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CHAPTER 230
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INTRODUCED BY Committee on Budget (Oropeza (Chair), Bermudez, Chan,
Chu, Diaz, Dutra, Dymally, Goldberg, Hancock, Jackson, Liu,
Montanez, Nakano, Pavley, Reyes, Simitian, and Wolk)

MARCH 11, 2003

An act to amend Sections 6254 and 16531.1 of, and to repeal Section 13967 of, the Government Code, to amend Sections 1266, 104465, 104898.5, 120955, 124555, 124710, and 127280.1 of, to amend and repeal Section 1316.5 of, to add Sections 104181.6, 104466, 123853, and 125191 to, to add Article 7.5 (commencing with Section 1324) to Chapter 2 of Division 2 of, and to add Chapter 16 (commencing with Section 121345) to Part 4 of Division 105 of, the Health and Safety Code, to amend Sections 12693.43, 12693.70, 12693.73, 12693.91, 12693.98, 12695.04, 12695.06, 12695.08, 12696.7, 12697, 12698.05, 12698.30, 12699.50, 12699.51, 12699.52, 12699.53, 12699.54, 12699.56, 12699.58, 12699.60, 12699.61, and 12699.62 of, to amend the heading of Part 6.4 (commencing with Section 12699.50) of Division 2 of, to add Section 12693.765 to, to add and repeal Section 12693.275 of, and to repeal Sections 12693.99 and 12698.10 of, the Insurance Code, to amend Section 1026.2 of the Penal Code, to amend Sections 4094.2, 4433, 4512, 4631.5, 4640.6, 4643, 4685.5, 4781.5, 5775, 14011.7, 14019.3, 14105.37, 14124.79, 14126.02, 14132.88, 14154, and 16809 of, to amend and repeal Sections 14005.81 and 14110.65 of, to add Sections 4620.2, 4648.4, 4681.5, 4691.6, 14044, 14087.101, 14087.103, 14087.105, 14105.06, 14105.21, 14105.22, 14105.395, 14105.48, 14105.49, 14105.51, 14105.86, 14124.795, 14132.27, 14159, and 14684.1 to, to add Article 5.5 (commencing with Section 14464.5) to Chapter 8 of Part 3 of Division 9 of, and to add and repeal Section 14105.19 of, the Welfare and Institutions Code, and to repeal

Section 13 of Chapter 9 of the Statutes of the First Extraordinary Session of 2003, relating to health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

Article 7.5. Intermediate Care Facilities' Quality Assurance Fees

1324. For purposes of this article, the following definitions shall apply:

(a) (1) "Gross receipts" means gross receipts paid as compensation for services provided to residents of a designated intermediate care facility.

(2) "Gross receipts" does not mean charitable contributions.

(3) For state and local government owned facilities, "gross receipts" shall include any contributions from government sources or General Fund expenditures for the care of residents of a designated intermediate care facility.

(b) "Eligible facility" means a designated intermediate care facility that has paid the fee as described in Section 1324.2, for a particular state fiscal year.

(c) "Designated intermediate care facility" or "facility" means a facility as defined in subdivision (e), (g), or (h) of Section 1250.

1324.2. (a) As a condition for participation in the Medi-Cal program, there shall be imposed each state fiscal year upon the entire gross receipts of a designated intermediate care facility a quality assurance fee, as calculated in accordance with subdivision (b).

(b) The quality assurance fee to be paid pursuant to subdivision (c) of Section 1324.4 shall be an amount determined each quarter of the state fiscal year by multiplying the facility's gross receipts in the preceding quarter by 6 percent. For reporting purposes, the quality assurance fee is considered to be on a cash basis of accounting.

1324.4. (a) On or before August 31 of each year, each designated intermediate care facility subject to Section 1324.2 shall report to the department, in a prescribed form, the facility's gross receipts for the preceding state fiscal year.

(b) On or before the last day of each calendar quarter, each designated intermediate care facility shall file a report with the department, in a prescribed form, showing the facility's gross receipts for the preceding quarter.

(c) A newly licensed care facility, as defined by the department, shall be exempt from the requirements of subdivision (a) for its year of operation, but shall complete all requirements of subdivision (b) for any portion of the quarter in which it commences operations.

(d) The quality assurance fee, as calculated pursuant to subdivision (b) of Section 1324.2, shall be paid to the department on or before the last day of the quarter following the quarter for which the fee is imposed.

(e) The payment of the quality assurance fee a designated intermediate care facility shall be reported as an allowable cost for Medi-Cal reimbursement purposes.

14105.06. (a) Notwithstanding Section 14105 and any other provision of law, the Medi-Cal reimbursement rates in effect on August 1, 2003, shall remain in effect through July 31, 2005, for the following providers:

(1) Freestanding nursing facilities licensed as any of the following:

(A) A skilled nursing facility pursuant to subdivision (c) of Section 1250 of the Health and Safety Code.

(B) An intermediate care facility pursuant to subdivision (d) of Section 1250 of the Health and Safety Code.

(C) An intermediate care facility for the developmentally disabled pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code.

(2) A skilled nursing facility that is a distinct part of a general acute care hospital. For purposes of this paragraph, "distinct part" shall have the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(3) A subacute care program, as described in Section 14132.25 or subacute care unit, as described in Sections 51215.5 and 51215.8 of Title 22 of the California Code of Regulations.

(4) An adult day health care center.

(b) (1) The director may adopt regulations as are necessary to implement subdivision (a). These regulations shall be adopted as emergency regulations in accordance with the rulemaking provisions of the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For purposes of this section, the adoption of regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare.

(2) As an alternative to paragraph (1), and Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement this article by means of a provider bulletin, or similar instructions, without taking regulatory action.

(c) The director shall implement subdivision (a) in a manner that is consistent with federal medicaid law and regulations. The director shall seek any necessary federal approvals for the implementation of this section. This section shall be implemented only to the extent that federal approval is obtained.

SEC. 70.5. Section 14126.02 of the Welfare and Institutions Code is amended to read:

14126.02. (a) It is the intent of the Legislature to devise a Medi-Cal long-term care reimbursement methodology that more effectively ensures individual access to appropriate long-term care services, promotes quality resident care,

advances decent wages and benefits for nursing home workers, supports provider compliance with all applicable state and federal requirements, and encourages administrative efficiency.

(b) (1) The department shall implement a facility-specific rate-setting system by August 1, 2005, subject to federal approval, that reflects the costs and staffing levels associated with quality of care for residents in nursing facilities, as defined in subdivision (k) of Section 1250 of the Health and Safety Code, which shall include hospital-based nursing facilities.

(2) The department shall examine several alternative rate methodology models for a new Medi-Cal reimbursement system for skilled nursing facilities to include, but not be limited to, consideration of the following:

(A) Classification of residents based on the resource utilization group system or other appropriate acuity classification system.

(B) Facility specific case mix factors.

(C) Direct care labor based factors.

(D) Geographic or regional differences in the cost of operating facilities and providing resident care.

(E) Facility-specific cost based rate models used in other states.

(c) The department shall submit to the Legislature a status report on the implementation of this section on April 1, 2002, April 1, 2003, and April 1, 2004.

(d) The alternatives for a new system described in paragraph (2) of subdivision (b) shall be developed in consultation with recognized experts with experience in long-term care reimbursement, economists, the Attorney General, the federal Centers for Medicare and Medicaid Services, and other interested parties.

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