

Assembly Bill No. 203

CHAPTER 188

An act to add Section 13343 to the Government Code, to amend Sections 1250.8, 1266, 1279, 1280.1, 1280.3, 1324.21, 1324.23, 1324.28, 1324.29, 1324.30, 1422, 101317, 101320, 120955, 124910, 124977, and 130542 of, and to add Section 1204.5 to, the Health and Safety Code, to amend and repeal Section 12693.981 of the Insurance Code, to amend Sections 4640.6, 4643, 4648.4, 4681.5, 4691.6, 4781.5, 10020, 10022, 10024, 14011.6, 14043.1, 14043.15, 14043.2, 14043.26, 14043.27, 14043.28, 14043.36, 14043.46, 14043.47, 14043.61, 14043.62, 14043.65, 14043.7, 14087.305, 14087.5, 14088, 14088.14, 14088.25, 14089, 14091.21, 14100.95, 14105.2, 14105.3, 14105.45, 14105.47, 14105.8, 14105.85, 14110, 14124.70, 14124.76, 14124.78, 14124.89, 14124.90, 14124.94, 14125, 14125.2, 14125.8, 14126.027, 14126.033, 14132.100, 14134.5, 14166.4, 14199.2, 14199.3, 14464.5, 14495.10, 14499.5, 16809, and 24005 of, to add Sections 4474.4, 4474.5, 4474.8, 4781.6, 14011.65b, 14105.475, 14124.785, 14124.792, and 14301.1 to, to amend and repeal Section 14262 of, and to repeal and add Section 14043.45 of, the Welfare and Institutions Code, relating to health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

This subdivision shall also apply to violation of regulations set forth in Article 3 (commencing with Section 127400) of Chapter 2 of Part 2 of Division 107 or the rules and regulations promulgated thereunder.

The department shall promulgate regulations establishing the criteria to assess an administrative penalty against a health facility licensed pursuant to subdivisions (a), (b), or (f) of Section 1250. The criteria shall include, but need not be limited to, the following:

- (1) The patient's physical and mental condition.
 - (2) The probability and severity of the risk that the violation presents to the patient.
 - (3) The actual financial harm to patients, if any.
 - (4) The nature, scope, and severity of the violation.
 - (5) The facility's history of compliance with related state and federal statutes and regulations.
 - (6) Factors beyond the facility's control that restrict the facility's ability to comply with this chapter or the rules and regulations promulgated thereunder.
 - (7) The demonstrated willfulness of the violation.
 - (8) The extent to which the facility detected the violation and took steps to immediately correct the violation and prevent the violation from recurring.
- (c) The department shall not assess an administrative penalty for minor violations.
- (d) The regulations shall not change the definition of immediate jeopardy as established in this section.
- (e) The regulations shall apply only to incidents occurring on or after the effective date of the regulations.

(f) If the licensee disputes a determination by the department regarding the alleged deficiency or alleged failure to correct a deficiency, or regarding the reasonableness of the proposed deadline for correction or the amount of the penalty, the licensee may, within 10 working days, request a hearing pursuant to Section 100171. Penalties shall be paid when all appeals have been exhausted and the department's position has been upheld.

(g) Moneys collected by the department as a result of administrative penalties imposed under this section and Section 1280.1 shall be deposited into the Licensing and Certification Program Fund established pursuant to Section 1266.9. These moneys shall be tracked and available for expenditure, upon appropriation by the Legislature, to support internal departmental quality improvement activities.

(h) For purposes of this section, "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient.

SEC. 8. Section 1324.21 of the Health and Safety Code is amended to read:

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

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

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

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

(2) For the rate year 2005–06 and subsequent rate years through and including the 2008–09 rate year, the net revenue shall be projected for all skilled nursing facilities subject to the uniform quality assurance fee. The projection of net revenue shall be based on the prior rate year's data. Once determined, the aggregate projected net revenue for all facilities shall be multiplied by 6 percent, as determined under the approved methodology, and then divided by the projected total resident days of all providers subject to the fee. The amounts so determined shall be subject to the provisions of subdivision (d).

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

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

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

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

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

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

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

SEC. 9. Section 1324.23 of the Health and Safety Code is amended to read:

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

(b) The director may adopt regulations as are necessary to implement this article. These regulations may 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 article, 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. The regulations shall include, but need not be limited to, any regulations necessary for any of the following purposes:

(1) The administration of this article, including the proper imposition and collection of the quality assurance fee not to exceed amounts reasonably necessary for purposes of this article.

(2) The development of any forms necessary to obtain required information from facilities subject to the quality assurance fee.

(3) To provide details, definitions, formulas, and other requirements.

(c) As an alternative to subdivision (b), and notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement this article, in whole or in part, by means of a provider bulletin, or other similar instructions, without taking regulatory action, provided that no such bulletin or other similar instructions shall remain in effect after July 31, 2008. It is the intent of the Legislature that the regulations adopted pursuant to subdivision (b) shall be adopted on or before July 31, 2008.

SEC. 10. Section 1324.28 of the Health and Safety Code is amended to read:

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

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

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

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

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

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

(3) The state has continued its maintenance of effort for the level of state funding of nursing facility reimbursement for rate year 2005–06, and for every subsequent rate year continuing through the 2008–09 rate year, in an amount not less than the amount that specific facilities would have received under the rate methodology in effect on July 31, 2004, plus Medi-Cal's projected proportional costs for new state or federal mandates, not including the quality assurance fee.

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

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

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

SEC. 11. Section 1324.29 of the Health and Safety Code is amended to read:

1324.29. The quality assurance fee shall cease to be assessed and collected on or after July 31, 2009.

SEC. 12. Section 1324.30 of the Health and Safety Code is amended to read:

1324.30. This article shall become inoperative on July 31, 2009, and, as of January 1, 2010, is repealed, unless a later enacted statute, that becomes operative on or before

January 1, 2010, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 13. Section 1422 of the Health and Safety Code, as amended by Section 6 of Chapter 895 of the Statutes of 2006, is amended to read:

1422. (a) The Legislature finds and declares that it is the public policy of this state to ensure that long-term health care facilities provide the highest level of care possible. The Legislature further finds that inspections are the most effective means of furthering this policy. It is not the intent of the Legislature by the amendment of subdivision (b) enacted by Chapter 1595 of the Statutes of 1982 to reduce in any way the resources available to the state department for inspections, but rather to provide the state department with the greatest flexibility to concentrate its resources where they can be most effective. It is the intent of the Legislature to create a survey process that includes state-based survey components and that determines compliance with federal and California requirements for certified long-term health care facilities. It is the further intent of the Legislature to execute this inspection in the form of a single survey process, to the extent that this is possible and permitted under federal law.

The inability of the state to conduct a single survey in no way exempts the state from the requirement under this section that state-based components be inspected in long-term health care facilities as required by law.

(b) (1) (A) Notwithstanding Section 1279 or any other provision of law, without providing notice of these inspections, the department, in addition to any inspections conducted pursuant to complaints filed pursuant to Section 1419, shall conduct inspections annually, except with regard to those facilities which have no class "AA," class "A," or class "B" violations in the past 12 months. The state department shall also conduct inspections as may be necessary to ensure the health, safety, and security of patients in long-term health care facilities. Every facility shall be inspected at least once every two years. The department shall vary the cycle in which inspections of long-term health care facilities are conducted to reduce the predictability of the inspections.

(B) Inspections and investigations of long-term health care facilities that are certified by the Medicare Program or the Medicaid investors, disclosure of all manufacturers, suppliers, and providers currently doing business with the applicant, and disclosure of all entities to whom the applicant has extended a line of credit.

(5) A statement certifying that all information supplied pursuant to this section is accurate.

(b) A Medi-Cal provider of incontinence supplies shall not submit a claim for goods or services to the department prior to the date the goods or services are delivered to the Medi-Cal beneficiary. The date of delivery to a beneficiary shall be the earlier of the date the beneficiary actually received the goods or services, or the date the goods were posted or otherwise dispatched from the provider's premises and control. A claim submitted to the department prior to the date of delivery shall not be paid. Violation of this subdivision shall be grounds for expulsion from the Medi-Cal program.

(c) The department may implement a 180-day moratorium on the enrollment of new providers or new business addresses for incontinence medical supply dealers when the

department determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program.

SEC. 81. Section 14126.027 of the Welfare and Institutions Code is amended to read: 14126.027. (a) (1) The Director of Health Services, or his or her designee, shall administer this article.

(2) The regulations and other similar instructions adopted pursuant to this article shall be developed in consultation with representatives of the long-term care industry, organized labor, seniors, and consumers.

(b) (1) The director may adopt regulations as are necessary to implement this article. The adoption, amendment, repeal, or readoption of a regulation authorized by this section is deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe specific facts showing the need for immediate action.

(2) The regulations adopted pursuant to this section may include, but need not be limited to, any regulations necessary for any of the following purposes:

(A) The administration of this article, including the specific analytical process for the proper determination of long-term care rates.

(B) The development of any forms necessary to obtain required cost data and other information from facilities subject to the ratesetting methodology.

(C) To provide details, definitions, formulas, and other requirements.

(c) As an alternative to the adoption of regulations pursuant to subdivision

(b), and notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement this article, in whole or in part, by means of a provider bulletin or other similar instructions, without taking regulatory action, provided that no such bulletin or other similar instructions shall remain in effect after July 31, 2008. It is the intent that regulations adopted pursuant to subdivision (b) shall be in place on or before July 31, 2008.

SEC. 82. Section 14126.033 of the Welfare and Institutions Code is amended to read:

14126.033. (a) This article, including Section 14126.031, 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 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) To the extent that new rates are projected to exceed the adjusted limits calculated pursuant to subparagraph (A) or (B), the department shall adjust the increase to each skilled nursing facility's projected rate for the applicable rate year by an equal percentage.

(b) The rate methodology shall cease to be implemented on and after July 31, 2009.

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

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

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

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

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

(C) The staffing retention rates prior to 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 prior to 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 prior to 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.

(d) This section shall become inoperative on July 31, 2009, and as of January 1, 2010, is repealed, unless a later enacted statute, that is enacted before January 1, 2010, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 83. Section 14132.100 of the Welfare and Institutions Code is amended to read:

14132.100. (a) The federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d (a)(2)(B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accord with the definition of "visit" set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1, thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to January 1, 2004, FQHC and RHC per-visit rates shall be adjusted by the Medicare Economic Index in accord with the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC. Rate changes based on a change in the scope of services provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.