AB-81 Public health funding: health facilities and services. (2019-2020)

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Assembly Bill No. 81

CHAPTER 13

An act to amend Sections 1324.20, 1324.22, 1324.23, 1324.24, 1324.27, 1324.29, and 1324.30 of the Health and Safety Code, and to amend Sections 5847, 5892, 14126.022, 14126.023, 14126.027, 14126.033, and 14126.036 of, and to add Section 14126.032 to, the Welfare and Institutions Code, relating to public health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor June 29, 2020. Filed with Secretary of State June 29, 2020.]

LEGISLATIVE COUNSEL'S DIGEST

AB 81, Committee on Budget. Public health funding: health facilities and services.

(1) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

Existing law requires the department to impose a uniform quality assurance fee on each skilled nursing facility, with certain exceptions, in accordance with a prescribed formula. Existing law requires that the fee be based on the entire net revenue of all skilled nursing facilities subject to the fee. Existing law prohibits the fee from being assessed after July 31, 2020, and repeals these provisions on January 1, 2021. Existing law authorizes the Director of Health Care Services to promulgate regulations on these provisions, and to implement these provisions by provider bulletin or similar instruction so long as that guidance remains in effect only until July 31, 2020, and that regulations are adopted by that date. Existing law requires the department to request approval from the federal Centers for Medicare and Medicaid Services to implement these provisions, and authorizes the director to alter the methodology, to the extent necessary to meet the requirements of federal law or regulations or to obtain federal approval.

This bill would establish various enforcement mechanisms for the department to collect delinquent quality assurance fees, such as requiring the department to assess interest on a skilled nursing facility that fails to pay all or part of the quality assurance fee within 60 days of the date that payment is due, beginning on the 61st calendar day from the date the payment is due, until the unpaid amount due and any interest is paid in full, and authorizing the department to deduct 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.

In the event of a merger, acquisition, or change of ownership involving a skilled nursing facility, this bill would authorize the department to 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, to take specified action 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, and to waive a portion

or all of the interest or penalties, or interest or penalties assessed if the department determines that the facility has demonstrated that imposing the full amount of fees 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.

The bill would extend the department's imposition of a uniform quality assurance fee to December 31, 2022, and would repeal those provisions on January 1, 2024.

(2) Existing law, the Medi-Cal Long-Term Care Reimbursement Act, requires the department to implement a facility-specific reimbursement ratesetting system for certain skilled nursing facilities. Reimbursement rates for freestanding skilled nursing facilities are funded by a combination of federal funds and moneys collected pursuant to the skilled nursing uniform quality assurance fee. Existing law also establishes the Skilled Nursing Facility Quality and Accountability Special Fund in the State Treasury, which is a continuously appropriated fund that contains moneys from the assessment of specified administrative penalties and set asides of General Fund moneys, for the purposes of making quality and accountability payments, including supplemental payments. Under the act, the department is required to develop the Skilled Nursing Facility Quality and Accountability Supplemental Payment System (system), which is utilized to provide supplemental payments to skilled nursing facilities that improve the quality and accountability of care rendered to residents in skilled nursing facilities, and to penalize those facilities that do not meet measurable standards. Under existing law, the rate methodology becomes inoperative after July 31, 2020, and these provisions will be repealed on January 1, 2021. Existing law authorizes the director to promulgate regulations on these provisions, and to implement these provisions by provider bulletin or similar instruction so long as that guidance remains in effect only until July 31, 2020, and that regulations are adopted by that date.

This bill would make various changes to the act, including providing that special program services for the mentally disordered that are entitled to receive supplemental payment are exempt from the system. The bill would extend the department's use of the Skilled Nursing Facility Quality and Accountability Special Fund to December 31, 2022. The bill would modify parameters of the supplemental payment, and would cease the availability of those payments on January 1, 2023. The bill would require the department to convene a stakeholder process by September 1, 2021 to develop a successor supplemental payment or similar quality-based payment methodology to replace the supplemental payments, starting in calendar year 2023.

The bill would make various changes to the Medi-Cal rate reimbursement methodology, including that the reimbursement rates established for the rate period of August 1, 2020, to December 31, 2020, inclusive, be no less than the amounts that would otherwise have been established under the reimbursement methodology for the 2019–20 rate year, and that the weighted average Medi-Cal reimbursement rate increase not exceed the applicable federal upper payment limit. The bill would also exempt a unit that provides freestanding pediatric subacute care services in a skilled nursing facility from the quality assurance fee requirements for that rate period and every subsequent calendar year thereafter. The bill would establish annual aggregate rate increases for the 2020 to 2024, inclusive, calendar years, as prescribed, and set forth the annual rate methodologies. The bill would authorize the department to modify any methodology or other provision regarding the reimbursement methodology, 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. Before implementing a modification, the bill would require the department to consult with affected providers and stakeholders to the extent practicable, and to 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.

The bill would require the department to audit the costs and revenues of skilled nursing facilities that are associated with the COVID-19 Public Health Emergency, as determined by the department, to determine whether a skilled nursing facility has adequately used increased Medicaid payments associated with the COVID-19 Public Health Emergency, as specified, for only allowable costs. The bill would implement the auditing requirement only to the extent any necessary federal approvals are obtained, and federal financial participation is available and is not otherwise jeopardized.

The bill would extend the operative date of the act to December 31, 2022, and would repeal those provisions on January 1, 2024.

By extending the period of time during which moneys are deposited in the Skilled Nursing Facility Quality and Accountability Special Fund, the bill would make an appropriation.

(3) Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Fund (MHSF), a continuously appropriated fund, to fund various county mental health programs, including children's mental health care, adult and older adult mental health care, and prevention and early intervention programs. Existing law requires funds, other than those placed in a prudent reserve, to revert to the state if the funds have not been spent or encumbered within 3 years.

This bill would authorize the State Department of Health Care Services to allow counties to determine the percentage of funds to allocate across specified mental health programs for the 2020–21 fiscal year by means of all-county letters or other similar

instructions without taking any further regulatory action. The bill would amend the MHSA by making funds that are subject to reversion as of July 1, 2019, and July 1, 2020, instead subject to reversion as of July 1, 2021.

The MHSA established the Mental Health Services Oversight and Accountability Commission and requires the counties to prepare and submit a 3-year program and expenditure plan, and annual updates, as specified, to the commission and the department.

This bill would authorize a county that is unable to complete and submit a 3-year plan or annual update for the 2020–21 fiscal year due to the COVID-19 Public Health Emergency to extend the effective timeframe of its currently approved 3-year plan or annual update to include the 2020–21 fiscal year. The bill would require a county to submit a 3-year program and expenditure plan or annual update to the commission and the department by July 1, 2021.

Existing law authorizes the MHSA to be amended by a 2/3 vote of each house of the Legislature if the amendments are consistent with, and further the intent of, the MHSA. Existing law authorizes the Legislature to add provisions to the act to clarify procedures and terms of the act by majority vote.

This bill would state the finding of the Legislature that the changes made are consistent with, and further the purposes of, the MHSA.

(4) Existing law requires a county to establish and maintain a prudent reserve as part of the 3-year plan to ensure the county program will continue to be able to serve children, adults, and seniors, as specified, and requires the county to allocate funds from the reserve for services in years when the allocation of funds for services are not adequate to serve the same number of individuals as the county had served in the previous fiscal year.

This bill would specify that a county may, during the 2020–21 fiscal year, use funds from its prudent reserve for specified services to persons who are served by the MHSA, including housing assistance.

(5) This bill would state that its provisions are severable.

(6) This bill would include a change in state statute that would result in a taxpayer paying a higher tax within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of $^{2}/_{3}$ of the membership of each house of the Legislature.

(7) This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.
Vote: 2/3 Appropriation: yes Fiscal Committee: yes Local Program: no

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1324.20 of the Health and Safety Code is amended to read:

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.

SEC. 2. Section 1324.22 of the Health and Safety Code is amended to read:

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.

(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 Chapter 3.5 (commencing with Section 6250) of Division 7 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.

SEC. 3. Section 1324.23 of the Health and Safety Code is amended to read:

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.

SEC. 4. Section 1324.24 of the Health and Safety Code is amended to read:

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.

SEC. 5. Section 1324.27 of the Health and Safety Code is amended to read:

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.

SEC. 6. Section 1324.29 of the Health and Safety Code is amended to read:

1324.29. (a) The quality assurance fee shall cease to be assessed after December 31, 2022.

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

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

SEC. 7. Section 1324.30 of the Health and Safety Code is amended to read:

1324.30. This article shall become inoperative after December 31, 2022, and as of January 1, 2024, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2024, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 8. Section 5847 of the Welfare and Institutions Code is amended to read:

5847. Integrated Plans for Prevention, Innovation, and System of Care Services.

(a) Each county mental health program shall prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors, to the Mental Health Services Oversight and Accountability Commission and the State Department of Health Care Services within 30 days after adoption.

(b) The three-year program and expenditure plan shall be based on available unspent funds and estimated revenue allocations provided by the state and in accordance with established stakeholder engagement and planning requirements, as required in Section 5848. The three-year program and expenditure plan and annual updates shall include all of the following:

(1) A program for prevention and early intervention in accordance with Part 3.6 (commencing with Section 5840).

(2) A program for services to children in accordance with Part 4 (commencing with Section 5850), to include a program pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9 or provide substantial evidence that it is not feasible to establish a wraparound program in that county.

(3) A program for services to adults and seniors in accordance with Part 3 (commencing with Section 5800).

(4) A program for innovations in accordance with Part 3.2 (commencing with Section 5830).

(5) A program for technological needs and capital facilities needed to provide services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting, such as permanent supportive housing.

(6) Identification of shortages in personnel to provide services pursuant to the above programs and the additional assistance needed from the education and training programs established pursuant to Part 3.1 (commencing with Section 5820).

(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults, and seniors that it is currently serving pursuant to Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act, Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs, and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act, during years in which

revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

(8) Certification by the county behavioral health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements.

(9) Certification by the county behavioral health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act.

(c) The programs established pursuant to paragraphs (2) and (3) of subdivision (b) shall include services to address the needs of transition age youth 16 to 25 years of age. In implementing this subdivision, county mental health programs shall consider the needs of transition age foster youth.

(d) Each year, the State Department of Health Care Services shall inform the County Behavioral Health Directors Association of California and the Mental Health Services Oversight and Accountability Commission of the methodology used for revenue allocation to the counties.

(e) Each county mental health program shall prepare expenditure plans pursuant to Part 3 (commencing with Section 5800) for adults and seniors, Part 3.2 (commencing with Section 5830) for innovative programs, Part 3.6 (commencing with Section 5840) for prevention and early intervention programs, and Part 4 (commencing with Section 5850) for services for children, and updates to the plans developed pursuant to this section. Each expenditure update shall indicate the number of children, adults, and seniors to be served pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.

(f) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (7) of subdivision (b) for services pursuant to paragraphs (2) and (3) of subdivision (b) in years in which the allocation of funds for services pursuant to subdivision (e) are not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.

(g) The department shall post on its internet website the three-year program and expenditure plans submitted by every county pursuant to subdivision (a) in a timely manner.

(h) (1) Notwithstanding subdivision (a), a county that is unable to complete and submit a three-year plan or annual update for the 2020–21 fiscal year due to the COVID-19 Public Health Emergency may extend the effective timeframe of its currently approved three-year plan or annual update to include the 2020–21 fiscal year. A county shall submit a three-year program and expenditure plan or annual update to the Mental Health Services Oversight and Accountability Commission and the State Department of Health Care Services by July 1, 2021.

(2) For purposes of this subdivision, “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.

(i) Notwithstanding paragraph (7) of subdivision (b) and subdivision (f), a county may, during the 2020–21 fiscal year, use funds from its prudent reserve for prevention and early intervention programs created in accordance with Part 3.6 (commencing with Section 5840) and for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850) for the children’s system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care. These services may include housing assistance, as defined in Section 5892.5, to the target population specified in Section 5600.3.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific subdivisions (h) and (i) of this section and subdivision (i) of Section 5892 by means of all-county letters or other similar instructions.

SEC. 9. Section 5892 of the Welfare and Institutions Code is amended to read:

5892. (a) In order to promote efficient implementation of this act, the county shall use funds distributed from the Mental Health Services Fund as follows:

(1) In the 2005–06, 2006–07, and 2007–08 fiscal years, 10 percent shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1 (commencing with Section 5820).

(2) In the 2005–06, 2006–07, and 2007–08 fiscal years, 10 percent for capital facilities and technological needs shall be distributed to counties in accordance with a formula developed in consultation with the County Behavioral Health Directors Association of California to implement plans developed pursuant to Section 5847.

(3) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5840).

(4) The expenditure for prevention and early intervention may be increased in any county in which the department determines that the increase will decrease the need and cost for additional services to persons with severe mental illness in that county by an amount at least commensurate with the proposed increase.

(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care. These services may include housing assistance, as defined in Section 5892.5, to the target population specified in Section 5600.3.

(6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850), shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848.

(b) (1) In any fiscal year after the 2007–08 fiscal year, programs for services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five fiscal years pursuant to this section.

(2) A county shall calculate an amount it establishes as the prudent reserve for its Local Mental Health Services Fund, not to exceed 33 percent of the average community services and support revenue received for the fund in the preceding five years. The county shall reassess the maximum amount of this reserve every five years and certify the reassessment as part of the three-year program and expenditure plan required pursuant to Section 5847.

(3) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may allow counties to determine the percentage of funds to allocate across programs created pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care for the 2020–21 fiscal year by means of all-county letters or other similar instructions without taking further regulatory action.

(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850).

(d) Prior to making the allocations pursuant to subdivisions (a), (b), and (c), funds shall be reserved for the costs for the State Department of Health Care Services, the California Behavioral Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). The amount of funds available for the purposes of this subdivision in any fiscal year is subject to appropriation in the annual Budget Act.

(e) In the 2004–05 fiscal year, funds shall be allocated as follows:

(1) Forty-five percent for education and training pursuant to Part 3.1 (commencing with Section 5820).

(2) Forty-five percent for capital facilities and technology needs in the manner specified by paragraph (2) of subdivision (a).

(3) Five percent for local planning in the manner specified in subdivision (c).

(4) Five percent for state implementation in the manner specified in subdivision (d).

(f) Each county shall place all funds received from the State Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on the investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future fiscal years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) (1) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county that have not been spent for their authorized purpose within three years, and the interest accruing on those funds, shall revert to the state to be deposited into the Reversion Account, hereby established in the fund, and available for other counties in future years, provided, however, that funds, including interest accrued on those funds, for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the Reversion Account.

(2) (A) If a county receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) so long as they are encumbered under the terms of the approved project plan, including any subsequent amendments approved by the commission, or until three years after the date of approval, whichever is later.

(B) Subparagraph (A) applies to all plans for innovative programs that have received commission approval and are in the process at the time of enactment of the act that added this subparagraph, and to all plans that receive commission approval thereafter.

(3) Notwithstanding paragraph (1), funds allocated to a county with a population of less than 200,000 that have not been spent for their authorized purpose within five years shall revert to the state as described in paragraph (1).

(4) (A) Notwithstanding paragraphs (1) and (2), if a county with a population of less than 200,000 receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) so long as they are encumbered under the terms of the approved project plan, including any subsequent amendments approved by the commission, or until five years after the date of approval, whichever is later.

(B) Subparagraph (A) applies to all plans for innovative programs that have received commission approval and are in the process at the time of enactment of the act that added this subparagraph, and to all plans that receive commission approval thereafter.

(i) Notwithstanding subdivision (h) and Section 5892.1, unspent funds allocated to a county, and interest accruing on those funds, which are subject to reversion as of July 1, 2019, and July 1, 2020, shall be subject to reversion on July 1, 2021.

(j) If there are revenues available in the fund after the Mental Health Services Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this section, including all purposes of the Prevention and Early Intervention Program, the commission shall develop a plan for expenditures of these revenues to further the purposes of this act and the Legislature may appropriate these funds for any purpose consistent with the commission's adopted plan that furthers the purposes of this act.

SEC. 10. Section 14126.022 of the Welfare and Institutions Code is amended to read:

14126.022. (a) (1) By August 1, 2011, the department shall develop the Skilled Nursing Facility Quality and Accountability Supplemental Payment System, subject to approval by the federal Centers for Medicare and Medicaid Services, and the availability of federal, state, or other funds.

(2) (A) The system shall be utilized to provide supplemental payments to skilled nursing facilities that improve the quality and accountability of care rendered to residents in skilled nursing facilities, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, and to penalize those facilities that do not meet measurable standards.

(B) A freestanding pediatric subacute care facility, as defined in Section 51215.8 of Title 22 of the California Code of Regulations, shall be exempt from the Skilled Nursing Facility Quality and Accountability Supplemental Payment System.

(C) 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 continue to be exempt from the Skilled Nursing Facility Quality and Accountability Supplemental Payment System.

(3) The system shall be phased in, beginning with the 2010–11 rate year.

(4) The department may utilize the system to do all of the following:

(A) Assess overall facility quality of care and quality of care improvement, and assign quality and accountability payments to skilled nursing facilities pursuant to performance measures described in subdivision (i).

(B) Assign quality and accountability payments or penalties relating to quality of care, or direct care staffing levels, wages, and benefits, or both.

(C) Limit the reimbursement of legal fees incurred by skilled nursing facilities engaged in the defense of governmental legal actions filed against the facilities.

(D) Publish each facility's quality assessment and quality and accountability payments in a manner and form determined by the director, or their designee.

(E) Beginning with the 2011–12 fiscal year, establish a base year to collect performance measures described in subdivision (i).

(F) Beginning with the 2011–12 fiscal year, in coordination with the State Department of Public Health, publish the direct care staffing level data and the performance measures required pursuant to subdivision (i).

(5) The department, in coordination with the State Department of Public Health, shall report to the relevant Assembly and Senate budget subcommittees by May 1, 2016, information on the quality and accountability supplemental payments, including, but not limited to, its assessment of whether the payments are adequate to incentivize quality care and to sustain the program.

(b) (1) There is hereby created in the State Treasury, the Skilled Nursing Facility Quality and Accountability Special Fund. The fund shall contain moneys deposited pursuant to subdivisions (g) and (j) to (m), inclusive. Notwithstanding Section 16305.7 of the Government Code, the fund shall contain all interest and dividends earned on moneys in the fund.

(2) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated without regard to fiscal year to the department for making quality and accountability payments, in accordance with subdivision (n), to facilities that meet or exceed predefined measures as established by this section through December 31, 2022.

(3) Upon appropriation by the Legislature, moneys in the fund may also be used for any of the following purposes:

(A) To cover the administrative costs incurred by the State Department of Public Health for positions and contract funding required to implement this section.

(B) To cover the administrative costs incurred by the State Department of Health Care Services for positions and contract funding required to implement this section.

(C) To provide funding assistance for the Long-Term Care Ombudsman Program activities pursuant to Chapter 11 (commencing with Section 9700) of Division 8.5.

(c) Any appropriation associated with Chapter 717 of the Statutes of 2010 is not intended to implement Section 1276.65 of the Health and Safety Code.

(d) (1) There is hereby appropriated for the 2010–11 fiscal year, one million nine hundred thousand dollars ($1,900,000) from the Skilled Nursing Facility Quality and Accountability Special Fund to the California Department of Aging for the Long-Term Care Ombudsman Program activities pursuant to Chapter 11 (commencing with Section 9700) of Division 8.5. It is the intent of the Legislature for the one million nine hundred thousand dollars ($1,900,000) from the fund to be in addition to the four million one hundred sixty-eight thousand dollars ($4,168,000) proposed in the Governor's May Revision for the 2010–11 Budget. It is further the intent of the Legislature to increase this level of appropriation in subsequent years to provide support sufficient to carry out the mandates and activities pursuant to Chapter 11 (commencing with Section 9700) of Division 8.5.

(2) The department, in partnership with the California Department of Aging, shall seek approval from the federal Centers for Medicare and Medicaid Services to obtain federal Medicaid reimbursement for activities conducted by the Long-Term Care Ombudsman Program. The department shall report to the fiscal committees of the Legislature during budget hearings on progress being made and any unresolved issues during the 2011–12 budget deliberations.

(e) There is hereby created in the Special Deposit Fund established pursuant to Section 16370 of the Government Code, the Skilled Nursing Facility Minimum Staffing Penalty Account. The account shall contain all moneys deposited pursuant to subdivision (f).

(f) (1) Beginning with the 2010–11 fiscal year, the State Department of Public Health shall use the direct care staffing level data it collects to determine whether a skilled nursing facility has met the nursing hours or direct care service hours per patient per day requirements pursuant to Section 1276.5 or 1276.65, as applicable, of the Health and Safety Code.

(2) (A) Beginning with the 2010–11 fiscal year, the State Department of Public Health shall assess a skilled nursing facility, licensed pursuant to subdivision (c) of Section 1250 of the Health and Safety Code, an administrative penalty if the State Department of Public Health determines that the skilled nursing facility fails to meet the nursing hours or direct care service hours per patient per day requirements pursuant to Section 1276.5 or 1276.65, as applicable, of the Health and Safety Code, as follows:

(i) Twenty-five thousand dollars ($25,000) if the facility fails to meet the requirements for 5 percent or more of the audited days up to 49 percent.

(ii) Fifty thousand dollars ($50,000) if the facility fails to meet the requirements for over 49 percent or more of the audited days.

(B) (i) If the skilled nursing facility does not dispute the determination or assessment, the penalties shall be paid in full by the licensee to the State Department of Public Health within 30 days of the facility's receipt of the notice of penalty and deposited into the Skilled Nursing Facility Minimum Staffing Penalty Account.

(ii) The State Department of Public Health may, upon written notification to the licensee, request that the department offset any moneys owed to the licensee by the Medi-Cal program or any other payment program administered by the department to recoup the penalty provided for in this section.

(C) (i) If a facility disputes the determination or assessment made pursuant to this paragraph, the facility shall, within 15 days of the facility's receipt of the determination and assessment, simultaneously submit a request for appeal to both the department and the State Department of Public Health. A request for an appeal may be made by a facility based upon a determination that does not result in an assessment. The request shall include a detailed statement describing the reason for appeal and include all supporting documents the facility will present at the hearing.

(ii) Within 10 days of the State Department of Public Health's receipt of the facility's request for appeal, the State Department of Public Health shall submit, to both the facility and the department, all supporting documents that will be presented at the hearing.

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

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

(ii) The department shall issue a decision within 120 days from the date of receipt by the department of the facility's timely request for appeal.

(iii) The decision of the department's hearing officer, when issued, shall be the final decision of the State Department of Public Health.

(E) The appeals process set forth in this paragraph shall be exempt from Chapter 4.5 (commencing with Section 11400) and Chapter 5 (commencing with Section 11500), of Part 1 of Division 3 of Title 2 of the Government Code. Sections 100171 and 131071 of the Health and Safety Code do not apply to appeals under this paragraph.

(F) If a hearing decision issued pursuant to subparagraph (D) is in favor of the State Department of Public Health, the skilled nursing facility shall pay the penalties to the State Department of Public Health within 30 days of the facility's receipt of the decision. The penalties collected shall be deposited into the Skilled Nursing Facility Minimum Staffing Penalty Account.

(G) The assessment of a penalty under this subdivision does not supplant the State Department of Public Health's investigation process or issuance of deficiencies or citations under Chapter 2.4 (commencing with Section 1417) of Division 2 of the Health and Safety Code.

(g) The State Department of Public Health shall transfer, on a monthly basis, all penalty payments collected pursuant to subdivision (f) into the Skilled Nursing Facility Quality and Accountability Special Fund.

(h) This section does not impact the effectiveness or utilization of Section 1278.5 or 1432 of the Health and Safety Code relating to whistleblower protections, or Section 1420 of the Health and Safety Code relating to complaints.

(i) (1) Beginning in the 2010–11 fiscal year, the department, in consultation with representatives from the long-term care industry, organized labor, and consumers, shall establish and publish quality and accountability measures, benchmarks, and data

submission deadlines by November 30, 2010.

(2) The supplemental payment methodology developed pursuant to this section shall include, but not be limited to, the following requirements and performance measures:

(A) Beginning in the 2011–12 fiscal year:

(i) Immunization rates.

(ii) Facility acquired pressure ulcer incidence.

(iii) The use of physical restraints.

(iv) Compliance with the nursing hours or direct care service hours per patient per day requirements pursuant to Section 1276.5 or 1276.65, as applicable, of the Health and Safety Code.

(v) Resident and family satisfaction.

(vi) Direct care staff retention, if sufficient data is available.

(B) If this act is extended beyond the dates on which it becomes inoperative and is repealed, in accordance with Section 14126.033, the department, in consultation with representatives from the long-term care industry, organized labor, and consumers, beginning in the 2013–14 rate year, shall incorporate additional measures into the system, including, but not limited to, quality and accountability measures required by federal health care reform that are identified by the federal Centers for Medicare and Medicaid Services.

(C) The department, in consultation with representatives from the long-term care industry, organized labor, and consumers, may incorporate additional performance measures, including, but not limited to, the following:

(i) Compliance with state policy associated with the United States Supreme Court decision in Olmstead v. L.C. ex rel. Zimring (1999) 527 U.S. 581.

(ii) Direct care staff retention, if not addressed in the 2012–13 rate year.

(iii) The use of chemical restraints.

(D) Beginning with the 2015–16 fiscal year, the department, in consultation with representatives from the long-term care industry, organized labor, and consumers, shall incorporate direct care staff retention as a performance measure in the methodology developed pursuant to this section.

(E) (i) Beginning with the 2020–21 fiscal year, and only to the extent any necessary federal approvals are obtained, the department may incorporate an additional performance measure based upon a facility's compliance 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.

(j) (1) Beginning with the 2010–11 rate year, and pursuant to subparagraph (B) of paragraph (5) of subdivision (a) of Section 14126.023, the department shall set aside savings achieved from setting the professional liability insurance cost category, including any insurance deductible costs paid by the facility, at the 75th percentile. From this amount, the department shall transfer the General Fund portion into the Skilled Nursing Facility Quality and Accountability Special Fund. A skilled nursing facility shall provide supplemental data on insurance deductible costs to facilitate this adjustment, in the format and by the deadlines determined by the department. If this data is not provided, a facility's insurance deductible costs will remain in the administrative costs category.

(2) Notwithstanding paragraph (1), for the 2012–13 rate year only, savings from capping the professional liability insurance cost category pursuant to paragraph (1) shall remain in the General Fund and shall not be transferred to the Skilled Nursing Facility Quality and Accountability Special Fund.

(k) 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 the first 1 percent of the weighted average Medi-Cal reimbursement rate increase for the Skilled Nursing Facility

Quality and Accountability Special Fund.

(l) If this act is extended beyond the dates on which it becomes inoperative and is repealed, for the 2014–15 rate year, in addition to the amount set aside pursuant to subdivision (k), if there is a rate increase in the weighted average Medi-Cal reimbursement rate, the department shall set aside at least one-third of the weighted average Medi-Cal reimbursement rate increase, up to a maximum of 1 percent, from which the department shall transfer the General Fund portion of this amount into the Skilled Nursing Facility Quality and Accountability Special Fund.

(m) Beginning with the 2015–16 rate year, and each subsequent rate or calendar year thereafter for which this article is operative, an amount equal to the amount deposited in the fund pursuant to subdivisions (k) and (l) for the 2014–15 rate year shall be deposited into the Skilled Nursing Facility Quality and Accountability Special Fund, for the purposes specified in this section.

(n) (1) (A) Beginning with the 2013–14 rate year, and through the conclusion of the rate period from August 1, 2020, to December 31, 2020, inclusive, the department shall pay a supplemental payment, by April 30 of each applicable rate year, to skilled nursing facilities based on all of the criteria in subdivision (i), as published by the department, and according to performance measure benchmarks determined by the department in consultation with stakeholders.

(B) For the 2021 and 2022 calendar years, the department shall pay a supplemental payment, by April 30 of each applicable calendar year, to qualified skilled nursing facilities based on the criteria in subdivision (i), as published by the department, and according to performance measure benchmarks determined by the department in consultation with stakeholders.

(C) (i) The department may convene a diverse stakeholder group, including, but not limited to, representatives from consumer groups and organizations, labor, nursing home providers, advocacy organizations involved with the aging community, staff from the Legislature, and other interested parties, to discuss and analyze alternative mechanisms to implement the quality and accountability payments provided to nursing homes for reimbursement.

(ii) The department shall articulate in a report to the fiscal and appropriate policy committees of the Legislature the implementation of an alternative mechanism as described in clause (i) at least 90 days prior to any policy or budgetary changes, and seek subsequent legislation in order to enact the proposed changes.

(2) Skilled nursing facilities that do not submit required performance data by the department's specified data submission deadlines pursuant to subdivision (i) are ineligible to receive supplemental payments.

(3) Notwithstanding paragraph (1), if a facility appeals the performance measure of compliance with the nursing hours or direct care service hours per patient per day requirements, pursuant to Section 1276.5 or 1276.65, as applicable, of the Health and Safety Code, to the State Department of Public Health, and it is unresolved by the department's published due date, the department shall not use that performance measure when determining the facility's supplemental payment.

(4) Notwithstanding paragraph (1), if the department is unable to pay the supplemental payments by April 30, 2014, then on May 1, 2014, the department shall use the funds available in the Skilled Nursing Facility Quality and Accountability Special Fund as a result of savings identified in subdivisions (k) and (l), less the administrative costs required to implement subparagraphs (A) and (B) of paragraph (3) of subdivision (b), in addition to any Medicaid funds that are available as of December 31, 2013, to increase provider rates retroactively to August 1, 2013.

(o) The department shall seek necessary approvals from the federal Centers for Medicare and Medicaid Services to implement this section. The department shall implement this section only in a manner that is consistent with federal Medicaid law and regulations, and only to the extent that approval is obtained from the federal Centers for Medicare and Medicaid Services and federal financial participation is available and not otherwise jeopardized.

(p) In implementing this section, the department and the State Department of Public Health may contract as necessary, with California's Medicare Quality Improvement Organization, or other entities deemed qualified by the department or the State Department of Public Health, not associated with a skilled nursing facility, to assist with development, collection, analysis, and reporting of the performance data pursuant to subdivision (i), and with demonstrated expertise in long-term care quality, data collection or analysis, and accountability performance measurement models pursuant to subdivision (i). This subdivision establishes an accelerated process for issuing any contract pursuant to this section. Any contract entered into pursuant to this subdivision is exempt from the requirements of the Public Contract Code.

(q) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the following apply:

(1) The director shall implement this section, in whole or in part, by means of provider bulletins, or other similar instructions without taking regulatory action.

(2) The State Public Health Officer may implement this section by means of all-facility letters, or other similar instructions without taking regulatory action.

(r) Notwithstanding paragraph (1) of subdivision (n), if a final judicial determination is made by any state or federal court that is not appealed, in any action by any party, or a final determination is made by the administrator of the federal Centers for Medicare and Medicaid Services, that any payments pursuant to subdivisions (a) and (n), are invalid, unlawful, or contrary to federal law or regulations, or of state law, these subdivisions shall become inoperative, and for the 2011–12 rate year, the rate increase provided under subparagraph (A) of paragraph (4) of subdivision (c) of Section 14126.033 shall be reduced by the amounts described in subdivision (j). For the 2013–14 and 2014–15 rate years, any rate increase shall be reduced by the amounts described in subdivisions (j) to (l), inclusive.

(s) Notwithstanding any other provision of this section, but only to the extent the department determines federal financial participation is available and not otherwise jeopardized, for performance periods in the 2017–18 and 2018–19 fiscal years, a skilled nursing facility shall remain eligible to participate in the supplemental payment program pursuant to this section if the facility meets the applicable nursing hours per patient per day requirements pursuant to Section 1276.5 of the Health and Safety Code.

(t) Notwithstanding any provision of this section, but only to the extent the department determines federal financial participation is available and not otherwise jeopardized, compliance with subdivision (c) of Section 1276.65 of the Health and Safety Code, as amended by Chapter 52 of the Statutes of 2017, shall not be used to determine facility qualification for the supplemental payments provided for in this section until the performance period beginning in the 2019–20 fiscal year. This limitation shall also apply to the issuance of citations pursuant to subdivisions (c) and (d) of Section 1424 of the Health and Safety Code based upon the failure to comply with subdivision (c) of Section 1276.65 of the Health and Safety Code as amended by Chapter 52 of the Statutes of 2017. Until the performance period beginning in the 2019–20 fiscal year, the department shall apply Section 1276.5 of the Health and Safety Code for purposes of administering the supplemental payments pursuant to this section. For performance periods beginning in the 2019–20 fiscal year and each fiscal year thereafter, a skilled nursing facility that is granted a waiver pursuant to subdivision (l) of Section 1276.65 of the Health and Safety Code shall remain eligible to participate in the supplemental payment program pursuant to this section so long as the facility meets the applicable nursing hours per patient per day requirement pursuant to Section 1276.5 of the Health and Safety Code that would have applied in the absence of Chapter 52 of the Statutes of 2017 for the duration of the time for which the waiver is granted.

(u) (1) Effective January 1, 2023, the department shall cease to make supplemental payments pursuant to subdivision (n). The department shall be authorized to conduct all necessary closeout activities after this date and to continue implementing this section for supplemental payments applicable to any rate period before January 1, 2023.

(2) The department shall convene a stakeholder process by September 1, 2021, to develop a successor supplemental payment or similar quality-based payment methodology to replace the supplemental payments described in subdivision (n) starting in calendar year 2023.

(v) Any outstanding amount of the quality assurance fee, as calculated pursuant to Section 1324.21 of the Health and Safety Code, or interest assessed pursuant to subdivision (e) of Section 1324.22 of the Health and Safety Code, or penalties assessed pursuant to paragraph (1) of subdivision (h) of Section 1324.22 of the Health and Safety Code for a facility may be deducted by the department from any Medi-Cal payments to the facility, including, but not limited to, supplemental payments pursuant to subdivision (n), until the outstanding amount is paid in full.

SEC. 11. Section 14126.023 of the Welfare and Institutions Code is amended to read:

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

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

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

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

(B) Notwithstanding subparagraph (A), beginning with the 2010–11 rate year and in each subsequent rate 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 and each rate or calendar year thereafter, the department may determine a facility ineligible to receive supplemental payments pursuant to Section 14126.022 if a facility fails to provide supplemental data as requested by the department.

(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.

SEC. 12. Section 14126.027 of the Welfare and Institutions Code is amended to read:

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.

SEC. 13. Section 14126.032 is added to the Welfare and Institutions Code, to read:

14126.032. (a) 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, 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).

(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 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.

SEC. 14. Section 14126.033 of the Welfare and Institutions Code is amended to read:

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

(1) Costs within the Medi-Cal program continue to grow due to the rising cost of providing health care throughout the state and 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) 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.

(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, 2022.

(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 Bureau of State Audits shall conduct an accountability evaluation of the department's progress toward implementing a facility-specific reimbursement system, including a review of data to ensure that the new system is appropriately reimbursing facilities within specified cost categories and a review of the fiscal impact of the new system on the General Fund.

(3) Not later than January 1, 2007, to the extent information is available for the three years immediately preceding the implementation of this article, the department shall provide baseline information in a report to the Legislature on all of the following:

(A) The number and percent of freestanding skilled nursing facilities that complied with minimum staffing requirements.

(B) The staffing levels 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.

SEC. 15. Section 14126.036 of the Welfare and Institutions Code is amended to read:

14126.036. This article shall become inoperative on December 31, 2022, and as of January 1, 2024, is repealed, unless a later enacted statute that is enacted before, January 1, 2024, deletes or extends that date.

SEC. 16. The provisions of this measure are severable. If any provision of this measure or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 17. The Legislature hereby finds and declares that the amendments made by this act to Sections 5847 and 5892 of the Welfare and Institutions Code all further the Mental Health Services Act enacted by the approval of Proposition 63 at the November 2, 2004, statewide general election, and are consistent with its purposes.

SEC. 18. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.