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AB-186 Public health. (2021-2022)

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Assembly Bill No. 186

CHAPTER 46

An act amend Sections 1324.29 and 1324.30 of, and to add 1276.66 to, the Health and Safety Code, to amend Section 31005 of the Revenue and Taxation Code, and to amend Sections 14114, 14126.023, 14126.032, 14126.033, 14126.036, and 14197.2 of, to amend and repeal Section 14126.022 of, and to add Sections 14126.024 and 14126.026 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 30, 2022. Filed with Secretary of State June 30, 2022.]

LEGISLATIVE COUNSEL'S DIGEST

AB 186, Committee on Budget. Public health.

(1) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and 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, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, an initiative measure approved as Proposition 56 at the November 8, 2016, statewide general election, increases taxes imposed on distributors of cigarettes and tobacco products and requires all revenues to be deposited into the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund, a continuously appropriated fund. Proposition 56 requires the Controller to transfer 82% of those revenues to the Healthcare Treatment Fund, to be used by the department to increase funding for the Medi-Cal program and other specified health care programs and services in a way that, among other things, ensures timely access, limits geographic shortages of services, and ensures quality care. The act authorizes the Legislature to amend the provision relating to the allocation of revenues in the Healthcare Treatment Fund to further the purposes of the act with a $\frac{2}{3}$ vote of the membership of each house of the Legislature.

Existing law, until January 1, 2026, establishes the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program, which requires the department to develop and administer the program to provide loan assistance payments to qualifying, recent graduate physicians and dentists who serve beneficiaries of the Medi-Cal program and other specified health care programs. Existing law requires this program to be funded using moneys appropriated to the department for this purpose in the Budget Act of 2018 from the Healthcare Treatment Fund, and requires the department to administer 2 separate payment pools for participating physicians and dentists, respectively, consistent with the allocations provided for in the Budget Act of 2018.

This bill would rename the program the Medi-Cal Physicians and Dentists Loan Repayment Program and would make conforming changes. The bill would instead make the administratively created Loan Repayment Program Account, within the Healthcare Treatment Fund, continuously appropriated to implement the Medi-Cal Physicians and Dentists Loan Repayment Act Program. The bill would require that the account contain funds appropriated by the Legislature from the Healthcare Treatment Fund. The

bill would also establish the Medi-Cal Loan Repayment Program Special Fund in the State Treasury and require the fund to contain funds transferred from the California Electronic Cigarette Excise Tax Fund, as specified, funds collected from remittances by Medi-Cal managed care plans as described below, and any other moneys appropriated to the program. The bill would make the Medi-Cal Loan Repayment Program Special Fund continuously appropriated to implement the Medi-Cal Physicians and Dentists Loan Repayment Program. The bill would require, for the Medi-Cal Loan Repayment Program Special Fund, the department and the State Controller's office to maintain separate subaccounts for funds appropriated or transferred from each funding source.

The bill would require the department to expend all funds appropriated from the Loan Repayment Program Account of the Healthcare Treatment Fund before expending any funds from the Medi-Cal Loan Repayment Program Special Fund. The bill would make other changes to the allocations associated with the 2 separate payment pools. The bill would delete the provision making this program inoperative on January 1, 2026, thereby extending it indefinitely. By extending the operation of this program and the expenditure of certain allocated revenues for this program, the bill would amend Proposition 56.

(2) Existing law requires a Medi-Cal managed care plan to comply with a minimum 85% medical loss ratio (MLR) consistent with specified federal regulations. Effective for contract rating periods commencing on or after July 1, 2023, existing law requires a Medi-Cal managed care plan to provide a remittance for noncompliance with the minimum MLR standard. After the department returns the requisite federal share amounts to the federal Centers for Medicare and Medicaid Services, existing law requires the transfer of the remaining remitted amounts to the Medically Underserved Account for Physicians within the Health Professions Education Fund for use, upon appropriation, for the Steven M. Thompson Physician Corps Loan Repayment Program, as specified.

This bill would instead require that the remaining remitted amounts be transferred to the Medi-Cal Loan Repayment Program Special Fund for purposes of the above-described Medi-Cal Physicians and Dentists Loan Repayment Program.

(3) 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 prohibits the fee from being assessed after December 31, 2022, and repeals these provisions on January 1, 2024. 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. Existing law extends the department's use of the Skilled Nursing Facility Quality and Accountability Special Fund to December 31, 2022, and ceases the availability of those payments on January 1, 2023. Under existing law, the rate methodology becomes inoperative after December 31, 2022, and these provisions will be repealed on January 1, 2024.

This bill would revise and recast these provisions. The bill would allow the system to lapse and would require the department, subject to an appropriation by the Legislature, to implement the Workforce and Quality Incentive Program, which would render a network provider furnishing skilled nursing services to a Medi-Cal managed care enrollee eligible to earn performance-based directed payments for the managed care plan with which they contract. The bill would require the department, in consultation with certain stakeholders, to establish a methodology, parameters, and eligibility criteria for the directed payments. The bill would implement these provisions only to the extent that any necessary federal approvals are obtained and federal financial participation is available. The bill would authorize the Department of Finance to administratively abolish the Skilled Nursing Facility Quality and Accountability Special Fund. The bill would continue the Skilled Nursing Facility Minimum Staffing Penalty Account. By extending the period of time during which transfers are made to the Skilled Nursing Facility Minimum Staffing Penalty Account, the bill would make an appropriation.

This bill would establish the maximum annual aggregate rate increases for the 2023 to 2026, 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. The bill would extend the operative date of the Medi-Cal Long-Term Care Reimbursement Act to December 31, 2026, and would authorize the department to conduct necessary closeout activities after that date. The bill would repeal these provisions on January 1, 2028.

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 $\frac{2}{3}$ of the membership of each

house of the Legislature.

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

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

SECTION 1. It is the intent of the Legislature in enacting these sections to provide a long-term funding framework that assures the long-term financial viability of skilled nursing facilities is predicated on enabling these providers to invest in quality patient care, improving workforce retention, and empowering the voices of essential workers responsible for the health and safety of nursing home residents.

SEC. 2. Section 1276.66 is added to the Health and Safety Code, to read:

1276.66. (a) (1) There is hereby continued 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 (b).

(2) Notwithstanding Section 13340 of the Government Code or any other law, the Skilled Nursing Facility Minimum Staffing Penalty Account is hereby continuously appropriated, without regard to fiscal years, to the State Department of Public Health to support the implementation of this section.

(b) (1) 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.

(2) (A) The State Department of Public Health shall assess a skilled nursing facility, licensed pursuant to subdivision (c) of Section 1250, 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, 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 State Department of Health Care Services offset any moneys owed to the licensee by the Medi-Cal program or any other payment program administered by the State Department of Health Care Services 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 30 days of the facility's receipt of the determination and assessment, simultaneously submit a request for appeal to both the State Department of Health Care Services 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 30 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 State Department of Health Care Services, its responsive arguments and all supporting documents that the State Department of Public Health will present at the hearing.

(D) The State Department of Health Care Services 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 State Department of Health Care Services of the facility's timely request for appeal.

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

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

(E) The appeals process set forth in this paragraph shall be exempt from Chapter 4.5 (commencing with Section 11400), and Chapter 5 (commencing with Section 11500), of Part 1 of Division 3 of Title 2 of the Government Code. The provisions of Sections 100171 and 131071 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.

(c) The assessment of a penalty under this section shall not prohibit any state or federal enforcement action, including, but not limited to, State Department of Public Health's investigation process or issuance of deficiencies or citations under Chapter 2.4 (commencing with Section 1417).

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

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

(f) This section shall become operative on January 1, 2023.

SEC. 3. 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, 2026.

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

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

SEC. 4. Section 1324.30 of the Health and Safety Code is amended to read:

1324.30. This article shall become inoperative after December 31, 2026, except that the department shall be authorized to conduct all necessary closeout activities after this date and to continue implementing this article for any rate period before December 31, 2026, and as of January 1, 2028, this article is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2028, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 5. Section 31005 of the Revenue and Taxation Code is amended to read:

31005. (a) All revenues, interest, and penalties derived from the California Electronic Cigarette Excise Tax shall be deposited into the California Electronic Cigarette Excise Tax Fund, which is hereby created in the State Treasury, less payments for refunds and reimbursement to the department for expenses incurred in the administration and collection of the tax.

(b) Notwithstanding Section 13340 of the Government Code and subject to subdivision (d), all amounts in the California Electronic Cigarette Excise Tax Fund are continuously appropriated without regard to fiscal year as follows:

(1) Eighteen percent of the moneys to the Health Education Account, established in paragraph (1) of subdivision (b) of Section 30122, for tobacco control programs described in Article 1 (commencing with Section 104350) of Chapter 1 of Part 3 of Division 103 of the Health and Safety Code.

(2) Twelve percent of the moneys into the California Children and Families Trust Fund created by Section 30131.

(3) (A) Forty-eight percent of the moneys to fund the Medi-Cal Physicians and Dentists Loan Repayment Program (Section 14114 of the Welfare and Institutions Code).

(B) Of the moneys described by subparagraph (A), 70 percent shall be allocated to the physician payment pool and 30 percent to the dentist payment pool.

(4) Five percent of the moneys to the Department of Health Care Access and Information to fund the Health Professions Career Opportunity Program described by Section 127885 of the Health and Safety Code.

(5) Seven percent of the moneys to the University of California to support the joint program in medical education between the University of California San Francisco (UCSF) School of Medicine, UCSF Fresno, and the University of California, Merced, including, but not limited to, using funds to establish new residency and clinical rotation positions for program participants and graduates in the San Joaquin Valley.

(6) Ten percent of the moneys to the Small and Rural Hospital Relief Fund established in Section 130077 of the Health and Safety Code.

(c) (1) The department shall transmit the funds, pursuant to subdivision (b), periodically as promptly as feasible but shall transmit funds at least once in each calendar quarter.

(2) The department shall furnish a quarterly statement indicating the amounts paid and withheld for expenses of the department.

(d) (1) The amount of three million dollars (\$3,000,000) shall be loaned from the General Fund to the department during the 2021–22 fiscal year and deposited into the California Electronic Cigarette Excise Tax Fund for the purpose of implementing the tax imposed by this part and shall be repaid on or before June 30, 2023, from the taxes collected pursuant to this part.

(2) The loan made pursuant to this subdivision shall be repaid to the General Fund before any appropriations of funds pursuant to subdivisions (b) and (c) are made.

SEC. 6. Section 14114 of the Welfare and Institutions Code is amended to read:

14114. (a) This section shall be known, and may be cited, as Medi-Cal Physicians and Dentists Loan Repayment Program Act.

(b) Notwithstanding any other law, the department shall develop and administer the Medi-Cal Physicians and Dentists Loan Repayment Program to provide loan assistance payments to qualifying, recent graduate physicians and dentists that serve beneficiaries of existing health care programs described in Chapter 7 (commencing with Section 14000) to Chapter 8.9 (commencing with Section 14700), inclusive. To implement this section, the department shall consult with other state entities, including the Department of Health Care Access and Information, and with affected stakeholders.

(c) (1) The Medi-Cal Physicians and Dentists Loan Repayment Program shall be funded using moneys appropriated to the department for this purpose.

(2) The Loan Repayment Program Account is hereby continued in the State Treasury within the Healthcare Treatment Fund established pursuant to Section 30130.55 of the Revenue and Taxation Code. The Loan Repayment Program Account shall contain funds appropriated by the Legislature from the Healthcare Treatment Fund to the Medi-Cal Physicians and Dentists Loan Repayment Program. Notwithstanding Section 13340 of the Government Code, the Loan Repayment Program Account is hereby continuously appropriated, without regard to fiscal year, to implement the Medi-Cal Physicians and Dentists Loan Repayment Program.

(3) The Medi-Cal Loan Repayment Program Special Fund is hereby established in the State Treasury. The Medi-Cal Loan Repayment Program Special Fund shall contain funds transferred from the California Electronic Cigarette Excise Tax Fund pursuant to Section 31005 of the Revenue and Taxation Code, funds transferred pursuant to paragraph (2) of subdivision (c) of Section 14197.2, and any other moneys appropriated to the Medi-Cal Physicians and Dentists Loan Repayment Program other than funds appropriated from the Health Care Treatment Fund described in paragraph (2). The department and the State Controller's office shall maintain separate subaccounts for funds appropriated or transferred from each funding source. Notwithstanding Section 13340 of the Government Code, the Medi-Cal Loan Repayment Program Special Fund is hereby continuously appropriated, without regard to fiscal year, to implement the Medi-Cal Physicians and Dentists Loan Repayment Program.

(4) The department shall expend all funds available in the Loan Repayment Program Account of the Healthcare Treatment Fund prior to expending any funds from the Medi-Cal Loan Repayment Program Special Fund.

(5) Within each fund and subaccount, the department shall administer two separate payment pools for participating physicians and dentists, respectively, consistent with the allocations provided for in Item 4260-102-3305 of the Budget Act of 2018, Item

4260-102-3305 of the Budget Act of 2019, Section 31005 of the Revenue and Taxation Code, and paragraph (2) of subdivision (c) of Section 14197.2.

(6) Moneys appropriated to the department to implement this section shall be available to fund the administrative costs incurred by the department and any entity contracted with pursuant to subdivision (g). Administrative costs from the Loan Repayment Program Account of the Healthcare Treatment Fund are limited by subdivision (f) of Section 30130.57 of the Revenue and Taxation Code.

(d) The department shall develop the eligibility criteria to be used to evaluate physician and dentist participation in the Medi-Cal Physicians and Dentists Loan Repayment Program. In developing these criteria, the department shall prioritize ensuring timely access, limiting geographic shortages of services, and ensuring quality care in the Medi-Cal program. The department shall develop separate criteria for distribution of payments from the physician and dentist payment pools. At a minimum, the department shall establish the maximum number of years a physician or dentist may be in practice to qualify for payments pursuant to this section, and the minimum number of years a participating physician or dentist receiving payments pursuant to this section shall agree to participate as an enrolled provider in the Medi-Cal program.

(e) The selection of physicians and dentists for participation in the Medi-Cal Physicians and Dentists Loan Repayment Program and the amount of loan repayment assistance awarded to a participating physician or dentist shall be at the discretion of the department and any entity contracted with pursuant to subdivision (g), and shall be based on the criteria developed pursuant to subdivision (d). An exercise of discretion by the department and its contractors pursuant to this subdivision shall not be subject to judicial review, except that an applicant physician or dentist who is not selected for participation in the program may file for a writ of mandate pursuant to Section 1085 of the Code of Civil Procedure to rectify an abuse of discretion by the department and its contractors.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of policy letters, provider bulletins, or other similar instructions, without taking regulatory action. The department shall consult with affected stakeholders before taking action pursuant to this subdivision.

(g) To implement this section, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the review or approval of a division of the Department of General Services.

(h) This section shall be implemented only to the extent that the department determines that federal financial participation under the Medi-Cal program is not jeopardized. If the department determines there is a reasonable likelihood that federal financial participation is available for expenditures pursuant to this section, it may seek the federal approvals necessary to obtain federal financial participation.

(i) The Legislature finds and declares that the expenditures authorized by paragraph (2) of subdivision (c) are all of the following:

(1) Made in accordance with the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Article 2 (commencing with Section 30121) of Chapter 2 of Part 13 of Division 2 of the Revenue and Taxation Code).

(2) Based on criteria developed and periodically updated as part of the annual budget process in accordance with subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

(3) Consistent with the purposes and conditions for expenditures described in subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

(j) The Legislature finds and declares that this section is a state law within the meaning of Section 1621(d) of Title 8 of the United States Code.

SEC. 7. 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 subdivision (g) and subdivisions (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, pursuant to this section.

(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), and this section shall become inoperative, except that the department and the State Department of Public Health 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) Effective January 1, 2024, this section 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.

(3) Upon the completion of closeout activities, the department shall transfer any funding remaining in the Skilled Nursing Facility Quality and Accountability Special Fund to the General Fund and the Department of Finance may administratively abolish the Skilled Nursing Facility Quality and Accountability Special Fund.

(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. 8. 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 through December 31, 2022, the department may determine a facility ineligible to receive supplemental payments pursuant to Section 14126.022 if a facility fails to provide supplemental data as requested by the department.

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

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

(2) It is the intent of the Legislature that the department develop and implement limited scope audits of key cost centers or categories to assure that the rate paid in the years between each full scope audit required in paragraph (1) accurately reflects actual costs.

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

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

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

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

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

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

SEC. 9. Section 14126.024 is added to the Welfare and Institutions Code, to read:

14126.024. (a) For managed care rating periods that begin between January 1, 2023, and December 31, 2026, inclusive, the department, in consultation with representatives from the long-term care industry, organized labor, consumer advocates, and Medi-Cal managed care plans, shall establish and implement the Workforce and Quality Incentive Program under which a network provider furnishing skilled nursing facility services to a Medi-Cal managed care enrollee may earn performance-based directed payments from the Medi-Cal managed care plan they contract with in accordance with this section.

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

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

(2) For the 2024 through 2026 calendar years, the department shall set the amount of the performance-based directed payments to target the previous calendar year's target plus the annual increase specified by clause (ii) of subparagraph (A) of paragraphs (18), (19), and (20) of subdivision (c) of Section 14126.033.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 10. Section 14126.026 is added to the Welfare and Institutions Code, to read:

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

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

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

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

(d) Notwithstanding any other law, the amount of the assessed sanction, as calculated pursuant to subdivision (b), for a skilled nursing facility may be deducted by the department from any Medi-Cal payments to that facility until the sanction is paid in full. If the department deducts the sanction from the Medi-Cal payments to the facility, the department shall provide prior written notice to the facility, and, in taking into account the financial condition of the facility, may apply that deduction over a period of time.

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

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

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

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

(g) Any sanction collected by the department pursuant to this section shall be deposited into the General Fund, and, upon appropriation by the Legislature, shall be used to improve the quality of skilled nursing facility services under the Medi-Cal

program, and to fund the department's administrative costs associated with implementing the program described in this section.

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

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

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

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

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

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

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

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

(i) Any sanction issued pursuant to this section shall not prohibit any state or federal enforcement action, including, but not limited to, the State Department of Public Health's investigation process or issuance of deficiencies or citations under Chapter 2.4 (commencing with Section 1417) of Division 2 of the Health and Safety Code.

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

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

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

SEC. 11. Section 14126.032 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

SEC. 12. 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 also due to increases in enrollment, which are more pronounced during difficult economic times.

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

(3) The Medi-Cal program delivers its services and benefits to Medi-Cal beneficiaries through a wide variety of health care providers, under multiple delivery systems, including managed care, other contract models, or fee-for-service arrangements.

(4) The setting of rates within the Medi-Cal program is complex and is subject to close supervision by the United States Department of Health and Human Services.

(5) As the single state agency for the Medicaid program in California, the State Department of Health Care Services has unique expertise that can inform decisions that set or adjust reimbursement methodologies and levels consistent with the requirements of federal law.

(b) Therefore, it is the intent of the Legislature for the department to analyze and identify where reimbursement levels can be reduced consistent with the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and federal and state law and policies, including any exemptions contained in the act that added this section, provided that the reductions in reimbursement shall not exceed 10 percent on an aggregate basis for all providers, services, and products.

(c) Subject to an appropriation by the Legislature in the annual Budget Act, this article shall be funded as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) (A) Notwithstanding this section, the payment reductions and adjustments required by paragraph (6) shall be implemented only if the director determines that the payments that result from the application of paragraph (6) shall comply with applicable federal Medicaid requirements and that federal financial participation will be available.

(B) In determining whether federal financial participation is available, the director shall determine whether the payments comply with applicable federal Medicaid requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(C) To the extent that the director determines that the payments do not comply with applicable federal Medicaid requirements or that federal financial participation is unavailable with respect to any payment that is reduced pursuant to this section, the director retains the discretion to not implement the particular payment reduction or adjustment and may adjust the payment as necessary to comply with federal Medicaid requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) (i) Only to the extent any necessary federal approvals are obtained for this subparagraph, the department may condition a facility's receipt of the annual increase in the weighted average Medi-Cal reimbursement rate pursuant to this paragraph for the rate period of August 1, 2020, to December 31, 2020, inclusive, upon that facility's good faith efforts to comply with

any requirements related to the COVID-19 Public Health Emergency described in All Facility Letters issued by the State Department of Public Health. The department shall consult with the State Department of Public Health in determining a facility's compliance for purposes of this subparagraph.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) The workforce standards may include, but need not be limited to, criteria such as maintaining a collective bargaining agreement or comparable, legally binding, written commitment with its direct and indirect care staff, payment of a prevailing wage for its direct and indirect care staff, payment of an average salary above minimum wage, participation in a statewide, multiemployer joint labor-management committee of skilled nursing facility employers and workers, or other factors, as determined by the department in consultation with the stakeholders listed above. The criteria may vary for facilities based on facility demographics or other factors such as facility size, location or other factor, as determined by the department in consultation with the stakeholders listed above.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) If the department determines the facility meets the criteria described in paragraph (17), the facility's rate for the labor cost category shall equal the facility's audited costs within the labor cost category that would have been used for calculating the facility's 2024 calendar year rate had the facility met the criteria in the 2024 calendar year increased by up to 5 percent for each of the 2025 and 2026 calendar years based on audited cost reports trended to the applicable calendar year.

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

(ii) For the 2026 calendar year, for each of the indirect care nonlabor cost, administrative cost, capital cost, and direct passthrough categories as specified in paragraphs (2) through (5), inclusive, of subdivision (a) of Section 14126.023, the facility's rate for those categories shall equal the reimbursement included in the facility's 2025 calendar year rate for those categories increased by an aggregate of 1 percent in the weighted average Medi-Cal reimbursement rate for those categories. Additionally, for the 2026 calendar year, an amount equivalent to the annual aggregate increase of 1 percent calculated pursuant to this clause, as determined by the department, shall be used to supplement the funds available for payments made pursuant to subdivision (a) of Section 14126.024.

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

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

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

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

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

(f) (1) It is the intent of the Legislature that the implementation of this article result in individual access to appropriate long-term care services, quality resident care, decent wages and benefits for nursing home workers, a stable workforce, provider compliance with all applicable state and federal requirements, and administrative efficiency.

(2) Not later than December 1, 2006, the California State Auditor's Office shall conduct an accountability evaluation of the department's progress toward implementing a facility-specific reimbursement system, including a review of data to ensure that the new system is appropriately reimbursing facilities within specified cost categories and a review of the fiscal impact of the new system on the General Fund.

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

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

(B) The staffing levels before the implementation of this article.

(C) The staffing retention rates before the implementation of this article.

(D) The numbers and percentage of freestanding skilled nursing facilities with findings of immediate jeopardy, substandard quality of care, or actual harm, as determined by the certification survey of each freestanding skilled nursing facility conducted before the implementation of this article.

(E) The number of freestanding skilled nursing facilities that received state citations and the number and class of citations issued during calendar year 2004.

(F) The average wage and benefits for employees before the implementation of this article.

(4) Not later than January 1, 2009, the department shall provide a report to the Legislature that does both of the following:

(A) Compares the information required in paragraph (2) to that same information two years after the implementation of this article.

(B) Reports on the extent to which residents who had expressed a preference to return to the community, as provided in Section 1418.81 of the Health and Safety Code, were able to return to the community.

(5) The department may contract for the reports required under this subdivision.

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

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

(B) Applicable minimum wage laws.

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

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

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

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

SEC. 13. Section 14126.036 of the Welfare and Institutions Code is amended to read:

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

SEC. 14. Section 14197.2 of the Welfare and Institutions Code is amended to read:

14197.2. (a) This section implements the state option in subsection (j) of Section 438.8 of Title 42 of the Code of Federal Regulations.

(b) Commencing July 1, 2019, a Medi-Cal managed care plan shall comply with a minimum 85 percent medical loss ratio (MLR) consistent with Section 438.8 of Title 42 of the Code of Federal Regulations. The ratio shall be calculated and reported for each MLR reporting year by the Medi-Cal managed care plan consistent with Section 438.8 of Title 42 of the Code of Federal Regulations.

(c) (1) Effective for contract rating periods commencing on or after July 1, 2023, a Medi-Cal managed care plan shall provide a remittance for an MLR reporting year if the ratio for that MLR reporting year does not meet the minimum MLR standard of 85 percent. The department shall determine the remittance amount on a plan-specific basis for each rating region of the plan and shall calculate the federal and nonfederal share amounts associated with each remittance.

(2) After the department returns the requisite federal share amounts associated with any remittance funds collected in any applicable fiscal year to the federal Centers for Medicare and Medicaid Services, the remaining amounts remitted by a Medi-Cal managed care plan pursuant to this section shall be transferred to the Medi-Cal Loan Repayment Program Special Fund for the purposes of the Medi-Cal Physicians and Dentists Loan Repayment Program as described in Section 14114.

(d) Except as otherwise required under this section, the requirements under this section do not apply to a health care service plan under a subcontract with a Medi-Cal managed care plan to provide covered health care services to Medi-Cal beneficiaries enrolled in the Medi-Cal managed care plan.

(e) The department shall post on its internet website all of the following information:

- (1) The aggregate MLR of all Medi-Cal managed care plans.
- (2) The MLR of each Medi-Cal managed care plan.
- (3) Any required remittances owed by each Medi-Cal managed care plan.

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

(1) "Medical loss ratio (MLR) reporting year" shall have the same meaning as that term is defined in Section 438.8 of Title 42 of the Code of Federal Regulations.

(2) (A) "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

- (i) Article 2.7 (commencing with Section 14087.3).
- (ii) Article 2.8 (commencing with Section 14087.5).
- (iii) Article 2.81 (commencing with Section 14087.96).
- (iv) Article 2.82 (commencing with Section 14087.98).
- (v) Article 2.91 (commencing with Section 14089).

(vi) Article 1 (commencing with Section 14200) of Chapter 8.

(vii) Article 7 (commencing with Section 14490) of Chapter 8.

(B) For purposes of the remittance requirement described in subdivision (c), "Medi-Cal managed care plan" does not include dental managed care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200).

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

SEC. 15. 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.