Assembly Bill No. ABX4 5
CHAPTER 5
An act to add Section 293 to the Financial Code, to amend Sections 1250, 1265.5, 1266, 1275.3, 1324.20, 1326, 1337, 1418, 1567.50, 104820, 105250,
116565, 125175, 130500, 130507, 130509, and 130543 of, to amend and repeal Section 125165 of, and to add Sections 125155.1, 125157, and 125166
to, the Health and Safety Code, to amend Section 12739 of the Insurance Code, and to amend Sections 4107, 4684.60, 4684.74, 4684.75, 7502.5,
14005.40, 14007.9, 14011.2, 14087.9, 14105.191, 14105.436, 14105.45, 14110.55, 14126.033, 14132, 14132.951, 14166.20, 14166.225, 14166.23,
14166.245, 14495.10, and 14526.1 of, to add Sections 5783, 14005.50, 14013.5, 14105.455, 14105.46, 14132.20, 14132.952, 14166.115, 14522.4,
14525.1, 14526.2, and 14550.6 to, and to repeal Section 14522.3, 14526.1, and 14550.5 of, the Welfare and Institutions Code, relating to health, and
declaring the urgency thereof, to take effect immediately. [Approved by Governor July 28, 2009. Filed with Secretary of State July 28, 2009.]

Existing law, as long as prescribed conditions are met, provides for the imposition of a uniform quality assurance fee on skilled nursing facilities, subject to prescribed exemptions, to be administered by the Director of Health Care Services and deposited in the State Treasury to be available to enhance federal financial participation in the Medi-Cal program or to provide additional reimbursement to, and support facility quality improvement efforts in, licensed skilled nursing facilities. Existing law provides that the 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. Existing law defines “net revenue” to mean gross resident revenue for routine nursing services and ancillary services provided to all residents by a skilled nursing facility, less Medicare revenue for routine and ancillary services, including Medicare revenue for services provided to residents covered under a Medicare managed care plan, less payer discounts and applicable contractual allowances as permitted under federal law and regulation.
This bill would, for the 2009–10 and 2010–11 rate years, and subject to federal approval, also include within the definition of “net revenue” Medicare revenue for routine and ancillary services and Medicare revenue for services provided to residents covered under a Medicare managed care plan.

Existing law, the Medi-Cal Long-Term Reimbursement Act, requires the department to implement a cost-based reimbursement rate methodology for freestanding skilled nursing facilities, excluding skilled nursing facilities that are a distinct part of a facility that is licensed as a general acute care hospital. Reimbursement rates for these facilities are funded by a combination of federal funds and moneys collected pursuant to the above-described uniform quality assurance fees. Existing law provides that this rate methodology shall cease to be implemented on July 31, 2011, with these provisions to be repealed on January 1, 2012. Existing law provides, for the 2009–10 and 2010–11 rate years, that the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for purposes of the above-described provisions shall not exceed 5% of the weighted average Medi-Cal reimbursement rate for the prior fiscal year.

This bill would, instead, provide that for the 2009–10 and 2010–11 rate years, the weighted average Medi-Cal reimbursement rate required for purposes of the above-described provisions shall not be increased with respect to the weighted average Medi-Cal reimbursement rate for the 2008–09 rate year.

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

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

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

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

(2) Notwithstanding paragraph (1), for the 2009–10 and 2010–11 rate years, “net revenue” means gross resident revenue for routine nursing services and ancillary services provided to all residents by a skilled nursing facility, including Medicare revenue for routine and ancillary services and Medicare revenue for services provided to residents covered under a

Medicare managed care plan, less payer discounts and applicable contractual allowances as permitted under federal law and regulation. To implement this paragraph, the department shall request federal approval pursuant to Section 1324.27.
(3) “Net revenue” does not mean charitable contributions and bad debt.
(d) “Payer discounts and contractual allowances” means the difference between the facility’s resident charges for routine or ancillary services and the actual amount paid.
(e) “Skilled nursing facility” means a licensed facility as defined in subdivision (c) of Section 1250.
SEC. 42. 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 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 and 2010–11 rate years, 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.

(E) To the extent that new rates are projected to exceed the adjusted limits calculated pursuant to subparagraphs (A) to (D), inclusive, as applicable, the department shall adjust 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, 2011.
(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, 2011, and as of January 1, 2012, is repealed, unless a later enacted statute, that is enacted before January 1, 2012, deletes or extends the dates on which it becomes inoperative and is repealed.