(b) This article shall remain operative only as long as all of the following conditions are met:

(1) The federal Centers for Medicare and Medicaid Services continues to allow the use of the provider assessment provided in this article.

(2) The Medi-Cal Long-Term Care Reimbursement Act, Article 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, as added during the 2003–04 Regular Session by the act adding this section, is enacted and implemented on or before July 31, 2005, or as extended as provided in that article, and remains in effect thereafter.

(3) The state has continued its maintenance of effort for the level of state funding of nursing facility reimbursement for the 2005–06 rate year, and for every subsequent rate year continuing through the 2011–12 rate year, in an amount not less than the amount that specific facilities would have received under the rate methodology in effect on July 31, 2004, plus Medi-Cal's projected proportional costs for new state or federal mandates, not including the quality assurance fee.

(4) The full amount of the quality assurance fee assessed and collected pursuant to this article remains available for the purposes specified in Section 1324.25 and for related purposes.

(c) If all of the conditions in subdivision (a) are met, this article is implemented, and subsequently, any one of the conditions in subdivision (b) is not met, on and after the date that the department makes that determination, this article shall not be implemented, notwithstanding that the condition or conditions subsequently may be met.

(d) Notwithstanding subdivisions (a), (b), and (c), 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 federal 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 contrary to any provision of federal law or regulations, or of state law, this section shall become inoperative.

(Amended by Stats. 2010, Ch. 717, Sec. 8. (SB 853) Effective October 19, 2010. Conditionally inoperative as provided in subd. (d). Inoperative after December 31, 2026. Repealed as of January 1, 2028, pursuant to Section 1324.30. Note: Operational conditions in subds. (a), (b), and (c) apply to Article 7.6, commencing with Section 1324.20.)

1324.29. (a) The quality assurance fee shall cease to be assessed after December 31, 2026.

(b) Notwithstanding subdivision (a) and Section 1324.30, the department's authority and obligation to collect all quality assurance fees and penalties, including interest, shall continue in effect and shall not cease until the date that all amounts are paid or recovered in full.

(c) This section shall remain operative until the date that all fees and penalties, including interest, have been recovered pursuant to subdivision (b), and as of that date is repealed.

(Amended by Stats. 2022, Ch. 46, Sec. 3. (AB 186) Effective June 30, 2022. See operational conditions in Section 1324.28. Repealed as of date prescribed by its own provisions.)

1324.30. 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 becomes operative on or before January 1, 2028, deletes or extends the dates on which it becomes inoperative and is repealed.

(Amended by Stats. 2022, Ch. 46, Sec. 4. (AB 186) Effective June 30, 2022. Repealed as of January 1, 2028, by its own provisions. Note: Termination clause affects Article 7.6, commencing with Section 1324.20 (except Section 1324.29).)