

MEDI-CAL SKILLED NURSING FACILITY VALUE STRATEGY

Landscape Analysis Report

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

MEDI-CAL SKILLED NURSING FACILITY VALUE STRATEGY LANDSCAPE ANALYSIS REPORT

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CHAPTER I:
MEDI-CAL'S CURRENT PAYMENT AND RATE METHODOLOGY

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The California Department of Health Care Services (DHCS) is developing a Medi-Cal Skilled Nursing Facility (SNF) Value Strategy to guide the reauthorization of the Medi-Cal Long-Term Care (LTC) Reimbursement Act and govern the Medi-Cal payment framework for SNFs in the state. DHCS, with support from contractors Mathematica and Myers and Stauffer, developed this Landscape Analysis to (1) provide an overview of Medi-Cal's current and historical SNF payment and incentive policies and (2) summarize relevant policy and clinical literature, including existing payment models, workforce initiatives, and quality incentive programs used by Medicare, other state Medicaid programs, and other payors.

This Landscape Analysis includes chapters about the following topics: (1) a national scan of SNF payment methodologies; (2) workforce, capacity, staffing, and sustainability; (3) quality measurement, oversight, and performance; (4) care transitions, access, and whole person care; and (5) behavioral health capacity, integration, and payment in SNFs. This chapter serves as an introduction to the Landscape Analysis and describes Medi-Cal's current payment and rate methodology.

Overview of SNF Value Strategy

In California, the financing framework for freestanding level-B SNFs (FS/SNF-Bs)[1] is governed by the Medi-Cal LTC Reimbursement Act (Welfare & Institutions Code [WIC] 14126, et seq.). The Medi-Cal LTC Reimbursement Act was first enacted in 2004 via Assembly Bill (AB) 1629, which established the current cost-based reimbursement method for FS/SNF-Bs in California. The Act has been amended several times, most recently in 2022 by AB 186, which authorized the current financing framework through December 31, 2026. The current SNF financing framework was extended by Senate Bill (SB) 165, effective January 1, 2027, through December 31, 2027. DHCS is developing a comprehensive value strategy for Medi-Cal SNF services to inform the subsequent reauthorization of the Medi-Cal LTC Reimbursement Act, which will affect dates of service on or after January 1, 2028.

[1] Please see page 11 for other LTC provider types.

DHCS initiatives to support LTSS access and quality under CalAIM

The SNF Value Strategy fits into DHCS' larger efforts to improve access to and quality of long-term services and supports (LTSS) for Medi-Cal members, including initiatives that emphasize whole person care and the delivery of these services in appropriate settings. Beginning in January 2022, DHCS initiated a systemwide transformation of Medi-Cal, including delivery system, program, and payment reforms, referred to as the California Advancing and Innovating Medi-Cal (CalAIM). Building on prior Section 1115 demonstrations and related pilot programs of Whole Person Care and Health Home Programs, DHCS is working to standardize services across the state, hold managed care plans (MCPs) accountable to better coordinate care for people with LTC needs, and increase access to community-based options for these individuals.

Two CalAIM initiatives that have implications for people with LTC needs are (1) the shifting of responsibility of payment for institutional LTC to MCPs and (2) the creation of a menu of "in lieu of services," called Community Supports, which MCPs can use as community-based alternatives to more costly care, including institutional LTC.[2]

Integration of institutional LTC into managed care

As of January 1, 2023, all Medi-Cal MCPs in California are responsible for providing institutional LTC benefits across SNFs, including freestanding and distinct part SNFs. On January 1, 2024, Medi-Cal MCPs became responsible for providing institutional LTC benefits in intermediate care facilities for the developmentally disabled, as well as for adult and pediatric subacute care.[3] Before 2023, SNF benefits were provided under managed care in only 27 counties.[4]

This LTC integration (1) allows for the standardization of LTC coverage across MCPs statewide; (2) advances a more consistent, seamless, and integrated system of managed care that reduces complexity and increases flexibility; (3) increases access to comprehensive care coordination, care management, and a broad array of services for Medi-Cal members in LTC facilities; and (4) enables a more seamless transition for LTC

[2] For more information on Community Supports and their availability and use statewide, see Chapter 5.
[3] For more information about the CalAIM LTC carve-in, please visit the transition page at https://www.dhcs.ca.gov/provgovpart/Pages/Long-Term-Care-Carve-In-Transition.aspx.
[4] For more information about this transition, please see All Plan Letter 23-009: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-009.pdf.

members across settings, with no disruption in access to care.[5] Furthermore, because MCPs are responsible for the coverage of other Medi-Cal services (including physical and behavioral health services), institutional LTC services can now be better coordinated with those benefits, and managed care plans have the tools and incentives to more effectively coordinate services for people across settings.

As part of the LTC integration, DHCS implemented state-directed payments (SDPs) that established county-specific fee schedule requirements. In the 31 counties that had LTC services newly carved into managed care, MCPs must reimburse at the exact Medi-Cal fee-for-service per diem rate. In the 27 counties that previously had LTC carved into managed care, MCPs must reimburse no less than the fee-for-service rate and may negotiate higher rates.[6]

Availability of Community Supports to help people receiving or in need of LTSS

A central feature of CalAIM was the introduction of Enhanced Care Management (ECM) and 15 Community Supports. ECM is a care management benefit designed for people with the highest need on the care management continuum, and it can be used to serve people in specific populations of focus. Community Supports are services that, at the option of MCPs, can be made available to qualifying Medi-Cal members in place of more costly service options.

ECM and Community Supports are separate initiatives—and people can receive Community Supports without enrolling in ECM—but DHCS has encouraged MCPs to connect Medi-Cal members receiving ECM with related Community Supports, including nursing facility diversion services and environmental accessibility adaptations. Thus, Community Supports are an important tool that MCPs can use to prevent unnecessary institutionalization and to transition people from institutional to community-based settings.[7]

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[5] For more information, please visit the CalAIM SNF LTC integration transition page: https://www.dhcs.ca.gov/provgovpart/Pages/SNF-Carve-In-.aspx.

[6] The list of counties that fall into each of these categories can be found in All-Plan Letter 24-009: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-009.pdf.

[7] Two populations of focus eligible for ECM are adult nursing facility residents transitioning to the community and adults living in the community and at risk for LTC institutionalization. As an alternative to more costly institutional care, MCPs may offer a variety of Community Supports to people in these populations, including community transition services or nursing facility

SNF Value Strategy guiding principles

The upcoming renewal of the Medi-Cal LTC Reimbursement Act provides a historic opportunity to continue building on these CalAIM initiatives to support LTSS access and quality, as well as recent efforts in nursing facility finance reform. DHCS has articulated six guiding principles for the SNF Value Strategy, which were refined with input from the stakeholder community:

1. **Whole person care and care coordination:** Coordinating and integrating care throughout the Medi-Cal managed care and specialty behavioral health delivery systems to provide whole person care to members with institutional level-of-care needs and support the development of comprehensive managed long-term services and supports (MLTSS).
2. **Quality accountability and incentives:** Holding SNFs accountable for providing quality resident care and incentivizing quality improvement in alignment with and furtherance of DHCS' Comprehensive Quality Strategy.[8]
3. **Care transitions and financial alignment:** Creating financial incentives for the delivery of care in the right setting, including appropriate transitions from hospital settings to SNFs and from SNFs to home and community-based services (HCBS) settings.
4. **Workforce investment and accountability:** Emphasizing the critical role of workforce as a key driver of quality resident care and holding facilities accountable for using Medi-Cal funds to provide fair compensation and benefits to workers.
5. **Financial sustainability and efficiency:** Provisioning services economically and efficiently to support the financial sustainability and affordability of California's health care system.
6. **Access and system integrity:** Supporting adequate access to SNF care, including in rural areas, and removing perverse incentives in resident admissions, transfers, and discharges.

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transitions to a home; nursing facility transitions or diversions to assisted living facilities, such as residential care facilities for the elderly and adult residential facilities; medically tailored meals or medically supportive food; environmental accessibility adaptations (home modifications); respite services; and personal care and homemaker services. More information can be found in DHCS' ECM Policy Guide: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf.

[8] More information about DHCS' Comprehensive Quality Strategy is available at https://www.dhcs.ca.gov/services/Pages/DHCS-Comprehensive-Quality-Strategy.aspx.

Current approach to Medi-Cal SNF payment

Historic review of base rates and statutory requirements

Several statutory milestones have shaped California's current SNF financing methodology (See **Exhibit 1.1**). Medi-Cal began covering nursing facility services in 1967, authorizing reimbursement for long-term stay residents. At that time, the program was focused primarily on establishing access to institutional LTC for people who needed ongoing support. In 1985, California enacted the Nursing Home Patient Protections Act.[9] This legislation focused on strengthening oversight and quality through improvements in training for nursing facility inspectors, the development of resident councils, and increased attention to wages and staffing in Medi-Cal facilities. Though the program continued to use a flat-rate methodology based on geography and bed size, this legislation reflected an early shift toward linking reimbursement policy with quality and resident protections.

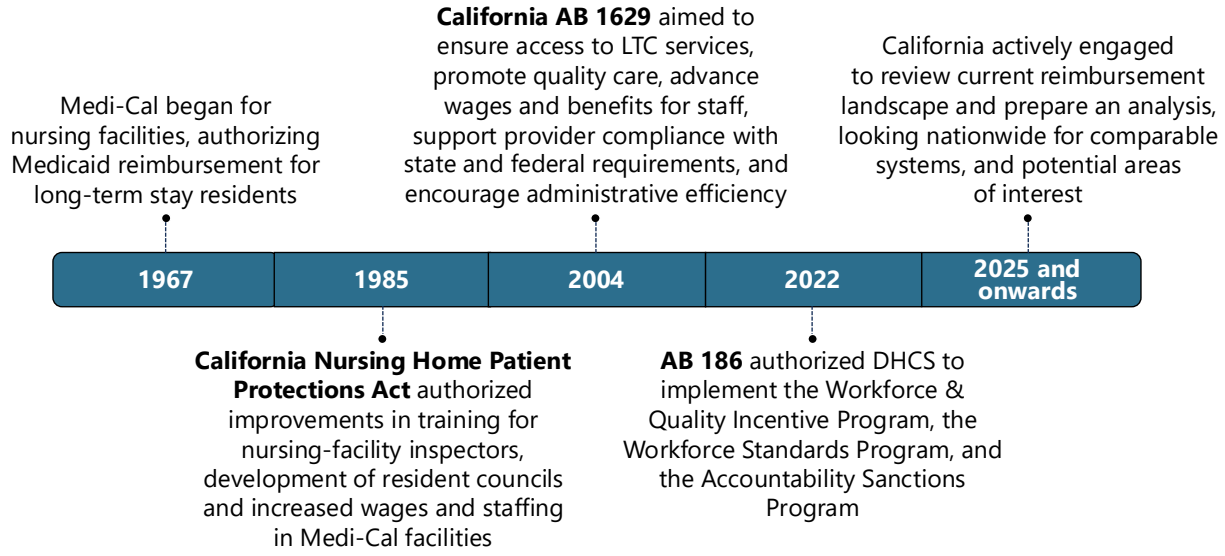
In 2004, California passed AB 1629,[10] which represented a major restructuring of the reimbursement framework for Medi-Cal nursing facilities. AB 1629 sought to ensure access to LTC, promote quality care, advance wages and benefits for staff, support provider compliance with state and federal requirements, and encourage administrative efficiency. This legislation established California's current cost-based payment methodology. In 2022, AB 186 authorized workforce and quality-focused programs, including the Workforce & Quality Incentive Program (WQIP), the Workforce Standards Program (WSP), and the Accountability Sanctions Program (ASP).[11] These three programs work together to (1) incentivize and hold facilities accountable for quality resident care, (2) emphasize the critical role of the workforce, (3) balance the distribution of annual rate increases, and (4) result in the long-term financial viability of facilities in the Medi-Cal managed care environment.[12]

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[9] Senate Bill 53 (Chapter 11) and AB 180 (Chapter 10), 1985.
[10] California Health & Safety Code, § 128735 and 128740 (Frommer, Chapter 875, Statutes of 2004).
[11] California Welfare and Institutions Code, § 14126.022 (House Budget Committee, Chapter 46, Statutes of 2022).
[12] More information about these programs is available at https://www.dhcs.ca.gov/services/medi-cal/Pages/Nursing-Facility-Financing-Reform-AB-186.aspx. WQIP was discontinued on December 31, 2025, pursuant to the 2025 Budget Act. DHCS remains interested in models that incentivize SNF workforce and quality improvement in future payment models.

The payment system now operates within the CalAIM framework, including the statewide managed care integration of institutional LTC services in 2023 (regulated by WIC § 14184.201 et seq.).

Exhibit 1.1. Timeline of Medi-Cal nursing facility reimbursement



Current methodology for calculating Medi-Cal SNF payment base rates

To pay FS/SNF-Bs and freestanding adult subacute level-B facilities (FS/SAs),13 Medi-Cal uses a cost-based, facility-specific per diem rate methodology that is updated each calendar year.14 Under this model, there are over 1,000 facility-specific rates based on each facility's average audited daily costs, subject to various cost and growth caps. Facilities receive published, facility-specific per diem rates until new calendar-year rates are published. Annual policy letters and rate tables specify the finalized per diem for each facility for the coming calendar year. Exhibit 1.2 showcases the minimum, maximum, and percentiles for total rates (inclusive of WSP and QAF) in rate year 2026 by FS/SNF-Bs and FS/SAs.

[13] See Appendix A for full definitions of provider types.

[14] The methodology and annual rate publication are implemented pursuant to Supplement 4 of Attachment 4.19-D of the California Medicaid State Plan, available at https://www.dhcs.ca.gov/formsandpubs/laws/Pages/Attachment419-D.aspx.

Exhibit 1.2. Rate year 2026 total enhanced rates by peer group

Facility Type	Min	25th Percentile	50th Percentile	75th Percentile	Max
Statewide FS/SNF-B	$168.84	$262.36	$284.61	$315.98	$526.48
Statewide FS/SA	$408.33	$547.74	$591.24	$631.63	$767.88

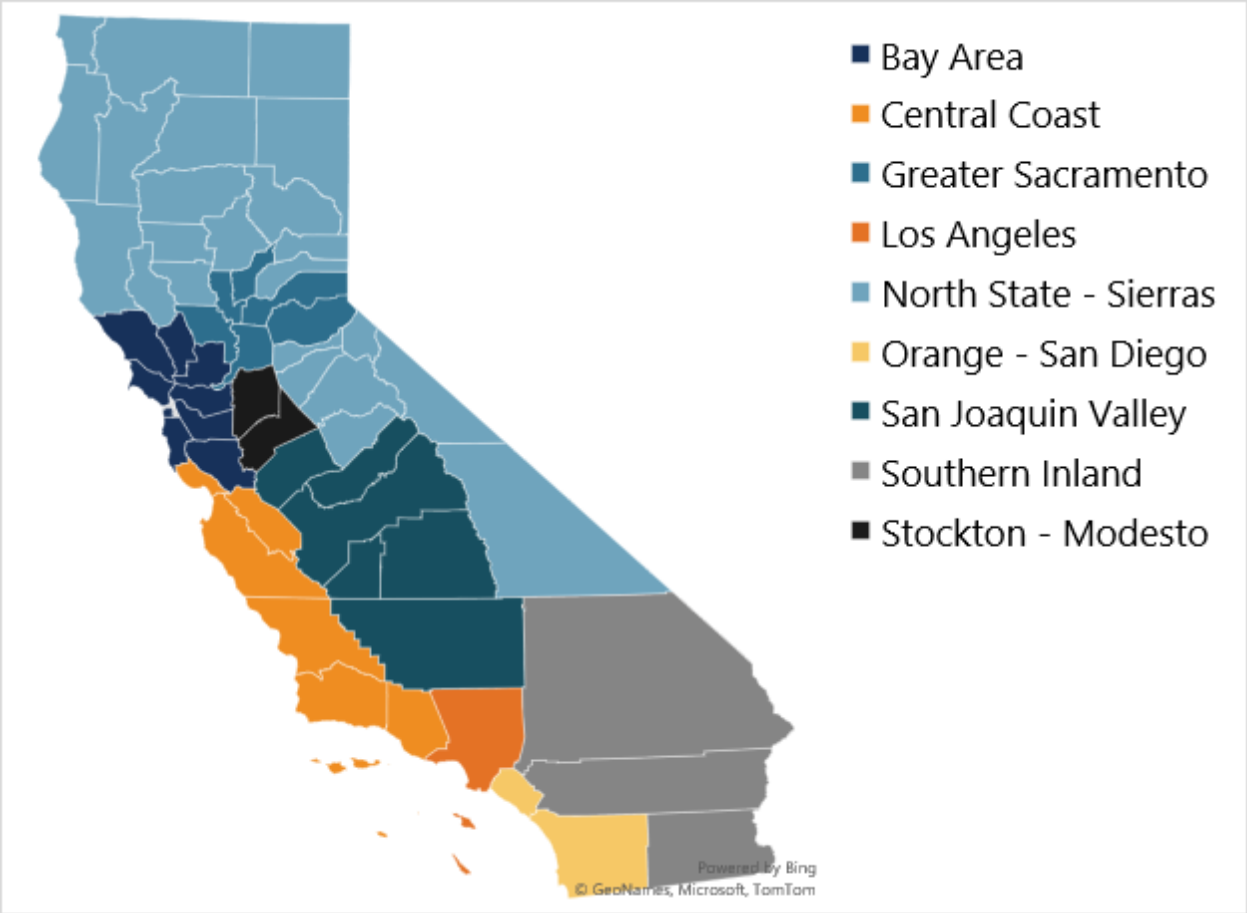
Source: Rates are inclusive of WSP and QAF add-ons and are calculated using the California FS/SNF-B rate studies found here: https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx.

The base per diem rate is calculated from allowable facility costs reported in cost reports and includes the elements permitted by the Medicaid State Plan and implementation guidance, such as direct and indirect labor and nonlabor costs, administration costs, professional liability insurance costs, licensing fees, capital costs using the fair rental value system (FRVS),[15] and various add-ons and adjustments.[16] For example, rates may be adjusted—or penalties and supplemental payments applied—according to facility performance in Medi-Cal's quality programs including WQIP, WSP, and ASP. Medi-Cal uses peer groups (categorized by geography, see **Exhibit 1.3**) to establish normative cost limits in rate calculations, ensuring cost-based rates or median cost caps reflect nuances such as geographic area and provider type (such as subacute or distinct part).

[15] The FRVS assigns an estimated rental value to facilities based on the effective age of the facility (which is determined via several criteria, such as major renovations or equipment replacements). This value is a component of the reimbursement rate that is intended to reimburse SNFs for their capital costs.

[16] The most recent LTC rate studies for all freestanding SNFs can be found at https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx.

Exhibit 1.3. FS/SNF-B peer groups by county



Rates typically do not vary by resident acuity[17] within a facility, except when the facility operates a distinct part subacute unit or behavioral health special treatment program. Nursing facilities that operate as a distinct part of a hospital unit (known as distinct part nursing facilities and distinct part adult subacute units) and pediatric subacute units (freestanding pediatric subacute units and distinct part pediatric subacute units)[18] operate under similar but distinct rate-setting methodologies.

Current Medi-Cal SNF base rate methodological details

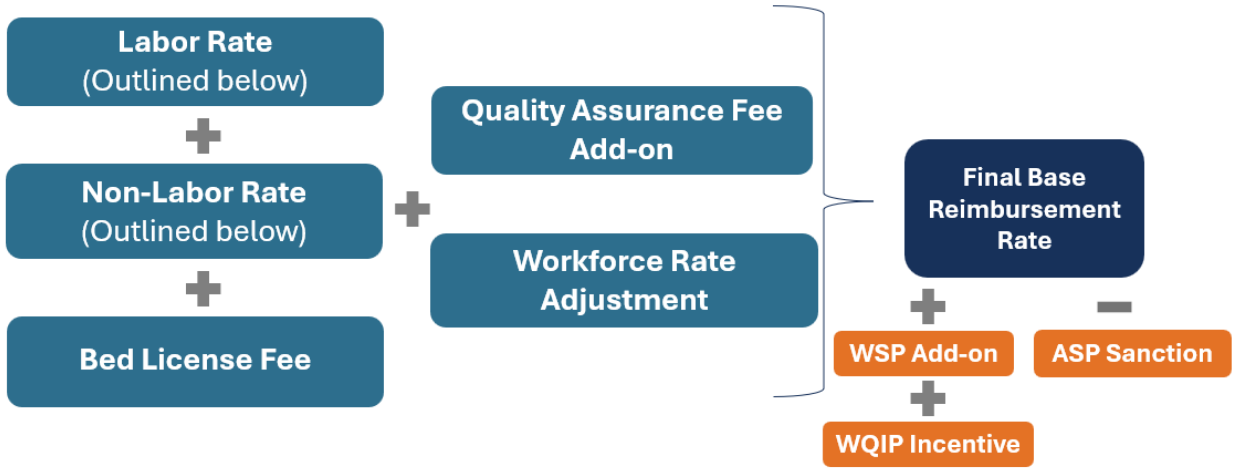
Medi-Cal uses peer groups (categories of providers grouped by geography) to establish normative cost limits in rate calculations and ensure cost-based rates or median cost caps reflect nuances such as geographic area and provider type (such as subacute or

[17] Acuity is a measure of how clinically complex a resident is, which can influence the resources needed to care for them.

[18] See **Appendix A** for the full definitions of provider types.

distinct part). Using the peer groups, DHCS ranks facilities based on allowable per diem costs by category (such as for direct care, indirect care, or administrative costs) from highest to lowest and identifies a percentile at which Medi-Cal reimbursement cannot exceed for that cost type. Currently, direct care reimbursement is limited to the 95th percentile of each peer group,[19] indirect care reimbursement is limited to the 75th percentile of each peer group, and administrative reimbursement is limited to the 50th percentile of each peer group.

Exhibit 1.4. Calculating the Medi-Cal FS/SNF-B payment



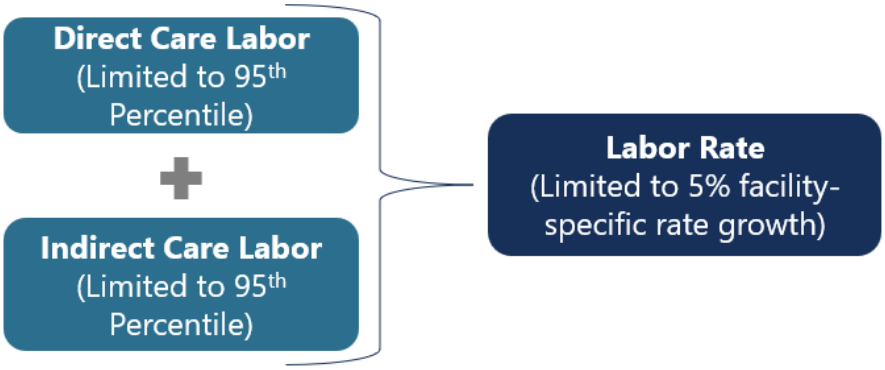
The final Medi-Cal base payment rate for a FS/SNF-B is a combination of the labor rate, the nonlabor rate, the bed license fee, any Quality Assurance Fee (QAF)20 add-ons, and a WSP rate adjustment, if applicable.

The final Medi-Cal payment for a FS/SNF-B is a combination of the base reimbursement rate with any WSP rate add-ons and any retrospective WQIP incentive payments minus any ASP sanctions (**Exhibit 1.4**).

[19] For example, for direct care costs, 95 percent of facilities' allowable direct care costs (in each peer group) will fall below the percentile. For the 5 percent of facilities whose allowable direct care costs exceed the percentile, their reimbursement will be capped at the 95th percentile, even when all of their costs were allowable.

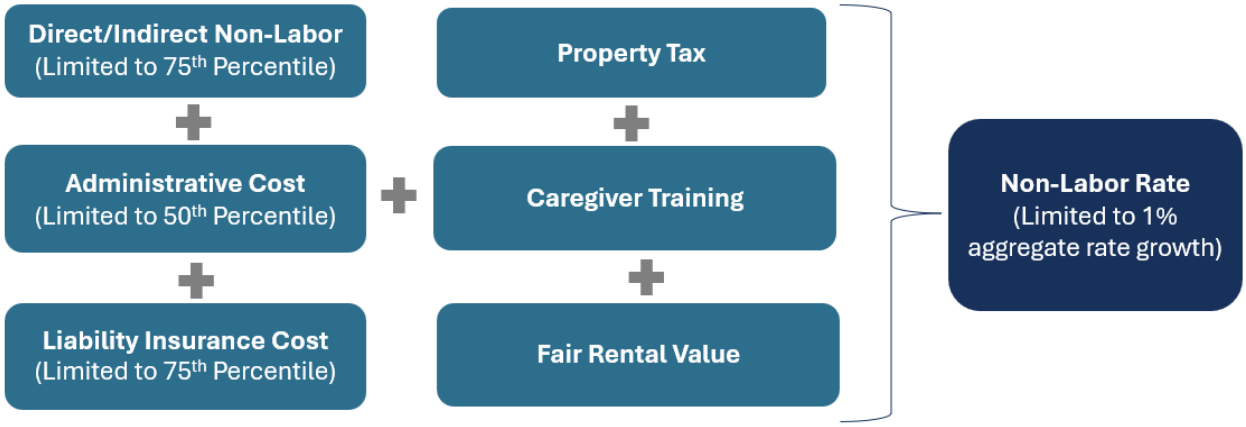
[20] The QAF is a provider assessment imposed on certain skilled nursing facilities and is used as the nonfederal share necessary to obtain federal financial participation (FFP) under Medicaid. By leveraging federal Medicaid matching funds, the SNF QAF supports Medi-Cal reimbursement and quality-related payments. The QAF functions as an add-on to the base reimbursement rate and is incorporated directly into the Medi-Cal SNF payment methodology.

Exhibit 1.5. Calculating the Medi-Cal FS/SNF-B rate: Labor rate component



The labor rate component for a FS/SNF-B is calculated by the labor costs of direct care and indirect care (limited to the 95th percentile for each) and is limited to a 5 percent facility-specific growth rate year over year (**Exhibit 1.5**).[21]

Exhibit 1.6. Calculating the Medi-Cal FS/SNF-B rate: Nonlabor rate component



The nonlabor rate component for a FS/SNF-B is calculated by the costs of indirect/directed labor (limited to the 75th percentile), administration (limited to the 50th percentile), liability insurance (limited to the 75th percentile), property tax, caregiving training, and the FRVS, and is capped to a 1 percent facility-specific growth rate year over year (**Exhibit 1.6**).

[21] More simply, if a FS/SNF-B's labor rate changes by more than 5 percent of the labor rate from their prior year, the extra reimbursement is not recognized for rate-setting purposes. Therefore, each facility has its own base, and its own 5 percent ceiling.

Distinct provider types and rate methodology variations

While the rate calculation process described above applies to FS/SNF-Bs, which represent the majority of Medi-Cal SNF beds, several other provider types operate under similar but distinct rate-setting methodologies. Understanding these variations is important for a complete picture of the Medi-Cal payment landscape.

Nursing Facilities Level A (NF-As) are facilities that do not provide skilled nursing care or participate in the Medicare program. These facilities were also historically referred to as "intermediate care facilities" (but are separate from Intermediate Care Facilities for the Developmentally Disabled described below). A small number of NF-As are licensed in California. NF-As are organized into three peer groups but their rates are not updated using an annual cost-based rate study. Instead, their rates are periodically updated with add-ons for new state or federal mandates.

Freestanding Subacute Facilities (FS/SAs) provide a higher level of care to medically complex residents requiring services such as ventilator support, wound care, or post-acute rehabilitation beyond the scope of a standard nursing facility. FS/SAs are placed in a single statewide peer group rather than county-based regional groups, reflecting the specialized nature of their services and the smaller number of facilities in this category. The rate calculation follows the same general structure as FS/SNF-Bs, but the statewide peer grouping means that percentile ceilings are computed across all FS/SA facilities rather than within regional subsets.

Distinct Part Nursing Facilities (DP/SNFs) are nursing facility units that operate as a distinct part of a hospital. Because these units share overhead and infrastructure with the host hospital, their cost structures differ materially from FS/SNF-Bs. The rate methodology for DP/SNFs accounts for this by applying different cost allocation rules to separate the nursing facility unit's costs from the hospital's broader operations. DP/SNFs receive annual field audits, in contrast to the three-year audit cycle for FS/SNF-Bs, reflecting the additional complexity of cost allocation in a hospital-based setting. DP/SNFs are organized in a single statewide peer group, and the rate is subject to a statewide ceiling at the projected median cost. Unlike FS/SNFs, the ceiling is calculated based on, and is applied to, the total rate rather than to individual rate components. Furthermore, DP/SNFs are not subject to an annual rate growth limit.

Distinct Part Subacute Facilities (DP/SAs) are subacute care units operating within hospitals. DP/SAs are subject to a similar rate methodology as DP/SNFs.

Pediatric Subacute Units (FS/PSAs and DP/PSAs) serve children requiring subacute skilled nursing services. Both freestanding and distinct part pediatric subacute units

operate under rate-setting methodologies that recognize the specialized staffing, equipment, and programming needs of pediatric populations. These units represent a small but critically important segment of the Medi-Cal nursing facility system.

Special Treatment Programs (STPs) are SNFs approved by DHCS to provide specialized mental health services to Medi-Cal beneficiaries with a diagnosed chronic psychiatric impairment and moderately impaired adaptive functioning. Chapter 6 provides an in-depth look at STPs.

Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs) are health facilities that provide specialized 24-hour-per-day residential services to individuals with intellectual or developmental disabilities. Medi-Cal pays ICF/DDs using a peer-grouped methodology based on audited cost reports submitted by providers annually. Unlike FS/SNFs, all ICF/DDs within each peer group are reimbursed at the 65th percentile of the group's projected costs rather than being reimbursed on a facility-specific basis.

Overall SNF financing framework

As part of the 2022 amendment to the Medi-Cal LTC Reimbursement Act, DHCS established three new supplemental programs. These programs sit outside of the base rate but exist as part of the SNF financing framework and influence total SNF payments.[22]

Workforce & Quality Incentive Program. WQIP provided payments tied to performance on workforce metrics (such as staffing ratios, total nursing hours, and staffing turnover), clinical outcome metrics, and equity metrics. DHCS calculated a facility performance score based on the metrics for the program year to inform the total additional add-on per qualifying bed day for each in-network SNF. The program was budgeted to provide total payments of $280 million for calendar year 2023, growing to a targeted $304.8 million for calendar year 2025,[23] which represented about 4 percent of total payments to SNFs.[24] The WQIP program made payments to facilities following the

[22] For more information about the three programs authorized by AB 186, please visit https://www.dhcs.ca.gov/services/medi-cal/Pages/Nursing-Facility-Financing-Reform-AB-186.aspx.
[23] DHCS. (2025). *Skilled nursing facility WQIP: 2025 technical assistance guide*. https://www.dhcs.ca.gov/wp-content/uploads/2025/12/WQIP-CY-2025-Technical-Assistance-Guide.pdf.
[24] More information on the evaluation of WQIP for calendar year 2023 can be found at https://www.dhcs.ca.gov/services/Documents/SNF-WQIP-PY1-CY2023-Annual-Evaluation-Report.pdf.

end of the performance period with an interim and final payment. WQIP succeeded the prior Quality and Accountability Supplemental Payment (QASP) program. While WQIP ended December 31, 2025, pursuant to the 2025 Budget Act, DHCS remains interested in models that incentivize SNF workforce and quality improvement in future payment models.

Workforce Standards Program. WSP provides an add-on to the base per diem reimbursement for participating facilities. Facilities can choose from three pathways to participate: having a collective bargaining agreement (CBA), joining a statewide labor management committee (LMC), or meeting DHCS-established basic wage and benefit (BWB) standards.[25] Participation in WSP is optional, and facilities must opt in or out annually; as of 2024, 83 percent of California nursing facilities opted to participate.[26]

Accountability Sanctions Program. As a separate mechanism, ASP authorizes DHCS to impose sanctions on facilities that fail to meet established quality or equity measures established by DHCS based on per Medi-Cal bed day, defined as one day in which a Medi-Cal member resides in the facility and for which Medi-Cal is the primary payor. DHCS is authorized to assess a sanction of up to $5 for each Medi-Cal bed day within the rating period. For each measure, the aggregate sanction assessed cannot exceed $150,000 in a single rating period.[27]

Federal statutory requirements

Several federal requirements govern and inform state SNF rate setting. 42 U.S.C. § 1396a(a)(13)(A) establishes a mandated public process for rate determination that publishes proposed rates and methodologies, outlines designated providers and beneficiaries, and publishes final rates. 42 CFR § 447.272 creates an upper-payment-limit requirement that ensures aggregate Medicaid payments to nursing facilities in the fee-for-service delivery system do not exceed what Medicare would have paid for equivalent services. More broadly, 42 CFR § 483 functions as a compliance constraint for rates by defining what services must be delivered and setting provisions for staffing requirements, quality standards, survey and certification rules, resident rights, and Minimum Data Set (MDS) requirements.

[25] More information on the three WSP pathways can be found in Chapter 2.
[26] More information on the SNF WSP can be found at https://www.dhcs.ca.gov/services/medi-cal/Pages/FFSRDD-LTC/SNFWSP.aspx.
[27] More information on the SNF ASP can be found at https://www.dhcs.ca.gov/services/Pages/SNF-ASP.aspx.

Medi-Cal SNF provider benchmarking profiles

To support analyses related to the SNF Value Strategy, we analyzed federal data to provide a preliminary snapshot of nursing facilities in California as of quarter 4 (Q4, October to December) 2024.[28] We merged these data with California's WQIP,[29] WSP,[30] and facility rate.[31] data sets using the Centers for Medicare & Medicaid Services (CMS) Certification Number (CCN), which is available for all facilities in the CMS nursing facility provider data set; the Health Care Access and Information ID (HCAI ID) for facilities in California; and/or the National Provider Identifier (NPI) based on what identifier(s) were not missing and available for each facility in each data set. To support merging across data sets, we also used the Licensed and Certified Healthcare Facility Crosswalk file from the California Department of Health and Human Services open data portal. Facilities were included in the analysis if they were either Medi-Cal-only or Medi-Cal and Medicare facilities present in the CMS provider file.

We identified 1,118 nursing facilities as of quarter 4, 2024, excluding 46 Medicare-only facilities.[32] **Exhibit 1.7** summarizes facility characteristics by peer group.[33] Of these, 915 were classified as FS/SNF-Bs. Most facilities (98 percent) were certified to receive payments from both Medicare and Medi-Cal.

Most facilities (88 percent) were for profit. More distinct part facilities were nonprofit (n=23) versus for profit (n=19) or government (n=19). Among the FS/SNF-B geographic peer groups, the Los Angeles and Bay Area peer groups had the most nonprofit facilities, but San Joaquin Valley had the greatest proportion of nonprofit and

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[28] These data are from the Centers for Medicare & Medicaid Services and provide information about all Medicare and Medicaid certified nursing homes including rehab services. Data are available at https://data.cms.gov/provider-data/dataset/4pq5-n9py.

[29] The WQIP Quarterly Performance Reports contain facility-level WQIP scores across various metrics including staffing, MDS clinical metrics, and claims-based metrics. Data are available at https://data.chhs.ca.gov/dataset/workforce-quality-incentive-program-performance.

[30] The WSP data contain facility-level indicators about participation in WSP and the pathway for each facility (CBA, LMC, or BWB).

[31] DHCS publicly posts rates for FS/SNF-Bs, FS/SA, and DP/SNFs. For these analyses, we used 2024 rates that were updated in 2026.

[32] 59 facilities were unable to be classified by peer group (FS/SNF-Bs), or as FS/SA or as DP/SNF because they were present in the CMS data, but they were not present in the other sources used to classify these designations. Their characteristics are reported where available.

[33] DHCS establishes geographic peer groups for Medi-Cal reimbursement purposes for FS/SNF-Bs. FS/SA facilities (which includes FS/SA only and FS/SA + FS/SNF-Bs) and DP/SNFs are reported separately in our analyses from the FS/SNF-Bs that are reported by peer group. For a list of counties by peer group, see **Appendix B** or the map in **Exhibit 1.3**.

government-owned facilities (14 percent) relative to their overall facility count (**Exhibit 1.7**).

The average certified bed count[34] per geographic peer group for FS/SNF-Bs was 93 to 115 beds.[35] Each FS/SNF-B peer group contained a relatively similar distribution of facility bed counts, including interquartile ranges that were typically 60 to 130 beds and several outlier facilities across peer groups with upwards of 300 to 400 certified beds, particularly in Los Angeles, which has the largest overall count of facilities (**Exhibit 1.7**). FS/SA facilities had the highest average certified bed count at 131 beds, and DP/SNFs had several outlier facilities with a high number of certified beds.

[34] The certified bed count is the total number of beds in a facility that are approved to participate in Medicare or Medicaid programs.
[35] All averages reported by peer group are unweighted averages.

Exhibit 1.7. Characteristics of California SNFs by peer group, quarter 4, 2024

Characteristic	Total	Bay Area	Central Coast	Greater Sacramento	LA Region 1	LA Region 2	LA Region 3
Facility count	1,118[b]	181	45	54	94	99	95
Ownership type							
For-profit	981	161	40	49	83	95	90
Government	30	1	0	0	1	0	0
Nonprofit	107	19	5	5	10	4	5
Provider type							
Medicaid-only	25	6	0	0	0	1	0
Medicare and Medicaid	1,093	175	45	54	94	98	95
Size							
Average bed count[c]	100.61	93.59	98.56	106.24	94.01	106.74	103.58
Average number of residents per day	87.46	81.03	82.31	95.8	80.53	94.94	92.1

Exhibit 1.7. (continued) Characteristics of California SNFs by peer group, quarter 4, 2024

Characteristic	North State-Sierras	Orange-San Diego	San Joaquin Valley	Southern Inland	Stockton-Modesto	DP/SNF	FS/SA[a]
Facility count	40	110	71	87	39	61	83
Ownership type							
For-profit	39	100	61	82	36	19	83
Government	1	2	1	2	0	19	0
Nonprofit	0	8	9	3	3	23	0
Provider type							
Medicaid-only	0	1	1	0	2	1	0
Medicare and Medicaid	40	109	70	87	37	60	83
Size							
Average bed count[c]	100.1	114.97	93.8	95.56	107.21	93.33	131.22
Average number of residents per day	79.35	102.77	83.75	87.31	93.69	64.84	116.25

Source: CMS' archived data snapshot from October 2024 for nursing homes including rehab services https://data.cms.gov/provider-data/dataset/4pq5-n9py; California Health and Human Services Open Data Portal WQIP Performance PY2 2024 WQIP Quarterly Performance Report #1 https://data.chhs.ca.gov/dataset/workforce-quality-incentive-program-performance; publicly available 2024 California FS/SNF-B, FS/SA, and DP/SNF rate data updated in 2026 https://www.dhcs.ca.gov/services/medi-cal-resources/freestanding-skilled-nursing-facilities-and-subacute-units/ and https://www.dhcs.ca.gov/services/medi-cal-resources/distinct-part-nursing-facilities-level-b-dp-nf-b/.

Notes: The facility sample is based on a snapshot of active facilities as of October 2024 based on the CMS data for nursing homes including rehab services. Facilities that were present in the CMS data, but not other California sources, are still included but have

missing information for certain measures. Medicare-only facilities are not included. Facilities with missing data for any characteristics were excluded from the calculations for the relevant characteristics reported in this exhibit.

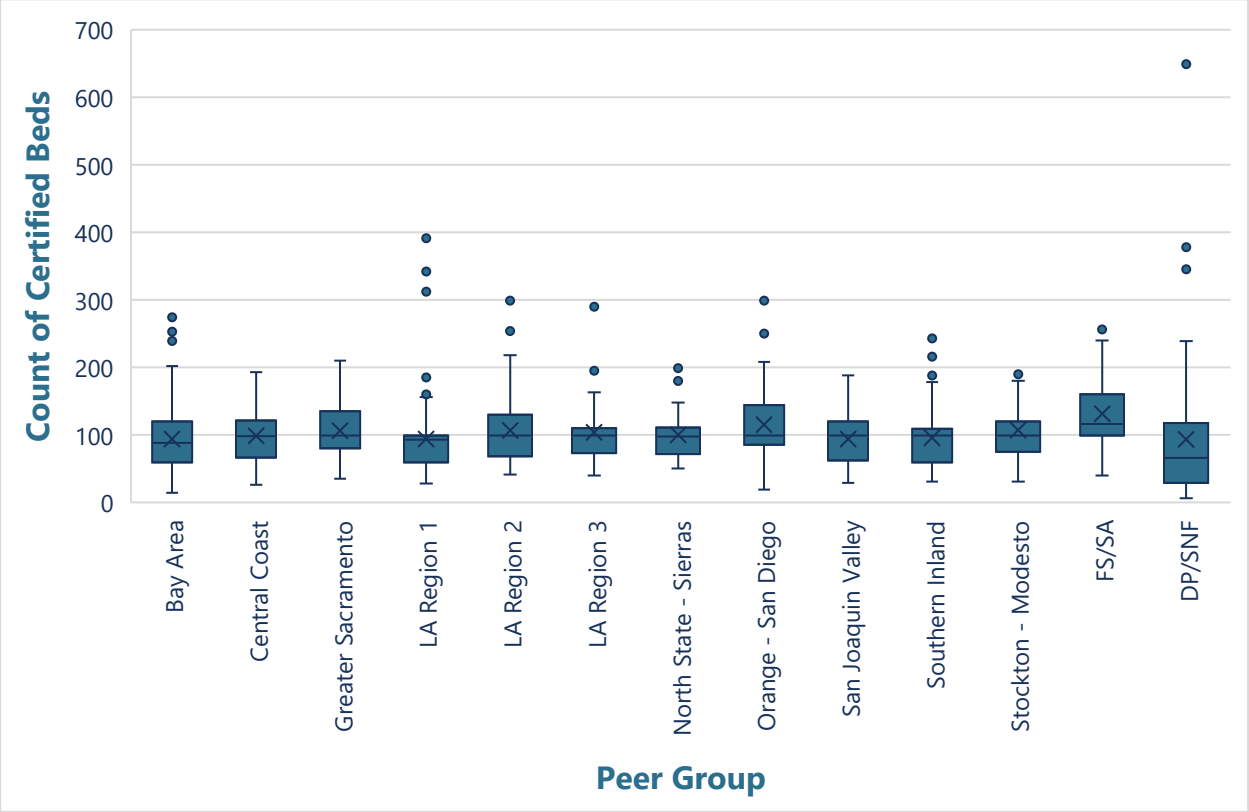
[a] FS/SA facilities include FS/SA only facilities and FS/SA + FS/SNF-Bs.

[b]59 facilities were unable to be classified by peer group (FS/SNF-Bs), or as FS/SA or as DP/SNF because they were present in the CMS data, but they were not present in the other sources used to classify these designations. Their characteristics are reported where available.

[c] All averages reported by peer group are unweighted averages.

DP/SNF = distinct part skilled nursing facility; FS/SA = adult freestanding subacute facility; FS/SNF-B = freestanding skilled nursing facilities level-B; SNF = skilled nursing facility.

Exhibit 1.8. Certified bed count among SNFs by peer group, quarter 4, 2024



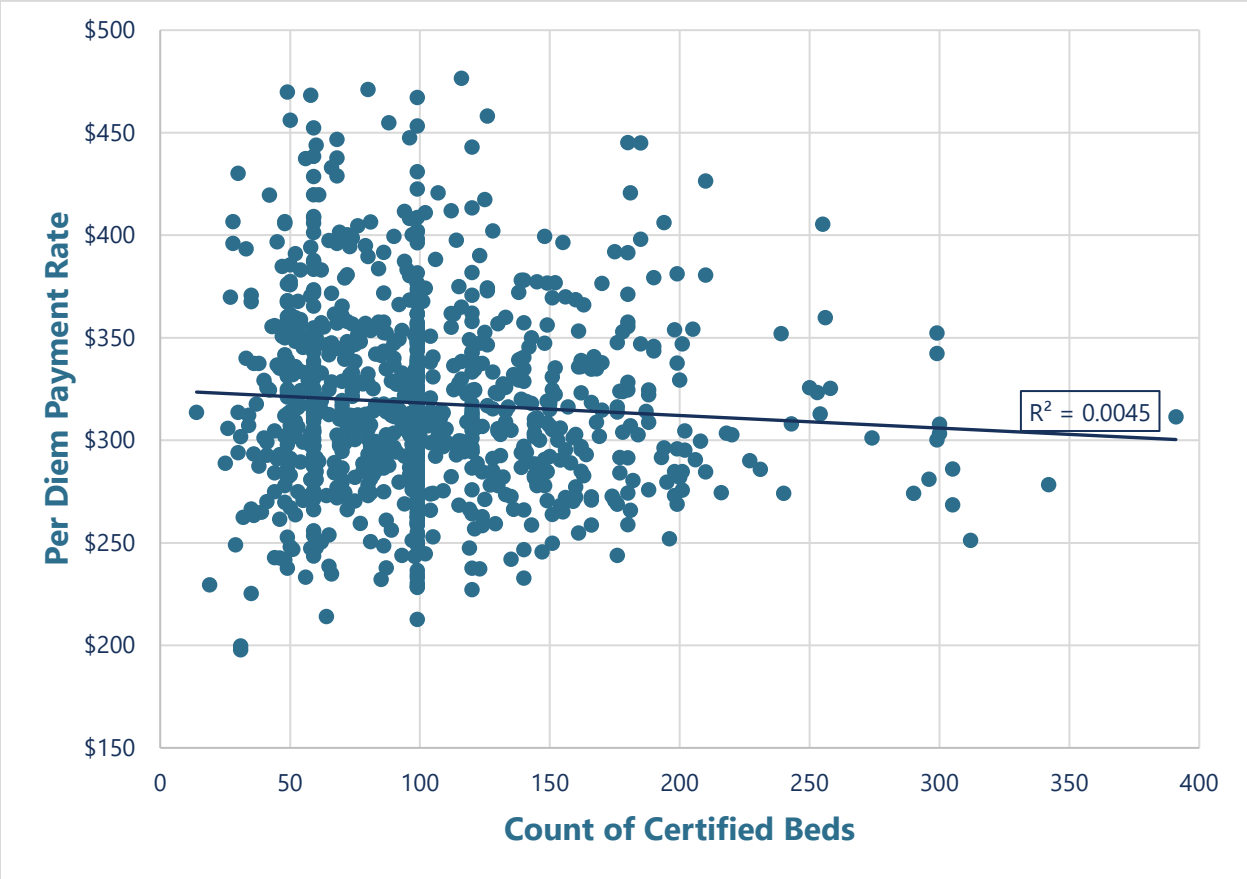
Source: CMS' archived data snapshot from October 2024 for nursing homes including rehab services https://data.cms.gov/provider-data/dataset/4pq5-n9py.
Notes: The facility sample is based on a snapshot of active facilities as of October 2024 based on the CMS data for nursing homes including rehab services. Medicare-only facilities are not included. FS/SA facilities include FS/SA only facilities and FS/SA + FS/SNF-Bs. The calculations reported in this exhibit exclude facilities with missing data. All averages reported by peer group are unweighted averages.
DP/SNF = distinct part skilled nursing facility; FS/SA = adult freestanding subacute facility; LA = Los Angeles.

The average count of residents per day among FS/SNF-B geographic peer groups was 81 to 103. FS/SA facilities had the highest average count of resident per day, and DP/SNFs had the lowest. These counts were congruent with average bed counts across facilities (**Exhibit 1.8**).

Relationship between current rates and facility bed counts

Exhibit 1.9 compares Medi-Cal per diem payment rates[36] to facility bed counts from the CMS Provider file. There is an overall small negative linear trend[37] between the number of beds in a facility and the facility rates.

Exhibit 1.9. Relationship between per diem payment rate and certified bed count among FS/SNF-Bs, quarter 4, 2024



Source: CMS' archived data snapshot from October 2024 for nursing homes including rehab services https://data.cms.gov/provider-data/dataset/4pq5-n9py; publicly available 2024 California FS/SNF-B rate data updated in 2026 https://www.dhcs.ca.gov/services/medi-cal-resources/freestanding-skilled-nursing-facilities-and-subacute-units/.

[36] Rates included in scatterplots are FS/SNF-B rates only. FS/SA and DP/SNF rates are not included in the scatterplots. The FS/SNF-B rates presented are the Regular Services rate for each facility for 2024. Rates include WSP adjustments when applicable.

[37] The linear trend line on the scatterplot shows the overall trend, but it does not represent a causal relationship.

Notes: The facility sample is based on a snapshot of active facilities as of October 2024 based on the CMS data for nursing homes including rehab services. Medicare-only facilities are not included. The calculations reported in this exhibit exclude facilities with missing data. The FS/SNF-B rates presented are the Regular Services rate for each facility for 2024. Rates include Workforce Standards Program (WSP) adjustments when applicable.

Medi-Cal SNF length of stays

To better understand length of time that individuals reside in California SNFs as part of a single stay ("lengths of stay"), we conducted an analysis using Medi-Cal SNF claims data[38] for service dates ending between January 1, 2022 and June 30, 2025.[39] This analysis provides information about the proportion of stays that are shorter versus longer term, whether there is clustering of stays at particular numbers of days, and whether certain types of facilities have different proportions of shorter versus longer term stays to inform about the population being served by California SNFs.

We grouped stays into short stays, medium stays, and long stays according to the following definitions:

- **Short stays:** 1 to 20 days
- **Medium stays:** 21 to 100 days
- **Long stays:** Greater than or equal to 101 days

Exhibit 1.10 provides descriptive statistics for the length of stays identified.

[38] We used CLAIMS_HDR.FI_CLAIM_TYPE_CD value of '02' (Long Term Care) and CLAIMS_HDR.LAST_POSITIVE_CLAIM_IND of 'Y' to identify SNF claims.

[39] On January 1, 2023, FS/SNF-B and DP/SNF facility SNF services were carved into managed care, followed by DP facilities on January 1, 2024. The cutover may have an impact on billing practices that could impact stay length calculations for this analysis because it spanned this period. However, this analysis is not designed to examine the impact of the change to managed care delivery and is only focused on the patterns of length of stays.

Exhibit 1.10. Length of stay distributions

Length of Stay (days)	
Range	1–1,276
25th percentile	19
50th percentile	53
75th percentile	209

Source: SNF claims data from the California Enterprise Data Warehouse (EDW) for service dates ending between January 1, 2022, and June 30, 2025, where CLAIMS_HDR.FI_CLAIM_TYPE_CD value = '02' (Long Term Care) and CLAIMS_HDR.LAST_POSITIVE_CLAIM_IND = 'Y'. Stays were included if they linked to CCNs in the CMS' archived data snapshot from October 2024 for nursing homes including rehab services https://data.cms.gov/provider-data/dataset/4pq5-n9py.
Notes: Medicare fee-for-service and Medicare Advantage data were not available at the time of this analysis. Therefore, stays under 100 days are expected to be undercounted due to Medicare SNF coverage and stay lengths may be misclassified as we may not identify the true start date of all stays.

Length of stay distributions for stays that began in 2023 and stays that began prior to 2023

We grouped stays into two cohorts using January 1, 2023, as our anchor date.

1. **Stays that began in 2023 (n = 306,976):** The member was admitted to a facility during 2023, after January 1. The analysis time period provided a minimum of 1.5 years of claims data for those admitted at the end of CY 2023, up to 2.5 years of claims data for those admitted at the beginning of CY 2023. This cohort provided more accurate summaries of lengths of stay for facilities that have more churn in admissions and can be used to better understand how often individuals remain in facilities long-term if they are newly admitted. Additionally, admission start dates for very long stays are more accurate for this cohort compared to those with admission dates prior to 2023, which can have start dates before the claims look back period used.

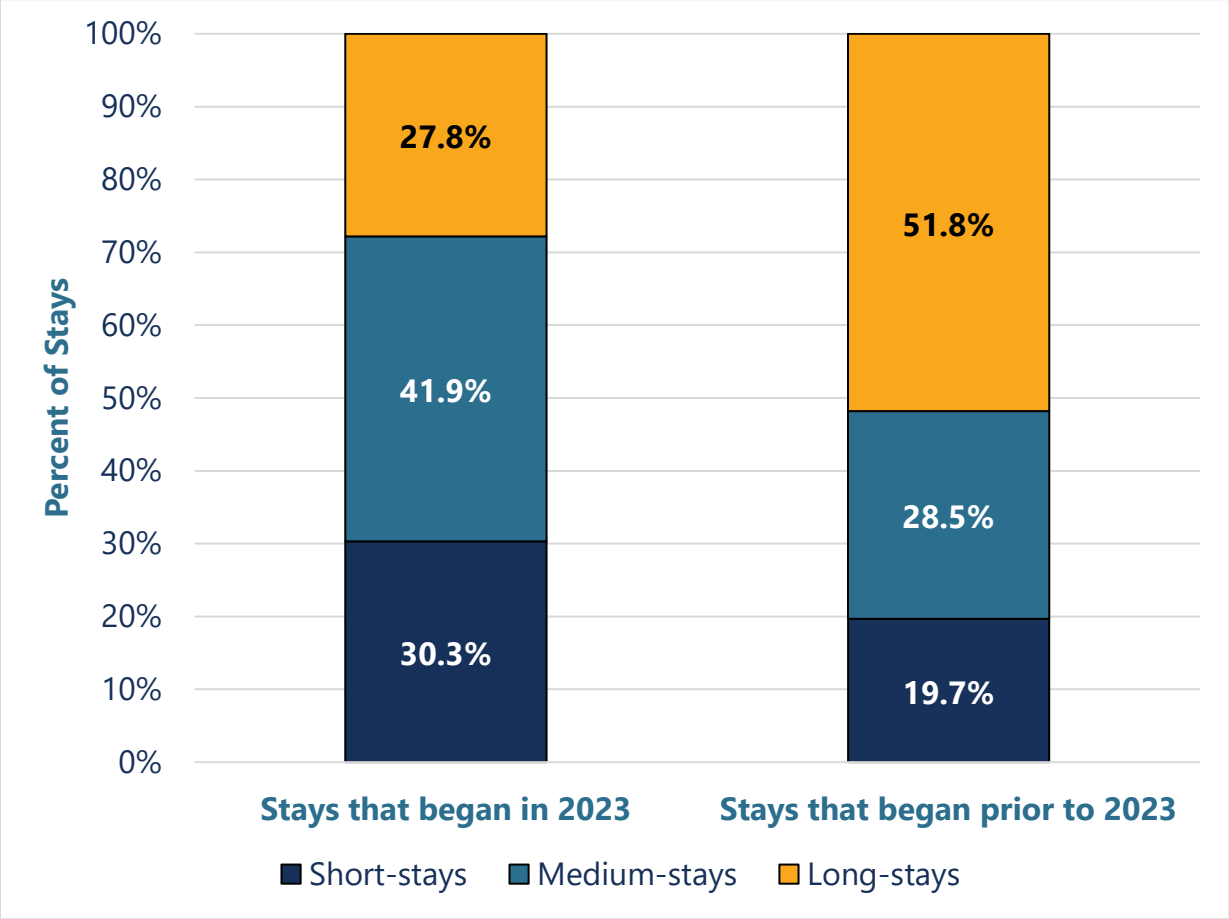
2. **Stays that began prior to 2023 (n = 166,752):** The member was residing in the facility on January 1, 2023, regardless of when the stay began or ended. The analysis period provided a total of 3.5 years of claims data for this cohort. Because this cohort was restricted to stays that spanned a specific day, the total count of stays in this cohort was smaller. This cohort captured most of the population that is permanently residing in a nursing facility, and these stays provided a more complete picture for facilities with less churn in admissions.

Of the 473,728 stays in the final sample, 26.6 percent were classified as short stays, 37.2 percent were classified as medium stays, and 36.3 percent were classified as long stays.[40] **Exhibit 1.11** summarizes the distribution of lengths of stay between the two cohorts of residents. These results indicate that the majority of stays in California SNFs are longer than 20 days, and a substantial proportion are categorized as long stay (more than 100 days).[41]

[40] The length of stay was calculated using the difference between the latest and earliest service date on claims grouped into the same stay using a 45-day allowable gap. Therefore, the length of stay includes days that the member was not in the facility if the member was readmitted to the same facility within the allowable gap window.

[41] Medicare fee-for-service and Medicare Advantage data were not available at the time of this analysis. Therefore, stays under 100 days are expected to be undercounted due to Medicare SNF coverage, and stay lengths may be misclassified as we may not identify the true start date of all stays.

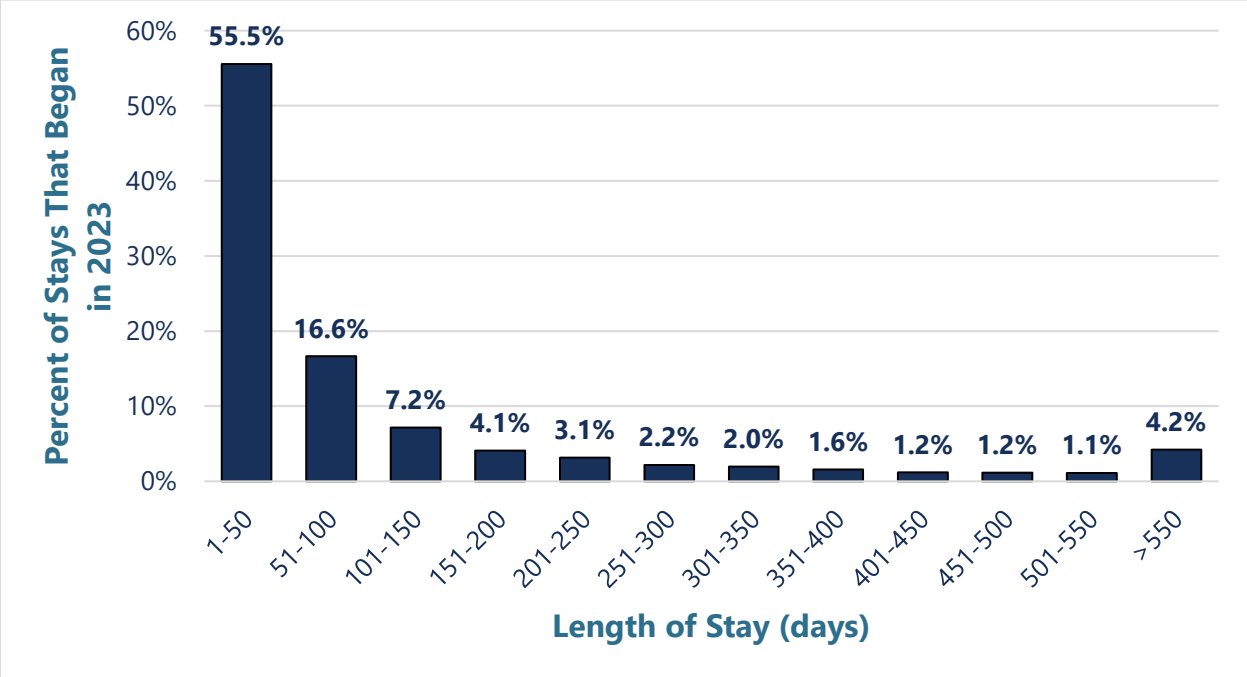
Exhibit 1.11. Stay length for stays that began in 2023 and stays that began prior to 2023, Jan. 1, 2022–Jun. 30, 2025



Source: SNF claims data from the California Enterprise Data Warehouse (EDW) for service dates ending between January 1, 2022, and June 30, 2025, where CLAIMS_HDR.FI_CLAIM_TYPE_CD value = '02' (Long Term Care) and CLAIMS_HDR.LAST_POSITIVE_CLAIM_IND = 'Y'. Stays were included if they linked to CCNs in the CMS' archived data snapshot from October 2024 for nursing homes including rehab services https://data.cms.gov/provider-data/dataset/4pq5-n9py.
Notes: Short stays are defined as those lasting 1 to 20 days. Medium stays are defined as those lasting 21 to 100 days. Long stays are defined as those lasting 101 days or more. Medicare fee-for-service and Medicare Advantage data were not available at the time of this analysis. Therefore, stays under 100 days are expected to be undercounted due to Medicare SNF coverage and stay lengths may be misclassified as we may not identify the true start date of all stays.

Exhibit 1.12 and **Exhibit 1.13** display the distribution of length of stay for stays that began in 2023 and stays that began prior to 2023, respectively. Taken together, these results show that if we observe any given stays that began in 2023, it is more likely to end up being a short or medium stay (half of stays that began in 2023 were 40 days or shorter), but if we examine all of the people in a facility on a given day (in this case, January 1, 2023, based on the period used for this analysis), the majority of them are long stays. These patterns are consistent with national trends for stay lengths based on observing people newly admitted to a nursing facility within a year versus examining residents at a point-in-time.[42]

Exhibit 1.12. Length of stay distribution for all stays that began in 2023, Jan. 2, 2023–Jun. 30, 2025

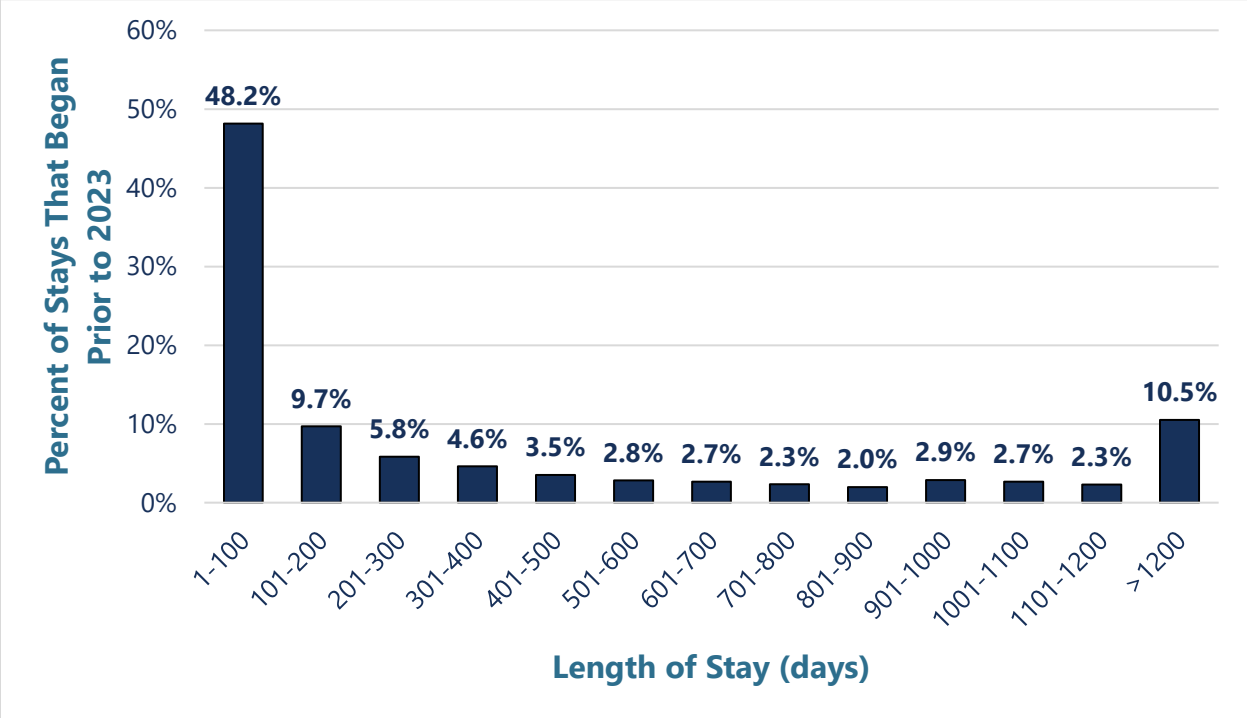


Source: SNF claims data from the California Enterprise Data Warehouse (EDW) for service dates ending between January 1, 2022, and June 30, 2025, where CLAIMS_HDR.FI_CLAIM_TYPE_CD

[42] The American Health Care Association (AHCA) and National Center for Assisted Living (NCAL) reported that on any given day, more than 1.3 million individuals receive care in a nursing home or skilled nursing facility, and a total of more than 4 million receive care each year. Among new admissions, 6 out of 10 admissions (64%) are short-stay residents (stays 100 days or less) who remain in a skilled nursing facility for an average of 25 days, while nearly 4 out of 10 admissions (36%) are long-stay residents. Other literature also finds that among nursing facility residents at a point in time, the majority are long-stay residents (for example, https://pubmed.ncbi.nlm.nih.gov/21734211/).

value = '02' (Long Term Care) and CLAIMS_HDR.LAST_POSITIVE_CLAIM_IND = 'Y'. Stays were included if they linked to CCNs in the CMS' archived data snapshot from October 2024 for nursing homes including rehab services https://data.cms.gov/provider-data/dataset/4pq5-n9py. Notes: Medicare fee-for-service and Medicare Advantage data were not available at the time of this analysis. Therefore, stays under 100 days are expected to be undercounted due to Medicare SNF coverage and stay lengths may be misclassified as we may not identify the true start date of all stays.

Exhibit 1.13. Length of stay distribution for all stays that began prior to 2023, Jan. 1, 2022–Jun. 30, 2025

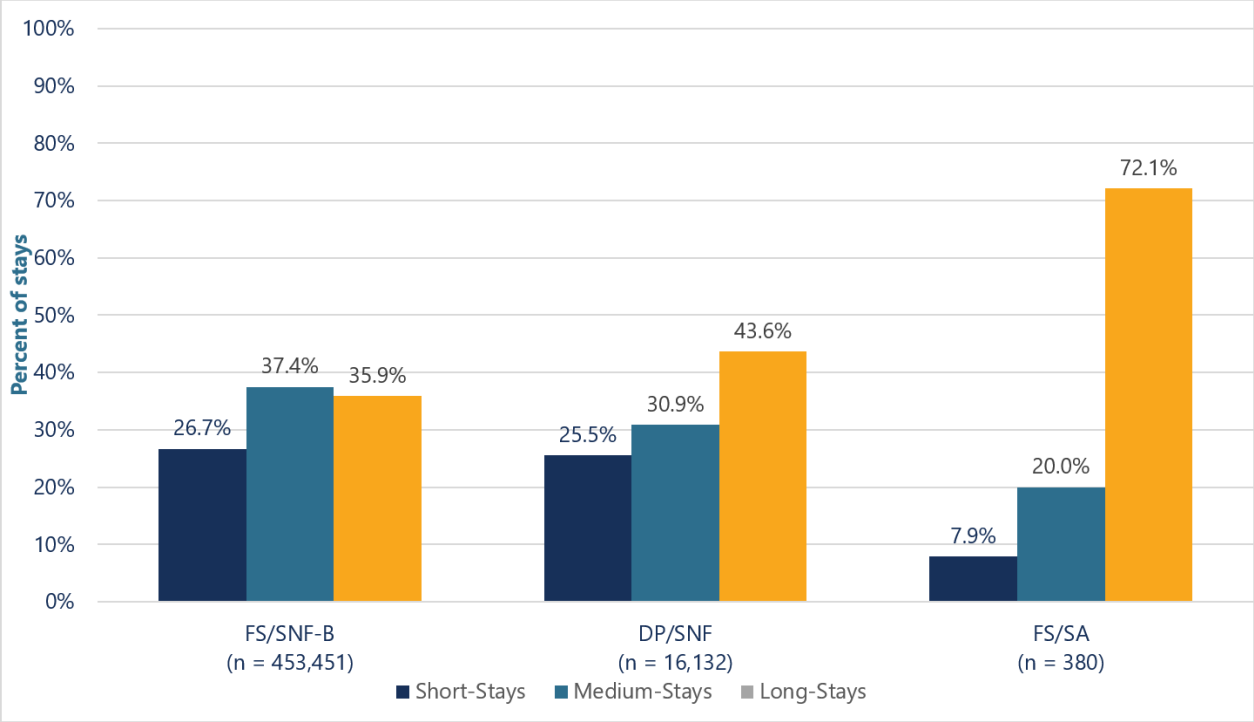


Source: SNF claims data from the California Enterprise Data Warehouse (EDW) for service dates ending between January 1, 2022, and June 30, 2025, where CLAIMS_HDR.FI_CLAIM_TYPE_CD value = '02' (Long Term Care) and CLAIMS_HDR.LAST_POSITIVE_CLAIM_IND = 'Y'. Stays were included if they linked to CCNs in the CMS' archived data snapshot from October 2024 for nursing homes including rehab services https://data.cms.gov/provider-data/dataset/4pq5-n9py. Notes: Medicare fee-for-service and Medicare Advantage data were not available at the time of this analysis. Therefore, stays under 100 days are expected to be undercounted due to Medicare SNF coverage and stay lengths may be misclassified as we may not identify the true start date of all stays.

Length of stay by facility attributes

The proportion of short stays was similar among FS/SNF-B and DP/SNF facilities at 26.7 percent and 25.5 percent of stays, respectively (**Exhibit 1.14**). Nearly two-thirds of stays in FS/SNF-B facilities were short stays or medium stays (64.1 percent). FS/SA stays made up less than 1 percent of stays in the analysis, but these stays were mostly long stays (72.1 percent).

Exhibit 1.14. Length of stay by facility type, Jan. 1, 2022–Jun. 30, 2025



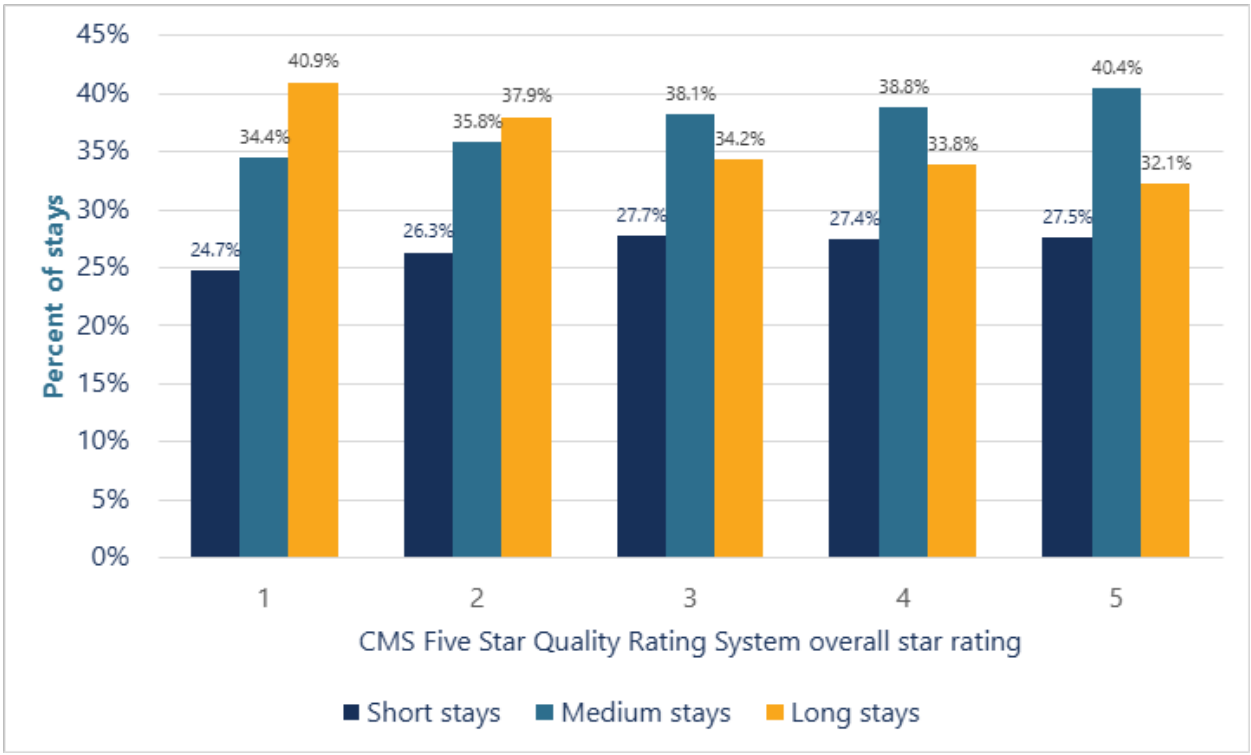
Source: SNF claims data from the California Enterprise Data Warehouse (EDW) for service dates ending between January 1, 2022, and June 30, 2025, where CLAIMS_HDR.FI_CLAIM_TYPE_CD value = '02' (Long Term Care) and CLAIMS_HDR.LAST_POSITIVE_CLAIM_IND = 'Y'. Stays were included if they linked to CCNs in the CMS' archived data snapshot from October 2024 for nursing homes including rehab services https://data.cms.gov/provider-data/dataset/4pq5-n9py; publicly available 2024 California FS/SNF-B, FS/SA, and DP/SNF rate data updated in 2026 https://www.dhcs.ca.gov/services/medi-cal-resources/freestanding-skilled-nursing-facilities-and-subacute-units/ and https://www.dhcs.ca.gov/services/medi-cal-resources/distinct-part-nursing-facilities-level-b-dp-nf-b/.

Notes: Short stays are defined as those lasting 1 to 20 days. Medium stays are defined as those lasting 21 to 100 days. Long stays are defined as those lasting 101 days or more. Medicare fee-for-service and Medicare Advantage data were not available at the time of this analysis. Therefore, stays under 100 days are expected to be undercounted due to Medicare SNF

coverage and stay lengths may be misclassified as we may not identify the true start date of all stays.
FS/SNF-B = freestanding skilled nursing facility, level-B, DP/SNF = distinct part skilled nursing facility; FS/SA = adult freestanding subacute facility.

Exhibit 1.15 displays the percent of stays that are short stays, medium stays, and long stays by facilities' overall star rating on the CMS Five Star Quality Rating System. As a facility's overall star rating increased from 1 to 5 stars, the proportion of long stays decreased. The proportion of long stays in five-star facilities was 9 percentage points lower than the proportion of long stays in one-star facilities. Long stays are most likely to be Medi-Cal residents because Medicare generally does not cover stays over 100 days. This analysis suggests that higher quality facilities may be serving fewer Medi-Cal residents. See Chapter 4 for additional analyses on characteristics of high performing facilities.

Exhibit 1.15. Length of stay categories by CMS Five Star Quality Rating System overall star rating, quarter 4, 2024



Source: CMS' archived data snapshot from October 2024 for nursing homes including rehabilitation services, available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py; SNF claims data from the California Enterprise Data Warehouse (EDW) for service dates ending between January 1, 2022, and June 30, 2025, where CLAIMS_HDR.FI_CLAIM_TYPE_CD value = '02'

(Long Term Care) and CLAIMS_HDR.LAST_POSITIVE_CLAIM_IND = 'Y'. Stays were included if they linked to CCNs in the CMS' archived data snapshot from October 2024 for nursing homes including rehab services.
Notes: The overall nursing home rating is a composite of the health inspection rating, staffing rating, and quality measure rating. The ratings take the form of "star" ratings for each nursing home, ranging from one to five stars, with five stars representing "much above average" and one star representing "much below average." Medicare fee-for-service and Medicare Advantage data were not available at the time of this analysis. Therefore, stays under 100 days are expected to be undercounted due to Medicare SNF coverage and stay lengths may be misclassified as we may not identify the true start date of all stays.

We also examined the percent of stays at the CCN-level that were short stays, medium stays, and long stays and compared these proportions to the facility's Medi-Cal disproportionate share rate. We found there was no substantial relationship between the facility's Medi-Cal disproportionate share rate and the percentage of short- or medium stays, but there was some indication of a small relationship between this share and the percentage of long stays at a facility.

Stakeholder engagement in the Landscape Analysis development

California has a robust and engaged stakeholder community that is interested in Medi-Cal's SNF financing framework. This community includes individual facility operators and administrators, associations of facility operators, direct care staff and the unions that represent their interests, managed care plans and their associations, resident and consumer advocates, and Medi-Cal members receiving SNF services and their family members. To inform this Landscape Analysis development, DHCS convened a dedicated Stakeholder Advisory Workgroup consisting of 26 members with diverse perspectives to provide feedback on the current Medi-Cal SNF financing framework and identify opportunities to inform the future. DHCS also engages stakeholders through various other forums, including existing meetings with managed care plans, providers and their associations and public meetings.



CHAPTER II:
SNF PAYMENT METHODOLOGIES: NATIONAL SCAN

CHAPTER II: SNF PAYMENT METHODOLOGIES: NATIONAL SCAN

To guide California's evaluation of its Medi-Cal nursing facility payment framework, we conducted a comprehensive scan of nursing facility payment methodologies used across state Medicaid programs nationwide. In this section, we present findings organized by rate methodology structure, direct care cost classification, acuity-based payment systems, capital cost approaches, high-need resident add-ons, and managed care payment considerations.

Rate methodology overview

Cost-based versus price-based models

State Medicaid programs generally structure nursing facility per diem payment by adopting one of three broad approaches: cost-based models, price-based models, or a hybrid of the two applied to different rate components. Each involves distinct advantages and trade-offs.

Cost-based models reimburse providers based on individual facility-reported costs, typically subject to ceilings or caps at a specified percentile of the facility's peer group. California's current SNF payment system is a cost-based model with several layers of adjustments. This approach's primary advantage is responsiveness to each facility's specific cost and operating environment, which is particularly important for smaller or rural facilities with higher costs per unit. A system using a uniform price for payment might systematically underfund such facilities. Value under a cost-based system is driven by the relationship between a facility's actual costs and its applicable ceiling: facilities that operate below the ceiling are reimbursed for their unique cost environment, and the ceiling itself functions as a soft benchmark, signaling where a facility's spending stands relative to that of its peers. Cost-based models also involve drawbacks, for instance, the efficiency incentive is bounded, not open-ended. A facility operating well below the system cost ceiling has no incentive to continue operating below the ceiling and may therefore allow costs to drift toward the cap, particularly during rebasing periods when reported costs reset the peer-group distribution and payment levels. The administrative burden on states and operators to maintain a cost-based model is significant, requiring annual cost reporting, audit of allowable expenses, and ongoing scrutiny of related-party transactions that can distort facility-reported costs. These

administrative burdens and the adversarial nature of audit appeals may divert both state agency staff and operators' focus on implementing innovative strategies that drive value. Facility-specific growth limits, though intended to constrain spending, can also lock providers into lower rate trajectories based on historical cost patterns that no longer reflect current wages, acuity, or operating conditions. In **Exhibit 2.1**, we provide an example calculation of a cost-based direct care rate.

Exhibit 2.1. Cost-based model rate example

	Direct Care Cost per Day	Direct Care Rate
Facility D	$25.67	$25.67
Facility F	$29.31	$29.31
Facility E	$34.58	$34.58
Facility A	$36.54	$36.54
Facility H	$36.89	$36.54
Facility B	$39.15	$36.54
Facility C	$40.55	$36.54
50th Percentile		$36.54
Direct Care Statewide Ceiling		$36.54

Facilities H, B, and C are paid at the ceiling as their costs exceed allowable limits

Case study: Missouri (cost-based model with limits)

Missouri operates a cost-based model distinguished by a layered incentive structure. Base cost ceilings are set at 120 percent of the statewide median for direct care costs and indirect care costs and at 110 percent of the statewide median for administrative costs. Capital is reimbursed through a fair rental value (FRV) methodology. Ceiling-impacted direct care costs are then multiplied by facility-specific Medicaid acuity to arrive at the facility-specific direct care rate component.

What distinguishes Missouri is the series of incentive components: a patient care incentive at 4.75 percent of direct care spending up to the ceiling (all facilities are eligible based exclusively on the amount of spending on direct care areas); a Medicaid utilization incentive of up to $0.20 per day based on Medicaid census (determined by the percentage of all patient days attributed to Medicaid residents, above 85 percent, thereby encouraging facilities to admit Medicaid patients); a multiple-component incentive of up to $0.20 per day tied to the proportion of direct care within the total rate (based on the percentage of the total rate represented by the direct care component, above 70 percent, thereby encouraging direct care spending over other cost

components); and a quality component worth up to approximately 10 percent of the per diem rate based on long-stay quality measures and mental health diagnosis prevalence. The quality adjustment's magnitude, up to 10 percent of the base rate, represents a meaningful financial stake in performance, and its inclusion of mental health prevalence acknowledges the elevated resource demands of behavioral health populations.

Missouri does not rebase cost data annually but instead uses periodic rebasing as a budget management tool. Collectively, Missouri's model illustrates how incentive layers can significantly augment a cost-based framework, promoting direct care investment, Medicaid acuity, and quality outcomes.[43]

Price-based models set standard prices for nursing facility services, potentially differentiated by population type, acuity level, peer group, or provider type. The primary advantage is the efficiency incentive structure: the full spread between the set price and a facility's actual cost of delivering care flows directly to the facility's profit margin. In other words, the facility retains every saved dollar through operational improvement without ceiling interaction or rebasing risk. The result is stronger and more consistent cost containment incentives than those embedded in a cost-based system. In addition, price-based models lead to a substantial reduction in administrative burden by eliminating the need for extensive audits of every facility's cost report because rates are set in the aggregate rather than based on each facility's unique cost. However, as a trade-off, a price-based model inherently means that some facilities receive payments that are greater or less than their actual costs. Facilities serving high-cost populations or operating in high-wage markets may find themselves structurally underfunded if the price does not adequately differentiate across peer groups; on the other hand, facilities with lower costs capture the margin the state cannot see or redirect. For these reasons, effective price-based models are typically paired with safeguards such as quality incentives or pay-for-performance (P4P) components to discourage underspending on resident care, constrain requirements on minimum direct care spending to ensure that efficiency gains are not achieved at the expense of direct care, and minimize periodic recalibration to keep the rate anchored to current cost realities. In **Exhibit 2.2**, we provide an example calculation of a price-based direct care rate.

[43] Missouri Code of State Regulations Title 13 Mo. Code Regs. tit. 13, § 70-10.020.

Exhibit 2.2. Direct care price-based model rate example

	Direct Care Cost per Day	Direct Care Rate
Facility D	$25.67	$37.82
Facility F	$29.31	$37.82
Facility E	$34.58	$37.82
Facility A	$36.54	$37.82
Facility H	$36.89	$37.82
Facility B	$39.15	$37.82
Facility C	$40.55	$37.82
50th Percentile		$36.54
Multiply by Price Percentage		103.50%
Direct Care Statewide Ceiling		$37.82

All facilities are paid the prevailing price

Case study: Louisiana (price-based model)

Louisiana provides an instructive example of a price-based, acuity-informed Medicaid nursing facility payment system. The state establishes prices for each major rate component as a percentage of the statewide day-weighted median cost: direct care at 112.4 percent of the day-weighted, case-mix normalized cost per day; care-related costs (indirect care) at 112.4 percent of the day-weighted cost per day; and administrative costs at 105 percent of the day-weighted cost per day. The use of case-mix normalization for the direct care component means that price adjustments are based on a facility's resident acuity profile to arrive at a case-mix (acuity) neutral cost before determination of the statewide day-weighted median. The state then multiplies the direct care price by each facility's total acuity to arrive at the facility-specific direct care rate component.

A distinguishing feature is Louisiana's direct care spending floor, set at 94 percent of the statewide direct care median. If the median is $100 per day, each provider must demonstrate spending of at least $94 per day in direct care, with spending below the floor resulting in retrospective recoupment. This mechanism ensures that facilities deploy payment toward nursing staff and direct care.[44]

Hybrid models blend cost-based and price-based methodologies to balance fiscal predictability with responsiveness to individual facility circumstances. Under this

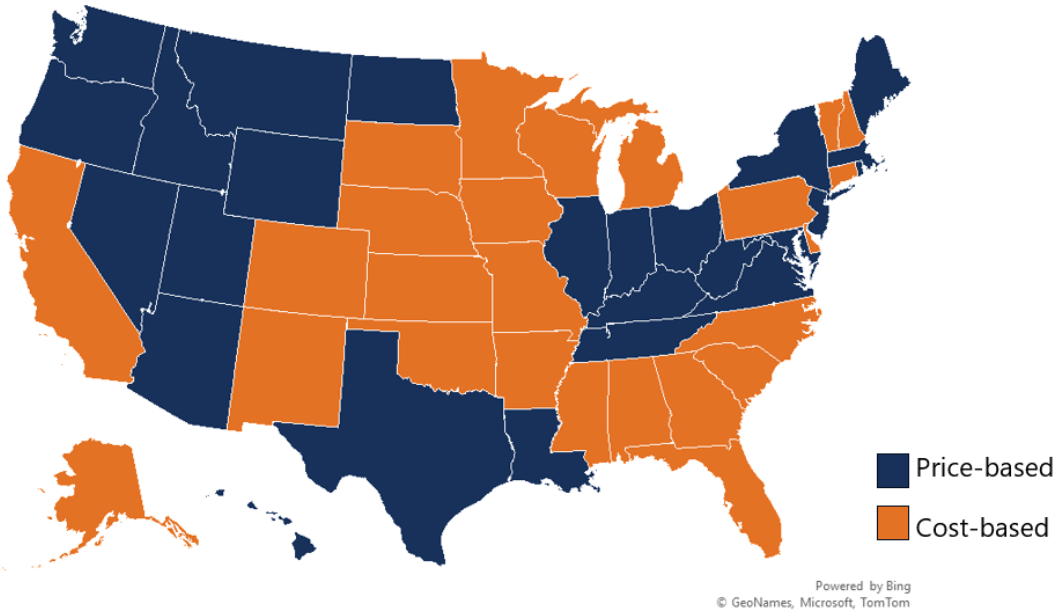
[44] La. Admin. Code tit. 50, pt. II, § 20000.

approach, certain cost centers, typically direct care, are reimbursed based on facility-specific allowable costs, often subject to ceilings or peer-group medians. As a result, rates reflect actual spending on resident care while discouraging inefficiency. Other cost centers such as administrative and general expenses, capital, and ancillary services are reimbursed based on price-based methodologies: flat per diem amounts or tiered rates derived from statewide or peer-group benchmarks rather than from a facility's reported costs. These price-based components create incentives for operational efficiency because facilities that manage costs below the set price retain the margin; those that operate above the set price absorb the difference. This type of structure protects access to care by tying direct care spending to documented costs while using market-style pricing for general and administrative expenditures to drive value and promote efficiency.

Adoption of payment models nationwide

On a nationwide basis, states are largely split between those that have adopted price- or cost-based models (**Exhibit 2.3**). The designation of price or cost relates to the majority of the rate components. If a large share of rate components is price-based, the state is identified as price-based. The Medicare program reimburses through a prospective price-based system framework as well.

Exhibit 2.3. Adoption of price- or cost-based systems nationwide



Source: Determination of price or cost basis came from a nationwide review of publicly available State Plan or regulatory documentation as of January 1, 2026.

Typical cost components, rebase frequency, and cost containment mechanisms

Nationwide, nursing facility per diem rates are generally structured around four primary cost components: direct care, indirect care, administrative/overhead, and capital. The frequency with which states rebase their cost data and the mechanisms they use to control cost growth vary considerably and are important policy design choices.

Using the most recently available cost report data, California conducts annual rate studies and applies year-over-year growth caps between 1 and 5 percent to individual rate components.[45] This approach maintains a relatively current connection between reported costs and payment but relies on the individual facility's growth cap to constrain rate increases.

Other states have adopted different cost control strategies. New York[46] and Missouri,[47] for example, do not rebase cost data on a fixed annual cycle; instead, they rely on periodic rebasing as a deliberate budget management tool. By freezing the cost base for extended periods, they achieve greater fiscal predictability at the expense of rate-to-cost accuracy, a trade-off that can disadvantage facilities whose cost environments have undergone significant change since the last rebase. Tennessee employs a Budget Adjustment Factor approach, applying a legislatively determined adjustment to rates that may be set above or below natural system spending, depending on state budget conditions (California operated a similar budget factor approach before adoption of AB 186). Several other states use similar budgetary adjustment controls, effectively decoupling rate growth from facility-reported cost trends and linking rate growth instead to fiscal policy decisions and available appropriations.[48]

A third category of states, such as Louisiana, relies on inflation-based indexing, typically using the relevant market basket indices or state-specific inflation factors to update rates between rebasing cycles.[49] This approach provides a predictable growth trajectory that approximates general cost trends in the nursing facility industry without requiring

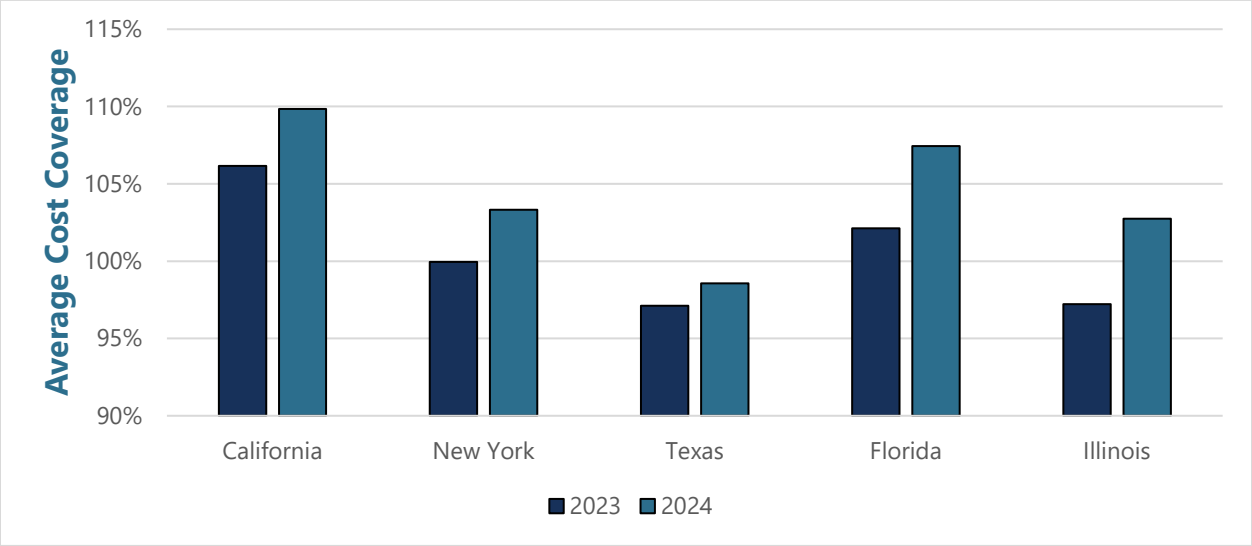
[45] California Department of Health Care Services. (n.d.). *Freestanding skilled nursing facilities and subacute units*. https://www.dhcs.ca.gov/services/medi-cal-resources/freestanding-skilled-nursing-facilities-and-subacute-units/.
[46] N.Y. Comp. Codes R. & Regs. tit. 10, § 86-2.40.
[47] Missouri Code of State Regulations Title 13 Mo. Code Regs. tit. 13, § 70-10.020.
[48] Tenn. Comp. R. & Regs. 1200-13-02.
[49] La. Admin. Code tit. 50, pt. II, § 20000.

annual cost report analysis. The trade-off is that market basket indices reflect national cost patterns and may not capture state-specific or facility-specific cost pressures.

Cost coverage analysis

Analysis of Medicare cost report data from the Healthcare Provider Cost Reporting Information System (HCRIS) for calendar years 2023 and 2024 provides insight into allowable cost coverage ratios across the nursing facility industry (**Exhibit 2.4**). The analysis included only facilities identified as Medicaid-certified or Medicare- and Medicaid-certified to permit a better approximation of the nationwide purview of state Medicaid agencies. The analysis encompassed all payors and allocations of ancillary revenues and costs to ensure capture of relevant nursing facility activities. The data indicate that California's all-payor cost coverage ratio of about 110 percent in 2024, on a statewide basis, exceeded the national average of about 106 percent in the same year. This finding suggests that, in the aggregate, California's nursing facilities, relative to the national norm, receive total payments that cover a greater proportion of their reported costs.

Exhibit 2.4. Medicare cost report: Cost coverage analysis



Source: Calculations performed based on available information from the CMS HCRIS public-use files. For more information, see Centers for Medicare & Medicaid Services. (2024). Healthcare Cost Report Information System (HCRIS): Skilled Nursing Facility Cost Reports (Form CMS-2540-10, fiscal years ending 2023–2024) [data set], available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports.
Notes: The calculation includes allocation of ancillary costs and revenues based on worksheets G and B of the CMS 2540 cost report, which reflect costs reported after all overhead allocations

and any allowable cost or related party transaction adjustments. Ancillary cost and revenues related to non-nursing facility activities were carved out from those facilities that, based on an allocation process, report more than nursing facility operations on the cost report. Ancillary revenues/cost allocations were determined by taking ancillary revenue from worksheet G-2 and ancillary cost from worksheet B, Part I and allocating the data to nursing facility operations based on the proportion of nursing facility routine revenues to total reported routine revenues on worksheet G-2 (inclusive of proration of any worksheet G-3 contractual adjustments). The information, however, is based on potentially unaudited 2,540 cost reports, which may or may not include related party transaction information that, if removed, could result in materially different calculations.

However, for several reasons, these aggregate figures must be interpreted with caution. First, the HCRIS data reflects all-payor cost coverage, meaning that the data includes Medicare, Medicaid, private pay, and other payor revenue sources. Medicaid-specific cost coverage may differ materially from the all-payor ratio, and lower Medicaid-specific cost coverage may encourage facilities to admit fewer Medicaid residents in favor of other payor types. We will review Medicaid-specific cost coverage below in detail, focusing on Medi-Cal-specific cost and rate information. Second, given that facility costs and revenues are self-reported, they may reflect inefficient operations, excessive related-party transactions, or, conversely, inadequate staffing. A facility with low reported costs because of understaffing would appear to have a favorable payment-to-cost ratio despite its provision of inadequate care. Third, statewide averages mask significant variation across facilities, peer groups, and regions; facilities with higher proportions of Medicaid-covered days or those in high-cost labor markets may experience cost coverage ratios substantially below the statewide average. Fourth, the data in cost reports lag the rate-setting period by an average of one to two years such that cost coverage ratios may not reflect current market conditions. These limitations underscore the importance of supplementing financial analyses with staffing, quality, and access measures when evaluating rate adequacy.

Direct care cost classification and rate ceilings

Direct care costs represent the largest component of nursing facility reimbursement. The classification of costs as “direct care” versus “indirect” or “administrative” has significant implications for systems that apply different limitations to each component. In **Exhibit 2.5**, we provide an overview of the definitions of cost components in California and across the nation. In **Exhibit 2.6**, we compare California's rate ceilings with the range observed in other states that rely on cost-based systems. In particular, we compare

California's combined care-related labor categories (direct and indirect care labor) with other states' direct care cost centers and examine California's care-related nonlabor categories relative to other states' indirect care cost centers. The exhibit segregates comparable states and ranges by whether a system bases its cost ceilings on percentiles of comparable facilities or a median/mean basis.

Exhibit 2.5. California's nursing facility cost categories: Crosswalk to national terminology

California Rate Component	California Rate Component Definition	National Equivalent Nomenclature
Direct resident care labor	RN, LVN, and CNA wages and benefits; social services and activities personnel	Direct care (labor component)
Indirect care labor	Dietary, housekeeping, laundry, medical records, plant operations wages and benefits	Direct care (labor) in some states; indirect care or routine services in others
Direct care/indirect care nonlabor	Medical supplies, raw food costs, other nonwage care-related expenses	Indirect care/routine care (nonlabor component)
Administrative costs	Management, legal, accounting, general overhead	Administrative
Capital costs (FRVS)	Building, equipment, land via fair rental value formula	Capital
Pass-throughs	Property taxes, liability insurance, licensing fees, caregiver training	Pass-through/direct pass-through

Source: Accounting and Reporting Manual for California Long-Term Care Facilities, available at: https://hcai.ca.gov/wp-content/uploads/2023/11/Chpt3000_2023.pdf.
RN = registered nurse; LVN = licensed vocational nurse; CNA = certified nursing assistant; FRVS = Fair Rental Value System.

Exhibit 2.6. Comparison of rate component ceilings: California and other cost-based states

Rate Component	California	Other States (percentile)[a]	Other States (median/mean)[b]
Labor care costs	95th percentile	75th–95th percentile	100–130% of median/mean
Nonlabor care costs	75th percentile	80th–90th percentile	92–125% of median/mean
Administrative	50th percentile	75th–80th percentile	86–137% of median/mean

[a] States with percentile-based cost limits for direct care, indirect care, or administrative cost, as a result of a review of publicly available State Plan and regulatory information as of January 1, 2026: Arkansas, Delaware, Georgia, Illinois, Michigan, Oklahoma, Vermont.
[b] States with percentile-based cost limits for direct care, indirect care, or administrative cost, as a result of a review of publicly available State Plan and regulatory information as of January 1, 2026: Alabama, Colorado, Connecticut, Florida, Iowa, Kansas, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Mexico, North Carolina, South Carolina, South Dakota, Wisconsin.

California's 95th percentile direct care ceiling falls at the upper end of the national range. The administrative ceiling at the 50th percentile lies within a range comparable to that of other states. Even though other percentile-based states may generally exhibit a higher administrative percentile, California falls within a reasonable bound when compared with states using a median-/mean-driven approach. States using a median-/mean-cost approach for their administrative ceiling range from 86 to 137 percent of the median/mean cost; with the 50th percentile analogous to 100 percent of the median/mean, California occupies the middle of the range.

California's indirect care ceiling at the 75th percentile similarly falls below the range in other percentile-based states but not by as significant a margin as the direct care ceiling, although still within analogous bounds of a median approach. The overwhelming majority of cost-limited states uses the median rather than a percentile as the ceiling basis, representing a methodological convention that differs from California's approach.

The effect of percentile limitations and growth caps on cost coverage in California

Medi-Cal's SNF payment methodology for FS/SNF-Bs relies on two distinct layers of cost constraint: percentile-based ceilings on individual rate components and year-over-year growth caps applied to the resulting rate components. Each mechanism supports an independent policy purpose: the percentile ceilings limit excessive cost variation among facilities, and the growth caps limit total year-over-year system growth. In the following sections, we include our analyses related to Medicare rates' cost coverage. It is important to note that we compare Medicaid cost coverage with facilities' average per diem costs. To that end, this report recognizes the limitations of reliance on the average per diem cost.

The Medicaid resident population generally requires fewer nursing resources than other payor populations because of beneficiaries' greater need for custodial care. Using the Patient-Driven Payment Model nursing component,[50] one recent publication reports that Medicaid patients, on average, are 89 percent of the average acuity of a Medicare patient and 2 percent less acute than other payor populations. With this differential, the cost of care for Medicaid patients in nursing homes should generally be lower than that of other payor types, given the lower resource needs among nursing staff. For nursing homes, the MDS resident assessment generally determines resident acuity. In view of the timing, availability, and certain missing MDS data elements, we were unable to calculate an accurate view of Medicaid resident acuity in California at the time of this report's release. As such, Medicaid cost coverage estimates presented here do not contain acuity normalization and may be overstated for the Medicaid patient population as compared with more complex and higher-acuity Medicare and other payor patients.

Labor component: Percentile ceilings and growth caps

The labor component of the Medi-Cal per diem encompasses both direct care labor and indirect care labor. Direct care labor consists of nursing wages, salaries, and benefits for registered nurses (RNs), licensed vocational nurses (LVN)s,[51] certified nursing assistants

[50] White, A., & Zheng, Q. (2020). *Comparison of nursing facility acuity adjustment methods: Final report*. Abt Associates. Prepared for the Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/wp-content/uploads/2020/11/Comparison-of-Nursing-Facility-Acuity-Adjustment-Methods.pdf.

[51] California uses the title licensed vocational nurse (LVN), whereas CMS and most other states use the title licensed professional nurse (LPN). These two titles refer to the same type of licensed

(CNAs), and social service activities and other direct care personnel (per CCR Title 22, § 72038, licensed psychiatric technicians are direct caregivers). Indirect care labor includes wages, salaries, and benefits for non-nursing staff whose work supports resident care, such as dietary, housekeeping, and laundry personnel.[52] In California, both direct and indirect care labor costs are subject to a ceiling at the 95th percentile of the facility's peer group distribution.

The 95th percentile ceiling functions as a cross-facility constraint: in any given rate year, a facility whose reported per diem labor costs exceeded the ceiling sees its reimbursable costs reduced to the ceiling. Given that the ceiling is set at the 95th percentile, it constrains only the small number of facilities at the very top of the cost distribution within each peer group (86 facilities for the rate year 2026 rate study).[53] For the large share of facilities, the percentile ceiling is not a binding constraint on the labor component.

Year-over-year growth in the labor component is constrained to no more than 5 percent from the previous year's total, regardless of whether the facility's underlying cost growth exceeded that threshold.

To cap rate growth, the WSP rate adjustments increase a qualifying facility's rates by calculating the variance between the percentile-limited rate and the final growth-capped component. However, the WSP rate adjustments were originally calculated for calendar year 2024 rates (generally using cost reports for fiscal year-end 2021), with subsequent years' adjustments based on previous-year workforce rate adjustments and 5 percent growth. After application of year-to-year growth caps and inclusion of the WSP rate adjustment, the Medicaid day-weighted average cost coverage for direct and indirect labor stands at 95.36 percent of allowable Medicaid costs for rate year 2026. Without the inclusion of the WSP rate adjustments, the Medicaid day-weighted average cost coverage for direct and indirect labor stands at 86.37 percent.[54]

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nursing staff. This report uses LVN and LPN interchangeably, depending on context and section of the report.

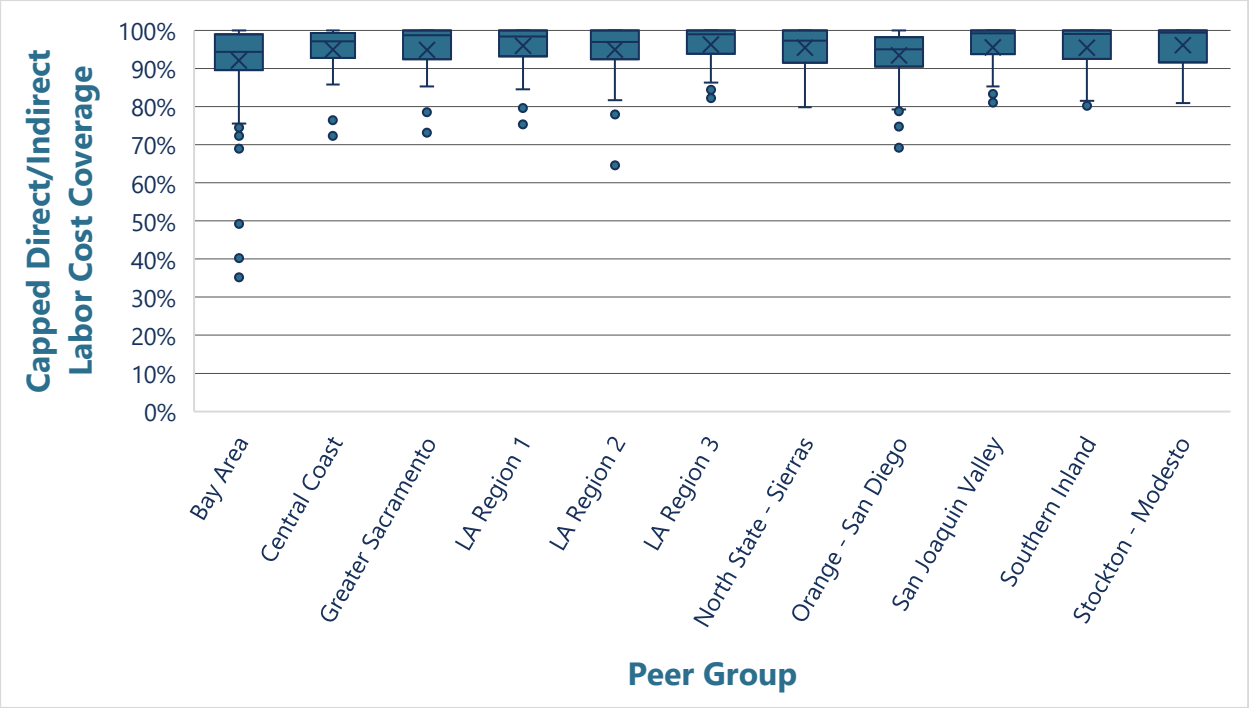
[52] WIC § 14126.023.

[53] California Department of Health Care Services, *Freestanding skilled nursing facilities*, n.d. https://www.dhcs.ca.gov/services/medi-cal-resources/freestanding-skilled-nursing-facilities-and-subacute-units/.

[54] Calculations performed based on the California FS/SNF-B rate studies, https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx, and by comparing total growth-capped rates to reported facility costs by component before application of percentile-based cost limits.

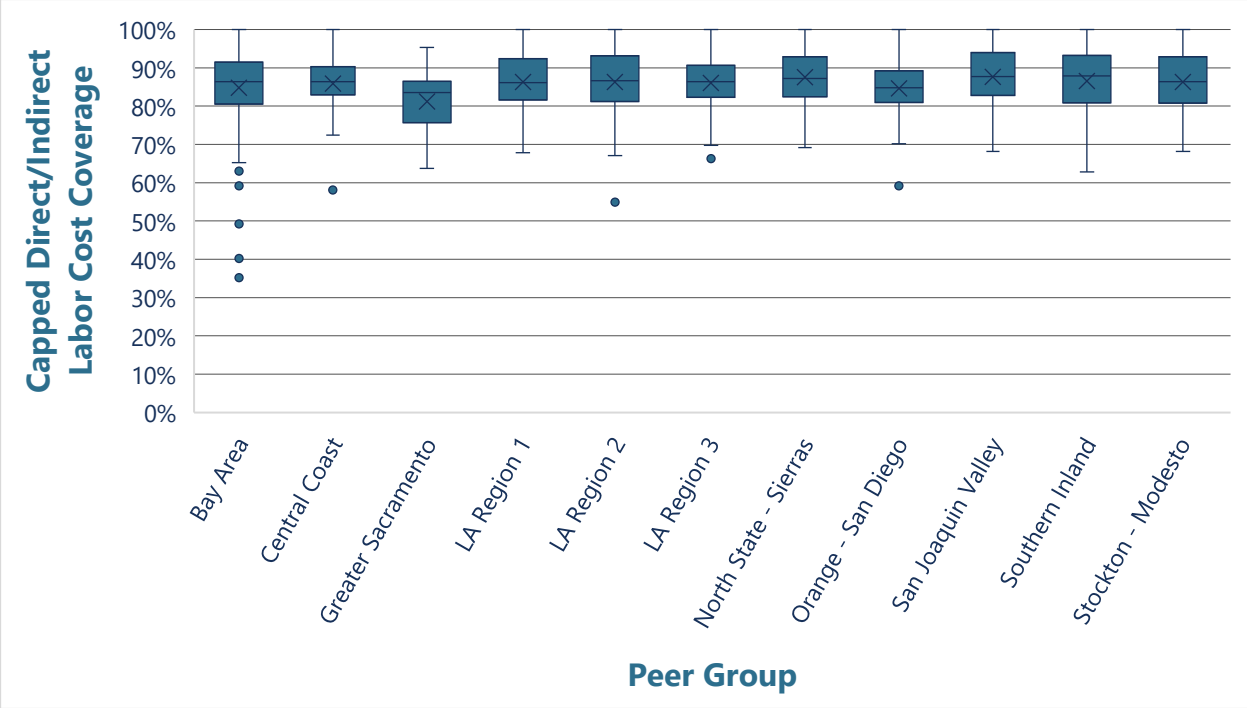
In **Exhibits 2.7** and **2.8**, we present statewide cost coverage for the direct/indirect labor component after application of all relevant percentile and growth limits both with and without WSP rate adjustments.

Exhibit 2.7. Direct/indirect labor component cost coverage with WSP for rate year 2026 by FS/SNF-B peer group



Source: Calculations performed based on the California FS/SNF-B rate studies, available at: https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx.
Note: Bay Area facilities below 50 percent cost coverage reflect implementation of growth caps.

Exhibit 2.8. Direct/indirect labor component cost coverage without WSP for rate year 2026 by FS/SNF-B peer group



Source: Calculations performed based on the California FS/SNF-B rate studies, available at: https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx.
Note: Bay Area facilities below 50 percent cost coverage reflect implementation of growth caps.

Nonlabor component: Several ceiling mechanisms and growth caps

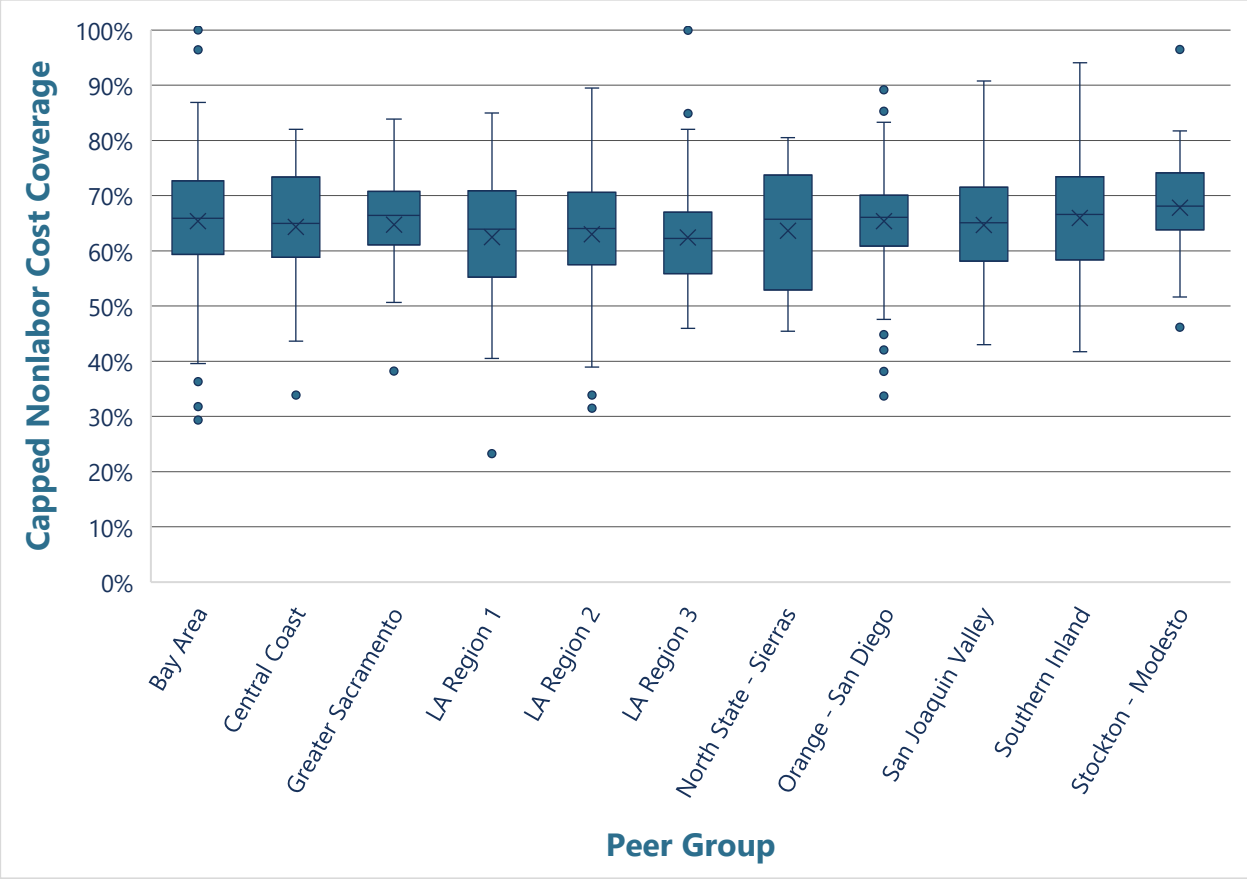
California's nonlabor component aggregates several cost categories, each subject to its own limitation methodology. The categories include administrative costs (management, accounting, and overhead personnel compensation), which are subject to a ceiling at the 50th percentile of the peer group; direct and indirect nonlabor operating costs (medical supplies, food, utilities, and similar expenses) and professional liability insurance costs, which are subject to a ceiling at the 75th percentile; caregiver training costs, which are included as reported; and capital costs, which are calculated through the FRVS rather than based on the facility's actual reported capital expenditures.

The nonlabor component is subject to a more complex set of cross-facility limits than the labor component. The overall rate component growth cap of 1 percent is applied to the sum of all nonlabor components, the 50th-percentile-limited administrative costs, the 75th-percentile-limited operating costs and liability insurance, caregiver training, and the FRVS-calculated capital component.

The result is a more layered compression of the nonlabor component when compared to the labor specific component. After application of the component-level year-to-year growth caps, the Medicaid day-weighted average cost coverage for the nonlabor rate component stands at 66.1 percent of allowable Medicaid costs for rate year 2026, assuming treatment of FRVS amounts as a proxy for allowable capital cost.[55]

In **Exhibit 2.9**, we present statewide cost coverage for the nonlabor component after application of all relevant growth caps for rate year 2026.

Exhibit 2.9. Nonlabor component cost coverage for rate year 2026 by FS/SNF-B peer group



Source: Calculations performed based on the California FS/SNF-B rate studies, available at: https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx.

[55] Calculations performed based on the California FS/SNF-B rate studies, https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx, and by comparing total growth-capped rates with reported facility costs by component before application of percentile-based cost limits.

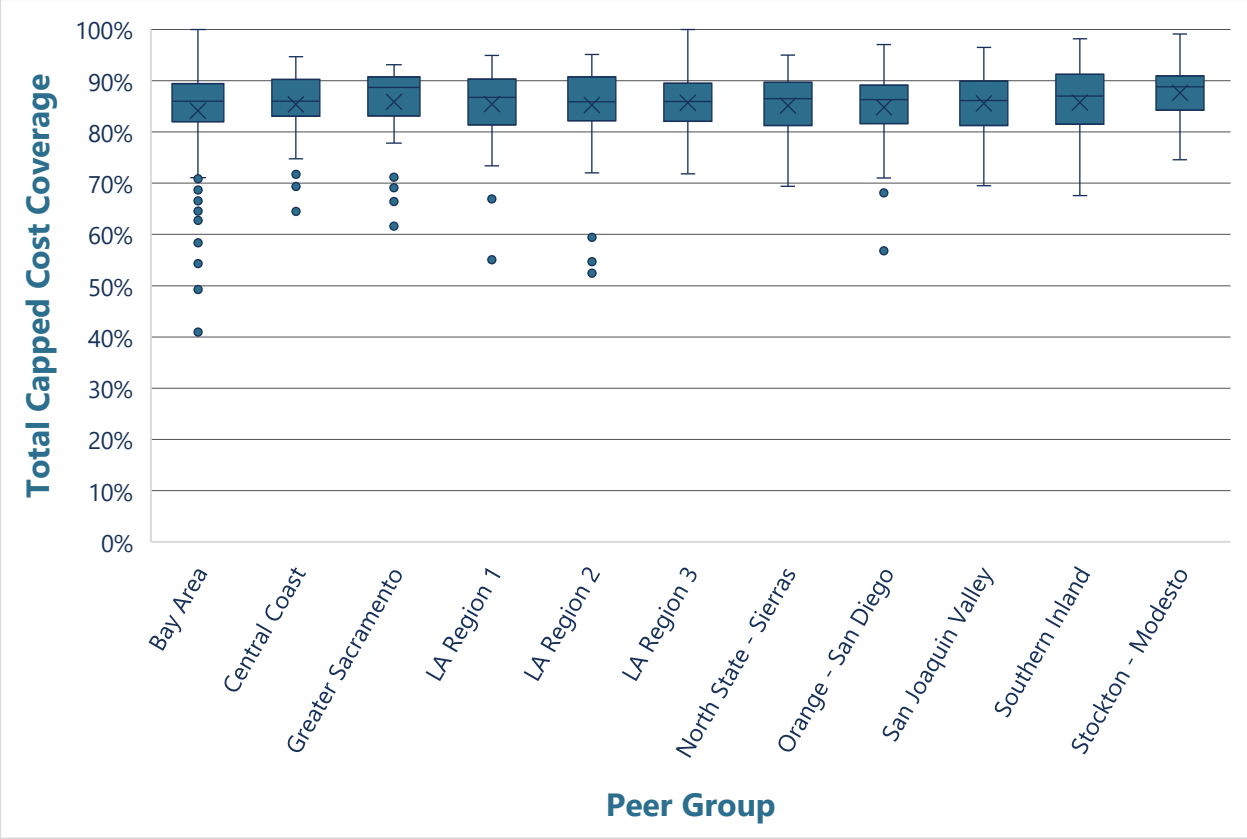
Total rate: Cumulative effect

The Medicaid day-weighted average cost coverage for the total rate component after summation of the direct/indirect labor, nonlabor, bed license fees, and quality adjustment factor, assuming treatment of FRVS amounts, license fees, and QAF add-ons as a proxy for allowable cost, stands at 86.6 percent of allowable Medicaid costs for rate year 2026, with the inclusion of WSP rate adjustments; it stands at 80.81 percent, without the inclusion of WSP rate adjustments.[56] It is important to note that rate year 2026 does not reflect provisions of the previous WQIP, which would inherently increase systemwide cost coverage if the program were in effect (in some cases potentially bringing individual facility cost coverage above 100 percent).

In **Exhibits 2.10** and **2.11**, we present the total statewide Medicaid allowable cost coverage for FS/SNF-Bs with and without WSP rate adjustments.

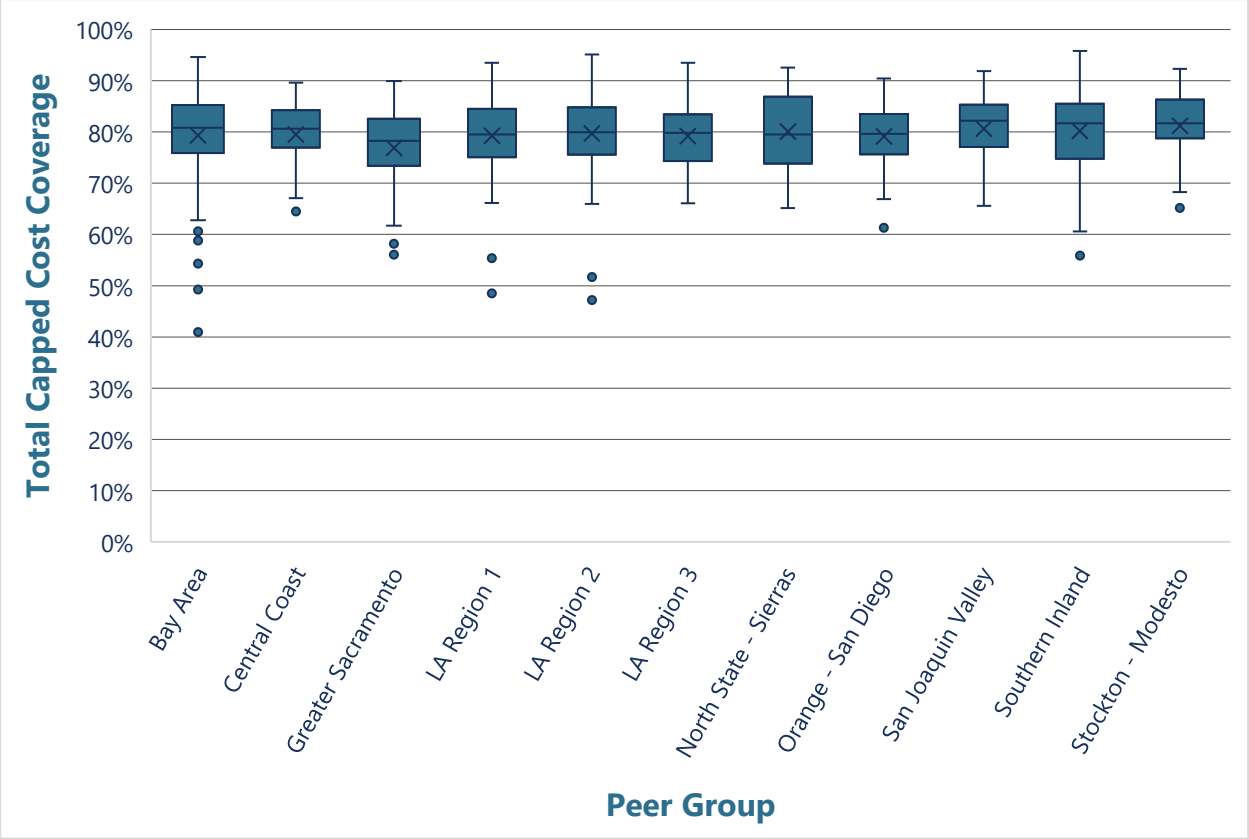
[56] Calculations performed based on the California FS/SNF-B rate studies, https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx, and by comparing total growth-capped rates with reported facility costs by component before application of percentile-based cost limits.

Exhibit 2.10. Total rate cost coverage with WSP for rate year 2026 by FS/SNF-B peer group



Source: Calculations performed based on the California FS/SNF-B rate studies, available at: https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx.

Exhibit 2.11. Total rate cost coverage without WSP for rate year 2026 by FS/SNF-B peer group



Source: Calculations performed based on the California FS/SNF-B rate studies, available at: https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx.

California cost coverage in national context: Comparison to Medicaid and CHIP Payment and Access Commission (MACPAC) findings

The most comprehensive national analysis of cost coverage in Medicaid nursing facilities is a Medicaid and CHIP Payment and Access Commission (MACPAC) issue brief on Estimates of Medicaid Nursing Facility Payments Relative to Costs, published in 2023 and using data from 2019. That analysis, developed with input from a technical expert panel convened by MACPAC in 2022, applied a standardized methodology across states to estimate the ratio of Medicaid base payments to acuity-adjusted facility costs.

MACPAC's findings provide the most rigorous benchmark for evaluating California's cost coverage position.[57]

MACPAC found that the national median Medicaid base payment rate was 86 percent of reported Medicaid allowable facility costs. The distribution was wide: approximately 15 percent of facilities received base payments covering less than 70 percent of their costs, whereas approximately 19 percent received payments exceeding 100 percent of their costs. MACPAC also documented substantial cross-state variation, with average base payment rates ranging from 62 to 182 percent of the national average after adjustments for area wages and resident acuity.

California's statewide cost coverage for FS/SNF-Bs places California very close to the national median of 86 percent coverage identified by MACPAC. MACPAC's analysis used 2019 data and applied a standardized acuity adjustment based on resource utilization group (RUG)-IV nursing case-mix indices. Our analysis of California's cost reports reflects current-year rate-to-cost ratios without acuity normalization. Despite the methodological differences between MACPAC's and our approach, the proximity of the two figures is notable. It indicates that California's growth-capped per diem reimbursement, after the compounding effect of percentile ceilings, FRVS limitations, and growth caps, produces an aggregate cost coverage outcome that is consistent with the identified national central tendency for base payments for Medicaid nursing facilities.

The MACPAC median of 86 percent Medicaid cost coverage reflects the national distribution of cost coverage across all states, including states that use price-based systems, states with less restrictive cost ceilings, and states that rebase less frequently. However, even though the aggregate cost coverage outcome is comparable to California's, the distributional effects within California may differ.

MACPAC's analysis further found that facilities serving a high share of Medicaid-covered residents generally had lower base payment rates and lower facility costs, than those with a lower share of Medicaid-covered residents in part because of lower staffing levels. The commission observed that the Medicaid payment-to-cost ratio for facilities with one-star quality ratings was, on average, seven percentage points higher than for facilities with five-star ratings because lower-rated facilities tended to account for lower

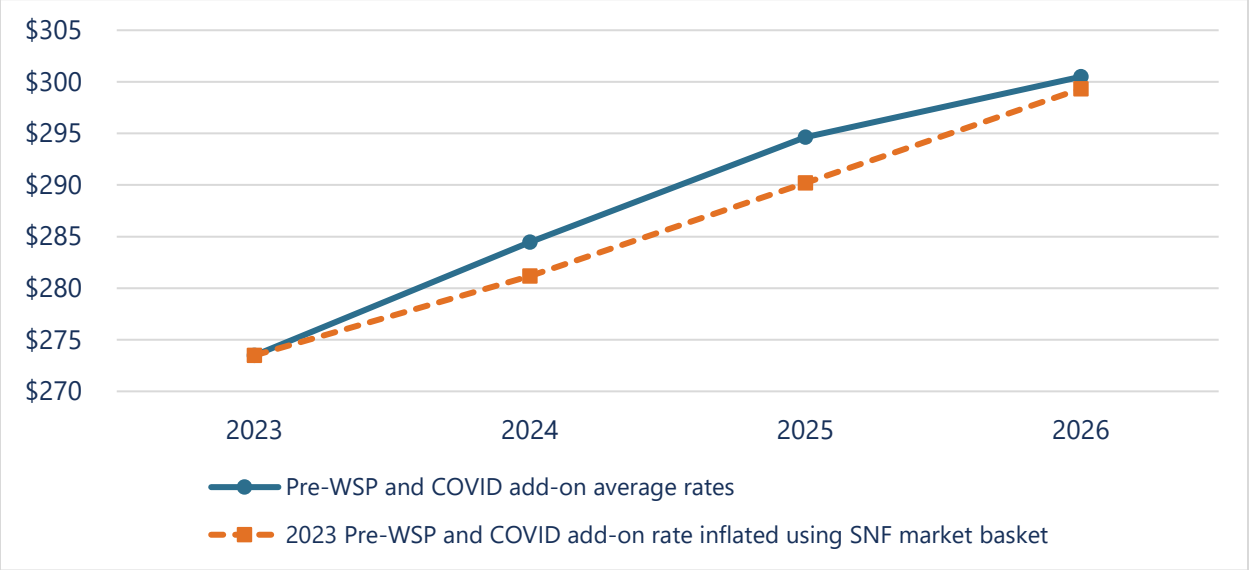
[57] Medicaid and CHIP Payment and Access Commission (MACPAC). (2023). Estimates of Medicaid nursing facility payments relative to costs [issue brief]. https://www.macpac.gov/publication/estimates-of-medicaid-nursing-facility-payments-relative-to-costs/.

staffing costs. This inverse relationship between quality and apparent cost coverage underscores a limitation of cost coverage as a standalone metric of adequate payments. A favorable ratio does not necessarily indicate adequate payment if the underlying costs reflect insufficient facility investments in staffing and quality.

Finally, the MACPAC analysis captured only base Medicaid payments and did not fully account for supplemental payment programs. In California, the previous WQIP provided a significant amount of additional funding to qualifying facilities such that inclusion of that funding would push Medicaid cost coverage above calculated amounts.

In **Exhibit 2.12**, we compare California's rate growth from rate year 2023 through rate year 2026 against the CMS SNF market basket with capital consideration inflation index over the same period, providing context for how California's growth cap mechanism has performed relative to industry-wide cost trends. The comparison indicates that the growth cap mechanism has kept base-rate inflation to near parity with the overall market basket inflation indices. It is important to note that individual state or local minimum wage ordinances may influence comparisons with inflation benchmarks. National inflation indices fail to capture state- or local-specific wage floors that exceed the national minimum wage, with wage floors reflecting a blended average of labor cost trends across all states. For nursing facilities, direct care labor represents the single largest cost category; moreover, a substantial share of the nursing facility workforce is compensated at or near minimum wage thresholds.

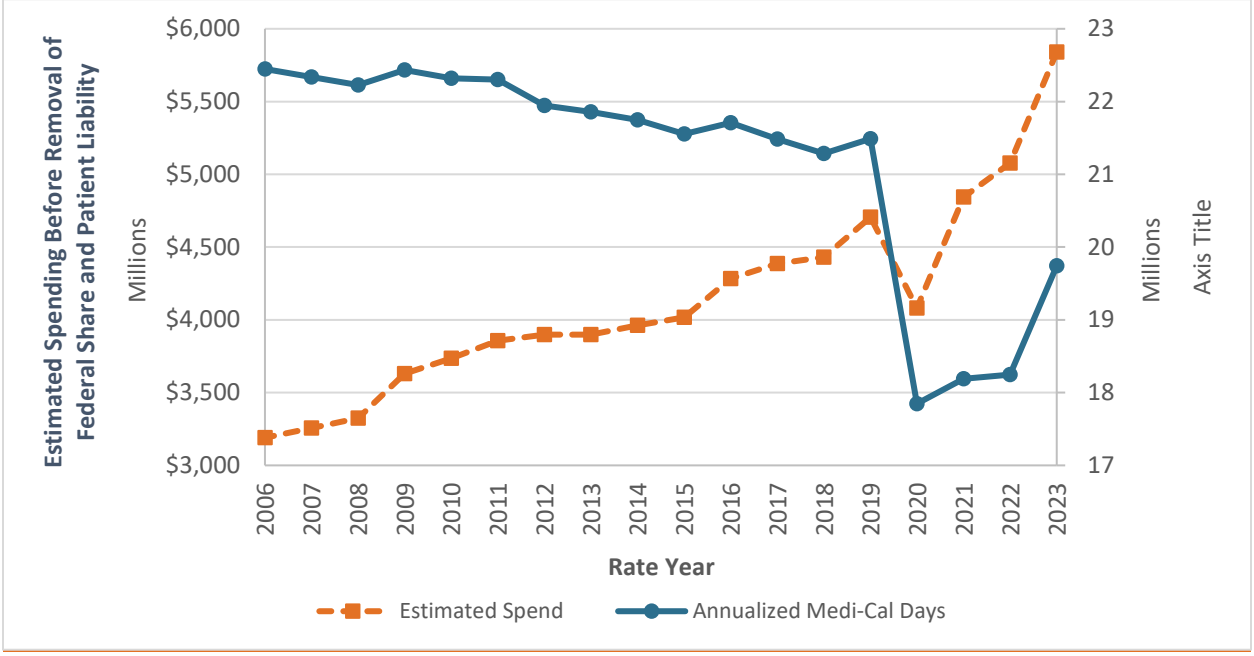
Exhibit 2.12. California rate growth versus SNF market basket inflation, rate years 2023–2026



Source: Calculations performed based on the California FS/SNF-B rate studies, https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx, compared with the S&P Global SNF Market basket index from quarter 3 of 2025.

Exhibit 2.13 shows the growth of estimated Medi-Cal final enhanced rate spending over time (before the removal of federal matching funds or the impact of resident liability) as well as the change in annualized reported Medicaid days reported on the cost reports used in each rate year. To match the relevant published rates with corresponding cost report day periods, the cost report annualized Medi-Cal days from a specific year end are multiplied by the Medi-Cal day-weighed rate for the corresponding rate year (e.g., rate study 2023 rates are multiplied by cost report year 2023 annualized Medi-Cal days). In 2006, estimated spending on SNFs was just over $3.27 billion; by 2026 estimated spending had increased by over 94.6 percent to $6.37 billion.

Exhibit 2.13. California system spend and reported Medicaid days growth, rate years 2006–2026



Source: Calculations performed based on the California FS/SNF-B rate studies available at https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx.

Notes: Rate studies for rate years 2007 and 2010 lacked Medi-Cal days data necessary to calculate estimated spend. The information for these years is the mid-point of the values for 2006/2008 and 2009/2011 respectively. The decrease in spending and annualized Medicaid days in rate year 2023 corresponds to data from cost report years ended 2020, the height of the COVID-19 pandemic. COVID-19 additional payments are reflected in 2021/2022/2023 rate study information but are not included in 2020 rate study data. The increase in spending beginning in 2022 reflects the introduction of the Workforce Standards Program.

California's payment in national context

At a day-weighted average final enhanced rate (inclusive of WSP and QAF) of $322.47 for rate year 2026,[58] California's per diem exceeds the national average of $305.81 among states with publicly available rate data (ranging from $163.68 in Nevada[59] to $518.22 in Oregon).[60,61] This rate positions California above the national midpoint in nominal terms, though comparisons require caution given differences in the cost of living, labor markets, the scope of base rate services, and supplemental payment programs.

However, the wide distribution of California facility-specific FS/SNF-B enhanced rates (inclusive of WSP and QAF), ranging from $187.32 to $484.43, reflects accumulated historical cost patterns rather than current resident needs or facility performance. Using rate year 2023 information, the R^2 of 0.15 for the relationship between base rates and Medi-Cal resident share (**Exhibit 2.14**) and the R^2 of less than 0.01 for rates versus WQIP quality scores (**Exhibit 2.15**) indicate that the current rate structure distributes the majority of payment according to historical facility cost experience and not necessarily according to quality or Medicaid utilization. These are not marginal correlations; an R^2 of less than 0.01 means that base per diem rates explain virtually none of the variation in quality outcomes across facilities and represent a structural disconnect between the core payment mechanism and the guiding principles articulated in the SNF Value Strategy.

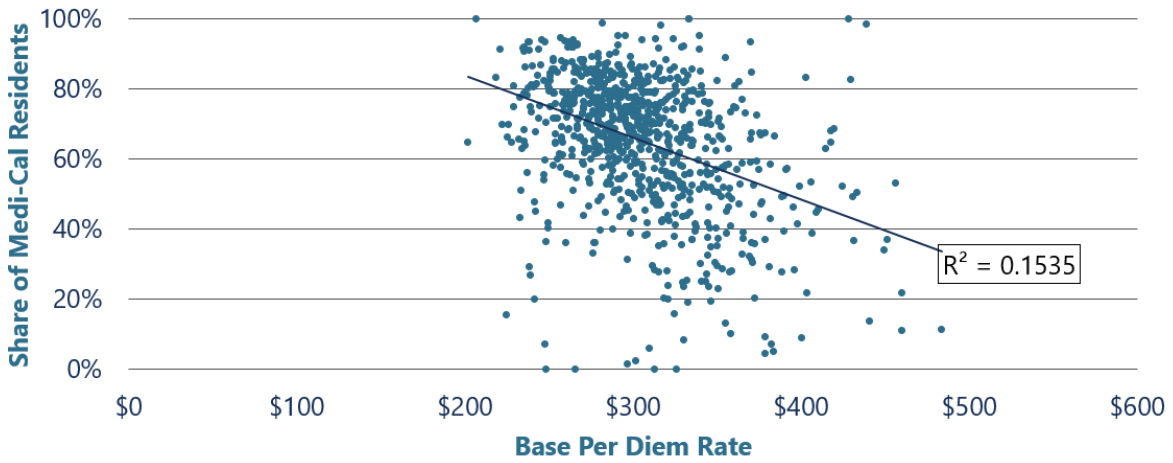
[58] Calculations performed based on the California FS/SNF-B rate studies, available at: https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx

[59] Calculations performed based on Nevada nursing facility rates (October 2025), available at: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/Rates/SFY%2026%20Q2%20Nursing%20Facility%20Rates%2010012025.pdf

[60] Calculations performed based on Oregon nursing facility Medicaid Reimbursement Rates (2024), available at: https://www.oregon.gov/odhs/licensing/apd/provideralerts/odhs-24-035-003-nf-2024-medicaid-reimbursement-rates.pdf.

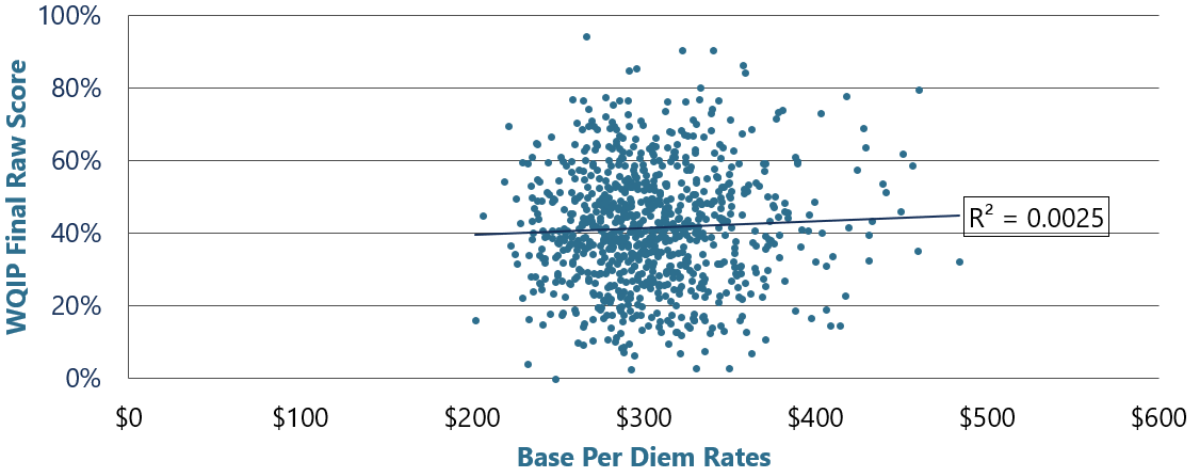
[61] Calculations performed based on review of publicly available rate information, January 1, 2026 (note that states listed as RUGs are actively investigating PDPM adoption).

Exhibit 2.14. Cost report year 2023 share of Medi-Cal residents and base per diem rate



Source: Calculations performed based on FS/SNF-B rates, available at: https://www.dhcs.ca.gov/services/medi-cal/Documents/LTCRU/FSNF-B-CY2023-Cost-Build-Up.xlsx.

Exhibit 2.15. Cost report year 2023 WQIP final raw score and base per diem rates



Source: Calculations performed based on FS/SNF-B rates, available at: https://www.dhcs.ca.gov/services/medi-cal/Documents/LTCRU/FSNF-B-CY2023-Cost-Build-Up.xlsx.

Use of resident acuity in SNF payment

One of the most consequential design choices in nursing facility payment is whether, and how, to incorporate resident acuity into rate determination. In this section, we review the primary classification systems, the current state of Medicaid adoption, and important implementation considerations.

Currently, 36 states use MDS-based acuity in their nursing facility payment systems, and 33 states have adopted Medicare's Patient-Driven Payment Model or have concrete plans to do so.[62] The nationwide adoption of acuity-based systems reflects a broad consensus among state Medicaid programs that per diem rates that do not include considerations of resident complexity may create structural misalignments between payment and the actual cost of care delivery. Studies have shown that the adoption of acuity-based payment structures have resulted in increased access to care for high-acuity Medicaid residents.[63]

This principle of acuity-based payment and increased access is not unique to nursing facilities. Across other institutional provider types, Medicare and Medicaid have moved away from flat or cost-based payment to systems that adjust for the patient's clinical profile. Medicare's Inpatient Prospective Payment System, implemented in 1983, replaced per diem cost payment for hospitals with per-case payments grouped by Medicare Severity Diagnosis-Related Group. Under that approach, a hospital admitting a patient for a coronary bypass receives a different payment than one admitting a patient for pneumonia. The Outpatient Prospective Payment System, introduced in 2000, applies a parallel logic to hospital outpatient departments by grouping services into Ambulatory Payment Classifications based on clinical and cost similarity.

In the following subsections, we detail the classification systems used with various nursing facility payment methodologies in Medicare and other states, along with the states' specific implementation approaches.

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[62] The 36 states are Colorado, Connecticut, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming. The three states that have not yet adopted the Patient-Driven Payment Model or have published concrete plans are Connecticut, New York, and Wyoming.

[63] Feng, Z., Grabowski, D. C., Intrator, O., & Mor, V. (2006). The effect of state Medicaid case-mix payment on nursing home resident acuity. *Health Services Research*. https://doi.org/10.1111/j.1475-6773.2006.00545.x.

Medicare's approach to SNF payment

The Minimum Data Set and federal assessment requirements

Federal law requires all Medicare- or Medicaid-certified nursing facilities to conduct comprehensive assessments of each patient's functional capacity, which they do through the MDS. Regardless of payor, facilities must complete an MDS assessment for each patient at a maximum of every 92 days.[64]

Resource Utilization Groups

The Resource Utilization Groups (RUG) classification system for nursing facilities was implemented under the Medicare SNF Prospective Payment System established by the Balanced Budget Act of 1997.[65] Under RUG-IV, the per diem Medicare rate paid to nursing facilities comprised two case-mix-adjusted components (therapy and nursing) and one non-case-mixed base rate. The nursing case-mix index (CMI) captured nursing services, social services, and nontherapy ancillary costs (NTA); the therapy index captured physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) costs. Even as RUG advanced acuity-adjusted payment, it emphasized the volume of therapy services as a payment driver, creating incentives for potentially unnecessary service provision, particularly for long-stay Medicaid beneficiaries.

Patient-Driven Payment Model

In October 2019, Medicare replaced RUG with the Patient-Driven Payment Model (PDPM), basing rates on resident characteristics (such as diagnoses, functional status, cognitive impairment) rather than on service volume. PDPM structures the rate on five case-mix-adjusted components (PT, OT, SLP, NTA, and nursing) plus one non-case-mixed base rate. Certain components include variable per diem adjustments reflecting the expectation that resource needs change during a stay.[66] The PDPM framework assigns residents to one of 25 nursing case-mix categories indicative of differences in care needs, with each category tied to a specific Health Insurance Prospective Payment System (HIPPS) code and an associated set of CMIs. Higher CMI values indicate residents with greater care needs and resource use. States that have incorporated PDPM

[64] 42 CFR § 483.20(b)(1), (c) (2024).
[65] Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (1997).
[66] Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2019, 83 Fed. Reg. 39,162 (Aug. 8, 2018).

into their Medicaid payment approaches have generally used the nursing component because it most closely aligns with the direct care cost for long-term residents.

Medicare Advantage and dual-eligible dynamics

The relationship among traditional fee-for-service Medicare, Medicare Advantage (MA), and Medicaid payment is particularly relevant for SNF populations, as the majority of nursing facility residents are dually eligible for both Medicare and Medicaid. Under traditional Medicare, reimbursement for SNF stays is based on the PDPM system described above. MA plans, however, enjoy greater flexibility in how they reimburse SNFs and are not required to use the PDPM rate structure. MA plans may negotiate rates with SNF providers whose rates differ from Medicare fee-for-service rates, and they may impose different utilization management requirements, authorization criteria, and length-of-stay limits.

For dually eligible residents, the interaction between Medicare (or MA) and Medicaid creates a complex multipayor environment. Medicare typically covers the first portion of a qualifying SNF stay (up to 100 days, with cost sharing after day 20), after which Medicaid assumes responsibility for ongoing long-term care costs. The transition from Medicare to Medicaid coverage can create discontinuities in payment levels and care approaches. Under an acuity-based Medicaid system, the alignment between PDPM (used for Medicare payment) and PDPM-derived Medicaid acuity classes can reduce administrative friction during these transitions and promote more consistent care planning across payor sources. In addition, as MA enrollment continues to grow nationwide, particularly among dual-eligible populations, the dynamics of MA-SNF negotiations and their downstream effects on Medicaid-funded long-stay care represent an evolving area of policy significance.

State adoption of acuity-based reimbursement

Adoption of PDPM acuity-based payment in state Medicaid programs has accelerated significantly since the adoption of PDPM measures at the federal level. In **Exhibit 2.16**, we summarize the PDPM component adoption patterns (see also **Exhibit 2.17** for a national map).

Exhibit 2.16. Medicaid PDPM adoption by component

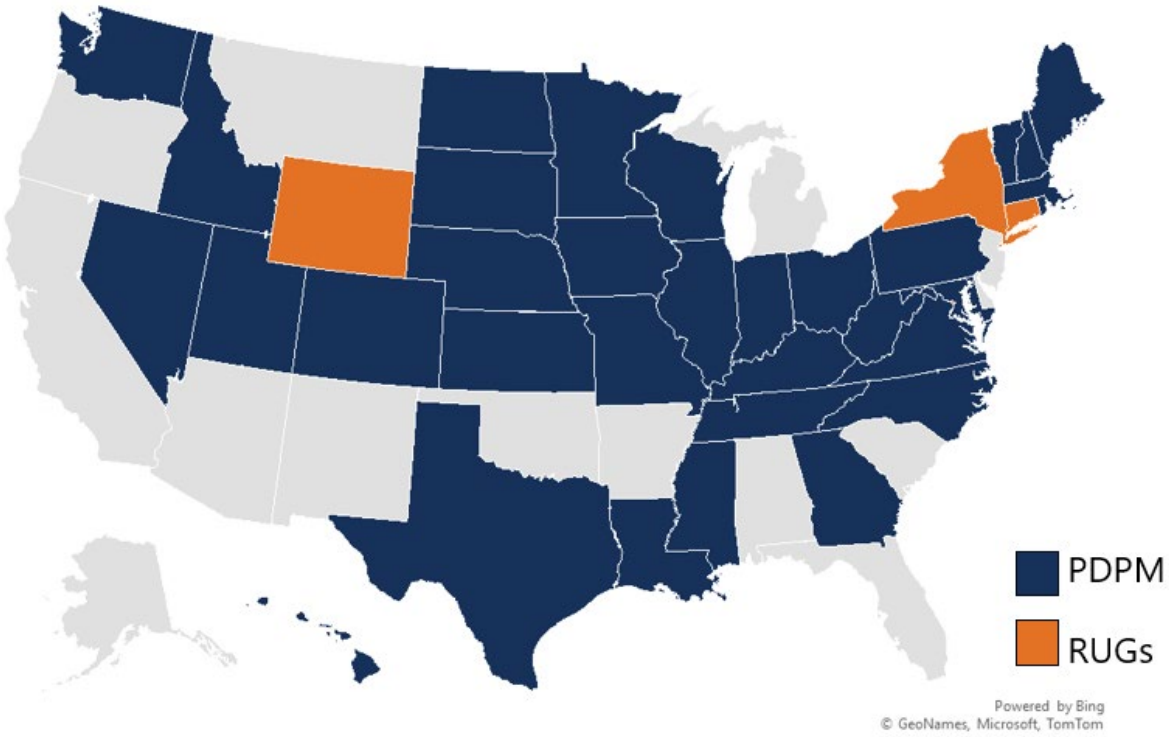
PDPM Components Used	States	Rationale
Nursing only[a]	24	Most closely correlated with nursing staff cost, the primary Medicaid direct care cost driver. Aligns with the RUG-IV classification methodology after removing the influence of therapy-minute coding. Other component costs covered by Medicare Part B for dual-eligibles or other Medicaid programs.
Nursing + NTA and/or SLP[b]	5	Attempts to capture comorbidity burden (NTA) and cognitive impairment (SLP). Nursing typically 60%+ of blended weight.
All components (PT, OT, SLP, NTA, nursing)[c]	4	Attempts to align with full Medicare PDPM weighting. Includes therapy components not typically Medicaid-funded for dual-eligible beneficiaries.

[a] Colorado, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, New Hampshire, Ohio, Pennsylvania, Rhode Island, South Dakota, Tennessee, Vermont, Washington, West Virginia.

[b] Nevada, North Carolina, North Dakota, Texas, Wisconsin.

[c] Louisiana, Mississippi, Utah, Virginia.

Exhibit 2.17. Acuity-based payment nationwide



Source: Determined from review of publicly available State Plan or regulatory documentation nationwide as of January 1, 2026 (note that states listed as RUGs are actively investigating PDPM adoption).
Note: States shaded in grey do not use RUG or PDPM acuity-based components in their SNF payment.

An important design distinction across state systems is whether acuity adjustment operates at the facility level or at a statewide or resident level. In facility-level systems, the overall acuity mix of a facility's resident population provides the basis for a single blended rate, whereas resident-level systems tie payment directly to each individual resident's assessed care needs. Medicare's SNF Prospective Payment System operates at the resident level, adjusting payment for each beneficiary based on the resident's specific clinical characteristics and resource requirements. In most states that have adopted acuity-based reimbursement, the adjustment is facility-specific. Each facility's Medicaid CMI undergoes ongoing recalculation by using MDS assessment data for its own resident population, with the resulting Medicaid CMI applied to the direct care component of that facility's per diem rate. This approach is the most responsive to actual patient acuity by tracking changes in the clinical profile of each facility's population as patients are admitted, discharged, or reassessed. The trade-off is high

administrative burden. Ongoing recalculation requires reliable MDS submission pipelines, the state data infrastructure needed to produce and distribute updated CMI reports, and a reconciliation window for facilities to review and correct patient listings before rates take effect.

Should California move toward adoption of an acuity-based payment system linked to data derived from MDS information, it would need to resolve data submission issues. We reviewed nearly 16 million California nursing facility MDS assessments from January 1, 2022, through December 31, 2025, to determine the inclusion of data elements required to classify residents into PDPM case-mix categories. The review showed that, even though data were available for calculation of the PDPM nursing component, over 40 percent of assessments lacked the information needed for accurately calculating the HIPPS code used to categorize residents into all PDPM component categories.[67] Given that MDS assessments are not a driving factor in Medi-Cal reimbursement, providers currently have little incentive to complete non-Medicare–required MDS assessment fields accurately for Medicaid patients. With such a large number of assessments lacking pertinent information, a complete view of statewide acuity is not currently possible. If Medi-Cal were to adopt an acuity-based system, DHCS may need to require nursing facilities to complete additional MDS assessment fields on all MDS assessments to include the relevant information, depending on which elements of PDPM California might adopt for payment purposes.

The adoption of acuity-based payment would not necessarily create new administrative requirements for facilities. With acuity-based payment systems predicated on MDS-based acuity classification, all Medicare- and/or Medicaid-certified facilities are already required to complete MDS assessments and transmit them through the CMS Internet Quality Improvement & Evaluation System (iQIES). The assessments provide the basis for ongoing care planning and resident needs assessments and should be completed accurately at the time of submission for all residents.

An acuity-based payment system does, however, create an incentive for provider upcoding, sometimes called "case-mix creep," in which facilities code MDS items to place residents in higher-paying classes than their clinical condition may warrant. CMS has recently scrutinized PDPM coding trends under Medicare, noting significant

[67] The most common missing MDS fields are: I0020, J2100, and O0400D.

increases in coding for certain conditions that may or may not reflect genuine changes in resident complexity.[68]

States have adopted several strategies to mitigate this risk. Many states conduct regular rebasing of their case-mix index, often annually, so that baseline acuity reflects current coding patterns and prevents the setting of rates that reflect the cumulative upward drift in payments. In particular, annual rebasing helps neutralize the financial gain from across-the-board upcoding because inflated scores raise the average against which all facilities are measured. CMS has employed analogous safeguards under Medicare's PDPM. Following PDPM implementation in FY 2020, CMS recalibrated its parity adjustment factor by 4.6 percent, phased in as a 2.3 percent reduction across FYs 2023 and 2024.[69] In still other cases, some states use a structured MDS review program, including random and targeted reviews of MDS assessments.

In one more approach to risk mitigation, the dual use of MDS data for both payment and quality measurement creates a natural check. A facility that overcodes acuity to maximize payment may simultaneously worsen its performance on MDS-derived quality indicators, potentially affecting its CMS Five-Star rating, Medicaid quality or staffing program performance, and public reputation.

Any one of the above strategies, or a combination, can reasonably limit upcoding risk and the degree to which a facility can influence the system without remediating consequences.

The need for such safeguards becomes clearer when viewed against the broader evolution of Medicaid reimbursement methodology. The movement from flat-rate to acuity-adjusted Medicaid nursing facility payment has unfolded over roughly four decades, with distinct waves of adoption. Through the early 1980s, retrospective cost-based and flat prospective systems dominated Medicaid nursing facility payment, with only four states (Illinois, Ohio, Washington, and West Virginia) incorporating any form of patient-level acuity classification into their rate setting by 1981. The late 1980s and early 1990s saw the first major wave of case-mix adoption, driven in part by the development of the RUG-III classification system and growing evidence that flat per diem rates were

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[68] Centers for Medicare & Medicaid Services. (2026). Medicare program; prospective payment system and consolidated billing for skilled nursing facilities; proposed rule. *Federal Register, 91*, 17685.

[69] Centers for Medicare & Medicaid Services. (2022). *Fiscal year (FY) 2023 skilled nursing facility prospective payment system final rule (CMS-1765-F)* [Fact sheet]. https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2023-skilled-nursing-facility-prospective-payment-system-final-rule-cms-1765-f.

suppressing access for higher-acuity Medicaid residents. By 1991, 19 states had adopted some form of case-mix adjustment, but this first wave slowed in the mid-1990s, a period Swan et al. characterized as a "hiatus" in methodological change.[70] A second wave followed in the late 1990s and early 2000s, partly catalyzed by Medicare's shift in 1998 to the RUG-IV-based SNF Prospective Payment System, which created infrastructure and data familiarity that lowered the barrier for Medicaid programs considering similar approaches. By 2002, 32 states had adopted case-mix payment.[71] CMS' transition from RUG-IV to PDPM for Medicare in October 2019 has fueled the most recent and ongoing wave, forcing states that rely on RUG-based classifications to evaluate whether to update their own systems in parallel.

Several patterns characterize how individual states have managed these transitions. Some states move directly from a flat per diem to a fully implemented, multicomponent acuity system in a single step. Others phase in changes. A state may first introduce a simplified case-mix adjustment with a reduced number of case-mix groupings applied only to the direct care cost center and then expand to more classes, categories, and cost centers in subsequent rate years. Washington, for example, implemented its initial case-mix system in October 1998 by using a seven-component rate structure that applied RUG-III classes to direct care and therapy components and then refined the methodology over successive legislative sessions.[72] Regardless of timeline, the shift to an acuity-based payment system requires not just a policy decision but also operational changes and provider education.

State implementation approaches

Case study: Texas

Texas provides a detailed example of tailored PDPM implementation. The state collapses the nursing component into six consolidated categories to adjust the component's direct-expense rate. It also collapses the NTA component into three categories to adjust supplies, ancillary, and therapy cost centers. Texas further customizes its system with two add-on mechanisms. First, it uses Brief Interview for Mental Status (BIMS) scores, a

[70] Swan, J. H., Harrington, C., Clemena, W., Pickard, R. B., Studer, L., & de Wit, S. K. (2000). Medicaid nursing facility reimbursement methods: 1979-1997. *Medical Care Research*.
[71] Grabowski, D. C., Feng, Z., Intrator, O., & Mor, V. (2004). Recent trends in state nursing home payment policies. *Health Affairs*, Web Exclusives: W4-363-373. Feng et al. (2006) report 19 states with case-mix systems by 1991 and 32 by 2002.
[72] Washington State Department of Social and Health Services, Aging and Disability Services Administration. (2003). *Report to the legislature: Medicaid Nursing Facility Payment System*.

cognitive screening tool within the MDS, to calculate a behavioral health rate component equal to 5 percent of the nursing rate component at the highest CMI. In other words, the BIMS add-on is a fixed dollar amount derived from the top of the nursing CMI scale, applied uniformly to all qualifying residents as a supplement to their otherwise individually classified nursing rate. Second, an HIV-specific add-on is applied as a claim-level adjustment equal to an 18 percent increase to the nursing component PDPM group. These customizations demonstrate how PDPM offers a flexible platform that encourages state-specific adjustments.[73]

Case study: Wisconsin

Wisconsin uses a two-component model, adjusting nursing staff costs by using the PDPM nursing component and adjusting supplies, therapies, and social services costs by using the PDPM NTA component. Wisconsin's decision to use only these two components in its payment model reflects the rationale that Medicare Part B generally covers PT, OT, and SLP costs for dually eligible residents, making those PDPM components less relevant to Medicaid rate setting. This two-component model offers a practical pathway for states seeking acuity-based payment without full PDPM complexity.[74]

Case study: Illinois

One outstanding feature of Illinois's PDPM implementation is the state's adoption of the PDPM nursing component in July 2022, using a phased blending approach. It calculated initial rates by using the higher of the full PDPM rate or blended PDPM/RUG rate, with the blend progressively shifting toward full PDPM over successive quarters. Because Illinois uses a price-based rate for direct care, it applied a budget neutralization factor to the PDPM nursing component's class weights to ensure that implementation was budget-neutral relative to the previous payment system. Another distinguishing factor of Illinois's payment system is its integration of the CMS Staff Time and Resource Intensity Verification (STRIVE) study benchmarks into the payment methodology. With a state-specific adjustment to CMS' reported case-mix hours, Illinois calculated (1) each facility's ratio of reported total nurse staffing hours per resident day (HPRD)–derived from Payroll-Based Journal (PBJ) submissions to CMS–and (2) the case-mix total nurse

[73] 1 Tex. Admin. Code § 355.318.

[74] Wisconsin Department of Health Services. (2024). *Methods of implementation for Wisconsin Medicaid nursing home payment rates (state fiscal year 2024).* https://www.dhs.wisconsin.gov/nh-rates/rate-setting.htm.

staffing HPRD, generating a sliding-scale staffing add-on to the per diem rate.[75] The add-on helps control for provider MDS upcoding as higher acuity leads to a higher denominator for the ratio calculation. Even though the add-on retains the STRIVE name (referencing the CMS case-mix total nurse staffing hours once based on the STRIVE study's expected staffing benchmarks), Illinois bases its more recent case-mix hour calculations on facility comparisons to the national average.[76, 77]

Case study: Louisiana

Louisiana shifted to PDPM effective July 1, 2025, using all five PDPM components in a weighted blend: nursing at 50 percent, PT at 15 percent, OT at 15 percent, NTA at 12 percent, and SLP at 8 percent. Of all the components, the weighting structure gives nursing the greatest influence over the Medicaid CMI while including therapy and ancillary needs. To manage the transition, Louisiana implemented a corridor-based phase-in in effect from July 1, 2025, through December 31, 2026, limiting the difference between a facility's pre-PDPM and post-PDPM rate at plus or minus $5 per day. Louisiana also maintains a direct care expenditure requirement under which facilities whose actual spending on direct care falls below a threshold of 94 percent of the direct care median must reimburse the state for the difference in spending totals.[78]

Capital and other cost payment structures

Capital payment addresses costs associated with a facility's physical plant. California uses an FRVS methodology, with growth limit caps constraining increases. In **Exhibit 2.18**, we present the national distribution of capital payment approaches.

[75] Illinois Public Act 102-1035; 305 ILCS 5/5-5.2.
[76] Centers for Medicare & Medicaid Services. (2026). *Design for Care Compare nursing home five-star quality rating system: Technical users' guide*. U.S. Department of Health and Human Services. https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf.
[77] Illinois Public Act 102-1035; 305 ILCS 5/5-5.2.
[78] La. Admin. Code tit. 50, pt. II, § 20000.

Exhibit 2.18. Capital payment methods nationwide

Method	States	Description
Fair rental value[a]	25	Estimates rental value based on facility age, size, and location. Encourages maintenance and upgrades. Used by California.
Cost-based[b]	17	Reimburses actual reported capital costs such as depreciation and interest. More complex to audit and significant interaction with related-party transactions.
Price-based[c]	9	Sets a flat capital rate (or total facility rate) independent of individual facility costs.

[a] Alabama, Arkansas, California, Colorado, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Nevada, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Virginia, Washington, West Virginia, Wyoming.
[b] Alaska, Connecticut, Delaware, District of Columbia, Iowa, Kansas, Maine, Massachusetts, Michigan, Nebraska, New Hampshire, New Mexico, New York, North Dakota, South Dakota, Vermont, Wisconsin.
[c] Arizona, Hawaii, Montana, Ohio, Oklahoma, Pennsylvania, Texas, Oregon, New Jersey.

The FRVS, used by 25 states including California, bases capital payment on the estimated current rental value of the facility rather than on the facility's actual reported capital costs. FRVS formulas typically incorporate variables such as facility age, bed count, square footage, and a per-bed construction cost allowance that may be adjusted by a regional construction index or inflation factor. The resulting payment approximates what a facility would pay to lease an equivalent physical plant on the open market. This approach offers several policy advantages. It eliminates the depreciation cliff that occurs under cost-based systems when a facility’s assets become fully depreciated, potentially leaving older facilities with minimal capital payment even when they continue to incur maintenance and renovation costs. It provides a continuing incentive for capital investments in facilities; and FRVS generally allows for capital investment to offset historic depreciation, making the facility less depreciated (reduced facility age) and resulting in a higher payment rate. It also neutralizes the incentive to engage in frequent resale or refinancing transactions to reset the depreciable basis, a pattern that cost-based systems can inadvertently reward. Most significantly, FRVS reduces the audit burden associated with related-party capital transactions. Under cost-based capital

reimbursement, a facility's operating entity may lease its building from a related real estate entity at an above-market rate, report the lease cost in its Medicaid cost report, and potentially convert profit into reimbursable expense. Given that FRVS bases the capital payment on a standardized formula rather than on reported costs, it removes the channel through which inflated related-party lease or rent arrangements flow into the payment rate.

Used by 17 states, cost-based capital reimbursement reimburses actual reported capital costs such as depreciation, amortization, and interest expense. It ties payment most directly to the facility's financial obligations but requires detailed cost reporting and audit of capital-related line items, including scrutiny of related-party leases, management fees, and intercompany transactions. States using cost-based capital systems must establish and enforce rules governing allowable costs, useful life assumptions for depreciation, and fair market value standards for related-party arrangements, all of which translate into administrative complexity. Cost-based systems also create a structural disadvantage for older facilities as a building's depreciable basis declines over time and leads to decreased or eliminated capital payment, even though the facility may face increasing maintenance and renovation needs.

Used by nine states, price-based capital reimbursement sets a flat or formula-driven capital rate (or a flat rate for all system components) that does not vary with the individual facility's reported costs. This approach is the simplest to administer because it requires no facility-level capital cost reporting, but it can underpay facilities with legitimately high capital obligations (such as those carrying debt from recent construction or major renovation) and overpay facilities with minimal capital costs (such as those with a fully paid-off mortgage).

High-need resident payment and add-ons

Nursing facility populations include individuals with specialized needs that standard per diem structures may not adequately address. States have developed various supplemental approaches, and most states have adopted at least some form of add-on for conditions such as ventilator dependence or traumatic brain injury (TBI), with a smaller number of states supplementing payment for complex behavioral health needs or bariatric care. California addresses some of these specialized needs through structural separation (subacute facility designation, behavioral health Special Treatment Programs) rather than through add-ons within a unified framework.

State approaches

Case study: Colorado

Colorado operates the Hospital Back-Up (HBU) Program, which, among the state programs reviewed for this report, is most structurally analogous to California's Subacute Care Program. Codified at 10 CCR 2505-10, section 8.470, HBU functions as a distinct programmatic designation layered on the standard SNF license, serving members who no longer require acute hospital care but need 24-hour monitoring and life-sustaining technology across three clinical categories: ventilator dependency, complex wound care, and medically complex conditions. As with California's subacute contracting model, HBU-participating facilities must undergo a formal application process, obtain a recommendation from the Colorado Department of Public Health and Environment, and designate a specific number of beds for HBU use. Payment differs entirely from the standard state Medicaid nursing facility per diem,[79] with rates based on the case-mix-adjusted federal payment rate. The payment methodology is structurally separate from rather than supplemental to the conventional rate structure. The program currently operates in approximately six certified facilities statewide, reflecting the similar concentrated-capacity approach in California's contracted subacute network.

Case study: Massachusetts

Massachusetts makes rate adjustments for residents requiring dialysis, individuals experiencing homelessness who require specialized discharge planning and social work, and residents with TBIs. It also makes provision for specific dietary requirements such as kosher meals. Massachusetts maintains enhanced rates for facilities with high proportions of behavioral health diagnoses and for specialized dementia care units. This portfolio of options treats the base rate as a foundation on which condition-specific adjustments are layered.[80]

Case study: Michigan

Michigan takes a facility-level approach, classifying nursing facilities into categories based on designated specializations, including mental illness designations (for facilities serving significant proportions of residents with serious and persistent mental illness)

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[79] 10 CCR 2505-10 section 8.470.2–8.470.3; for reimbursement methodology, see section 8.470.8; for facility participation requirements, see section 8.470.7.
[80] 101 Mass. Code Regs. 206.06-.15.

and ventilator care designations (for facilities equipped for long-term mechanical ventilation). Designated facilities benefit from enhanced rate structures reflecting specialized staffing, equipment, and programming costs. Michigan also maintains county-based geographic peer groupings alongside specialty designations, creating a classification matrix. The facility-level model concentrates specialized resources and is administratively straightforward, although it may create cliff effects at designation thresholds and limit the ability of non-designated facilities to receive enhanced payment for individual high-need residents.[81]

Case study: Ohio

Ohio maintains a separate per diem add-on for residents requiring ventilator-dependent care, calculated on the additional nursing and respiratory therapy costs associated with mechanical ventilation. The add-on is applied at the claim level (varying revenue code, modifier, etc.) rather than at the facility level. In other words, any qualifying facility can receive the enhanced rate for individual ventilator-dependent residents regardless of the facility's overall census composition. This resident-level approach avoids the threshold effects inherent in Michigan's facility designation model.[82]

Conclusion

The variety of approaches observed nationally reflects the range of design choices available to states. Each approach involves trade-offs among administrative complexity, targeting precision, and the breadth of populations served. The appropriate approach for any given state depends on its provider landscape, the prevalence of high-need populations within its nursing facility system, and its administrative capacity for implementing and monitoring add-on programs.

Significance of supplemental programs and high-need add-ons

The national landscape demonstrates that supplemental programs and high-need add-ons complement base rate structures across all model types. Louisiana's spending floor, Missouri's multilayered incentive structure, and Massachusetts's extensive add-on

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[81] Michigan Department of Health and Human Services. (n.d.). *Medicaid provider manual: Nursing facility cost reporting and reimbursement appendix*. https://www.michigan.gov/mdhhs/doing-business/providers/providers/medicaid/policyforms/medicaid-provider-manual.

[82] Ohio Department of Medicaid. (n.d.). *Ohio Medicaid state plan: Attachment 4.19-D, supplement 1*.

portfolio illustrate the range of mechanisms states can layer atop base per diem rates to address policy goals beyond what the core methodology alone can achieve.

California's current approach addresses high-need populations, such as residents with behavioral health needs, through structural separation rather than within a unified payment framework. This approach differs from the prevailing national trend toward integrated rate systems with specialized adjustments, whereby most states have adopted at least some form of add-on or enhanced rate for conditions such as ventilator dependence, TBI, and, to a lesser extent, complex behavioral health needs or bariatric care.

Minimum occupancy adjustments and bed hold policies

Minimum occupancy adjustments are an additional factor incorporated into payment structures. Medicaid payment policy includes occupancy considerations that, in many cases, use occupancy percentages to adjust Medicaid rates for SNFs.[83] The adjustments encourage facilities to maintain a census of residents as close as possible to the number of available beds in their facility. Maintaining desirable occupancy rates of 90 to 95 percent can be a particular challenge for small and rural facilities, which may experience more inconsistency in admissions and fluctuations in occupancy rates versus with their larger or urban counterparts. Some states grant facilities some flexibility with respect to occupancy rate adjustment to help maintain access in low-volume or rural markets.

Bed hold policies for residents affect facilities' occupancy levels and finances. Facilities need to articulate a policy related to bed holds for cases when a resident temporarily leaves a SNF because of hospitalization or a nonmedical reason ("therapeutic leave"). The policy must specify whether the facility will hold the resident's bed until the individual's return. States have flexibility to establish bed hold requirements and payment for these days.[84] California requires facilities to offer bed holds for seven days in the case of acute hospitalization; Medi-Cal reimburses facilities for these bed hold days at the facility's daily rate, less estimated food costs.[85] Payment policies that

[83] Rudder, C., Mollot, R. J., Holt, J., & Mathuria, B. (2009). *Modifying the Case-Mix Medicaid Nursing Home System to encourage quality, access and efficiency*. Long-Term Care Community Coalition. https://nursinghome411.org/wp-content/uploads/2017/03/final-national-version-of-LTCCC-reimbursement-study-report-color-7-15-10.pdf.

[84] Medicaid Therapeutic Leave Fact Sheet, available at: https://ltcombudsman.org/uploads/files/issues/Medicaid-Therapeutic-Leave-Fact-Sheet.pdf.

[85] California Code of Regulations Title 22, § 51535.1-Bed Hold for Acute Hospitalization.

reimburse SNFs for holding a resident's bed during temporary absences help stabilize facility revenue and support residents' continuity of care.

North Dakota

North Dakota Medicaid grants flexibility for facilities under both its bed hold requirements and occupancy limits policy. The policies help stabilize payment when residents are temporarily absent and address low occupancy in defined circumstances.

For bed holds, North Dakota covers both hospital leave and therapeutic leave days for nursing facility residents. The Medicaid agency covers a maximum of 15 days of hospital leave per occurrence and a maximum of 30 days of therapeutic leave per year.[86]

North Dakota uses a cost-based rate setting methodology that incorporates productivity by dividing allowable operating costs by the actual number of resident days. For facilities below 90 percent occupancy, the state may adjust the computation of indirect care costs to an imputed occupancy level at or below 90 percent. The state may also waive or reduce that 90 percent occupancy limit in specified situations, including when lower occupancy results from reliance on alternative home and community services and the facility has reduced or approved a reduction in capacity.[87]

Medicaid managed care and state-directed payments

Overview of SDP authority

Federal regulations generally prohibit states from directing how MCPs spend capitation revenue on provider reimbursements. The prohibition reflects the fundamental managed care principle that plans require flexibility to allocate resources based on enrollee needs while negotiating rates with contracted providers based on market dynamics. However, the transition of nursing facility services into managed care creates tension between this principle and states' historical role in setting institutional payment rates. Nursing facilities differ from other Medicaid provider types in several significant ways. In particular, they serve a highly vulnerable population with limited ability to change providers, and they operate under extensive state and federal regulatory requirements that constrain their ability to reduce or shift costs.

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[86] North Dakota Health and Human Services. (2025). *North Dakota Medicaid billing and policy manual: Nursing facilities*. https://www.hhs.nd.gov/sites/www/files/documents/medicaid-policies/nursing-facilities.pdf.

[87] North Dakota Century Code 50-24.4-10-Operating costs.

The legal authority for SDPs is at 42 CFR § 438.6(c), as established by the 2016 Medicaid Managed Care Final Rule (CMS-2390-F). Section 438.6(c) defines the categories of permissible SDP arrangements, as presented in **Exhibit 2.19**.

Exhibit 2.19. Permissible SPD arrangement categories

Category	Regulatory Citation	Description
Value-based purchasing	§ 438.6(c)(1)(i)	Alternative payment models (APMs), P4P arrangements, bundled payments, and other models that recognize value or outcomes over volume of services
Delivery system reform	§ 438.6(c)(1)(ii)	Multipayor or Medicaid-specific delivery system reform or performance improvement initiatives
Fee schedule requirements	§ 438.6(c)(1)(iii)(B)-(D)	Minimum or maximum fee schedules for network providers delivering a particular service under the contract
Uniform rate increases	§ 438.6(c)(1)(iii)(C)-(D)	Uniform dollar or percentage increases for network providers delivering a particular service under the contract

All SDPs must adhere to the requirements for the delivery and utilization of services under the managed care contract, must direct expenditures equally among providers within a defined class, must advance at least one goal in the state's managed care quality strategy under § 438.340, and must recognize that renewal is not automatic.

The regulatory framework governing SDPs has evolved substantially since 2016, reflecting both rapid growth in the number, scale, and complexity of SDP arrangements submitted by states and increasing federal concern over fiscal integrity. The 2024 Medicaid Managed Care Final Rule (CMS-2439-F) introduced several significant changes to § 438.6(c). Most notably, the 2024 final rule codified a total payment rate limit for certain SDPs, capping permissible payments at the average commercial rate (ACR) and requiring states to submit both a total payment rate comparison and an ACR demonstration as part of the preprint approval process. The rule also strengthened quality and program integrity requirements, added explicit provisions requiring states to demonstrate compliance with federal rules governing the nonfederal share of SDP

financing (including 42 CFR § 433, subpart B), and addressed impermissible redistribution arrangements in which providers are effectively held harmless for health-care-related tax contributions used to fund SDPs.

The regulatory trajectory then accelerated through legislation. In July 2025, Congress enacted Public Law 119-21 (H.R. 1), with Section 71116(a) directing the Secretary of the Department of Health and Human Services to revise 42 CFR § 438.6(c)(2)(iii) with the aim of limiting further the total payment rate for certain SDPs, including nursing facility services, to the Medicare rate, while temporarily grandfathering eligible existing arrangements. In May 2026, CMS published a Notice of Proposed Rulemaking responding to both the H.R. 1 directives and the Agency's own priorities. The proposed rule would require the Medicare payment limit for SDPs to be applied on a per-service basis for nursing facility services, presumably based on PDPM rates potentially applied at the claim level. CMS proposed additional regulatory changes that would restrict the design flexibility of value-based purchasing programs. The proposed rule's comment period closed on June 3, 2026, with a final rule pending at the time of this report.[88]

Between 2021 and 2025, CMS approved 73 directed payments from 17 states that included SNF services, with 25 incorporating value-based purchasing elements. California's SNF-related SDPs include the minimum/maximum or minimum-only fee schedule requirements and the former WQIP.[89] The growth in SDP use nationally reflects the increasing number of states that have integrated nursing facility services into managed care and subsequently determined that some degree of payment direction is necessary to ensure rate adequacy, maintain provider access, and advance quality objectives that might not be prioritized through unregulated plan-provider negotiation alone.

Fee schedule design in California

Under the CalAIM LTC carve-in, California established a bifurcated fee schedule framework (see **Exhibit 2.20** for a county-level map). In 31 counties, MCPs must reimburse SNF providers at exactly the Medi-Cal fee-for service per diem rate (minimum/maximum). In 27 counties, MCPs must reimburse at no less than the fee-for-

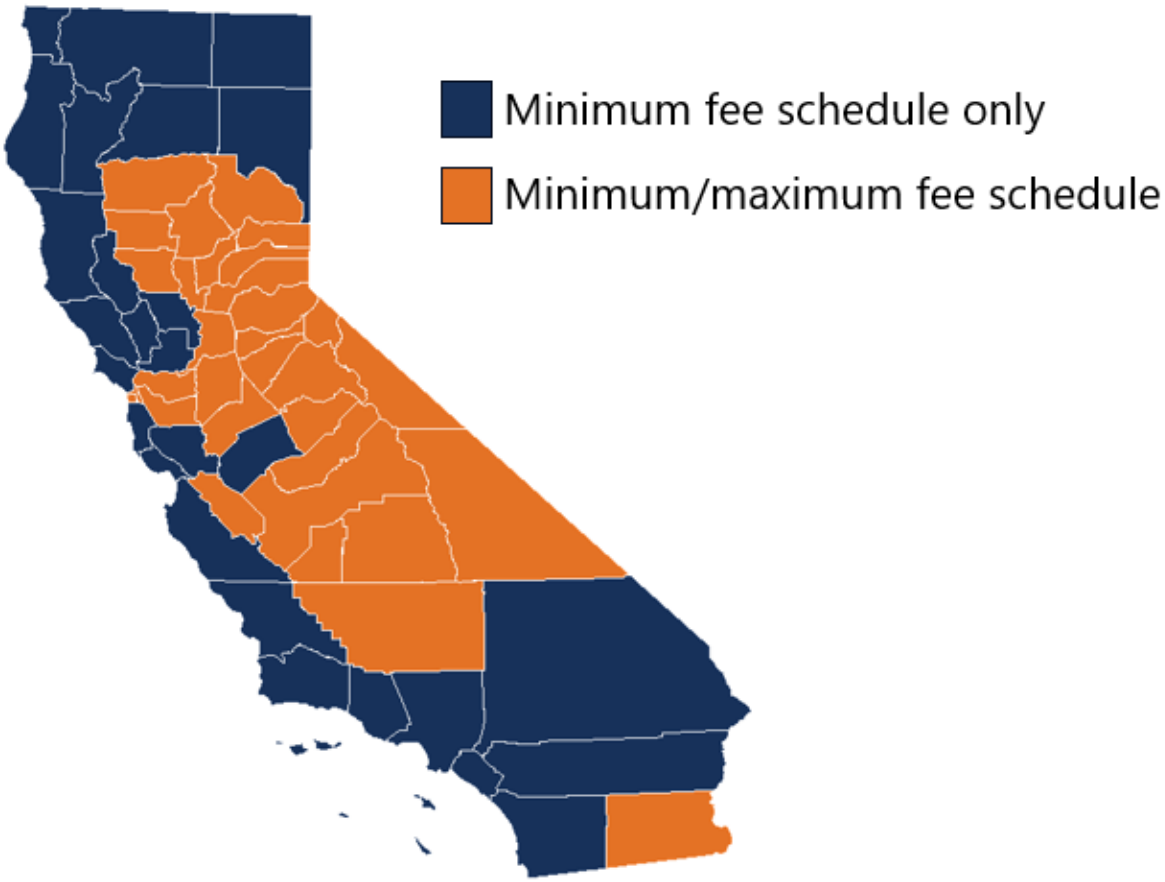
[88] Centers for Medicare & Medicaid Services. (2026). Medicaid program; Medicaid managed care state directed payments and Medicaid fee-for-service targeted Medicaid practitioner payments; proposed rule. *Federal Register, 91*, 30400.

[89] Aggregated from Centers for Medicare & Medicaid Services. (n.d.). *Approved state-directed payment preprints*. https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints.

service rate but may negotiate a higher rate (minimum only). The minimum/maximum structure provides certainty for both MCPs and facilities but eliminates flexibility for innovation. This split reflects the pre-CalAIM landscape. Before January 1, 2023, 27 counties already covered institutional LTC through their managed care plans and had established MCP-SNF contracting relationships. The remaining 31 counties did not have managed institutional LTC; instead, members underwent disenrollment to fee-for-service after the second continuous month of a SNF stay. When CalAIM carved LTC into managed care statewide, DHCS established the minimum/maximum fee schedule at the fee-for-service level in the 31 newly transitioned counties to prevent disruption where no contracting infrastructure or rate negotiation history existed. At the same time, it preserved negotiating flexibility in counties whose plans and providers already had operational experience. These provisions were intended as a transitional measure to be extended through at least rate year 2026.[90]

[90] DHCS. (2024). *All Plan Letter 24-009: Skilled nursing facilities—Long-term care benefit standardization and transition of members to managed care*.

Exhibit 2.20. Fee schedule requirement by county



Source: California Department of Health Care Services. (2024). All Plan Letter 24-009: Skilled nursing facilities—Long-term care benefit standardization and transition of members to managed care, available at: https://www.dhcs.ca.gov/wp-content/uploads/2025/10/APL24-009.pdf.

Fee schedule design options observed in other states

Beyond California's current approach, other states and the federal framework provide several alternative models for structuring state direction of MCP payments to nursing facilities. The four primary design structures observed across the nation are (1) minimum/maximum rates, (2) minimum rate only, (3) rate range, and (4) no state direction.

Under a minimum/maximum rate arrangement, MCPs must pay exactly the state-published rate. This SDP arrangement provides the greatest certainty for both MCPs and facilities, as all parties know the fixed per diem in advance. It is the least administratively burdensome arrangement for rate negotiations, effectively eliminating the need for

individual contract negotiations on base rate terms. It also supports stable revenue forecasting and workforce planning for facilities. However, it eliminates flexibility in addressing variation in resident-specific needs, geographic access, or cost. It also limits payment innovation such as value-based arrangements or quality incentive structures that could be layered atop the per diem rates.

Minimum rate payment arrangements require MCPs to pay at least the state-published rate but allow plans to set higher rates with individual facilities. This arrangement provides baseline payment certainty for facilities while preserving flexibility for MCPs to offer enhanced rates for higher-need residents, access-challenged localities, or facilities with specialized capabilities. The primary trade-off is one-sided cost pressure, as rates can move only upward from the floor, with no corresponding mechanism to constrain above-floor spending at the plan level. In addition, states have limited visibility into the above-floor negotiated amounts, potentially reducing the ability to monitor rate adequacy or equity across the system. Over time, upward-only pressure may contribute to aggregate Medicaid spending growth that outpaces assumptions about appropriations.

No state has yet to follow an approach that could direct plans to pay per diem rates within a specified percentage above or below the state-published rate, establishing both a ceiling and a floor around the benchmark. This approach provides significant flexibility within structural guardrails, introducing two-sided risk for both MCPs and facilities, which allows for more nuanced negotiations. It allows negotiated rates to reflect facility-specific circumstances, such as acuity mix, geographic cost differences, or specialized programming, but prevents rates from drifting too far from the state's intended payment level in either direction. This arrangement protects against both underpayment (which threatens access and quality) and overpayment (which strains plan solvency and state program costs). Administrative burden is moderate. States must define and maintain the permissible upper and lower bounds, and MCPs must demonstrate compliance with both bounds. If states were to set the bounds too narrow, they could establish a de facto fixed rate; if they were to set the range too wide, they could provide insufficient protection against rate inadequacy or excessive spending.

A final option for states would be not to direct payments between plans and facilities at all, allowing MCPs and facilities to negotiate rates independently without a state-published benchmark or mandated floor or ceiling. This approach offers maximum flexibility for plans and providers, allowing negotiated rates to reflect local conditions, facility capabilities, and the profile of the resident population. It also provides plans with flexibility to establish value-based payment (VBP) programs. However, the lack of state

direction could limit the state's ability to advance program objectives such as quality improvement and workforce investment. Absence of a published benchmark also reduces rate transparency across the system and may complicate system oversight.

Managed care payment approaches in California

Currently, 24 states, including California, structure their nursing facility payment frameworks by using capitated managed care payments rather than a fee-for-service model. Approaches range from payment at or above fee-for-service rates (the most common) to fully negotiated arrangements, including quality-based contract standards, payments limited to restorative services, mitigation pools for high-cost facilities, length-of-stay-based ranges, and alternative incentive programs exceeding fee-for-service benchmarks. Most contracts stipulate payments at or above fee-for-service-calculated rates.[91]

To understand the current landscape of payment arrangements between Medi-Cal MCPs and nursing facilities, DHCS developed and administered an all-plan survey to capture California-specific payment approaches that MCPs may currently be using beyond the standard fee schedule, including plan-specific tiering, P4P, and other forms of market-based payment innovation. In total, 22 plans responded to the survey, administered from March 23, 2026, through April 24, 2026.

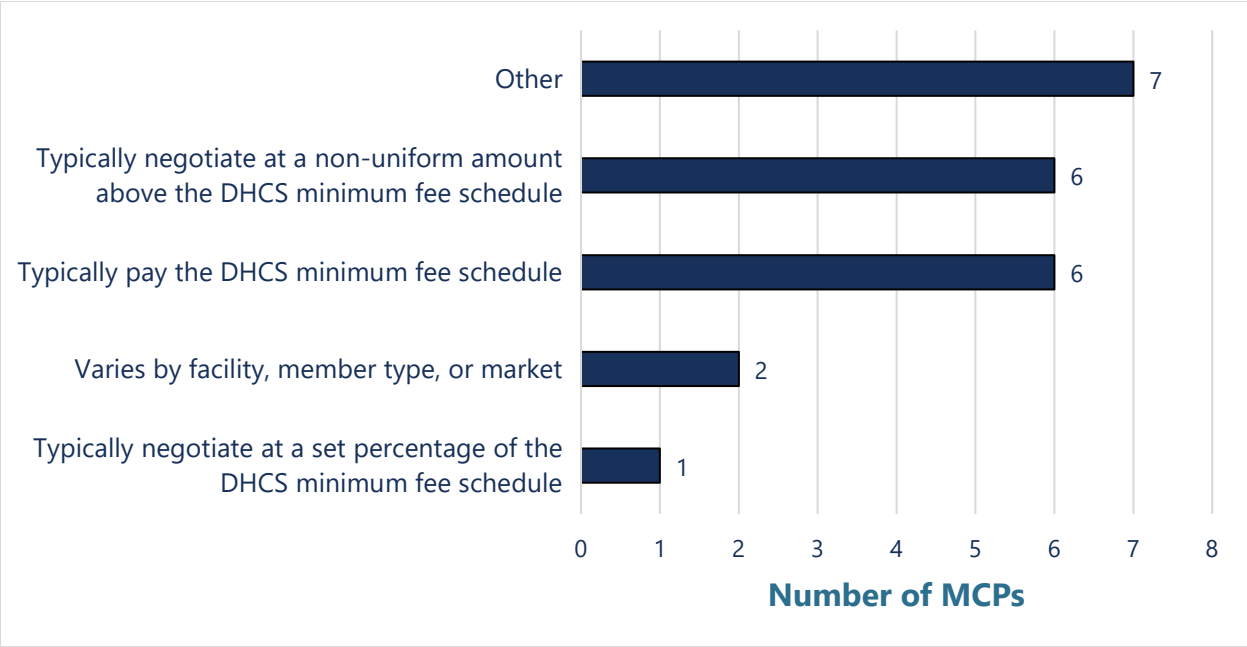
Rate flexibility

Representatives of 15 plans (68 percent) reported reliance on a documented approach, methodology, or strategy for contracting with SNFs. Most plans typically negotiate a nonuniform amount above the DHCS minimum fee schedule, pay the DHCS minimum fee schedule, or use another approach (**Exhibit 2.21**). "Other" responses generally reflected blended approaches that combine DHCS minimum rates with above-minimum payments driven by resident acuity, facility performance, or negotiated skilled care payments. The survey asked plan representatives about the considerations that drive their decisions to reimburse providers above the minimum fee schedule. Responses varied, but the most common reasons included the need for placements for higher-acuity members, access barriers related to network adequacy, and incentives to transition hard-to-place members out of higher levels of care. Payment approaches

[91] Determined from review of publicly available State Plan or regulatory documentation and managed care contracts nationwide as of January 1, 2026.

included carve-outs, add-ons, reimbursement as a percentage of the Medi-Cal fee schedule, and letters of agreement (LOAs)[92] with providers.

Exhibit 2.21. MCP's general approach to SNF payment rates for contracted providers

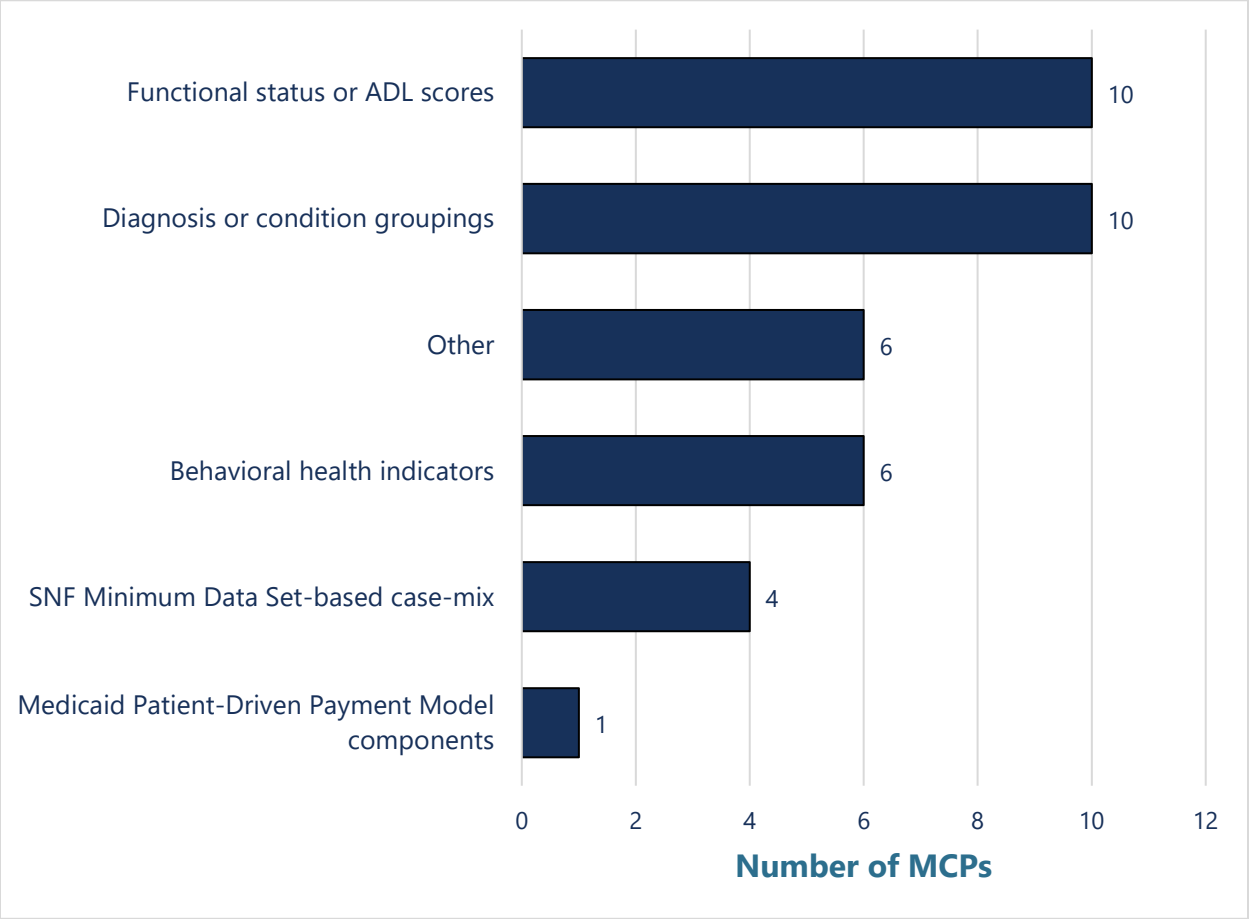


Source: Analysis of DHCS MCP Survey on SNF Payment and Quality Strategies, administered March 23, 2026, to April 24, 2026.

Representatives of 14 plans (64 percent) reported the use of acuity tiering or stratification as part of SNF payment. When asked how they primarily define acuity tiers, most plan representatives indicated that they use functional status or activities of daily living (ADL) scores and diagnosis or condition groupings (**Exhibit 2.22**). The most common "other" approach was defining acuity tiers by the intensity of required clinical services and the level of skilled nursing care received.

[92] A letter of agreement is an agreement between an MCP and an out-of-network provider that allows the provider to deliver services to an MCP's member.

Exhibit 2.22. How acuity tiers are primarily defined



Source: Analysis of DHCS MCP Survey on SNF Payment and Quality Strategies, administered March 23, 2026, to April 24, 2026.
Note: MCPs could select more than one response for this question.
ADL = activity of daily living.

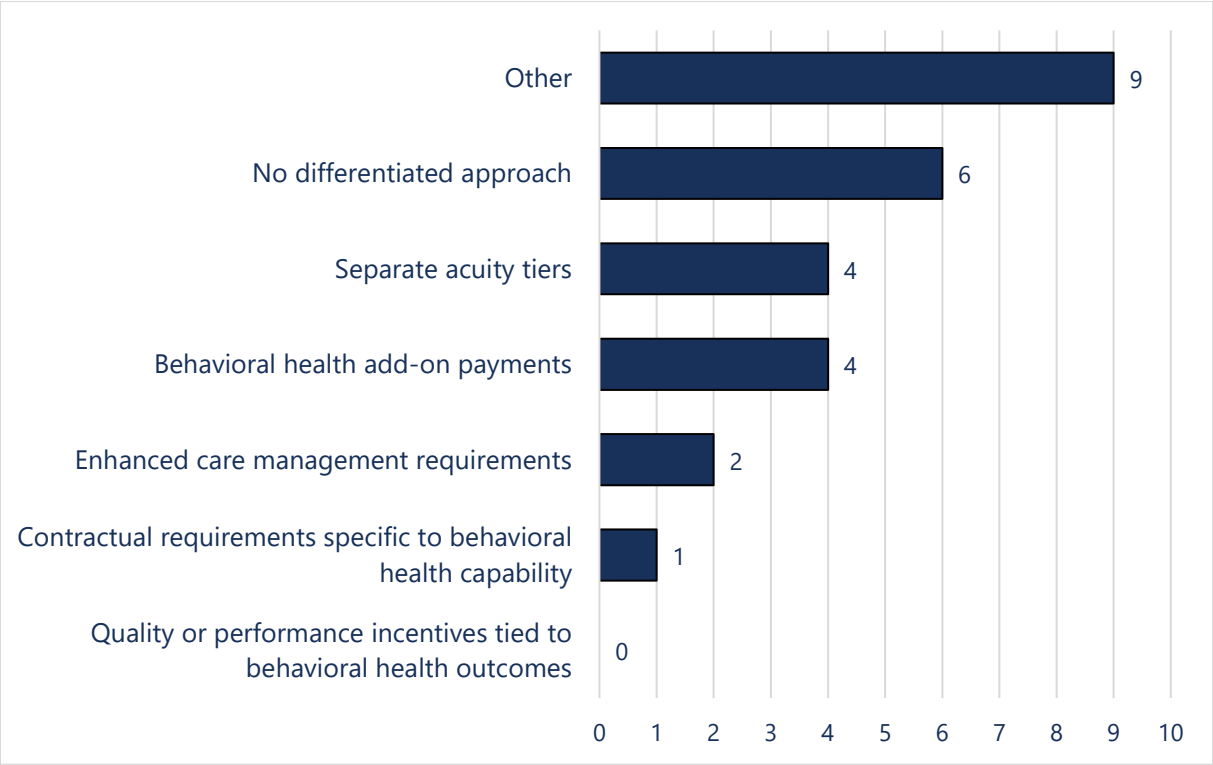
Behavioral health and complex health needs

Representatives of 13 plans (59 percent) reported that their plans used special payment approaches, tiering, or care coordination strategies for SNF residents with complex behavioral health and medical needs. Representatives consistently identified substance use disorder, dementia or cognitive impairment, aggression, homelessness, younger age, and co-occurring medical complexity as member characteristics that pose challenges with SNF placement.

When asked which mechanisms they use to support members with behavioral health needs in SNFs, plan representatives most frequently selected "other." These responses

described individual placements on a case-by-case basis, including the offer of higher rates to SNFs willing to accept members with behavioral health needs (**Exhibit 2.23**).

Exhibit 2.23. Mechanisms used to support members with behavioral health needs in SNFs



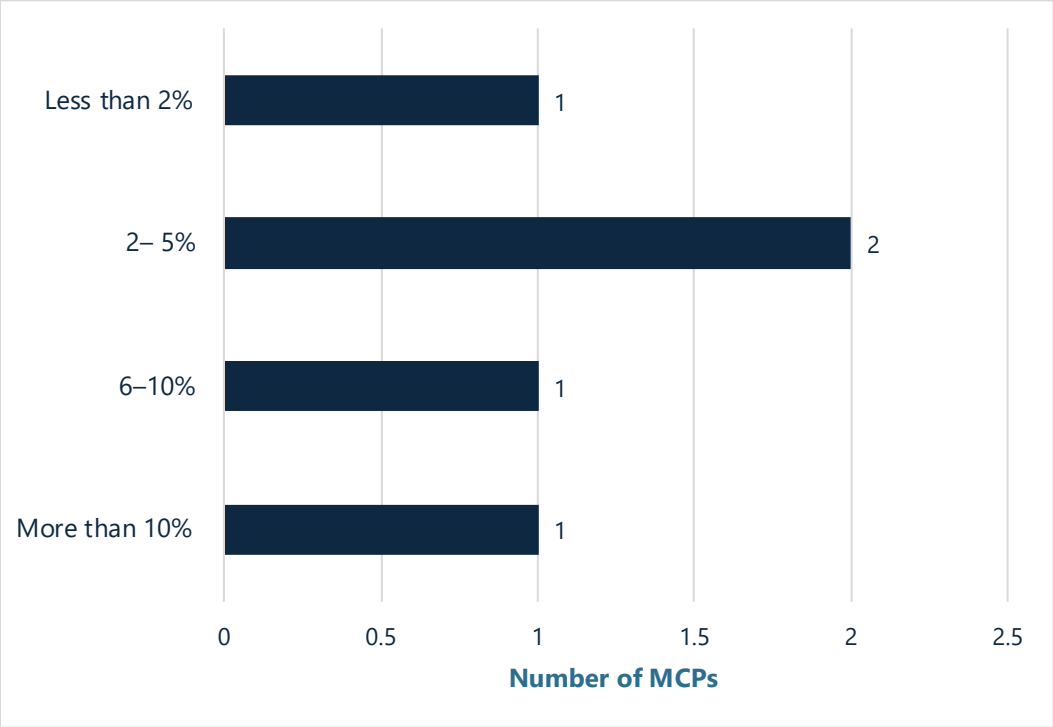
Source: Analysis of DHCS MCP Survey on SNF Payment and Quality Strategies, administered March 23, 2026, to April 24, 2026.
Note: MCPs could select more than one response for this question.

When asked what strategies have been successful in mitigating placement challenges for higher-acuity members with behavioral health needs, plan representatives again highlighted enhanced rates and LOAs, along with other supports such as reimbursement for one-to-one sitters, county behavioral health coordination, ECM and Community Supports, early discharge planning, and models involving medical professionals practicing primarily in SNFs.

Value-based payments, alternative payment models (APMs), and incentive structures

The survey also asked about plans' experience in implementing VBPs, alternative payment models (APMs), or other incentive structures to improve provider performance. Only five plans (23 percent) reported the inclusion of MCP-initiated VBP, APM, or incentive structures in SNF contracts. When asked what percentage of total SNF reimbursement is tied to these payment arrangements, respondents varied in their answers. Two of the five plans indicated that 2 to 5 percent of total reimbursement is tied to these arrangements; the other three plans reported different approaches (**Exhibit 2.24**).

Exhibit 2.24. Percentage of total SNF payment tied to VBPs, APMs, or incentive payments



Source: Analysis of DHCS MCP Survey on SNF Payment and Quality Strategies, administered March 23, 2026, to April 24, 2026.

Reported incentive structures included upside-only P4P arrangements, benchmark-based payments, year-over-year improvement incentives, and payment adjustments tied to CMS Star Ratings. One reported model also rewards successful community discharge by providing an additional payment when an eligible long-stay member transitions to a community setting and remains there for a sustained period.

Plan representatives reported more limited use of Quality Assurance and Performance Improvement (QAPI) metrics or related data in contracting and payment. Representatives of six plans (27 percent) reported leveraging QAPI-related metrics or other data as part of their contracting or payment approaches.

Whole person care and care transitions

Plans described using a variety of methods for ensuring that members are appropriately transitioned into community-based settings such as ECM, Community Supports, or transitional care services. However, most plans indicated that, although transition activities may be coordinated with SNF services, they are not factored into SNF reimbursement methodologies for providers.

Other payment methodologies, contracting approaches, or promising practices

Most plan representatives did not identify additional payment methodologies, contracting approaches, or promising practices beyond those described elsewhere in the survey. However, a small number of responses provided examples of plan-level innovation. One plan offers Medicare PDPM rates, tying reimbursement to resident need and perhaps encouraging SNF providers to admit Medi-Cal members. Another plan reimburses the cost of one-on-one supervision when necessary to support member placement and safety, even though the reimbursement is outside the current Medi-Cal benefit. A third plan may pilot test an APM or VBP arrangement with one or two selected strategic partners.



CHAPTER III:
NURSING FACILITY WORKFORCE

CHAPTER III: NURSING FACILITY WORKFORCE

DHCS recognizes the central role of staffing and workforce in supporting high-quality resident care in nursing facilities. We conducted a comprehensive scan of workforce strategies, programs, and requirements employed across state Medicaid programs nationwide. In this chapter, we present findings across several important areas, including staffing and quality considerations, federal requirements, national and California-specific trends, and policy levers available to influence nursing facility staffing.

Workforce capacity is a core driver of resident safety, care efficiency, and timely access to services, all of which are fundamental dimensions of care quality. Ongoing evidence shows that higher staffing levels in nursing facilities are associated with better outcomes, including lower rates of pressure ulcers, reduced use of restraints, and fewer transfers to acute care settings.[93,94,95]

Facility staffing is also a critical enabler of person-centered care. Direct care staff play the primary role in ensuring that residents feel recognized and supported while tailoring care to individual needs. Higher staffing levels increase staff capacity to build and sustain meaningful relationships–among staff and residents and among residents and the people important to them.

Systemwide factors affecting staffing shortages

Despite the well-established relationship between staffing and care quality, many nursing facilities continue to face persistent workforce shortages and ongoing challenges in hiring and retaining staff. A 2024 American Health Care Association (AHCA) survey of 441 facilities identified a lack of interested or qualified workers as the

[93] Centers for Medicare & Medicaid Services. (2023). *Nursing home staffing study: Final report appendix*. https://www.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.

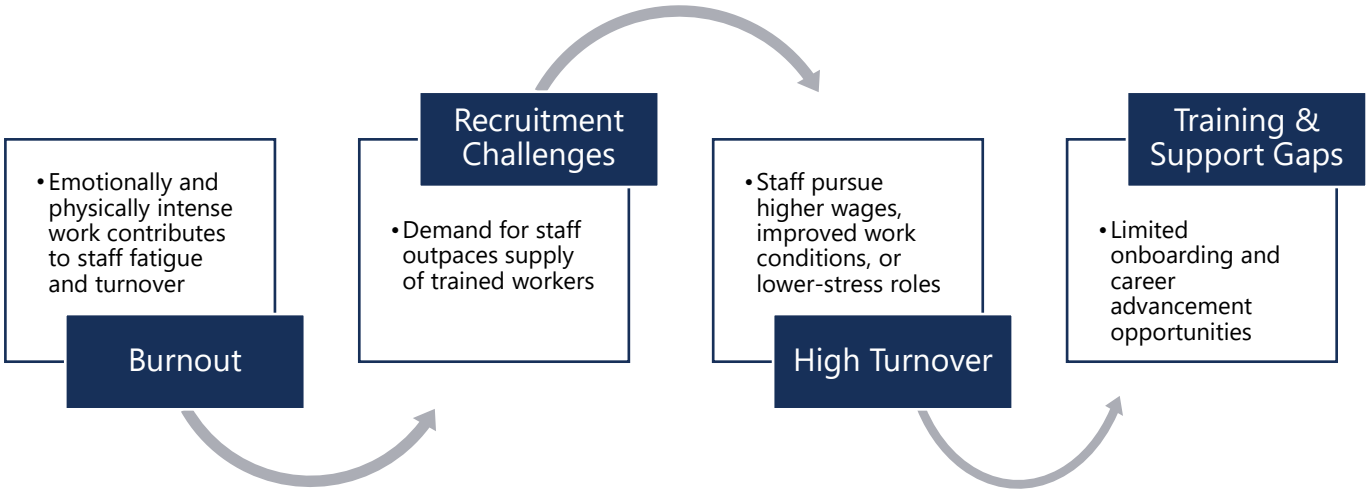
[94] Harrington, C. A., McLaughlin, R. A., Saliba, D., Halifax, E., Mollot, R. J., Romano, P. S., Tancredi, D. J., & Mukamel, D. B. (2025). Nursing home guide to adjusting nurse staffing for resident case-mix. *Journal of the American Geriatrics Society, 73*(7), 2137–2145. https://doi.org/10.1111/jgs.19501.

[95] Skinner, R. J., Yu, J., Unruh, M. A., Braun, R. T., Jung, H.-Y., Johnson, P., Fernandez, R., & Stevenson, D. G. (2025). State variation in staffing and characteristics of nursing homes under new federal staffing standards. *Health Affairs Scholar*. https://doi.org/10.1093/haschl/qxaf154.

primary barrier to hiring.[96] These challenges reflect both broader labor market pressures and the level of investment in the facility-level workforce. Together, these factors influence recruitment, retention, and turnover, as summarized in **Exhibit 3.1**.

The emotional and physical demands of direct care work contribute to staff burnout. Hourly wages for nursing facility staff are relatively low compared with those for other positions in health care. Providers often compete with positions in other settings that may offer comparable or higher pay with lower risk of burnout. At the facility level, decisions regarding compensation, staffing levels, scheduling, and career development also influence workforce stability. Facility investments in employee support and growth may improve retention, whereas gaps in onboarding and training processes as well as limited advancement opportunities can lead to job frustration.

Exhibit 3.1. Barriers influencing workforce shortage



Source: AHCA survey results, available at: https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/AHCA%20State%20of%20the%20Sector%202024.pdf.

[96] American Health Care Association. (2024). *State of the nursing home sector: Survey of 441 nursing home providers highlights persistent staffing and economic crisis*. https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/AHCA%20State%20of%20the%20Sector%202024.pdf.

Staffing considerations for quality

Several structural considerations are important in designing a sustainable workforce strategy, including the facility-specific staffing mix, resident acuity, the role of contract labor, and workforce turnover and instability. Each of these factors shapes how staffing levels translate into care delivery and quality outcomes.

Staffing mix

The relationship between staffing and quality varies by staff type, reflecting the distinct clinical and operational roles played by different staff in care delivery.[97] The direct care workforce in skilled nursing facilities is primarily composed of RNs, licensed practical nurses (LPNs)/LVNs, and CNAs, each of whom contributes differently to resident care.

Higher RN staffing levels are most consistently associated with improvements in quality and safety outcomes, consistent with RNs' responsibilities for resident assessment, care coordination, and clinical oversight.[98,99,100] CNA staffing is closely linked to residents' ADLs, including hands-on support with personal hygiene, bathing, and meals, CNA staffing plays a central role in day-to-day resident support.[101]

An inverse relationship is often observed between LPN and RN staffing, suggesting that facilities with higher LPN staffing levels may operate with lower RN coverage.[102] RNs and LPNs are responsible for different scopes of practice and contribute differently to clinical oversight and care delivery.

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[97] Centers for Medicare & Medicaid Services, *Nursing home staffing study*, 2023. https://www.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.

[98] Mukamel, D. B., Saliba, D., Ladd, H., & Konetzka, R. T. (2024). The relationship between nursing home staffing and health outcomes revisited. *Journal of the American Medical Directors Association, 25*(8), 105081. https://doi.org/10.1016/j.jamda.2024.105081.

[99] Skinner et al., *Health Affairs Scholar*, 2025. https://doi.org/10.1093/haschl/qxaf154.

[100] Mukamel et al., *Journal of the American Medical Directors* Association, 2024. https://doi.org/10.1016/j.jamda.2024.105081.

[101] Mukamel et al., *Journal of the American Medical Directors Association,* 2024. https://doi.org/10.1016/j.jamda.2024.105081.

[102] Centers for Medicare & Medicaid Services, *Nursing home staffing study*, 2023. https://www.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.

Facilities can increase their overall staff HPRD to support care delivery; however, the impact of increased staffing levels depends on alignment between resident needs and staff scopes of practice.[103]

Resident acuity

Resident needs, sometimes called acuity, should play a role in determining both the number of staff and the clinical skills required to care safely for residents. Facilities caring for residents with higher acuity generally require greater RN presence and higher total staffing hours to meet resident needs. In many cases, the staffing levels needed for appropriately supporting resident clinical complexity exceed minimum regulatory staffing requirements.

There are several approaches for assessing resident acuity-adjusted staffing in nursing facilities. California's former WQIP used six acuity-adjusted staffing measures (**Exhibit 4.5**) to assess whether staffing ratios aligned with resident need. CMS' Care Compare Five-Star Quality Rating System uses three case-mix-adjusted staffing measures: total nursing HPRD across all days, RN HPRD across all days, and total nursing HPRD on weekends. Reports of staffing hours use data from the PBJ system for quarterly submission.[104,105]

To determine facility-level staffing ratings, CMS calculates expected staffing levels for resident acuity by leveraging CMI derived from the nursing component of the PDPM resident classification methodology, reflecting the relative intensity of the nursing care required per residents' need.

CMS' approach compares a facility's average CMI, derived from MDS resident assessment data used in the PDPM resident classification, with the national average CMI, producing a facility-specific CMI ratio. CMS then applies the ratio to the national average HPRD, calculated by using PBJ data, to estimate an expected staffing level for the facility based on its resident acuity. Next, CMS compares facilities with national

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[103] Mukamel et al., *Journal of the American Medical Directors Association,* 2024. https://doi.org/10.1016/j.jamda.2024.105081.

[104] Centers for Medicare & Medicaid Services, *Design for Care Compare,* 2026. https://www.cms.gov/medicare/health-safety-standards/certification-compliance/five-star-quality-rating-system.https://www.cms.gov/medicare/provider-enrollment-and certification/certificationandcompliance/downloads/usersguide.pdf.

[105] Centers for Medicare & Medicaid Services, *Staffing data submission*, n.d. https://www.cms.gov/medicare/quality/nursing-home-improvement/staffing-data-submission.

benchmarks and separates them into staffing deciles, which provide the basis for the staffing star ratings.

The current case-mix adjustment methodology, which relies on PDPM to calculate facility staffing ratings, represents a departure from the framework previously used by CMS. The framework was based on the findings of the STRIVE study, a national time-and-motion study initiated by CMS in 2005 and completed in 2007.[106] The resulting STRIVE staffing tables provided static, job code–specific expected minutes of staff time per resident. CMS used the tables' benchmarks to assign a star rating to facilities based on facilities' reported staffing levels. To align with the PDPM resident classification system, however, in July 2024 CMS developed a new staffing benchmark methodology for the staffing ratings. It features a more dynamic methodology that incorporates updates as the national distribution of resident acuity and staffing patterns shifts over time.[107]

A separate study by Harrington et al. (2025) detailed another approach to calculating case-mix– adjusted staffing levels. It translated the 25 PDPM nursing CMI weights into expected RN, CNA, and total staffing levels.[108] Using nonlinear regression guided by CMS' Staff Time Measurement (STM) time-and-motion study and a CNA workload study, the study's model estimates the expected HPRD for RNs, CNAs, and total nursing staff across the PDPM nursing range of CMI weights.[109] The model also allows comparison of expected and reported staffing levels across facilities and acuity groups, helping assess whether facility staffing levels align with expected resident care and nursing resource needs.

Use of contract labor

When nursing facilities cannot hire permanent staff, they may turn to contract labor. Reliance on contract labor is associated with differences in how care teams function, potentially disrupting continuity in team-based practices, especially with respect to

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[106] Centers for Medicare & Medicaid Services. SNF Research Studies and Reports. https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/research-studies-reports.

[107] Centers for Medicare & Medicaid Services. *Design for Care Compare*, 2024.

[108] Harrington et al., *Journal of the American Geriatrics Society,* 2025.

[109] Schnelle, J. F., Schroyer, L. D., Saraf, A. A., & Simmons, S. F. (2016). Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model. *Journal of the American Medical Directors Association, 17*(10), 970–977. https://doi.org/10.1016/j.jamda.2016.07.012.

facility protocols and resident care plans.[110] With contract labor, permanent staff may have to assume additional responsibilities to orient and support contract staff, affecting overall workload distribution.[111]

Contract staffing levels remain above pre-pandemic norms, despite higher costs relative to permanent staff.[112] Evidence from a study of 35,200 facilities between 2021 and 2023 shows that contracted HPRD increased across all staff types, including RNs (from 6.2 percent of all HPRD in 2021 to 8.9 percent of all HPRD in 2023), LPNs (from 8.9 to 11.6 percent), and CNAs (from 7.4 to 9.3 percent).[113] At the same time, facilities in the top quartile of contract labor utilization experienced significantly higher nursing staff turnover, including RN turnover rates 7.7 percent higher than in low utilization facilities.[114]

Staffing turnover and instability

Staff turnover and staffing instability are both indicators of workforce challenges. Staff turnover refers to the rate at which employees leave a facility over a given period. Care Compare defines staff turnover as any staff absence of 90 days or more.[115] The use of a 90-day reference period considers parental leave or other protected leave under the Family and Medical Leave Act (FMLA), not including turnover.[116] Care Compare's turnover measure uses PBJ data to calculate both the percentage of nursing staff who stopped working at a facility and the number of administrators who left the facility within a given year.[117] In contrast, staffing instability reflects short-term fluctuations in

[110] Pradhan, R., Davlyatov, G., Chisholm, L., Williams, C., Sen, K., Manning, A., & Weech-Maldonado, R. (2025). Agency nursing staff utilization and turnover in nursing homes: A longitudinal analysis. *Healthcare, 13*(4), 379. https://doi.org/10.3390/healthcare13040379.
[111] Pradhan et al., *Healthcare,* 2025. https://doi.org/10.3390/healthcare13040379.
[112] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2025). *Use of contract staff in nursing homes remains high after the COVID-19 pandemic*. https://aspe.hhs.gov/sites/default/files/documents/0efd4ee9d0d0e9e67c5442141053d71c/contract-staff-nhs-high-after-covid.pdf.
[113] Pradhan et al., *Healthcare*, 2025. https://doi.org/10.3390/healthcare13040379.
[114] Pradhan et al., *Healthcare,* 2025. https://doi.org/10.3390/healthcare13040379.
[115] Centers for Medicare & Medicaid Services. (2024). *QSO-24-14-NH: Updates to nursing home staffing and surveyor guidance*. https://www.cms.gov/files/document/qso-24-14-nh.pdf.
[116] Centers for Medicare & Medicaid Services, *QSO-24-14-NH*, 2024. https://www.cms.gov/files/document/qso-24-14-nh.pdf.
[117] Centers for Medicare & Medicaid Services, *QSO-24-14-NH*, 2024. https://www.cms.gov/files/document/qso-24-14-nh.pdf.

staffing coverage. A reference study defined staffing instability as "the percentage of days in the quarter in which total nurse staffing HPRD was 20 percent or more below the facility average total nurse staffing HPRD."[118] It is also possible to calculate staffing instability by using PBJ data.[119]

Implemented in 2016, PBJ captures staffing information at the daily level by drawing from auditable payroll and scheduling records rather than from facility self-reports. For each facility-day, PBJ data yield the total number of nursing staff hours worked by staff category (RNs, LPNs/LVNs, and nurse aides), which is then divided by the facility's resident census for that day to produce HPRD values. Given that the information is reported daily, it allows for granular analysis not only of average staffing levels across a reporting period but also of the frequency and magnitude of day-to-day variation in staffing within individual facilities. It is this daily granularity that makes PBJ particularly useful for identifying patterns of intermittent understaffing otherwise potentially obscured by facility-level averages.

Both staffing instability and turnover are closely related to continuity of care, though they reflect distinctly different workforce dynamics. A regression analysis of 11,840 nursing facilities between 2021 and 2022 examined how turnover and instability related to each other and to quality outcomes.[120] The analysis found that turnover and instability had a weak positive correlation, suggesting that they reflect different dimensions of workforce challenges. Staffing instability was more strongly associated with long-stay residents' antipsychotic drug use, declines in ADLs, and short-stay residents' functional status at discharge.[121] In contrast, staffing turnover was more strongly associated with long-stay residents' pressure ulcers, worsening mobility, and higher rates of short-stay hospitalizations.[122]

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[118] Mukamel, D. B., Saliba, D., Ladd, H., & Konetzka, R. T. (2024). Incorporating staffing instability in the nursing home Five-Star staffing composite. *Health Affairs Scholar, 2*(12), qxae159. https://doi.org/10.1093/haschl/qxae159.

[119] Mukamel et al., *Health Affairs Scholar*, 2024.

[120] Sinha, S., Mukamel, D. B., Saliba, D., Ladd, H., & Konetzka, R. T. (2023). New dimensions of staffing patterns in nursing homes and nursing home quality: Comparing staffing instability to staffing turnover. *Journal of the American Medical Directors Association, 24*(8), 1099–1105.e7. https://doi.org/10.1016/j.jamda.2023.05.018.

[121] Sinha et al., *Journal of the American Medical Directors Association*, 2023.

[122] Sinha et al., *Journal of the American Medical Directors Association,* 2023.

Federal workforce requirements

Federal regulations establish baseline staffing expectations for nursing facilities to protect resident safety and support residents in attaining or maintaining their highest level of physical, mental, and psychosocial well-being.[123] Current requirements call for the presence of an RN for at least 8 consecutive hours per day and licensed nursing staff (RNs, LPNs/LVNs) on site 24 hours per day.[124] The 2024 Long-Term Care Final Rule (CMS-3442-F) would have made these requirements more stringent by specifying minimum staffing thresholds, including 24-hour RN coverage and a minimum threshold of 3.48 nursing HPRD. The U.S. District Court for the Northern District of Texas vacated these provisions; Congress then delayed their implementation through Section 71111 of H.R. 1 and ultimately repealed them before they took effect.[125,126] The 2024 LTC Final Rule also introduced requirements for institutional payment transparency that will require states to report the share of Medicaid revenue spent on the workforce as of 2028.[127] The rule also expanded facility assessment requirements, directing facilities to conduct comprehensive annual evaluations of resident needs and staffing capacity.

Institutional payment transparency

The institutional payment transparency requirement in the 2024 LTC Final Rule aims to increase visibility into how Medicaid payments are used to support the direct care workforce. The provision will require states to report publicly the share of nursing facility Medicaid payments spent on compensation for direct care workers delivering care under both fee-for-service and managed care delivery systems. The rule does not set a minimum spending threshold for workforce expenditures.[128]

Long-term care facility assessment

Since 2016, CMS has mandated that nursing homes conduct an annual facility-wide assessment of the resources needed to provide care for residents.[129] The original 2016 requirement directed facilities to evaluate resident characteristics and determine the staffing levels and other resources needed to meet resident needs. Updates to the 2016

[123] 42 CFR § 483.35.
[124] 42 CFR § 483.35.
[125] H.R. 1, Pub. L. No. 119-21, § 71111 (July 4, 2025).
[126] CMS-3442-IFC.
[127] 42 CFR § 483.20.
[128] 42 CFR § 442.43.
[129] 42 CFR § 483.20.

requirements in the 2024 LTC Final Rule and codified at 42 CFR § 483.71 now require facilities to evaluate the resources needed to deliver competent care during both routine operations and emergencies. In addition to evaluating workforce capacity, the assessment must consider broader facility resources, including physical infrastructure, equipment, personnel, cleanliness for infection control, and health information technology that may influence care delivery. Updated regulations require processes that solicit input from facility leaders, direct care staff, and residents or their representatives to ensure well-informed staffing decisions.[130]

Workforce national trends

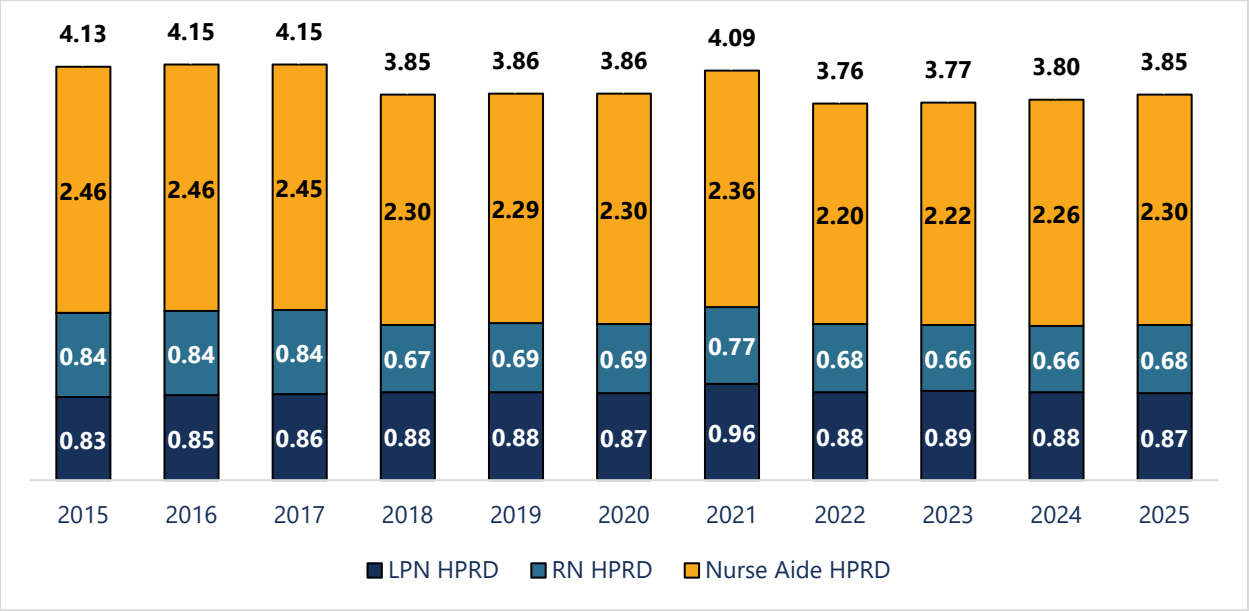
National trends in staffing levels

Over the past decade, national workforce trends in facilities show an overall decline in total nursing care hours, driven primarily by reductions in RN and nurse aide staffing. Between 2015 and 2025, average nursing HPRD decreased from roughly 4.1 hours to about 3.85 hours (**Exhibit 3.2**). During this period, RN hours declined by approximately 19 percent and nurse aide hours by about 7 percent. In contrast, LPN hours increased slightly, by about 5 percent, suggesting some substitution toward mid-level nursing staff. After reaching a low around 2022, staffing levels have gradually begun to recover, with incremental increases in HPRD.[131]

[130] 42 CFR § 483.71.

[131] Chidambaram, P., & Burns, A. (2025). *A look at nursing facility characteristics in 2025*. KFF. https://www.kff.org/medicaid/a-look-at-nursing-facility-characteristics/.

Exhibit 3.2. National trends in staffing hours, 2015–2025

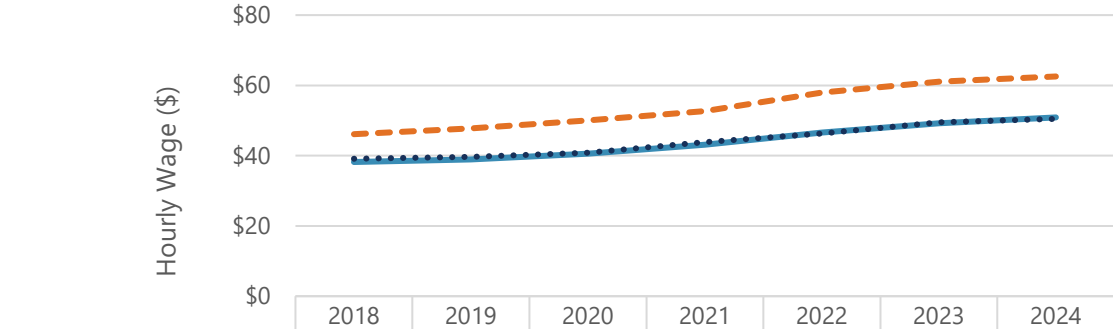


Source: Adapted from Chidambaram, P., & Burns, A. (2025). A look at nursing facility characteristics in 2025, available at https://www.kff.org/medicaid/a-look-at-nursing-facility-characteristics/.
Notes: HPRD = Hours per resident day; LPN = licensed practical nurse; RN = registered nurse. Prior to January 2022, CMS excluded nursing facilities with total nurse staffing <1.5 hours per resident day from its calculation of hours per resident day.

National trends in workforce compensation

Nationally, RN wages for those working in SNFs rose from $38.19 per hour in 2018 to $50.88 per hour in 2024 (**Exhibit 3.3**). Comparable states showed similar variability and experienced notable wage growth over the period, from $39.12 per hour in 2018 to $50.47 per hour in 2024, with a peak in 2023. California experienced similar steady wage growth, with wages higher than those of comparable states and exceeding national averages.

Exhibit 3.3. National trends in SNF RN compensation, 2018–2024

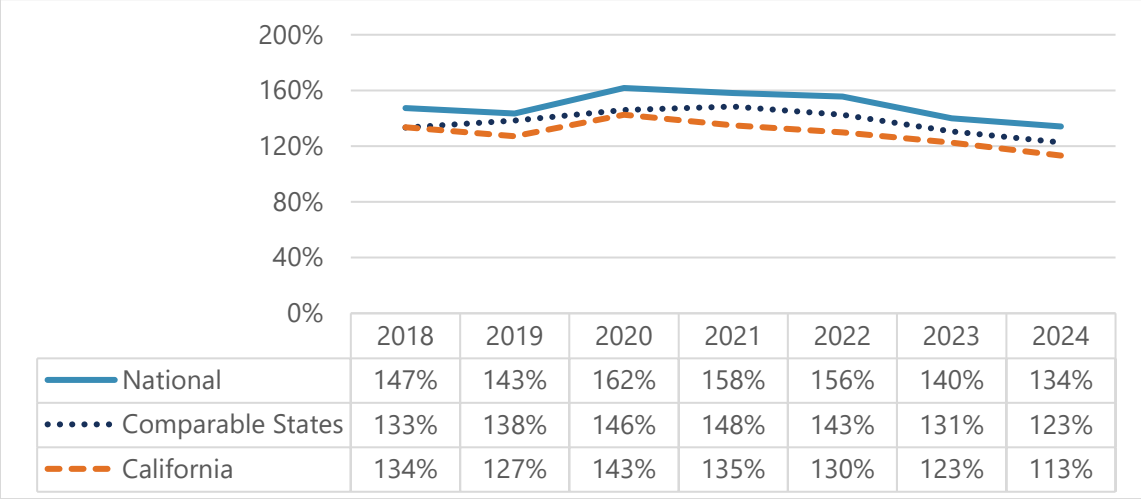


	2018	2019	2020	2021	2022	2023	2024
National	$38.19	$38.90	$40.55	$43.07	$46.59	$49.19	$50.88
Comparable States	$39.12	$39.61	$40.80	$43.85	$46.33	$49.45	$50.47
California	$46.11	$47.75	$50.02	$52.67	$57.96	$61.07	$62.53

Source: Calculations performed based on publicly available information from the CMS HCRIS public-use files. For more information, see Centers for Medicare & Medicaid Services. (2024). Healthcare Cost Report Information System (HCRIS): Skilled nursing facility cost reports (Form CMS-2540-10, fiscal years ending 2018–2024) [Data set], available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports.
Notes: Comparable states are Florida, Illinois, New York, and Texas. Data comes from worksheet S-3 of the 2540 cost report, excluding all Medicare-only facilities and facilities more than two standard deviations from the average. Information included on worksheet S-3 is generally unaudited. Figures reflect a simple average and include wages and salaries.

Wages for contracted RNs working in SNFs consistently exceeded wages for directly employed RNs across all states and the nation (**Exhibit 3.4**). Nationally, the ratio of contract to employed RN wages peaked in 2020, coinciding with the height of the COVID-19 pandemic and then declining steadily through 2024. Comparable states exhibited a similar downward trend in the wage differential, peaking in 2021. California demonstrated the same trend over the period, with a peak in 2020 followed by a steady reduction in the wage differential.

Exhibit 3.4. National trends in SNF contract RN wages compared to directly employed RNs, 2018–2024



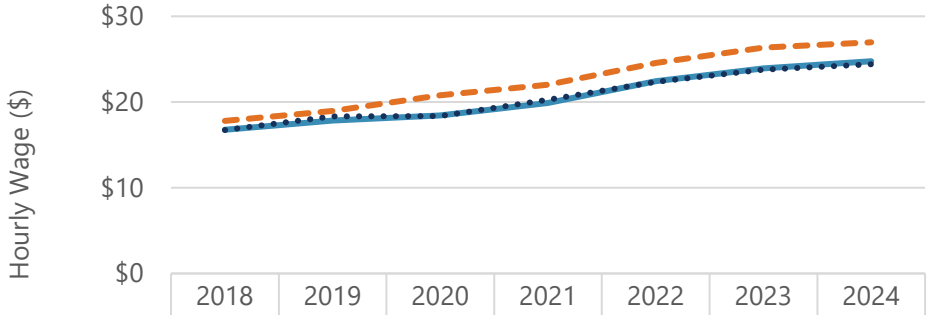
	2018	2019	2020	2021	2022	2023	2024
National	147%	143%	162%	158%	156%	140%	134%
Comparable States	133%	138%	146%	148%	143%	131%	123%
California	134%	127%	143%	135%	130%	123%	113%

Source: Calculations performed based on publicly available information from the CMS HCRIS public-use files. For more information, see Centers for Medicare & Medicaid Services. (2024). Healthcare Cost Report Information System (HCRIS): Skilled nursing facility cost reports (Form CMS-2540-10, fiscal years ending 2018–2024) [Data set], available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports.

Notes: Comparable states are Florida, Illinois, New York, and Texas. Data comes from worksheet S-3 of the 2540 cost report, excluding all Medicare-only facilities and facilities more than two standard deviations from the average. Information included on worksheet S-3 is generally unaudited.

Nationally, CNA wages for those working in SNFs rose from $16.76 per hour in 2018 to $24.76 per hour in 2024, with the largest increase occurring between 2021 and 2022 (**Exhibit 3.5**). Comparable states experienced similar growth in wages, from $16.73 per hour in 2018 to a peak of $24.41 per hour. California saw similar consistent growth over the period, with wages rising from $17.80 per hour in 2018 to $26.97 per hour in 2024.

Exhibit 3.5. National trends in SNF CNA compensation, 2018–2024



	2018	2019	2020	2021	2022	2023	2024
National	$16.76	$17.85	$18.44	$19.89	$22.44	$23.92	$24.76
Comparable States	$16.73	$18.31	$18.36	$20.27	$22.35	$23.76	$24.41
California	$17.80	$18.95	$20.80	$22.02	$24.56	$26.36	$26.97

Source: Calculations performed based on publicly available information from the CMS HCRIS public-use files. For more information, see Centers for Medicare & Medicaid Services. (2024). Healthcare Cost Report Information System (HCRIS): Skilled nursing facility cost reports (Form CMS-2540-10, fiscal years ending 2018–2024) [Data set], available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports.
Notes: Comparable states are Florida, Illinois, New York, and Texas. Data comes from worksheet S-3 of the 2540 cost report, excluding all Medicare-only facilities and facilities more than two standard deviations from the average. Information included on worksheet S-3 is generally unaudited. Figures reflect a simple average and include wages and salaries.

California SNF workforce landscape

California has developed a comprehensive policy framework to strengthen the SNF workforce through a combination of payment policy, regulatory standards, and performance-based incentives. The state has adopted complementary incentive strategies that establish baseline staffing expectations, encourage workforce investments through Medi-Cal's payment methodology, and reward staffing improvements. Collectively, the initiatives aim to support workforce recruitment and retention and promote staffing stability.

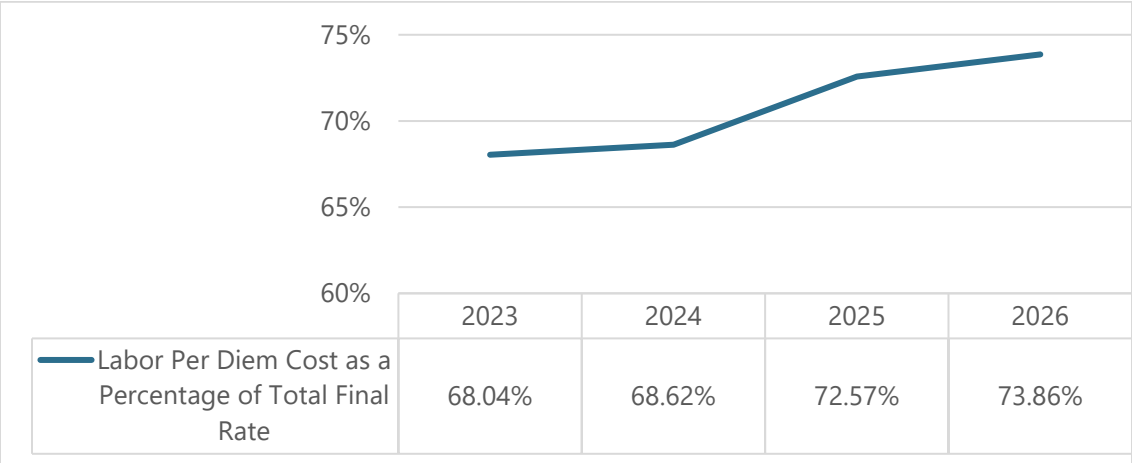
Key components of the incentive strategy include workforce-related provisions within the Medi-Cal per diem rate methodology, the WSP, which conditions enhanced payment on compliance with workforce standards, and the former WQIP, which linked incentive payments to workforce and quality performance metrics.

Labor component of base per diem rates

As described in Chapter 2, the Medi-Cal per diem rate for FS/SNF-Bs encompasses two major components: labor and nonlabor. Of these, the labor component typically represents the larger share of the total rate. The state sets caps on direct and indirect labor at the 95th percentile, meaning that facilities retain a strong incentive to invest in their workforce even if their labor costs are relatively higher than those of other facilities in their peer group. Furthermore, the maximum facility-specific annual increase (growth limit) for the labor rate component is capped at 5 percent, whereas the maximum aggregate annual increase for the nonlabor rate component is capped at 1 percent, thereby encouraging facilities to invest in the workforce.

A review of the ratio of weighted average facility labor costs against FS/SNF-B payment rates (**Exhibit 3.6**) shows that the labor per diem (pregrowth limit) as a percentage of the total Medi-Cal rate has steadily increased from rate year 2023 to rate year 2026, from 68.04 to 73.86 percent. **Exhibit 3.7** and **Exhibit 3.8** show the count of facilities' labor cost per day as a percentage of total final enhanced rate for continuing FS/SNF-Bs and FS/SAs, broken into 5 percent increments.

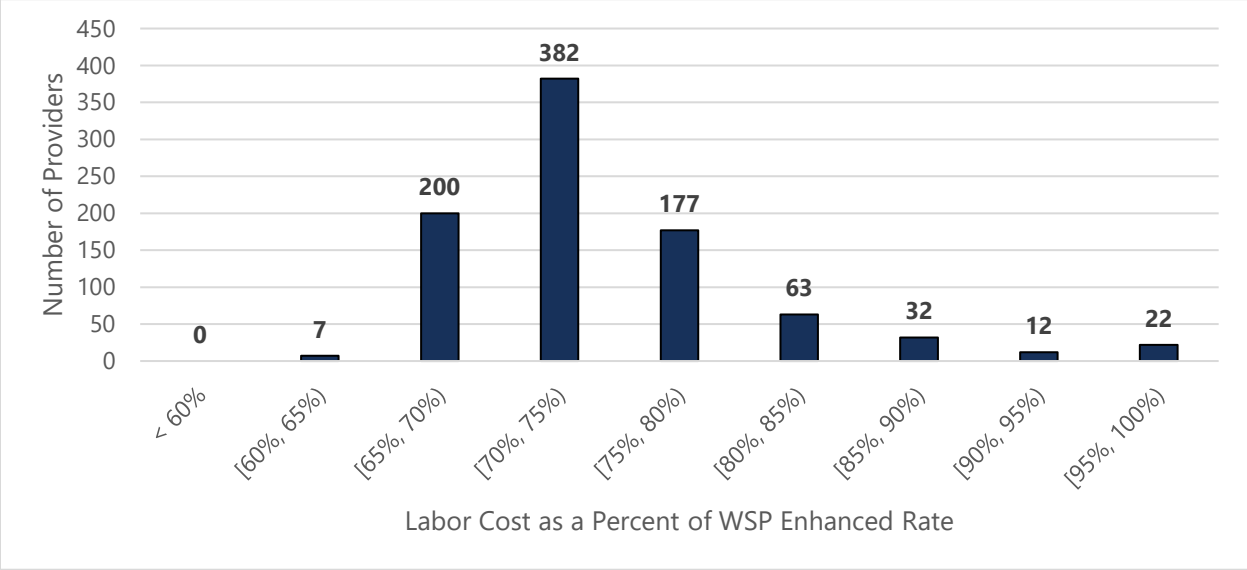
Exhibit 3.6. Labor per diem cost as a percentage of total final enhanced rate (inclusive of WSP and QAF), 2023–2026



	2023	2024	2025	2026
Labor Per Diem Cost as a Percentage of Total Final Rate	68.04%	68.62%	72.57%	73.86%

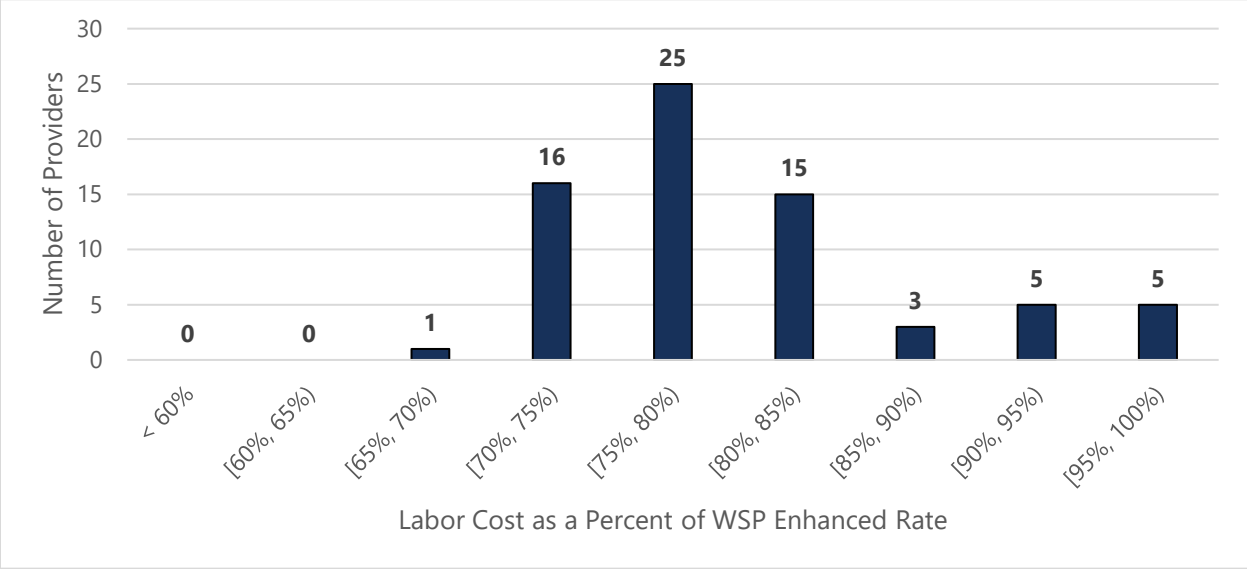
Source: Calculations performed based on DHCS published rate studies for rate year 2026: https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx.
Note: Health care worker minimum wage increases went into effect starting in 2024 under SB 525. Workers at skilled nursing facilities not owned, operated, or controlled by hospitals or health care systems were excluded.

Exhibit 3.7. Labor cost per day as a percentage of the total final enhanced rate for FS/SNF-Bs, rate year 2026



Source: Source: Calculations performed based on DHCS published rate studies for rate year 2026: https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx.

Exhibit 3.8. Labor cost per day as a percentage of the total final enhanced rate for FS/SAs, rate year 2026



Source: Source: Calculations performed based on DHCS published rate studies for rate year 2026: https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx.

Staffing minimums

California mandates a minimum of 3.5 direct care HPRD in nursing facilities, with the standard encompassing at least 2.4 CNA HPRD.[132] The California Department of Public Health's (CDPH) Staffing Audits Section monitors compliance with the state's minimum staffing requirements through unannounced staffing audits in which CDPH randomly selects 24 resident days from the preceding 90-day period to determine staffing compliance. Data used to verify staffing compliance include payroll records, staff rosters, daily assignment sheets, daily census records, staff licensure, and certification documentation. Facilities must document direct care hours by using payroll records and report average daily census and direct care hours per patient day (DHPPD). DHPPD calculations include only direct care hours provided by RNs, LVNs, CNAs, psychiatric technicians, and certain nurse assistants in training. Separate calculations assess compliance with both the overall 3.5 DHPPD requirement and the CNA-specific 2.4 DHPPD requirement.

Following the audits, CDPH conducts a final review to determine whether the facility was compliant, noncompliant for one audited day, or noncompliant for two or more audited days. Facilities cited for noncompliance must submit a plan of correction for each deficiency and may be subject to administrative penalties based on the extent of noncompliance. Facilities that fail to meet staffing requirements on fewer than 5 percent of audited days are not subject to a monetary penalty; deficiencies cited on 5 to 49 percent of audited days result in a $25,000 administrative penalty; deficiencies on 50 percent or more of audited days result in a $50,000 penalty. Facilities may appeal audit findings through CDPH's administrative hearing process, which establishes timelines for requesting a hearing, submitting supporting documentation, and issuing a final decision before any penalty is assessed.

The overall structure of the staffing audits program predates the 2016 launch of the national PBJ system. Audit findings do not verify the accuracy of PBJ data.

Adherence to minimum staffing requirements and use of waivers

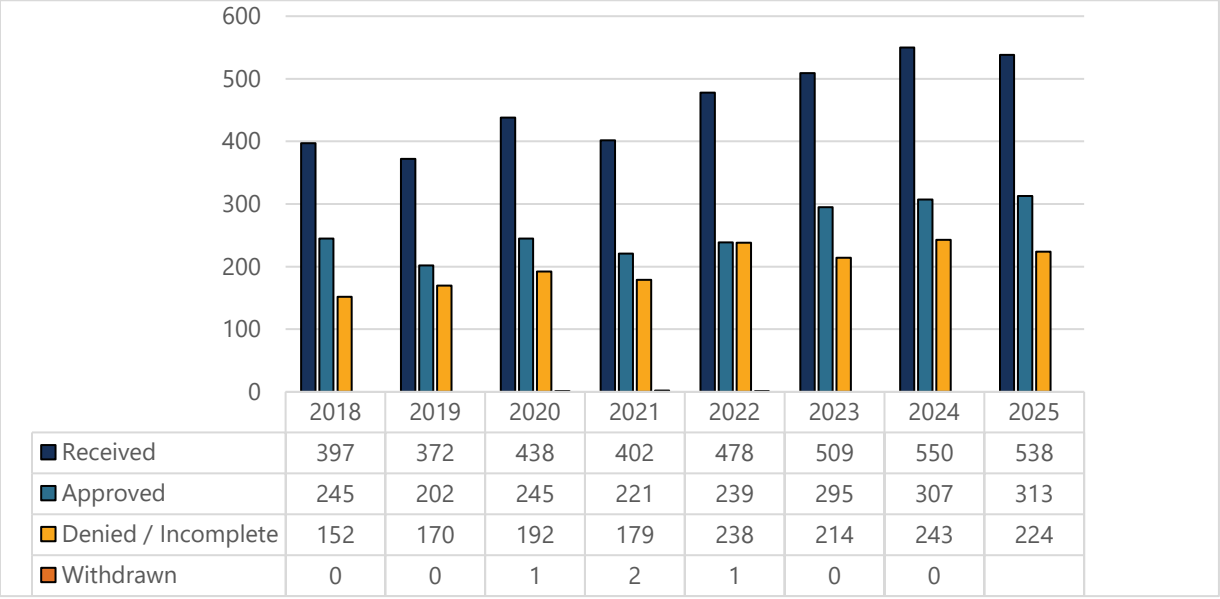
Sections 1276.65(l) and (c)(2) of the California Health & Safety Code require CDPH to institute a process for SNFs seeking a waiver for minimum staffing requirements. There are two waiver types. With a patient needs waiver, CDPH waives the 2.4 HPRD CNA requirement as long as the facility meets the minimum 3.5 HPRD direct care requirement. To be considered for such a waiver, the facility must substantiate the need

[132] California Health & Safety Code, § 1276.65.

for a greater number of licensed nurses than CNAs and describe how residents receive services that do not require licensed nursing staff. With a workforce shortage waiver, CDPH waives the 3.5 HPRD direct care requirement and/or the 2.4 HPRD CNA requirement because of a shortage of available and appropriate health care professionals and direct care staff. To apply for a workforce shortage waiver, facilities must provide evidence of recruitment and retention efforts along with a recruitment plan outlining strategies to resolve the shortage. Applicants must also provide a resident care plan describing how the facility will continue to meet residents' needs despite reduced staffing levels. Facilities with significant recent enforcement actions, such as citations or license sanctions, are ineligible for workforce shortage waivers. Approved waivers require annual renewal, with facilities demonstrating progress toward meeting the state's staffing standards.

In **Exhibit 3.9**, we present the distribution of approved patient needs waivers from 2018 through 2025. Requests for waivers increased from 397 in 2018 to 538 in 2025. Approval rates ranged from 61.7 to 50 percent.

Exhibit 3.9. Distribution of patient needs waiver approvals, 2018–2025

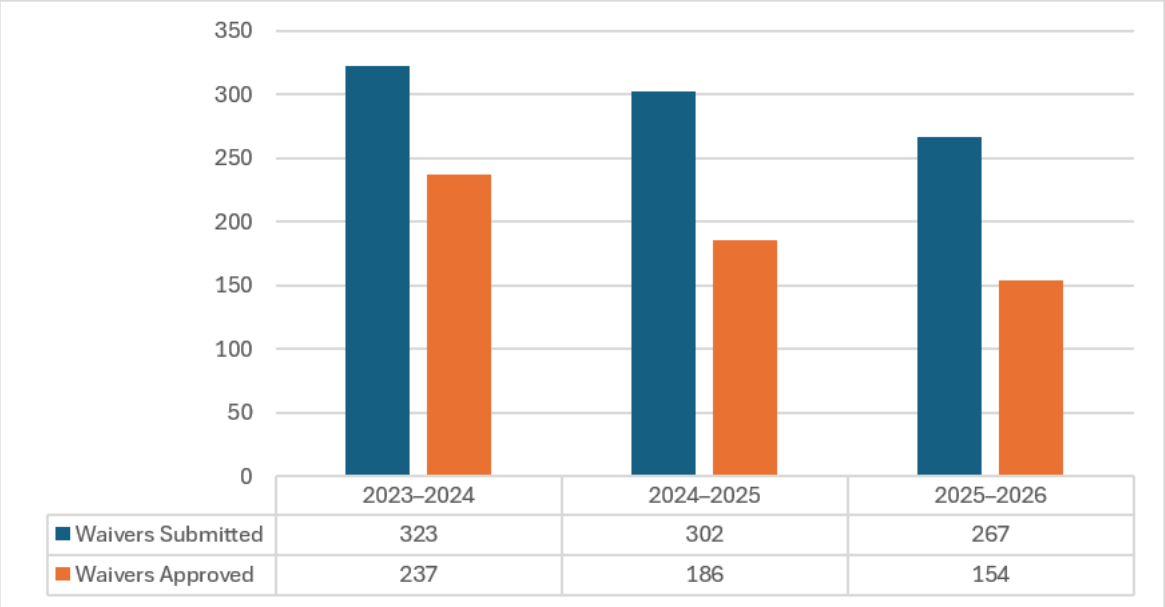


	2018	2019	2020	2021	2022	2023	2024	2025
Received	397	372	438	402	478	509	550	538
Approved	245	202	245	221	239	295	307	313
Denied / Incomplete	152	170	192	179	238	214	243	224
Withdrawn	0	0	1	2	1	0	0	

Source: Data provided by CDPH.

In **Exhibit 3.10**, we present the distribution of approved workforce shortage waivers from 2023 through 2026. Over the three-year period, workforce shortage waiver approvals and submissions decreased from 237 in 2023–2024 to 186 in 2024–2025 and 154 in 2025–2026. The decrease represents a reduction of approximately 35 percent over the period, with CDPH approving about 65 percent of waiver requests.

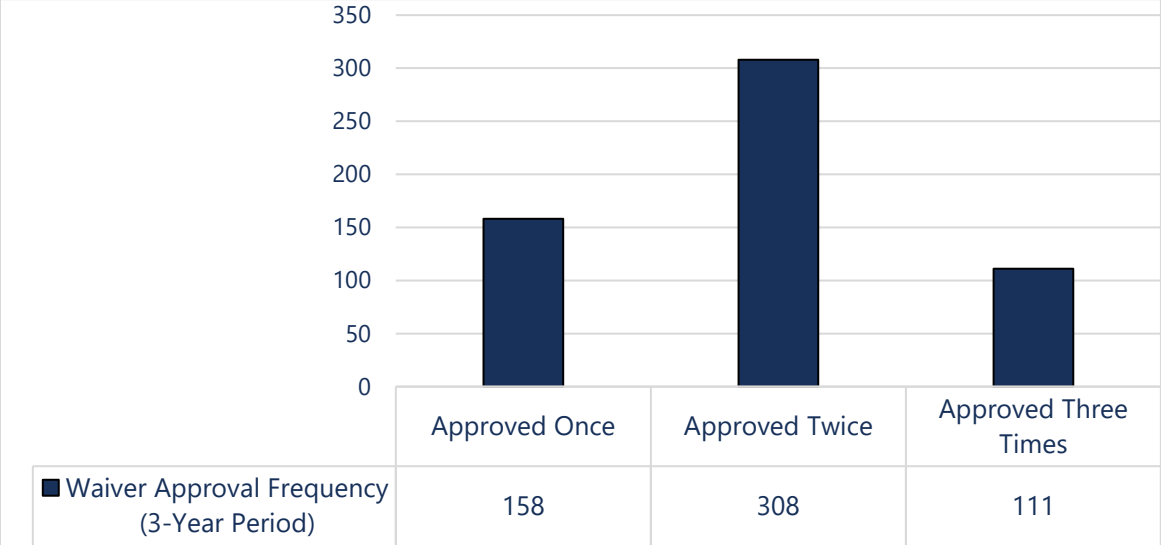
Exhibit 3.10. Distribution of workforce shortage waiver approvals, 2023–2026



Source: Calculations performed based on review of publicly available waiver approvals records, available at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/Final-Waiver-Approval-Report.aspx.

Between 2023 and 2026, most facilities that received a workforce shortage waiver received an approval more than once (**Exhibit 3.11**). Some 308 facilities received two approvals compared with 158 facilities receiving one approval and 111 facilities receiving three approvals.

Exhibit 3.11. Distribution of workforce shortage waiver approval frequency, 2023–2026



Source: Calculations performed based on review of publicly available waiver approvals records, available at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/Final-Waiver-Approval-Report.aspx.

Workforce Standards Program

California also supports workforce investment through WSP, which provides a workforce rate adjustment to the per diem rate of the facility-specific base.[133] DHCS established the WSP rate adjustment in calendar year 2024 on a facility-specific basis by rebasing the labor cost component to 100 percent cost coverage (generally using fiscal year–ending 2021 cost reports). For calendar year 2024, the Medicaid day-weighted average per diem paid to eligible continuing FS/SNF-B facilities was $28.35. Subsequent rate years capped growth of the WSP rate adjustment at 5 percent. Facilities that choose not to participate or fail to satisfy program requirements receive the base per diem rate without the workforce adjustment. WSP provides three pathways through which facilities may participate in the program. Despite differences in the pathway requirements, all three pathways lead to the same facility-specific workforce rate enhancement if facilities meet the specified standards:

- **CBA Pathway:** A majority of a participating facility's direct care staff must be covered by a collective bargaining agreement (CBA).

[133] California Code of Regulations Title 22, § 72329.2.

- **LMC Pathway:** A participating facility must be a member of a statewide multi-employer labor management committee certified by DHCS. LMCs bring together employers and labor representatives to address workforce issues at the statewide level.
- **BWB Pathway:** Participating facilities must meet four basic wage and benefit (BWB) standards established by DHCS:
    1. Pay at least a basic wage to indirect and direct care workers, based on a regional median wage for comparable occupations and updated annually by DHCS.
    2. Offer health care benefits to full-time employees with a minimum actuarial value of 85 percent and employer share of 80 percent of the premium.
    3. Provide paid sick leave totaling 10 days.
    4. Provide paid time and tuition for continuing education requirements for CNAs.[134]

WSP uses payment policy to promote workforce investment beyond minimum staffing expectations. By conditioning enhanced payment on workforce practices, WSP encourages facilities to invest in compensation, benefits, and other workforce structures to support workforce stability. The program relies on a structured mechanism to support workforce development while granting facilities flexibility in how to satisfy workforce standards.

In 2024, 928 (83 percent) of facilities were participating in WSP through one of the three pathways. In **Exhibit 3.12**, we include counts of facilities participating in WSP by peer group and pathway. San Joaquin Valley accounted for the lowest participation rate in the program (89 percent), and Greater Sacramento and Los Angeles Region 3 accounted for the highest rates (98 and 97 percent, respectively). FS/SA facilities also demonstrated high participation in WSP (98 percent).

Of the facilities participating in WSP, most participate through the LMC pathway (53 percent) or the BWB pathway (40 percent), with few facilities overall participating through the CBA pathway (7 percent). The Bay Area peer group has the greatest proportion of facility participation in the CBA pathway (18 percent), followed by Los Angeles Region 3 (11 percent).

[134] California Department of Health Care Services. (n.d.). *Skilled nursing facilities workforce standards program*. https://www.dhcs.ca.gov/services/medi-cal-resources/skilled-nursing-facilities-workforce-standards-program/.

Exhibit 3.12. WSP pathway participation by peer group, quarter 4, 2024

Total	Bay Area	Central Coast	FS/SA	DP/SNF	Greater Sacramento	LA Region 1	LA Region 2	LA Region 3	North State-Sierras	Orange-San Diego	San Joaquin Valley	Southern Inland	Stockton-Modesto
BWB Pathway													
372	46	22	0	22	5	45	38	54	20	47	28	30	15
CBA Pathway													
67	29	1	0	4	4	5	2	10	3	2	3	2	2
LMC Pathway													
489	88	18	0	55	44	38	50	28	15	53	32	48	20
Did not participate/ missing pathway													
190	18	4	61	2	1	6	9	3	2	8	8	7	2

Source: CMS' archived data snapshot from October 2024 for nursing homes, including rehabilitation services, available at: https://data.cms.gov/provider-data/dataset/4pq5-n9; Workforce Standards Program indicator data; publicly available 2024 California FS/SNF-B, FS/SA, and DP/SNF rate data updated in 2026, available at: https://www.dhcs.ca.gov/services/medi-cal-

resources/freestanding-skilled-nursing-facilities-and-subacute-units/ and https://www.dhcs.ca.gov/services/medi-cal-resources/distinct-part-nursing-facilities-level-b-dp-nf-b/.

[a] FS/SA facilities include FS/SA-only facilities and FS/SA + FS/SNF-Bs.

BWB = basic wage and benefit; CBA = collective bargaining agreement; DP = distinct part facility; FS/SA = adult freestanding subacute facility; LMC = labor management committee; WSP = Workforce Standards Program.

California has also established workforce standards through labor policy. California SB 525 (Durazo, Chapter 890, Statutes of 2023) specified a phased-in minimum wage for health care workers, ultimately raising wages to $25 per hour across many health care settings. SB 525's implementation timelines and applicability vary by facility type.[135] In **Exhibit 3.13**, we present SB 525's phase-in minimum wage timeline.

Exhibit 3.13. SB 525 phased-in minimum wage standards and timeline

	Minimum Wage Standard	Minimum Wage Standard
SB 525 Timeline	Facilities with High Governmental Payor Mix	All Other Covered Health Care Facilities
July 1, 2024–June 30, 2026	$18–$18.63 per hour	$21 per hour
July 1, 2026–June 30, 2028	$19.28–$19.95 per hour	$23 per hour
July 1, 2028	$20.65 per hour	$25 per hour
July 1, 2033	$25 per hour	$25 per hour

Source: California Labor Code, §§ 1182.14 and 1182.15.

Notably, SB 525 does not apply to workers in SNFs that are not owned or operated by hospitals. In **Exhibit 3.14**, we compare the current SB 525 minimum wage standard to the direct and indirect care wage standards established under WSP's basic wage and benefit pathway. Given that the BWB pathway standards vary across metropolitan statistical areas (MSAs), the exhibit's calculations summarize the number of MSAs above or below SB 525's minimum wage standard.

[135] California Labor Code, §§ 1182.14 and 1182.15.

Exhibit 3.14. Basic wage and benefit WSP pathway standards, calendar year 2026

Comparison Measure	Direct Care Wage Standard	Indirect Care Wage Standard
Minimum	$19.99 per hour	$18.55 per hour
Average	$21.62 per hour	$19.63 per hour
Maximum	$25.93 per hour	$22.04 per hour

Source: Calculations performed based on review of publicly available wage standards, available at: https://www.dhcs.ca.gov/wp-content/uploads/2025/12/CY-2026-Wage-Standard.xlsx.

Although most MSAs have instituted direct care or indirect care wage standards below the current SB 525 minimum wage of $23 per hour, the BWB wage standards applicable to direct care workers are generally closer to the SB 525 benchmark than those applicable to indirect care workers. In addition, as shown in **Exhibit 3.5**, which uses Medicare cost report data, California SNFs paid an average CNA wage of $26.97 per hour in 2024, exceeding the current SB 525 minimum wage of $23 per hour.

Workforce & Quality Incentive Program

Medi-Cal previously incorporated workforce and quality incentives into SNF payment policy through the SNF WQIP. DHCS authorized WQIP beginning January 2023; it was discontinued in 2025 by the 2025 Budget Act.[136] While active, WQIP operated as a directed payment program whereby facilities earned points based on performance in several quality domains such as workforce, clinical quality, and equity. In total, WQIP included 13 measures, of which 6 pertained to workforce. In **Exhibit 3.15**, we present WQIP staffing domain measures and, in **Exhibit 4.5**, all WQIP measures. In Chapter 4, we provide data on WQIP's outcomes while the program was in effect.

[136] Welfare & Institutions Code, § 14126.024. WQIP was discontinued pursuant to the 2025 Budget Act.

Exhibit 3.15. WQIP staffing-based quality measures

Domain	WQIP Measures
Staffing	Acuity-adjusted total nursing hours
	Acuity-adjusted weekend total nursing hours
	Acuity-adjusted RN hours
	Acuity-adjusted LVN hours
	Acuity-adjusted CNA hours
	Staffing turnover

RN = registered nurse; LVN = licensed vocational nurse; CNA = certified nursing assistant.

WQIP aimed to reward Medi-Cal-participating SNFs for both the quantity and quality of their workforce. The staffing domain consisted of five acuity-adjusted staffing hour measures that accounted for RN, LVN, and CNA acuity-adjusted hours as well as for weekend total nursing hours. WQIP also prorated scores for PBJ staffing data incompleteness and for any days that did not meet minimum staffing requirements under state law. The measures encouraged facilities to maintain an appropriate skill mix and consistent staffing throughout the week. WQIP measured staffing turnover, which recognized workforce retention as an indicator of quality.

Staffing in California SNFs: Methodology and observed patterns

Staffing patterns by peer group

To understand staffing patterns across facilities in California, we used PBJ data to examine staffing by peer group in quarter 4 of 2024. Across peer groups, permanent staff as opposed to contract staff accounted primarily for average staff HPRD (**Exhibit 3.16**). Specifically, average total nurse HPRD across all facilities for employees in quarter 4 of 2024 was 4.25 (or 3.98 after removing all administrative nursing staff employees), but only 0.14 HPRD for contract employees (or 0.13 after removing all administrative nurse contract staff). Although the averages varied, the patterns were consistent across peer groups (**Exhibits 3.16** and **3.17**). Contract staff were uncommon staffing categories other than nurses; other categories included medical directors, direct service workers, social workers, and activity staff (**Exhibit 3.17**). DP/SNF facilities accounted for the highest average total nurse HPRD and the greatest variance, likely reflecting the facilities' higher acuity needs (**Exhibit 3.17** and **3.18**).

Exhibit 3.16. Average HPRD staffing for California SNFs by peer group, quarter 4, 2024

Measure	Total (all facilities)	Total (SNF-B only)	Bay Area	Central Coast	DP/SNF	FS/SA[a]	Greater Sacramento
Employees							
Average RN employee HPRD	0.57	0.46	0.62	0.49	2.16	0.68	0.57
Average LPN employee HPRD	1.17	1.10	0.98	1.05	1.61	1.69	1.07
Average CNA employee HPRD	2.51	2.50	2.36	2.56	2.88	2.45	2.44
Average total nurse employee HPRD	4.25	4.06	3.96	4.11	6.65	4.82	4.08
Average RN (no administrative staff) employee HPRD	0.43	0.35	0.49	0.37	1.54	0.59	0.46
Average LPN (no administrative staff) employee HPRD	1.04	0.96	0.85	0.92	1.50	1.56	0.96
Average total nurse (no administrative staff) employee HPRD	3.98	3.81	3.70	3.85	5.91	4.60	3.86
Average medical director employee HPRD	0.00	0.00	0.00	0.00	0.07	0.00	0.00
Average direct service employee HPRD	0.32	0.31	0.30	0.30	0.39	0.31	0.30
Average qualified social worker employee HPRD	0.03	0.03	0.04	0.03	0.05	0.02	0.05

Measure	Total (all facilities)	Total (SNF-B only)	Bay Area	Central Coast	DP/SNF	FS/SA[a]	Greater Sacramento
Average total social worker employee HPRD	0.11	0.11	0.10	0.12	0.07	0.11	0.11
Average qualified activity employee HPRD	0.05	0.05	0.05	0.05	0.20	0.04	0.05
Average total activity employee HPRD	0.20	0.19	0.18	0.18	0.31	0.19	0.16
Contract staff							
Average RN contract HPRD	0.01	0.01	0.02	0.01	0.04	0.01	0.00
Average LPN contract HPRD	0.03	0.03	0.03	0.03	0.05	0.04	0.02
Average CNA contract HPRD	0.10	0.09	0.17	0.12	0.15	0.08	0.06
Average total nurse contract HPRD	0.14	0.13	0.22	0.16	0.24	0.13	0.08
Average RN (no administrative staff) contract HPRD	0.01	0.01	0.01	0.01	0.04	0.01	0.00
Average LPN (no administrative staff) contract HPRD	0.03	0.03	0.03	0.03	0.05	0.04	0.02
Average total nurse (no administrative staff) contract HPRD	0.13	0.13	0.22	0.16	0.23	0.12	0.08

Measure	Total (all facilities)	Total (SNF-B only)	Bay Area	Central Coast	DP/SNF	FS/SA[a]	Greater Sacramento
Average medical director contract HPRD	0.00	0.00	0.00	0.00	0.01	0.00	0.01
Average direct service contract HPRD	0.00	0.00	0.00	0.00	0.01	0.00	0.00
Average qualified social worker contract HPRD	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Average total social worker contract HPRD	0.00	0.00	0.00	0.00	0.01	0.00	0.00
Average qualified activity contract HPRD	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Average total activity contract HPRD	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Exhibit 3.16. (continued) Average HPRD staffing for California SNFs by peer group, quarter 4, 2024

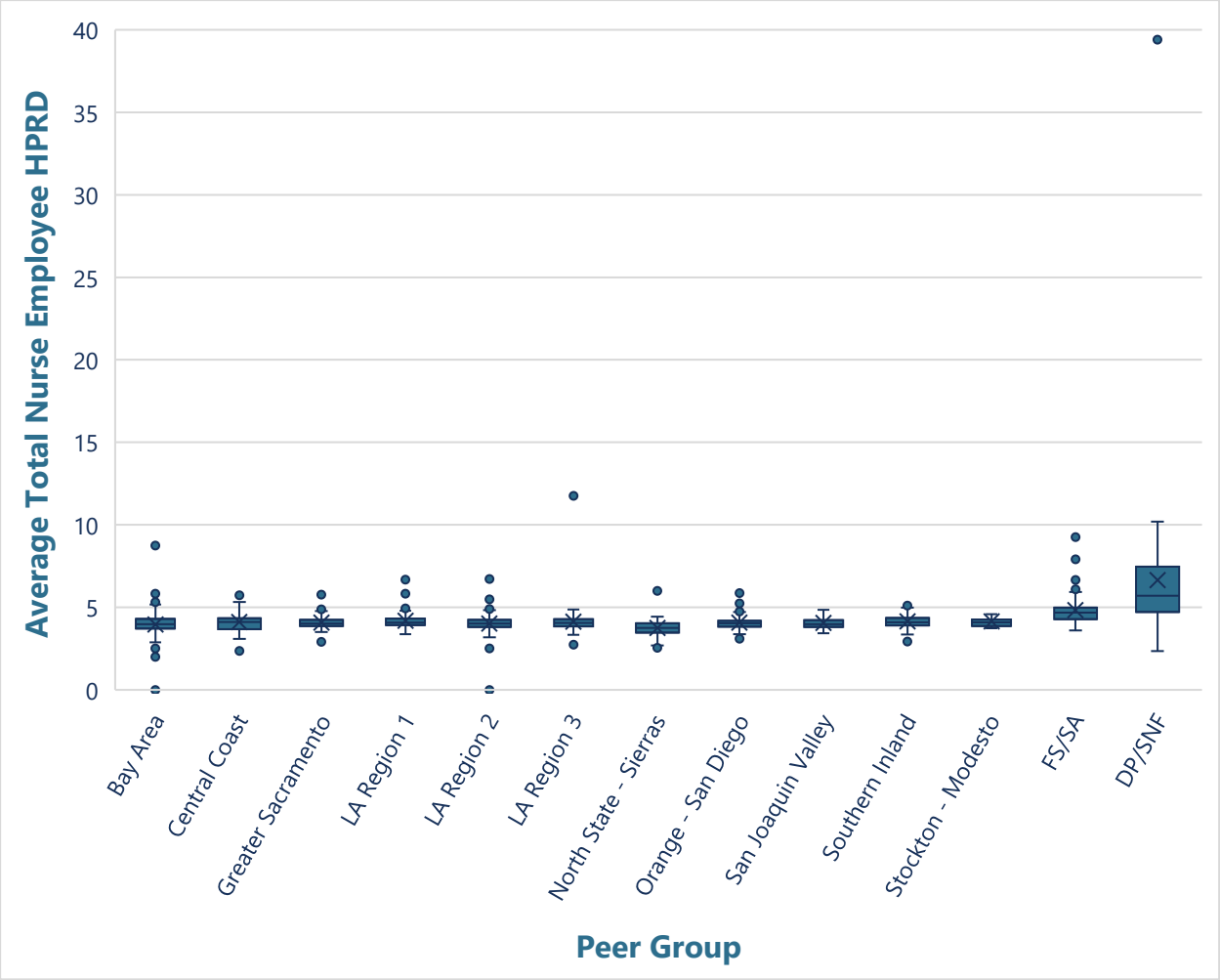
Measure	LA Region 1	LA Region 2	LA Region 3	North State-Sierras	Orange-San Diego	San Joaquin Valley	Southern Inland	Stockton-Modesto
Employees								
Average RN employee HPRD	0.43	0.39	0.35	0.43	0.47	0.38	0.35	0.44
Average LPN employee HPRD	1.17	1.08	1.15	1.04	1.15	1.06	1.26	1.14
Average CNA employee HPRD	2.58	2.54	2.63	2.30	2.45	2.61	2.54	2.56
Average total nurse employee HPRD	4.18	4.02	4.13	3.76	4.07	4.06	4.15	4.15
Average RN (no administrative staff) employee HPRD	0.31	0.30	0.26	0.29	0.37	0.28	0.25	0.34
Average LPN (no administrative staff) employee HPRD	1.01	0.94	1.00	0.95	1.01	0.95	1.12	0.99
Average total nurse (no administrative staff) employee HPRD	3.89	3.78	3.89	3.54	3.82	3.85	3.91	3.89
Average medical director employee HPRD	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Measure	LA Region 1	LA Region 2	LA Region 3	North State-Sierras	Orange-San Diego	San Joaquin Valley	Southern Inland	Stockton-Modesto
Average direct service employee HPRD	0.33	0.32	0.35	0.26	0.34	0.30	0.30	0.31
Average qualified social worker employee HPRD	0.04	0.03	0.03	0.02	0.02	0.03	0.03	0.04
Average total social worker employee HPRD	0.11	0.10	0.11	0.09	0.14	0.11	0.12	0.11
Average qualified activity employee HPRD	0.05	0.04	0.05	0.04	0.05	0.06	0.04	0.04
Average total activity employee HPRD	0.21	0.21	0.23	0.17	0.19	0.19	0.17	0.18
Contract staff								
Average RN contract HPRD	0.01	0.02	0.02	0.03	0.01	0.00	0.00	0.00
Average LPN contract HPRD	0.02	0.02	0.03	0.09	0.02	0.01	0.02	0.01
Average CNA contract HPRD	0.06	0.08	0.12	0.21	0.07	0.02	0.04	0.02
Average total nurse contract HPRD	0.09	0.11	0.17	0.34	0.10	0.04	0.06	0.03

Measure	LA Region 1	LA Region 2	LA Region 3	North State-Sierras	Orange-San Diego	San Joaquin Valley	Southern Inland	Stockton-Modesto
Average RN (no administrative staff) contract HPRD	0.01	0.01	0.01	0.02	0.00	0.00	0.00	0.00
Average LPN (no administrative staff) contract HPRD	0.02	0.02	0.03	0.09	0.02	0.01	0.02	0.01
Average total nurse (no administrative staff) contract HPRD	0.09	0.10	0.16	0.33	0.10	0.04	0.06	0.02
Average medical director contract HPRD	0.00	0.00	0.00	0.01	0.00	0.00	0.00	0.00
Average direct service contract HPRD	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Average qualified social worker contract HPRD	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Average total social worker contract HPRD	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Average qualified activity contract HPRD	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Average total activity contract HPRD	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Source: CMS' archived data snapshot from October 2024 for nursing homes, including rehabilitation services, available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py; 2024 quarterly PBJ Employee Detail Nursing Home Staffing Data, available at: https://data.cms.gov/quality-of-care/payroll-based-journal-employee-detail-nursing-home-staffing
Note: The facility sample is based on a snapshot of active facilities as of October 2024 based on CMS data for nursing homes, including rehabilitation services. The sample does not include Medicare-only facilities. The calculations excluded facilities with missing data for any of the relevant characteristics reported in this exhibit. All averages reported by peer group are unweighted averages.
[a] FS/SA facilities include FS/SA-only facilities and FS/SA + FS/SNF-Bs.
CNA = certified nursing assistant; DP/SNF = distinct part skilled nursing facility; FS/SA = adult freestanding subacute facility; HPRD = hours per resident day; LPN = licensed practical nurse; RN = registered nurse.

Exhibit 3.17. Average total nurse employee HPRD for California SNFs by peer group, quarter 4, 2024



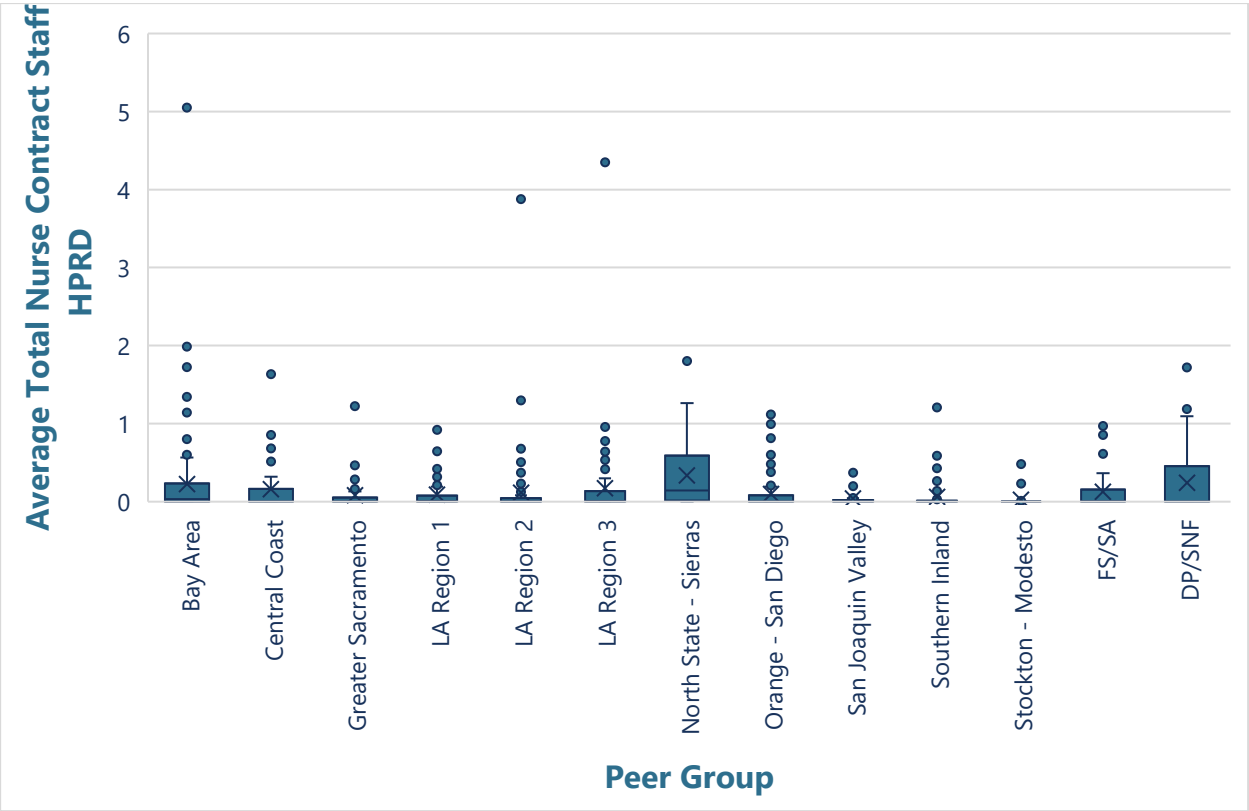
Source: CMS' archived data snapshot from October 2024 for nursing homes, including rehabilitation services, available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py; 2024 quarterly PBJ Employee Detail Nursing Home Staffing Data, available at: https://data.cms.gov/quality-of-care/payroll-based-journal-employee-detail-nursing-home-staffing.

Note: The facility sample is based on a snapshot of active facilities as of October 2024 based on CMS data for nursing homes, including rehabilitation services. The sample does not include Medicare-only facilities. The calculations excluded facilities with missing data for any of the relevant characteristics reported in this exhibit. All averages reported by peer group are unweighted averages.

[a] FS/SA facilities include FS/SA-only facilities and FS/SA + FS/SNF-Bs.

DP/SNF = distinct part skilled nursing facility; FS/SA = adult freestanding subacute facility; HPRD = hours per resident day.

Exhibit 3.18. Average total nurse contract staff HPRD for California SNFs by peer group, quarter 4, 2024



Source: CMS' archived data snapshot from October 2024 for nursing homes, including rehabilitation services, available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py; 2024 quarterly PBJ Employee Detail Nursing Home Staffing Data, available at: https://data.cms.gov/quality-of-care/payroll-based-journal-employee-detail-nursing-home-staffing.

Note: The facility sample is based on a snapshot of active facilities as of October 2024 based on CMS data for nursing homes, including rehabilitation services. The sample does not include Medicare-only facilities. The calculations excluded facilities with missing data for any relevant characteristics reported in this exhibit. All averages reported by peer group are unweighted averages.

[a] FS/SA facilities include FS/SA-only facilities and FS/SA + FS/SNF-Bs.

DP/SNF = distinct part skilled nursing facility; FS/SA = adult freestanding subacute facility; HPRD = per resident day.

The share of RN staff out of total nursing staff ranged from 8 percent for the Southern Inland FS/SNF-B peer group to 15 percent for the Bay Area (**Exhibit 3.19**). DP/SNFs reported the highest share of RN staff out of total nursing staff (24 percent). Across all peer groups, CNAs comprised the largest share of nursing staff.

Exhibit 3.19. Average share of nurse staff types out of total nursing staff for California SNFs by peer group, quarter 4, 2024 (percentage)

Measure	Total	Bay Area	Central Coast	DP/SNF	FS/SA[a]	Greater Sacramento	LA Region 1
Share of RN staff	12.05	15.29	11.81	24.22	13.72	13.45	10.14
Share of LPN staff	27.40	24.04	25.44	26.12	34.50	26.34	27.85
Share of CNA staff	60.55	60.67	62.75	49.66	51.78	60.21	62.00

Measure	LA Region 2	LA Region 3	North State-Sierras	Orange-San Diego	San Joaquin Valley	Southern Inland	Stockton-Modesto
Share of RN staff	9.73	8.58	10.46	11.41	9.27	8.28	10.61
Share of LPN staff	26.79	27.41	27.93	28.05	26.20	30.25	27.50
Share of CNA staff	63.48	64.01	61.61	60.55	64.53	61.47	61.89

Federal regulations require SNFs with more than 120 beds to employ a full-time qualified social worker.[137] When we investigated whether any facilities in California with more than 120 beds in quarter 4 of 2024 employed less than a full-time equivalent social worker across permanent and contract staff, we found that 8 facilities fell below the threshold (results not displayed). When we restricted our investigation to the category of qualified social worker, we found that 151 facilities fell below the threshold. The results suggest that some facilities that should employ a full-time equivalent qualified social worker do not meet the requirement because they either employ social work staff who do not meet the qualification or misclassify some staff in the data (for example, staff who should be qualified social workers may instead be classified as general social workers). Despite the absence of a similar threshold requirement for

[137] 42 CFR § 483.70. Qualified social workers must obtain a state license to practice in this role, in alignment with the state regulated scope of practice.

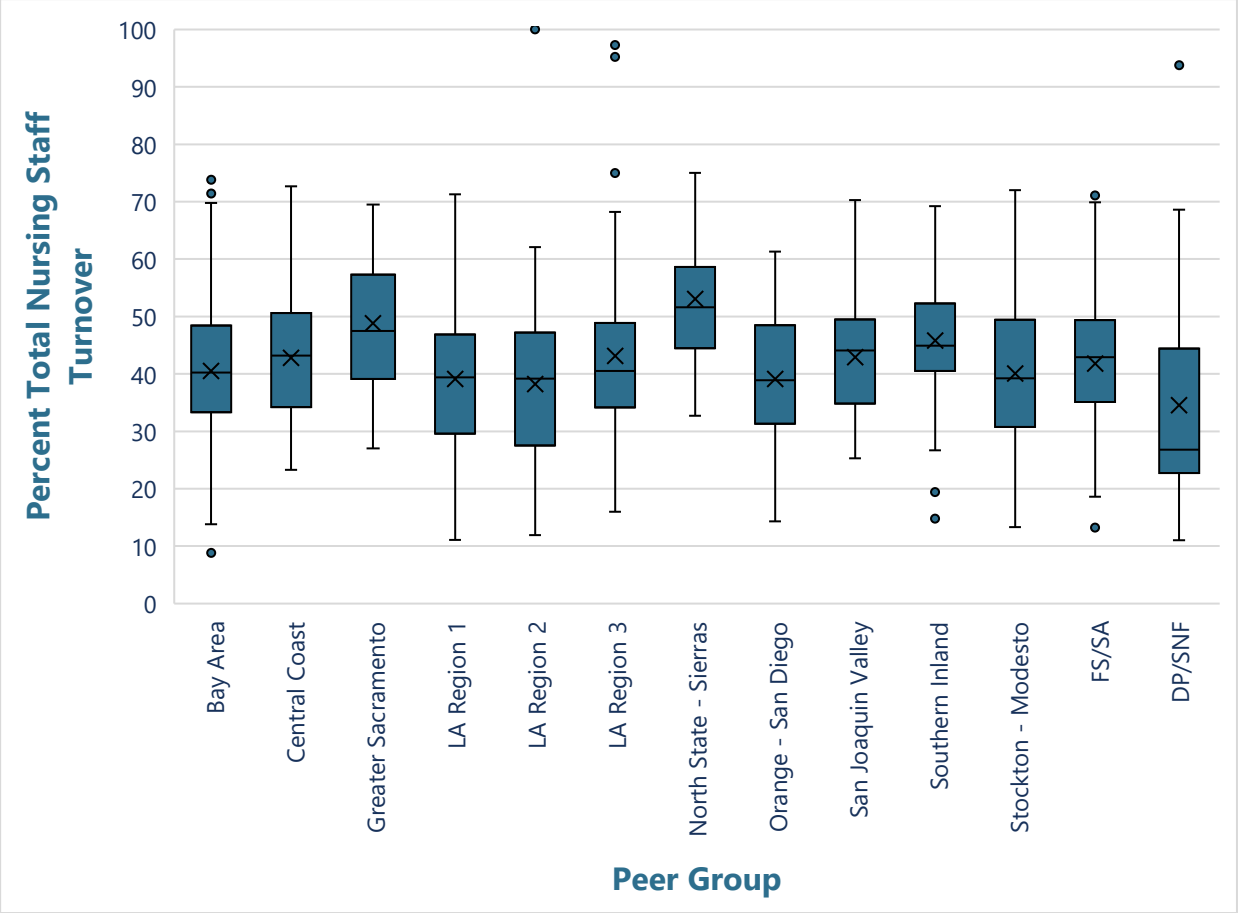
activities staff, we discovered that fewer facilities did not employ a full-time equivalent activity staff in quarter 4 of 2024 (6 facilities fell below the threshold for any activity staff, and 128 facilities fell below the threshold for qualified activity staff).

To determine whether facilities might rely on more than one individual to fill their medical director needs, we also examined the number of unique medical directors reported in the PBJ data by facility in quarter 4 of 2024. Overall, we found that 92 facilities in quarter 4 of 2024 listed more than one medical director dedicated to the facility, suggesting that some facilities rely on more than one individual to fill the medical director role.

Nursing staff turnover

Average total nursing staff turnover was 39 to 53 percent across FS/SNF-B peer groups, with the highest turnover in North State-Sierras. DP/SNF facilities accounted for the lowest average total nursing staff turnover (35 percent). We found considerable variation in the rate of nursing staff turnover across facilities (**Exhibit 3.20**).

Exhibit 3.20. Percent total nursing staff turnover among SNFs by peer group, quarter 4, 2024



Source: CMS' archived data snapshot from October 2024 for nursing homes, including rehabilitation services, available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py.
Note: The facility sample is based on a snapshot of active facilities as of October 2024 based on CMS data for nursing homes, including rehabilitation services. The sample does not include Medicare-only facilities. FS/SA facilities include FS/SA-only facilities and FS/SA + FS/SNF-Bs. The calculations exclude facilities with missing data. All averages reported by peer group are unweighted averages.
DP/SNF = distinct part skilled nursing facility; FS/SA = adult freestanding subacute facility; LA = Los Angeles.

Analysis of California and national SNF staffing trends

California's staffing profile appears mixed rather than uniformly high or low when compared with national averages. A look at the Care Compare data tables for quarter 4 of 2024 reveals that California ranks sixth nationally in reported total nurse staffing HPRD at 4.37 versus 3.94 and third nationally in total nursing staff turnover at 41.05 versus 49.55.[138] At the same time, California ranks 40th in reported RN HPRD. In **Exhibit 3.19**, we compare California's performance on staffing measures with the national average.

Exhibit 3.21. California versus national average staffing measure comparison

Metric	Preferred Outcome	CA Average	National Average	National Ranking
Registered nurse aide staffing hours per resident per day	Higher	2.57	2.40	10
Reported LPN staffing hours per resident per day	Higher	1.22	0.80	1
Reported RN staffing hours per resident per day	Higher	0.58	0.74	40
Reported licensed nurse staffing hours per resident per day	Higher	1.81	1.54	4
Reported total nurse staffing hours per resident per day	Higher	4.37	3.94	6
Total number of nurse staffing hours per resident per day on the weekend	Higher	3.95	3.42	5
RN hours per resident per day on the weekend	Higher	0.44	0.50	30
Total nursing staff turnover	Lower	41.05	49.55	3
RN turnover	Lower	42.44	45.07	16

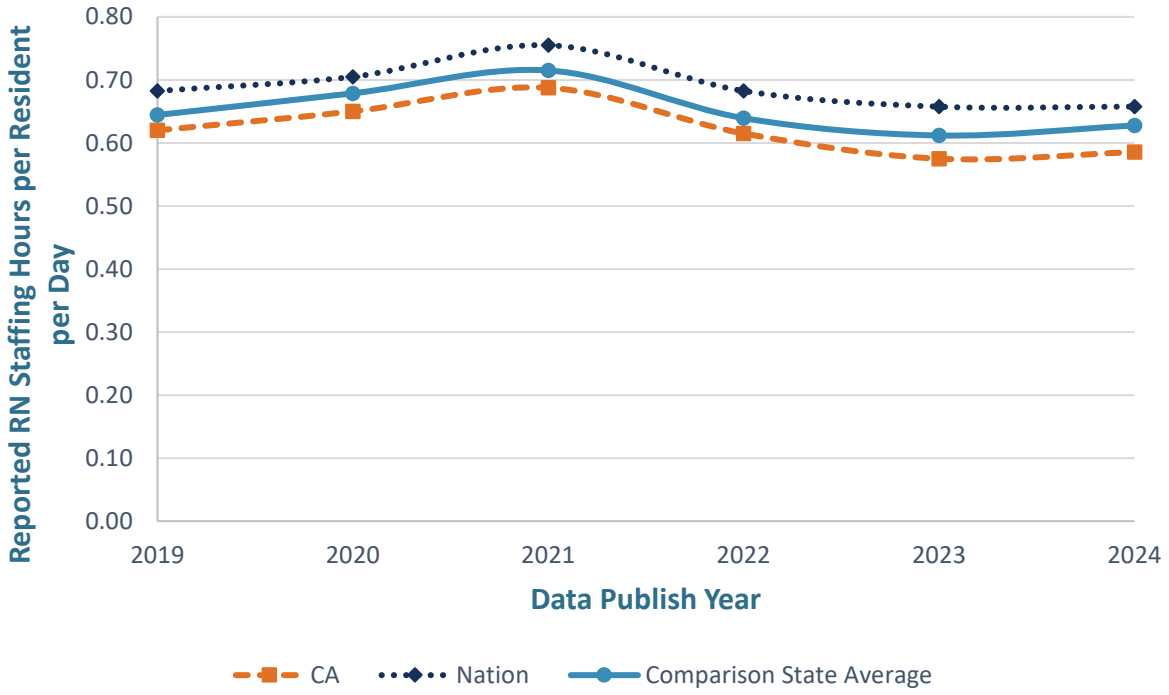
[138] Centers for Medicare & Medicaid Services. (n.d.). *Provider data catalog.* https://data.cms.gov/provider-data/dataset/xcdc-v8bm.

Metric	Preferred Outcome	CA Average	National Average	National Ranking
Adjusted nurse aide staffing hours per resident per day	Higher	2.49	2.24	5
Adjusted LPN staffing hours per resident per day	Higher	0.95	0.86	5
Adjusted RN staffing hours per resident per day	Higher	0.73	0.65	5
Adjusted total nursing staff hours per resident per day	Higher	4.17	3.75	5
Adjusted weekend total nursing staffing hours per resident per day	Higher	2.44	2.49	23

Source: CMS' archived data snapshot from October 2024 for nursing homes, including rehabilitation services, available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py.

The staffing results suggest that California's challenge is not primarily one of total staffing volume but rather one of staffing mix, particularly the relative availability of RNs. Between 2019 and 2024, the Care Compare data place California consistently above the national average in total nurse staffing hours but below the national average in RN staffing hours (**Exhibit 3.22**).

Exhibit 3.22. Reported RN staffing hours per resident per day



Source: CMS' archived data snapshot from October 2024 for nursing homes, including rehabilitation services, available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py.

In quarter 4 of 2024, California reported 2.57 nurse aide HPRD versus 2.4 nationally, 1.22 LPN hours versus 0.8 nationally, and 4.37 total nurse hours versus 3.94 nationally, but only 0.58 RN hours versus 0.74 nationally. This distinction is meaningful because RN staffing is central to assessment, care planning, and clinical oversight. Viewed together, the California data suggest a system with comparatively strong aide and LPN staffing, but with weaker RN intensity than the state's total staffing profile might otherwise imply.

Separate from the HPRD framework, federal regulations require each SNF to provide RN coverage for at least eight consecutive hours per day, seven days per week, as codified at 42 CFR § 483.35(b)(1). Using PBJ data for quarter 4 of calendar year 2024, this analysis in **Exhibit 3.23** examined the frequency with which facilities failed to provide at least eight total hours of registered nurse time on a given day. PBJ data report total RN hours worked per facility-day without distinguishing whether the hours were consecutive; a facility documenting fewer than eight total RN hours is therefore a day on which the facility could not have satisfied the requirement regardless of how those hours were distributed. In **Exhibit 3.23**, we present the California nursing facility days that did or did not meet the requirement for eight hours per day for both work week and weekend

days, arrayed by peer group. Given that RN presence is essential for assessment, care planning, medication management, and the supervision of other nursing staff—oversight functions that cannot be delegated to other staff categories—facility days that fail to meet the threshold raise concerns about clinical judgment and oversight.

Exhibit 3.23. California nursing facility calendar days without eight hours of RN time (percentage)

Measure	Total	Bay Area	Central Coast	DP/SNF	FS/SA[a]	Greater Sacramento	LA Region 1
Percentage of weekday calendar days without eight hours of RN time	8.00	7.36	6.03	11.66	0.41	3.09	10.07
Percentage of weekend calendar days without eight hours of RN time	5.37	4.93	7.26	12.09	0.42	1.07	4.67

Exhibit 3.23. (continued) California nursing facility calendar days without eight hours of RN time (percentage)

Measure	LA Region 2	LA Region 3	North State-Sierras	Orange-San Diego	San Joaquin Valley	Southern Inland	Stockton-Modesto
Percentage of weekday calendar days without eight hours of RN time	7.25	8.34	15.23	3.09	15.47	15.98	6.92
Percentage of weekend calendar days without eight hours of RN time	6.41	5.89	10.29	4.16	6.28	6.71	6.41

Source: CMS' archived data snapshot from October 2024 for nursing homes, including rehabilitation services, available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py; 2024 quarterly PBJ employee detail nursing home staffing data, available at: https://data.cms.gov/quality-of-care/payroll-based-journal-employee-detail-nursing-home-staffing.

Note: The facility sample is based on a snapshot of active facilities as of October 2024 based on CMS data for nursing homes, including rehabilitation services. The sample does not include Medicare-only facilities. The calculations excluded facilities with missing data for any relevant characteristics reported in this exhibit. All averages reported by peer group are unweighted averages.
[a] FS/SA facilities include FS/SA-only facilities and FS/SA + FS/SNF-Bs.

In addition to examining RN presence, we analyzed overall staffing patterns (inclusive of RNs, LPNs, and CNAs). Using PBJ data for quarter 4 of calendar year 2024, we identified days on which the total nursing HPRD fell more than 20 percent below the average for a facility's measurement period. This measure is not a test of compliance with the state's 3.5 HPRD minimum, which sets an absolute floor. Rather, it captures the degree of variability exhibited by a facility relative to its typical operating level. A facility that averages 4.2 HPRD over a period but drops below 3.36 on a given day has experienced a meaningful departure from its own norm, perhaps reflecting weekend or holiday staffing gaps, seasonal resident census fluctuations, unplanned absences, or structural scheduling patterns.

We selected the 20 percent threshold in this analysis in accordance with an established and growing body of research on nursing home staffing instability. Mukamel et al. (2022)[139] first introduced a measure of staffing instability. They defined staffing instability as the percentage of days during a year in which a facility's staffing hours per resident-day fell more than 20 percent below the facility's annual mean. Analyzing PBJ data from over 13,000 certified nursing homes, the Mukamel study found that daily staffing variation measured at the 20 percent threshold was significantly associated with the CMS Five-Star Survey and Quality Measures rankings and, critically, demonstrated little agreement between facilities' average staffing rankings and their variability rankings. Stated another way, instability captures a dimension of quality that average HPRD alone does not reflect. Using the PBJ data, the analysis in **Exhibit 3.24** applies the same methodology to California facilities. Taken together, these indicators offer a view of the California skilled nursing landscape that the HPRD minimum alone does not provide.

[139] Mukamel, D. B., Saliba, D., Ladd, H., & Konetzka, R. T. (2022). Daily variation in nursing home staffing and its association with quality measures. *JAMA Network Open, 5*(3), e222051. https://doi.org/10.1001/jamanetworkopen.2022.2051.

Exhibit 3.24. California nursing facility calendar days meeting an inconsistent staffing threshold (percentage)

Measure	Total	Bay Area	Central Coast	DP/SNF	FS/SA[a]	Greater Sacramento	LA Region 1
Percentage of weekday calendar days with inconsistent staffing	0.56	0.79	0.54	2.31	0.42	0.08	0.24
Percentage of weekend calendar days with inconsistent staffing	4.91	5.14	6.67	14.38	2.44	4.27	4.26

Exhibit 3.24. (continued) California nursing facility calendar days meeting an inconsistent staffing threshold (percentage)

Measure	LA Region 2	LA Region 3	North State-Sierras	Orange-San Diego	San Joaquin Valley	Southern Inland	Stockton-Modesto
Percentage of weekday calendar days with inconsistent staffing	0.58	0.77	0.23	0.30	0.21	0.33	0.04
Percentage of weekend calendar days with inconsistent staffing	2.37	4.50	9.52	3.85	3.68	3.35	2.37

Source: CMS' archived data snapshot from October 2024 for nursing homes, including rehabilitation services, available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py; 2024 quarterly PBJ employee detail nursing home staffing data, available at: https://data.cms.gov/quality-of-care/payroll-based-journal-employee-detail-nursing-home-staffing.

Note: The facility sample is based on a snapshot of active facilities as of October 2024 based on CMS data for nursing homes, including rehabilitation services. The sample does not include Medicare-only facilities. The calculations excluded facilities with missing data for any relevant

characteristics reported in this exhibit. All averages reported by peer group are unweighted averages.
[a] FS/SA facilities include FS/SA-only facilities and FS/SA + FS/SNF-Bs.

Efforts to improve workforce: National scan

To guide California's evaluation of its SNF payment framework, we conducted a comprehensive review of workforce improvement efforts adopted by state Medicaid programs nationwide. In this section, we present findings organized around available policy levers used to influence workforce capacity, including minimum staffing requirements, direct care spending requirements, direct care minimum wage and workforce standards programs, wage pass-through programs, and workforce-focused quality incentive programs, all summarized in **Exhibit 3.25**.

Exhibit 3.25. Policy levers available to influence SNF workforce

Policy Lever	Definition
Minimum staffing hour requirements	States can set minimum standards for how many hours a day residents receive care from nursing staff.
Direct care spending requirements	States can direct facilities to use specific payments to fund direct care workers. Excluding temporary workers from these payments can encourage facilities to invest in permanent staff.
Direct care minimum wages	States can adopt higher or distinct minimum wage requirements targeting direct care workers.
Wage pass-throughs	States can provide facilities with funding specifically for workforce compensation through targeted rate increases or supplemental payments.
Incentive programs	States tie payments to staffing measure to encourage facilities to remain staffed and invest in workforce sustainability.

Policy Lever	Definition
Workforce standards programs	States can require facilities to meet specific staffing and workforce-related standards related to, for example, wages, benefits, training, and working conditions, as a condition of receiving specific funding.
Traditional recruitment efforts	States can implement various strategies to address barriers to staff recruitment and retention, such as building educational and career pathways.

Staffing standards: Minimum staffing hour requirements

To promote sound staffing practices, many states have established minimum staffing requirements for nursing facilities. Thirty-nine states and the District of Columbia maintain staffing requirements that exceed the federal baseline.[140] Among this group, eight states, including California and the District of Columbia, have adopted the most stringent standards, setting minimum staffing requirements at 3.3 HPRD or higher.[141]

States vary in how they define and implement minimum staffing requirements, reflecting approaches that encompass different dimensions of staffing. The approaches may incorporate considerations of resident acuity, total HPRD, staffing ratios by role or by shift, and variation in weekday and weekend coverage.

Case study: Illinois (acuity-based staffing standards)

Illinois applies an acuity-based framework for minimum staffing standards rather than a single uniform staffing floor. Under this structure, facilities self-report two categories of residents: skilled care and intermediate care. Each category calls for different minimum staffing requirements:

[140] The 39 states are Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.
[141] The eight states are Arkansas, California, Delaware, Florida, Massachusetts, New York, Rhode Island, and Washington.

- Residents classified as requiring skilled care need nursing or therapy services delivered under physician direction subject to ongoing clinical oversight; for this group, facilities must provide at least 3.8 hours of nursing and personal care per resident per day.
- Residents classified as requiring intermediate care need basic nursing care and restorative services under periodic medical direction at a lower minimum threshold of 2.5 hours of nursing and personal care per resident per day.

Illinois also specifies minimum requirements for staffing mix, requiring licensed nurses to devote at least 25 percent of their time to total nursing and personal care, with a minimum 10 percent provided by registered nurses.[142]

What distinguishes Illinois's model is its incorporation of resident acuity into minimum staffing requirements. Facilities may seek a waiver if they are unable to meet staffing requirements despite demonstrating diligent recruitment efforts. Approved waivers are subject to quarterly review by the Illinois Department of Public Health and require facilities to continue documenting their ongoing efforts to meet staffing standards.[143]

To enforce compliance, Illinois applies a penalty structure tied to the cost of unmet staffing hours. The penalty for a first offense is set at 125 percent of the wages and benefits associated with the missing hours, increasing to 150 percent for a second offense and 200 percent for a third and subsequent offenses.[144]

Case study: New Jersey (staffing mix standards)

New Jersey establishes minimum staffing standards through a combination of shift-based staff-to-resident ratios and acuity-adjusted hour requirements. The state sets baseline coverage requirements by shift:

- Evening shift: one direct care staff member per 10 residents
- Night shift: one direct care staff member per 14 residents

The model includes a base requirement of 2.5 nursing HPRD, with the requirement for additional hours triggered by the facility-wide presence of specified clinical characteristics, for instance, wound care, which adds 0.75 HPRD. Overall, the New Jersey

[142] Illinois Administrative code, § 300.1230 Direct Care Staffing.
[143] Illinois Administrative code, § 300.1232 Waiver of Registered Professional Nurse Staffing Requirements.
[144] Illinois Administrative code, § 300. 1234-Penalties and Notice of Violation.

structure combines time-of-day coverage thresholds with acuity-based adjustments to align staffing expectations with risk periods and resident care needs.[145]

Workforce investments: Direct care spending requirement

As discussed above, the 2024 LTC Final Rule includes an institutional payment transparency requirement calling for states to report publicly the proportion of Medicaid nursing facility payments allocated to compensation for direct care workers. The requirement increases transparency about the use of Medicaid payments, but it does not establish a standard for spending on minimum direct care. Some states have adopted requirements for direct care spending, mandating nursing facilities to spend a defined share of revenue on resident care, including workforce investment. To operationalize such requirements, states typically establish a minimum spending threshold, require facilities to report revenues and expenditures, and apply oversight mechanisms to verify compliance. Currently, at least four states require nursing facilities to allocate a specified portion of revenue to direct care.[146] The states' policies vary in how they define revenue, with some states applying spending thresholds to total operating revenue and others defining revenue exclusively as Medicaid revenue. States also vary in how they define direct care cost, typically including expenditures associated with hands-on resident care provided by nursing staff, such as wages and benefits. State requirements may vary in their treatment of administrative and capital expenses.

Some states have chosen to limit the extent to which contract labor costs count toward direct care spending requirements. They often operationalize the limits on contract labor through discounts that reduce the value of contract labor expenditures. In this way, direct care spending requirements not only set expectations for overall spending but also shape the allocation of resources across staffing models.

In 2024, the California Legislature considered a direct care spending requirement through AB 1537, though the bill ultimately failed. AB 1537 would have required SNFs to report revenues and expenses to DHCS and to spend 85 percent of their total non-Medicare health revenue in each fiscal year on direct patient-related services. The bill broadly defined spending on direct patient-related services to include costs such as nonadministrative staff, ancillary and support services, therapies, medical supplies, laundry and linen, housekeeping, dietary services, plant operations and maintenance, capital expenditures, and liability insurance. Facilities that failed to meet the threshold

[145] New Jersey Statutes, tit. 30. Institutions and Agencies 30 §§ 13-18.
[146] The four states are Massachusetts, New Jersey, New York, and Oklahoma.

would have been required to issue a pro rata dividend or credit to the state and private health care payors.[147]

Case study: New York

New York has adopted a direct care spending framework to ensure that a defined share of nursing facilities' operating revenue attributed to all payors is directed to resident care and the workforce. The state establishes explicit revenue thresholds for direct resident care and resident-facing staffing and limits the extent to which contract labor may satisfy the thresholds. The state pairs these rules with a profit cap. New York implemented the spending requirement for periods beginning April 1, 2022.

Facilities in New York must allocate funds as follows:

- At least 70 percent of all revenue must go to direct resident care, including at least 40 percent of revenue must be allocated to resident-facing staffing.
- All payor revenue must exclude funding received for the provider assessment, the average increase in the capital portion of the Medicaid rate from the previous three years, the full capital portion of the rate for nursing facilities with a CMS four- to five-star quality rating except for capital rate portions derived from related party transactions, and federal government grant funds for reimbursement of COVID-19 pandemic-related expenses.
- In addition, 15 percent of contract staffing costs must be deducted from the amounts counted toward both the direct resident care and resident-facing staffing thresholds.[148]
- For purposes of the spending requirement, direct resident care encompasses a broad range of cost centers reported in the nursing facility cost report. The centers include nonrevenue support services, such as housekeeping, patient food services, and nursing administration. The centers also include ancillary services, such as transportation, laboratory, and diagnostic services. Direct resident care also encompasses program services directly addressing residents' physical conditions and resident-facing staffing, which extend to all staffing expenses in the ancillary and program services categories. Direct resident care does not

[147] For more information on AB 1537, see California legislative information website, available at: https://leginfo.legislature.ca.gov/faces/billStatusClient.xhtml?bill_id=202320240AB1537.
[148] N.Y. Comp. Codes R. & Regs. Title 10 section 415.34-Minimum Direct Resident Care Spending.

include administrative costs, such as capital expenses, debt service, depreciation, rent and leases, or fiscal services.

New York annually assesses compliance with these requirements. Facilities are subject to recoupment if they either fail to meet the minimum spending requirements for direct resident care or retain operating revenue that exceeds by more than 5 percent their total operating and non-operating expenses. When a facility meets either condition for recoupment, the New York Department of Health issues a notice of noncompliance that specifies the amount the facility must remit. The amount subject to recoupment is based on either the facility's excess revenue above the allowable threshold or the difference between the required and actual spending on direct resident care. Any returned funds must be deposited to the state's nursing home quality pool.[149]

Case study: Massachusetts

Under 101 CMR 206.00, Massachusetts enforces a direct care spending requirement through the Direct Care Cost Quotient (DCC-Q), a ratio of a facility's total direct care expenses to its total adjusted nursing revenue. The DCC-Q took effect on October 1, 2020. Total direct care expenses include eligible workforce expenses associated with direct resident care and facility operations, such as nursing staff, dietary services, housekeeping, behavioral health, social services, and restorative and recreational therapy. It also includes selected resident care supplies related to food, laundry, housekeeping, and medical supplies. Total adjusted nursing revenue encompasses revenue from nursing facility and residential care services, adjusted to exclude user fee expenses and certain Medicare ancillary costs, such as laboratory, pharmacy, X-ray, ambulance, and specialty bed services. What distinguishes Massachusetts's approach is its use of enhanced weighting for workforce investments within the DCC-Q calculation, combined with enforcement through prospective rate reductions.

Under the framework, facilities must maintain a DCC-Q of at least 75 percent. Within the DCC-Q calculation, the state applies a multiplier to one or more designated workforce position types as an incentive. Eligible workforce position types include RNs, LPNs, CNAs, resident care aides, directors of nursing, dietary staff, housekeeping and laundry staff, behavioral health staff, social service workers, and other resident care categories. Under the current methodology, a multiplier of 1.5 in the DCC-Q calculation weights

[149] N.Y. Comp. Codes R. & Regs. Title 10 section 415.34-Minimum Direct Resident Care Spending.

expenditures for recreational therapy and social service worker positions.[150] This means that a facility with $100,000 in allowable social service worker expenses would receive credit for $150,000 in social service worker expense in the DCC-Q calculation. Through administrative bulletins, the regulation also grants facilities the flexibility to create additional designated workforce positions eligible for multipliers of 1.5 or higher, up to a maximum of 3, but only recreational therapy and social services are thus far eligible.

101 CMR 206.00 requires all nursing facilities to submit both interim and final compliance reports each year. Per the interim report, facilities determine whether they are likely to meet the 75 percent DCC-Q threshold; the final report indicates compliance. Facilities that fall below the 75 percent threshold are subject to payment consequences in the subsequent rate year. The graduated penalty structure applies a half-percentage rate reduction for every one percentage point a facility falls below the threshold, up to a maximum penalty of 5 percent.[151] The most recent DCC-Q reports published by the state cover the 2025 calendar year and document that 25 percent of nursing facilities failed to meet the 75 percent threshold and may be subject to a rate reduction.[152]

Compensation and payment policy

In addition to shaping how Medicaid funds are allocated, states use compensation-focused policy levers to influence the recruitment and retention of the direct care workforce in nursing facilities. The levers include direct care–specific minimum wage policies, wage pass-through mechanisms, and workforce standards programs.

Many states have established statewide minimum wages, but these floors apply across industries and generally do not create a competitive advantage for direct care settings. In response, some states have adopted higher or minimum wage requirements specific to direct care workers.

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[150] Massachusetts Executive Office of Health and Human Services. (2025). *101 CMR 206.00: Standard payments to nursing facilities: Nursing facility direct care cost quotient* (Administrative Bulletin No. 25-12). https://www.mass.gov/doc/administrative-bulletin-25-12-101-cmr-20600-standard-payments-to-nursing-facilities-nursing-facility-direct-care-cost-quotient-effective-june-13-2025-0/download.

[151] Code of Massachusetts Regulations 101 CMR-Executive Office for Health and Human Services Tit. 101 CMR 206.00-Standard Payments to Nursing Facilities.

[152] Massachusetts Executive Office of Health and Human Services. (2026). *DCC-Q report: January 1, 2025–December 31, 2025*. https://www.mass.gov/doc/dcc-q-report-january-1-2025-december-31-2025-0/download.

Wage pass-throughs differ from minimum wage policies by directing new Medicaid funding specifically to workforce compensation through targeted rate increases or supplemental payments. When funds are not used as intended, states often pair pass-throughs with reporting requirements and recoupment or rate adjustments. California used wage pass-throughs for SNFs in 1999-2000 to provide compensation increases, but this program was not extended.[153]

Finally, states may implement workforce standards programs to require or encourage investments in staffing, training, and compensation. Together, the approaches discussed above are aimed at linking payment policy and regulatory standards more directly to compensation and workforce investment.

Case study: New Jersey and Minnesota (direct care minimum wage)

New Jersey requires nursing facilities to pay direct care workers a wage floor set $3 above the statewide minimum wage, resulting in an $18.92 per hour minimum for long-term care direct care staff versus the state minimum of $15.92 per hour.[154] Minnesota has taken a similar but phased approach. In 2025, the Legislature approved funding to establish minimum wage standards for nursing home workers, with CNA wage floors currently set at $22.50 per hour and scheduled to increase to $24 per hour by 2027. Minnesota's policy also includes a requirement for time-and-a-half pay for work performed on the state's 11 holidays.[155]

Case study: Oregon (wage pass-through)

Oregon's wage pass-through increases compensation for CNAs by tying Medicaid rate enhancements directly to wage benchmarks. Between October 1, 2021, and June 30, 2023, eligible nursing facilities received a 4 percent add-on to their Medicaid rates if they met specified CNA wage thresholds. The pass-through involved a starting wage of $17 per hour, increasing to $17.50 per hour in the second year of the policy period.

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[153] California Welfare and Institutions Code § 14124.16. https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14110.6.

[154] New Jersey Department of Labor and Workforce Development. (2025). Minimum wage increases in New Jersey. New Jersey Department of Labor and Workforce Development. Retrieved from https://www.nj.gov/labor/lwdhome/press/2025/20251001_Minimum_Wage.shtml.

[155] Minnesota Department of Labor and Industry. (n.d.). *Nursing home workforce standards board wages*. https://www.dli.mn.gov/nhwsb-wages.

Participation required facilities to submit documentation demonstrating compliance with the wage standards as a condition of receiving the enhanced payment.[156]

Case study: Illinois (wage pass-through)

Illinois's wage pass-through policy focuses on addressing CNA workforce shortages. Through the CNA Pay Scale Program, the state establishes a standardized, experience-based wage scale that links Medicaid payment to CNA compensation and career progression.

The program is optional and reimburses facilities for the Medicaid share of any hourly rate increases for CNAs based on their experience level. The pay scale begins at $1.50 per hour for worker tenure of one year, ranging up to $6.50 per hour (at increments of $1 year) for workers with at least six years of tenure as a CNA. In addition, the program subsidizes facilities $1.50 per hour for Medicaid's share of any promotional pay increases into a higher-level CNA role.

Between program launch in 2022 and quarter 3 of 2023, program participation increased to nearly 70 percent of all facilities. Facilities with a larger proportion of Medicaid residents accounted for the highest levels of participation. More than 20,000 CNAs are receiving additional pay increments that average nearly $4.50 per hour above entry-level wages.[157]

Case study: Minnesota (workforce standards board)

Minnesota uses a workforce standards approach through its Nursing Home Workforce Standards Board, which is a state-established body authorized to set, review, and enforce minimum employment standards for nursing home workers statewide. The Board's scope extends beyond Medicaid payment policy and covers compensation, training, worker protections, and enforcement and coordinates with state agencies on rate impacts. Recent rulemaking includes standards such as holiday pay requirements and phased-in increases to minimum wage levels for direct care workers.[158]

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[156] Oregon State Plan Attachment 4.19-D, Part 1 Page 13.b.

[157] Illinois Department of Healthcare and Family Services. (2023). *Interim review of the 2022 nursing home payment reforms*. https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/interimreview2022nursinghomepaymentreformdecember2023.pdf.

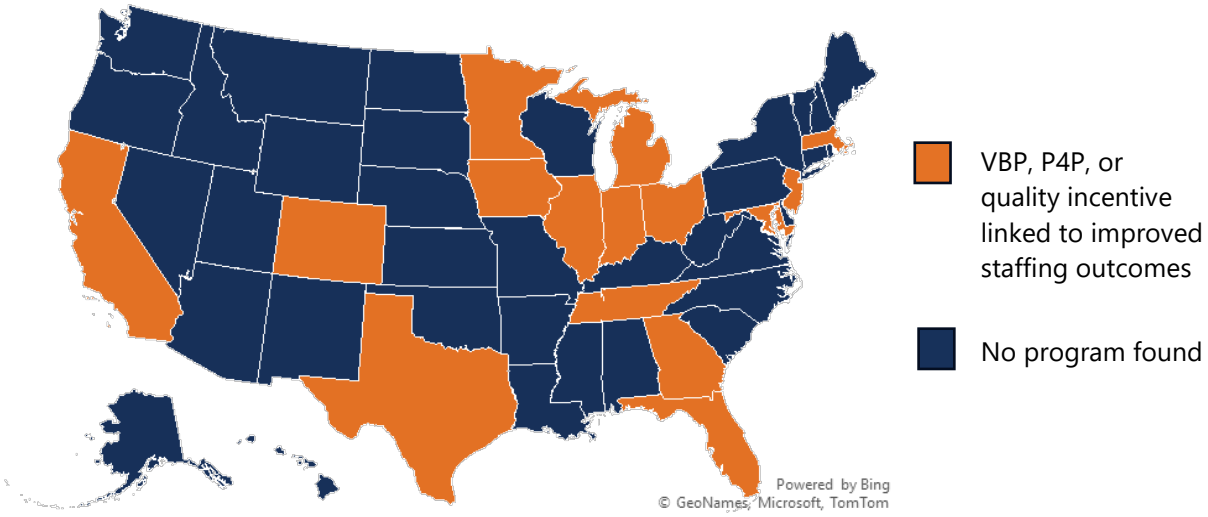
[158] Article 3 of 2023 Minnesota Session Laws Chapter 53.

Workforce incentive programs

Workforce-focused incentive programs encourage targeted staffing investments and support quality-related objectives. Such programs tie payment bonuses to staffing measures, shifting the focus from minimum compliance to performance-based rewards. Program designs vary across states and differ in, among other provisions, staffing measures, such as acuity-adjusted staffing, HPRD thresholds, and staff continuity and retention.

As of 2022, 16 states have instituted a nursing facility VBP, P4P, or quality incentive initiative linked to improving staffing outcomes (**Exhibit 3.26**). California previously implemented quality incentive programs with workforce performance domains, including WQIP and its predecessor, QASP.

Exhibit 3.26. Prevalence of workforce-linked VBP in nursing facilities



Source: Calculations performed based on review of the publicly available MACPAC Compendium of State Policies Related to Nursing Facility Staffing, March 2022.

Case study: Tennessee

Under TennCare's QuILTSS (Quality Improvement in Long-Term Services and Supports) initiative, Tennessee ties a portion of nursing facility payment to performance across several quality domains. The program spans resident, family, and employee satisfaction; culture change and quality of life; staffing and staff competency; and clinical performance. The staffing domain accounts for 25 percent of the total incentive structure. Within the staffing domain, facilities undergo evaluation for acuity-adjusted staffing levels, consistent staff assignment, and staff retention (**Exhibit 3.27**).

Exhibit 3.27. Tennessee staffing quality measures for nursing facilities

CNA HPRD	RN HRPD	Consistent Staff Assignment	Staff Retention	Staff Training
Benchmark based on CMS case-mix-adjusted HPRD. Facilities scored by distance from national average.	Benchmark based on CMS case-mix-adjusted HPRD. Facilities scored by distance from national average.	Share of LTC residents cared for by 12 or fewer caregivers. Facilities must report data for at least three months.	Percentage of staff continuously employed or contracted by the facility for at least 12 months.	All participating facilities receive full points for maintaining staff training programs.

What distinguishes Tennessee's approach is its selection of staffing measures that capture several dimensions of workforce quality and dynamics, such as staffing instability measured by consistent staff assignment and staffing turnover measured by staff retention.[159]

Case study: Illinois

Separate from the CNA Pay Scale Program described above, Illinois created a staffing-level incentive payment that links Medicaid reimbursement to facility staffing performance. The incentive payment is based on data published by CMS in the provider

[159] Tennessee Bureau of TennCare. (2025). *Nursing Facility Quality Incentive in Long-Term Services and Supports (NF QuILTSS) memorandum*. https://www.tn.gov/content/dam/tn/tenncare/documents/NFQuILTSS18Memo.pdf.

information file.[160] To calculate the payment, the state computes the ratio of reported total nurse staffing HPRD divided by an Illinois-specific case-mix total nurse staffing HPRD. The Illinois-specific case-mix total nurse staffing HPRD is the case-mix total nurse staffing hour per resident day from the provider information file multiplied by a uniform statewide factor.[161,162]

The staffing incentive program functions as a rate add-on that scales performance to benchmark targets. Rate add-ons range from approximately $9 per resident day for facilities meeting 70 percent of the target to up to $38.68 per resident day for facilities reaching 125 percent of the target.[163] The program rewards facilities that have achieved higher staffing levels while providing incremental financial support to facilities actively trying to improve their staffing levels. Incremental increases of the rate add-on are not uniform; rather, they account for higher incremental change at the lower staffing ratio levels.

Between quarter 1 of 2022 and quarter 3 of 2023, facilities that initially operated below 60 percent of the staffing incentive target increased average staffing performance from 48 to 75 percent. Over the same period, the number of Illinois facilities among the nation's 100 worst-staffed nursing homes declined from 46 to 18. Facilities with at least 60 percent Medicaid utilization experienced an average 15 percent increase in staffing ratios, from 78 to 90 percent of the staffing incentive benchmark targets.[164]

Illinois's staffing incentive program complements the state's PDPM payment framework by adding a layer of accountability to resident acuity reporting, tying payment to staffing performance relative to acuity-adjusted targets.[165]

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[160] Centers for Medicare & Medicaid Services. (n.d). *Provider data catalog*. Retrieved July 17, 2026, from https://data.cms.gov/provider-data/.
[161] Ill. Admin. Code title 89, section 147.310(c)(3) (2022).
[162] Illinois Department of Healthcare and Family Services. (2022). *Nursing home rate calculation handbook FY2023*. https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/hfsweb002.pdf.
[163] Ill. Admin. Code title 89, section 147.310(c)(3) (2022).
[164] Illinois Department of Healthcare and Family Services. (2023). *Interim review of the 2022 nursing home payment reforms*. https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/interimreview2022nursinghomepaymentreformdecember2023.pdf.
[165] Illinois Department of Healthcare and Family Services. *Interim review*, 2023. https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/interimreview2022nursinghomepaymentreformdecember2023.pdf.

Case study: Maine

Maine transitioned to a PDPM model in 2025 and paired the new rate methodology with a VBP program inclusive of staffing and quality measures. The VBP includes a three-year transitional bonus pool and phases in a quality withhold. The model measures performance by using total nursing staff turnover leveraged from Care Compare, resident experience (CoreQ), antipsychotic medication use (Care Compare), and urinary tract infection rates (**Exhibit 3.28**). Maine's approach is notable because it aligns payment reform with workforce stability and quality improvement while granting facilities a structured transition period.[166]

Exhibit 3.28. Maine VBP payment structure

Year 1 (2025)	Year 2 (2026)	Year 3 (2027)
Pay for Participation Nursing facilities must participate in selected quality improvement activities. Bonus dispersed by Medicaid bed days.	**Pay for Minimum Achievement** Nursing facilities must meet minimum threshold in two of three measures. Bonus dispersed by Medicaid bed days.	**Pay for Performance** Nursing facilities must meet minimum for all measures. Dollars dispersed by performance on measures. Staffing measure receives highest weights.
No withhold, NFs receive full rate.	Standard 1 percent withhold. Withholds paid back quarterly if NF meets minimum quality.	Variable 1 to 2 percent withhold. Withholds paid back quarterly if NF meets minimum quality.

[166] Maine Department of Health and Human Services. (2024). *Nursing facility reform revisions presented*. https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/NF%20Reform%20Revisions%20Presented%2010.23.24.pdf.



CHAPTER IV: QUALITY MEASUREMENT, OVERSIGHT, AND PERFORMANCE

CHAPTER IV: QUALITY MEASUREMENT, OVERSIGHT, AND PERFORMANCE

Quality measurement, oversight, and performance are vital to the delivery of high-quality care to nursing facility residents.[167] Effective quality systems not only safeguard resident well-being but also drive accountability and continuous improvement across skilled nursing facilities. In this section, we present findings across several key areas, including federal nursing home quality standards and reporting programs, California's current quality monitoring and accountability mechanisms, national trends influencing nursing facility quality outcomes, and emerging VBP strategies designed to link payment with measurable improvements in care quality.

Federal nursing home quality standards

Federal nursing home quality standards establish the regulatory framework governing care delivery in facilities participating in Medicare and Medicaid. The Nursing Home Reform provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) primarily defined these standards. The provisions set forth comprehensive federal requirements to ensure that nursing facility residents receive care that enables them to attain or maintain their highest practicable physical, mental, and psychosocial well-being.[168] OBRA '87 established the foundational regulatory structure still used today, including requirements related to resident rights, clinical care, staffing, quality assurance, and facility operations.

CMS established these requirements through federal regulations codified in 42 CFR § 483, which define the Conditions of Participation for nursing facilities seeking to receive Medicare or Medicaid payments.[169] The regulations outline expectations for resident care planning, staffing qualifications, infection prevention, medication management, quality improvement activities, and facility governance. Continued participation in federal health care programs requires compliance with these standards.

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[167] For purposes of this document, we define "quality" to encompass several dimensions, including provider experience, patient experience, and health equity, along with traditional measures of care quality.

[168] Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, 101 Stat. 1330 (1987). https://www.govinfo.gov/content/pkg/STATUTE-101/pdf/STATUTE-101-Pg1330.pdf.

[169] 42 CFR § 483.

The regulatory framework is designed to ensure both minimum standards of care and ongoing monitoring of facility performance. CMS' oversight of implementation of these standards is based on a cooperative federal-state survey system in which state survey agencies conduct inspections, investigate complaints, and enforce compliance with federal regulations.

Conditions of participation and resident care requirements

The Conditions of Participation establish detailed expectations for how nursing facilities must deliver care to residents. The requirements emphasize individualized care planning based on comprehensive resident assessments and multidisciplinary clinical oversight.

Using the MDS, facilities must conduct standardized assessments of each resident's clinical condition, collecting information about physical functioning, cognitive status, diagnoses, treatments, and care needs.[170] The MDS assessment process supports the development of individualized care plans tailored to each resident's needs and provides data used by CMS for quality measurement and federal payment.

Federal regulations also establish extensive protections related to residents' rights and autonomy. Facilities must ensure that residents are treated with dignity and respect and are able to participate in decisions regarding their care.[171] Protections include the right to participate in care planning, maintain privacy and confidentiality, voice grievances without fear of retaliation, and receive visitors. Facilities are also required to implement policies and procedures designed to prevent resident abuse, neglect, and exploitation.

As outlined in 42 CFR § 483, clinical care requirements govern infection control, medication management, dietary services, rehabilitation therapies, and specialized services for residents with cognitive impairment. Facilities must maintain policies and procedures designed to prevent avoidable declines in resident health status and to provide needed clinical services to support resident functioning.

Quality Assurance and Performance Improvement

Federal regulations require nursing facilities participating in Medicare or Medicaid to implement a Quality Assurance and Performance Improvement (QAPI) program.[172] QAPI

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[170] Centers for Medicare & Medicaid Services (CMS). (n.d.). *Minimum Data Set (MDS) for nursing homes and swing bed providers*. https://www.cms.gov/medicare/quality/nursing-home-improvement/minimum-data-sets-swing-bed-providers.
[171] 42 CFR § 483.
[172] 42 CFR § 483.75.

provides the primary internal quality management framework for nursing facilities and is intended to ensure that facilities systematically monitor care processes, identify performance issues, and implement improvements designed to enhance resident outcomes. Revisions to the Conditions of Participation under 42 CFR § 483.75 formally incorporated the QAPI requirement into federal nursing facility regulations, requiring facilities to maintain ongoing, data-driven quality improvement programs that address both clinical care and facility operations.

Under federal regulations, each nursing facility must develop a comprehensive QAPI program that reflects the scope and complexity of services provided by the facility. The program must address all aspects of facility operations that affect resident care, including clinical services, staffing practices, infection prevention, medication management, and resident safety. Facilities must establish written QAPI program plans that outline program objectives, leadership responsibilities, performance monitoring activities, and processes for implementing improvement initiatives.

A central component of QAPI programs is the use of data-driven performance monitoring. Facilities must collect and analyze data related to resident outcomes, operational performance, and regulatory compliance to identify areas where improvements may be needed. Data sources may include resident assessment information, quality measure reports, infection control data, survey findings, staffing information, and feedback from residents and families.

Federal guidance also emphasizes the importance of leadership engagement and organizational accountability within QAPI programs. Facility leaders, including administrators and directors of nursing, are responsible for ensuring that QAPI programs are adequately resourced and integrated into facility operations. Leadership teams are expected to support staff participation in quality improvement activities, allocate resources needed to implement improvement initiatives, and ensure that corrective actions are implemented when performance concerns are identified.

In addition to ongoing monitoring activities, QAPI requires facilities to conduct Performance Improvement Projects (PIPs) focused on specific areas of concern. PIPs involve structured investigations of identified problems or opportunities for improvement, followed by targeted interventions designed to address underlying causes.

Although federal regulations establish baseline QAPI program requirements, facilities may vary in how they structure and implement quality improvement programs. Factors

such as leadership engagement, staff training, data availability, and organizational culture can influence the effectiveness of QAPI program activities.

Overall, the QAPI requirement plays an important role within the federal nursing facility regulatory framework by requiring facilities to maintain structured, ongoing processes for evaluating and improving care quality. By combining data analysis, leadership accountability, and interdisciplinary collaboration, QAPI programs aim to support continuous improvement in resident care and help facilities address quality issues in a systematic and proactive manner.

Survey and certification process

The survey and certification process established by CMS monitors compliance with federal nursing home standards, but state agencies operating under agreement with CMS carry out monitoring activities.[173] Facilities participating in Medicare or Medicaid must undergo comprehensive health inspections at least once every 15 months, with an average interval of approximately 12 months between surveys. In California, CDPH acts as the survey and certification agency for licensed nursing facilities.

During inspections, survey teams evaluate facility performance across a wide range of regulatory requirements, including resident care practices, staffing levels, infection control protocols, medication management, and resident rights protections. Surveyors review medical records, interview staff and residents, and observe care delivery practices to determine whether facilities are complying with federal regulations.

When surveyors identify violations of federal standards, they cite deficiencies based on their scope and severity; deficiencies reflect both the number of residents affected and the seriousness of the deficiency. CMS uses a standardized deficiency scoring system to categorize violations and determine appropriate enforcement actions.

CMS publicly reports survey findings on the CMS Care Compare platform; the facility survey scores contribute to the health inspection component of the Five-Star Quality Rating System.[174]

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[173] Centers for Medicare & Medicaid Services. (n.d.). *Certification and compliance process*. U.S. Department of Health and Human Services. https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/certandcomplianceprocess.pdf.

[174] Centers for Medicare & Medicaid Services. (n.d.). *Nursing homes: Guidance for laws and regulations*. U.S. Department of Health and Human Services.

Enforcement and accountability mechanisms

Facilities that fail to meet federal quality standards may be subject to a range of enforcement actions intended to correct deficiencies and protect resident safety. In general, it is state agencies that conduct enforcement activities. State survey agencies may require facilities to implement corrective plans of action, impose financial penalties, or restrict admissions until the resolution of deficiencies.[175]

In California, the federal survey and certification process also provides the basis for state licensing enforcement administered by CDPH. In addition to citing federal deficiencies, CDPH may issue state citations when survey findings identify violations of California laws or regulations governing nursing facilities. California State citations are classified according to a violation's severity, with AA-level citations issued for violations that are a substantial factor in a resident's death, A-level citations issued for violations that present imminent danger or a substantial probability of death or serious harm, and B-level citations issued for violations that demonstrate a direct or immediate relationship to a resident's health, safety, or security.

One of the most common enforcement mechanisms is the imposition of Civil Money Penalties (CMPs), which are financial penalties assessed against facilities for noncompliance with federal or state requirements.[176] CMP amounts vary with the severity of the deficiency and whether the violation represents an isolated incident or ongoing noncompliance. Even though CMPs represent the primary enforcement action, California's licensing enforcement process provides an additional layer of accountability through state-issued citations and penalties that may be assessed concurrently with federal enforcement actions.

Civil litigation is an additional mechanism for holding SNFs and their owners and operators accountable for practices that threaten resident health and safety, complementing the administrative oversight and enforcement activities conducted by CDPH and CMS. At the state level, the California Attorney General, including through the Division of Medi-Cal Fraud and Elder Abuse, may investigate and pursue civil actions

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https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes.

[175] Centers for Medicare & Medicaid Services. (n.d.). *Nursing home enforcement*. U.S. Department of Health and Human Services. https://www.cms.gov/medicare/health-safety-standards/enforcement/nursing-home-enforcement.

[176] Centers for Medicare & Medicaid Services. (n.d.). *Civil Money Penalty Reinvestment Program*. https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/civil-money-penalty-reinvestment-program.

against facilities and corporate entities when organizational policies or practices contribute to resident neglect, substandard care, or other violations of state or federal law. These actions can address systemic conditions extending across multiple facilities, and may result in restitution, injunctive relief, monitoring, or other court-related corrective actions. At the federal level, the U.S. Department of Justice and attorneys may similarly pursue nursing home operators through civil enforcement authorities, including the False Claims Act, when facilities seek federal reimbursement while providing substandard level of care. Private civil actions also provide residents and their representatives with a separate avenue for seeking remedies for violations of resident rights or harm. Collectively, these forms of litigation provide an additional layer of accountability beyond citations and payment penalties.

Additional enforcement actions may include denial of payment for new admissions, appointment of temporary management to oversee facility operations, or termination of a facility's participation in Medicare and Medicaid programs in cases of severe or persistent noncompliance. These enforcement mechanisms are intended both to correct deficiencies and deter future violations.

Role of federal standards in quality improvement

Federal nursing home standards provide the foundational framework for monitoring and improving quality within the long-term care sector.[177] Through the Nursing Home Reform provisions of OBRA '87, the federal government established a consistent set of requirements governing resident care, staffing qualifications, facility operations, and resident rights. The requirements create a national baseline for nursing facility performance and ensure that facilities participating in Medicare and Medicaid adhere to minimum standards designed to protect resident safety and well-being.[178]

Beyond establishing regulatory requirements, federal standards support quality oversight by providing the structure for ongoing performance monitoring. Data collected through resident assessments, regulatory surveys, and other reporting mechanisms allow CMS and state survey agencies to identify possible deficiencies in

[177] National Academies of Sciences, Engineering, and Medicine. (2022). *The national imperative to improve nursing home quality: Honoring our commitment to residents, families, and staff* (Chap. 5). The National Academies Press. https://www.nationalacademies.org/read/26526/chapter/5.
[178] 42 CFR § 483.35.

facility quality.[179] In addition, federal standards provide the basis for broader quality measurement and transparency initiatives within the nursing home sector. Information derived from regulatory inspections, staffing reports, and clinical quality measures is publicly available on CMS platforms such as Care Compare, enabling consumers, policymakers, and regulators to evaluate facility performance. Public reporting and standardized quality metrics have increasingly become tools for encouraging improvement by expanding the public's access to information about facility performance and promoting greater accountability within the long-term care system.[180]

These regulatory, monitoring, and transparency mechanisms establish the foundation on which state Medicaid quality improvement initiatives are built. As a result, the federal regulatory system plays a central role in shaping quality measurement, accountability, and performance improvement efforts across the nursing facility sector.

Systemwide factors affecting quality outcomes

Quality performance in nursing facilities is influenced by a range of systemwide factors that extend beyond individual facility practices.[181] Even though facility leadership, clinical protocols, and quality improvement initiatives play an important role in determining resident outcomes, broader environmental conditions frequently shape the resources and constraints under which facilities operate. These conditions include workforce stability, payment policy, regulatory oversight, resident population characteristics, and broader health care system dynamics. Understanding these structural influences is essential when evaluating quality performance across the long-term care sector.

Workforce availability and stability

Workforce capacity represents one of the most significant determinants of nursing facility quality.[182] Nursing facilities rely heavily on direct care staff to provide daily resident support and monitor changes in clinical condition. Adequate staffing levels

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[179] Centers for Medicare & Medicaid Services, *Nursing homes: Guidance for laws and regulations,* n.d.

[180] Centers for Medicare & Medicaid Services. (n.d.). *State operations manual: Appendix PP—Guidance to surveyors for long-term care facilities*. https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf.

[181] National Academies of Sciences, Engineering, and Medicine, *The national imperative to improve nursing home quality: Honoring our commitment to residents, families, and staff*, 2022.

[182] Centers for Medicare & Medicaid Services. *State operations manual: Appendix PP,* n.d.

allow facilities to respond to clinical changes promptly, maintain consistent care plans, and provide necessary assistance with ADLs.[183] When staffing levels are insufficient or unstable, facilities may struggle to maintain consistent care delivery, increasing the risk of adverse resident outcomes.

In addition to absolute staffing levels, workforce stability plays an important role in determining quality outcomes.[184] High levels of staff turnover can disrupt continuity of care, reduce familiarity with resident care plans, and increase reliance on temporary staff. Research examining nursing facility workforce patterns has found that higher turnover rates are associated with poorer resident outcomes, including increased hospitalization rates and declines in functional status.[185]

Payment policy

The financial environment in which nursing facilities operate also plays a significant role in shaping quality outcomes.[186] In the United States, Medicaid is the primary payor for care in long-term nursing facilities, accounting for the majority of resident days in most facilities.[187] As a result, Medicaid payment policies influence the financial resources available to support resident care, workforce investment, capital improvements, and quality improvement initiatives. However, payment levels alone do not determine quality performance. Facility leaders make strategic decisions regarding allocation of financial resources, including investments in staffing, clinical programs, infrastructure, and other operational priorities such as profit. Accordingly, facilities operating under similar payment structures may achieve substantially different outcomes based on management practices, organizational culture, and investment strategies.

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[183] Harrington, C., Dellefield, M. E., Halifax, E., Fleming, M. L., & Bakerjian, D. (2020). Appropriate nurse staffing levels for U. S. nursing homes. *Health Services Insights*, *13*, 1178632920934785. https://doi.org/10.1177/1178632920934785.

[184] CMS, *State operations manual: Appendix PP.*, n.d.

[185] Grabowski, D. C., Mor, V., & Stevenson, D. G. (2020). Nursing home quality improvement and the COVID-19 pandemic. *Health Affairs*, 39(11), 1919–1927. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00957.

[186] Hackmann, M. B. (2019). Incentivizing better quality of care: The role of Medicaid and competition in the nursing home Industry. *The American Economic Review*, *109*(5), 1684–1716. https://doi.org/10.1257/aer.20151057.

[187] Chidambaram, P., Burns, A., Neuman, T., & Ridowitz, R. (2025) *5 key facts about nursing facilities and Medicaid*. Kaiser Family Foundation. https://www.kff.org/medicaid/5-key-facts-about-nursing-facilities-and-medicaid/.

Ownership structure can also influence how financial resources are deployed. For-profit facilities may face greater pressure to generate financial returns for owners and investors, whereas nonprofit and publicly owned facilities may allocate a greater share of available resources to staffing and resident care. As such, private equity-owned nursing facilities tend to account for fewer employees per bed compared with those not owned by private equity firms, leading to a higher likelihood of patients' emergency department visits or hospitalizations.[188]

Financial pressures may influence operational decisions related to staffing models, service availability, and capital investments. Facilities operating under constrained payment environments may rely more heavily on lower-cost staffing structures or delay infrastructure improvements, both of which can affect overall quality performance.[189] These financial dynamics help explain why facilities operating under similar regulatory requirements can exhibit meaningfully different quality outcomes.

Resident acuity and clinical complexity

Changes in resident acuity have also significantly altered the care environment within nursing facilities.[190] Advances in medical treatment, expanded availability of home- and community-based services (HCBS), and policy initiatives designed to support community-based care have shifted many lower-acuity individuals away from institutional care settings.[191] As a result, the population remaining in nursing facilities increasingly consists of residents with higher levels of clinical complexity.[192]

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[188] Eisenberg, R., & Gee, E. (2023). *5 consequences of private equity's expansion in health care*. Center for American Progress. https://www.americanprogress.org/article/5-consequences-of-private-equitys-expansion-in-health-care/.

[189] Hackmann, M. B., Incentivizing better quality of care: The role of Medicaid and competition in the nursing home industry, 2019.

[190] National Academies of Sciences, Engineering, and Medicine, *The National imperative to improve nursing home quality: Honoring our commitment to residents, families, and staff*, 2022.

[191] American Health Care Association (AHCA). (2023). *Historic staffing shortages continue to force nursing homes to limit new admissions, creating bottlenecks at hospitals and health systems*. https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/Historic-Staffing-Shortages-Continue-To-Force-Nursing-Homes-To-Limit-New-Admissions,-Creating-Bottlenecks-at-Hospitals-and-.aspx.

[192] Medicaid and CHIP Payment and Access Commission. (2023). *Estimates of Medicaid nursing facility payments relative to costs*. https://www.macpac.gov/wp-content/uploads/2023/01/Estimates-of-Medicaid-Nursing-Facility-Payments-Relative-to-Costs-1-6-23.pdf.

Higher resident acuity increases the demand for clinical oversight and specialized care. Facilities caring for residents with greater medical complexity require higher staffing levels, particularly from RNs and other licensed staff responsible for clinical assessment and care coordination. Research examining staffing patterns in nursing homes has consistently found that facilities serving higher-acuity populations must maintain higher staffing levels to safely meet resident needs.[193]

Medicare quality program overview

Quality oversight in nursing facilities operating under Medicare is structured through a series of complementary programs designed to measure performance, improve transparency, and encourage improvements in resident outcomes. The programs include the CMS Five-Star Quality Rating System, the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program, and the Skilled Nursing Facility Quality Reporting Program (SNF QRP). These initiatives establish a national framework for monitoring nursing facility performance and linking federal payments to measurable quality outcomes.

The modern Medicare quality reporting infrastructure for nursing facilities developed in response to increasing concerns about care quality across the long-term care sector.[194] Public concern pointing to differences in outcomes across facilities, even among providers operating under the same regulatory requirements, led to CMS' expansion of federal quality monitoring systems, culminating in the creation of publicly reported quality rating systems and performance-based payment programs.

The various programs rely heavily on standardized resident assessment data collected through the MDS as well as on staffing information submitted through the PBJ system and claims data from Medicare administrative records. The integration of these data sources allows CMS to evaluate facility performance across a variety of domains, including clinical outcomes, staffing levels, and regulatory compliance.

The structure of Medicare quality programs reflects several core policy objectives. In particular, quality measurement supports public reporting, payment, and quality

[193] Harrington et al., Appropriate nurse staffing levels for U.S. nursing homes, 2020.
[194] The National Consumer Voice for Quality Long-Term Care. (2025). *Summary: History of the federal Nursing Home Reform Act*. https://theconsumervoice.org/wp-content/uploads/2025/09/summary-history-federal-nursing-home-reform-act.pdf.

improvement activities.[195] Public reporting provides information to consumers about providers' performance to inform consumer choice, and quality reporting supports ongoing improvement through standardized data collection and performance monitoring. In addition, payment programs use quality measures to encourage improved performance.[196]

CMS Five-Star Quality Rating System

The CMS Five-Star Quality Rating System is the primary public reporting framework used to evaluate nursing home performance in the United States.[197] The system assigns each Medicare- or Medicaid-certified nursing facility an overall rating ranging from one to five stars based on performance across three domains: health inspections, staffing levels, and quality measures.[198] The CMS Care Compare website publicly reports the ratings, which consumers, regulators, and policymakers use to evaluate facility quality.

CMS introduced the Five-Star system in 2008 with the goal of making nursing home quality information more understandable and accessible to the public.[199] Before the system's implementation, consumers had limited ability to compare the quality of facilities. The rating system translates complex regulatory and clinical data into a standardized score intended to help consumers make informed decisions when selecting nursing home care.[200]

The rating system is structured so that each of the three domains produces a separate star rating; the domain-level ratings are then used to generate an overall star rating.[201] A facility's overall rating is grounded in its health inspection baseline rating; the overall rating can then increase or decrease depending on the facility's ratings in the staffing and quality measures domains, depending on performance relative to national benchmarks.[202]

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[195] The National Consumer Voice for Quality Long-Term Care. (2025). *Summary: History of the federal Nursing Home Reform Act*. https://theconsumervoice.org/wp-content/uploads/2025/09/summary-history-federal-nursing-home-reform-act.pdf.
[196] The National Consumer Voice for Quality Long-Term Care, *Summary: History of the federal Nursing Home Reform Act*, 2025.
[197] CMS, *State operations manual*, Appendix PP, n.d.
[198] CMS, *State operations manual*, Appendix PP, n.d.
[199] CMS, *State operations manual,* Appendix PP, n.d.
[200] CMS, *State operations manual*, Appendix PP, n.d.
[201] CMS, *State operations manual*, Appendix PP, n.d.
[202] CMS, *State operations manual*, Appendix PP, n.d.

Health inspection domain

The health inspection domain reflects the results of state survey inspections conducted as part of the federal survey and certification process. The inspections evaluate compliance with federal nursing home regulations. CMS considers them to be one of the most comprehensive indicators of facility quality because they involve independent state surveyors' direct observation of care delivery practices and facility operations.[203]

Multidisciplinary survey teams conduct inspections by reviewing resident records, interviewing residents and staff, and observing care practices. In addition to undergoing routine surveys, facilities may receive complaint investigations triggered by reports of potential quality issues. When facilities fail to meet federal standards, the survey agency issues a citation for the regulatory deficiency. Each deficiency is categorized according to its scope and severity, based on the number of residents affected and the seriousness of the violation. CMS assigns numeric point values to deficiencies based on the deficiency category, with more severe or widespread deficiencies receiving higher point values. The scoring process includes deficiencies cited in both standard surveys and complaint investigations. Facilities with fewer and less severe deficiencies receive lower deficiency scores and therefore higher star ratings. CMS assigns star ratings to according to the relative performance of facilities within a state where the top 10 percent of facilities (those with the lowest scores) receive a five-star rating, the bottom 20 percent receive a one-star rating, and the middle 70 percent receive a two-, three-, or four-star rating with an equal number in each category.[204] Given that the inspection score is derived from regulatory oversight rather than from self-reported data, CMS uses the health inspection domain as the foundation for the overall Five-Star rating.[205]

Staffing domain

The staffing domain of the Five-Star Quality Rating System aims to evaluate the adequacy of staffing levels in each facility.[206] SNF quality experts recognize adequate staffing as a key determinant of nursing home quality because sufficient staffing enables facilities to monitor resident conditions, respond to clinical needs, and assist with ADLs.

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[203] CMS, *State operations manual*, Appendix PP, n.d.
[204] Centers for Medicare & Medicaid Services (CMS). 2026. *Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical users' guide*. https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf.
[205] CMS, *State operations manual*, Appendix PP. n.d.
[206] CMS, *State operations manual*, Appendix PP, n.d.

Staffing data used in the Five-Star system are derived from the PBJ system, which requires nursing facilities to submit detailed data on quarterly staffing hours auditable back to payroll records.[207] The data includes hours worked by RNs, LPNs or LVNs, and CNAs.

CMS calculates staffing performance by using HPRD, which represents the number of staff hours available for each resident on average per day.[208] To account for differences in resident acuity across facilities, CMS adjusts staffing levels using a CMI derived from MDS assessments.[209]

The staffing domain includes six measures:

- Total nursing hours (RN + LPN + nurse aide hours) per resident day for a quarter averaged across all days (weekdays and weekends)
- RN HPRD for a quarter, averaged across all days (weekdays and weekends)
- Total nursing hours (RN + LPN + nurse aide hours) per resident day for a quarter averaged across all weekend days (Saturdays and Sundays)
- The percentage of nursing staff that left the nursing home over a 12-month period
- The percentage of RNs that left the nursing home over a 12-month period
- The number of administrators that left the nursing home over a 12-month period

CMS assigns star ratings to facilities based on how their staffing levels compare with national distributions for these measures.[210] Points are assigned to each of the six staffing measures, with more points assigned for higher case-mix adjusted staffing levels and lower staff turnover. In Chapter 3, we present California nursing facility performance on the measures that make up the staffing domain rating.

Quality measures domain

The quality measures domain evaluates facility performance by using a series of clinical outcome indicators derived from MDS and Medicare claims data. The domain includes 15 measures to capture a broad range of function and health status indicators indicative

[207] Centers for Medicare & Medicaid Services (CMS). (n.d.). Staffing data submission (PBJ). https://www.cms.gov/medicare/quality/nursing-home-improvement/staffing-data-submission.
[208] CMS, *State operations manual*, Appendix PP, n.d.
[209] CMS, *State operations manual*, Appendix PP, n.d.
[210] CMS, *State operations manual*, Appendix PP, n.d.

of resident health and well-being; the domains are divided into categories based on the length of resident stay.[211]

CMS distinguishes between short-stay residents, who typically receive post-acute rehabilitation services following hospitalization, and long-stay residents, who require ongoing custodial or chronic care and reside in the nursing home for more than 100 days. CMS uses separate quality measures to evaluate outcomes for these two populations.

Short-stay quality measures (**Exhibit 4.1**) focus on outcomes associated with post-acute recovery and care transitions.

Exhibit 4.1. Short-stay Five-Star quality measures

Measure Name	Measure Description
Claims-Based Short-Stay Measures	
Percentage of short-stay residents who were rehospitalized after a nursing home admission	This measure reports the percentage of all new admissions or readmissions to a nursing home from a hospital where the resident was re-admitted to a hospital for an inpatient or observation stay within 30 days of entry or reentry.
Percentage of short-stay residents who have had an outpatient ED visit	This measure reports the percentage of all new admissions or readmissions to a nursing home from a hospital where the resident had an outpatient ED visit (i.e., an ED visit not resulting in an inpatient hospital admission) within 30 days of entry or reentry.
Rate of successful return to home and community from a SNF	This measure reports the rate at which residents returned to home and community with no unplanned hospitalizations and no deaths in the 31 days following discharge from the SNF.

[211] CMS, *State operations manual*, Appendix PP, n.d.

Measure Name	Measure Description
MDS-Based Short-Stay Measures	
Percentage of SNF residents who are at or above an expected ability to care for themselves and move around at discharge	This measure reports the percentage of short-stay residents who are at or above an expected ability to care for themselves and move around at discharge.
Percentage of SNF residents with pressure ulcers/pressure injuries that are new or worsened	This measure captures the percentage of short-stay residents with pressure ulcers that are new or whose existing pressure ulcers worsened during their stay in the SNF and includes unstageable ulcers.
Percentage of residents who received antipsychotic medication for the first time	This measure reports the percentage of short-stay residents who are receiving an antipsychotic medication during the target period but not on their initial assessment.

Source: https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf.
ED = emergency department.

Long-stay measures (**Exhibit 4.2**) evaluate outcomes related to chronic care management and resident quality of life.[212] As Medicare does not cover long term custodial care, measures that use Medicare claims in this domain are limited to members who are dually eligible for Medicaid and Medicare.

[212] CMS, *State operations manual*, Appendix PP, n.d.

Exhibit 4.2. Long-stay Five-Star quality measures

Measure Name	Measure Description
Claims-Based Long-Stay Measures	
Number of hospitalizations per 1,000 resident days	This measure reports the number of unplanned inpatient admissions or outpatient observation stays that occurred among long-stay residents of a nursing home during a one-year period, expressed as the number of unplanned hospitalizations for every 1,000 days that the long-stay residents were admitted to the nursing home.
Number of outpatient ED visits per 1,000 resident days	This measure reports the number of outpatient ED visits that occurred among long-stay residents of a nursing home during a one-year period, expressed as the number of outpatient ED visits for every 1,000 days that the long-stay residents were admitted to the nursing home.
MDS-Based Long-Stay Measures	
Percentage of residents whose ability to walk independently worsened	This measure reports the percentage of long-stay residents who experienced a decline in independence of locomotion during the target period. Loss of independence in locomotion increases risks of hospitalization, pressure ulcers, falls, musculoskeletal disorders, pneumonia, circulatory problems, constipation, and reduced quality of life.
Percentage of residents whose need for help with daily activities has increased	This measure reports the percentage of long-stay residents whose need for help with late-loss ADLs has increased when compared to the prior assessment. This is a change measure that reflects worsening performance on at least two late-loss ADLs by one functional level or on one late-loss ADL by more than one functional level compared to the prior assessment. The late-loss ADLs are bed mobility, transfer, eating, and toileting.

Measure Name	Measure Description
Percentage of residents with pressure ulcers	This measure captures the percentage of long-stay residents with Stage II–IV or unstageable pressure ulcers.
Percentage of residents who have/had a catheter inserted and left in their bladder	This measure reports the percentage of residents who have had an indwelling catheter in the last seven days. Indwelling catheter use may result in complications, like urinary tract or blood infections, physical injury, skin problems, bladder stones, or blood in the urine.
Percentage of residents with a urinary tract infection	This measure reports the percentage of long-stay residents who have had a urinary tract infection within the past 30 days
Percentage of residents experiencing one or more falls with major injury	This measure reports the percentage of long-stay residents who have experienced one or more falls with major injury reported in the target period or look-back period (one full calendar year).
Percentage of residents who received an antipsychotic medication	This measure reports the percentage of long-stay residents who are receiving antipsychotic drugs in the target period. Reducing the rate of antipsychotic medication use has been the focus of several CMS initiatives.

Source: https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf.
ED = emergency department; ADL = activity of daily living.

CMS calculates facility performance on each measure by using risk-adjusted methodologies that account for differences in resident characteristics and clinical complexity. CMS then calculates quality performance by assigning points to individual measures and aggregating them across long-stay and short-stay populations. For each facility, points are summed to produce separate long-stay and short-stay scores as well as a combined total score. CMS then ranks facilities relative to national performance distributions and translates those rankings into star ratings for the quality measures domain.[213]

[213] CMS, *State operations manual*, Appendix PP, n.d.

Skilled Nursing Facility Value-Based Purchasing Program

The Medicare SNF VBP Program is the primary mechanism through which Medicare links nursing facility payments to quality performance. Established under Section 215 of the Protecting Access to Medicare Act of 2014, the program adjusts Medicare payments based on facility performance on selected quality measures.[214]

The SNF VBP program initially focused on reducing potentially preventable hospital readmissions for Medicare beneficiaries receiving post-acute care in nursing facilities.[215] Under the original design, CMS evaluated facilities by using the SNF 30-Day All-Cause Readmission Measure, which calculates the risk-adjusted rate of hospital readmissions occurring within 30 days of discharge from a hospital to a skilled nursing facility.

As of federal fiscal year 2019, CMS began implementing payment adjustments tied to facility performance on the SNF 30-Day All-Cause Readmission Measure.[216] Medicare withholds two percentage points of each facility's payments and redistributes a portion of those funds back to facilities based on relative performance.[217] Facilities performing better than national benchmarks receive positive payment adjustments; lower-performing facilities experience payment reductions.

The program has since expanded to incorporate additional measures intended to capture broader aspects of quality performance.[218] In Section 111 of the Consolidated Appropriations Act, 2021, as of federal fiscal year 2026, CMS expanded the SNF VBP program to include several measures covering areas such as discharge to the community, health care–associated infections, and functional outcomes. These changes reflect an effort to move beyond a single-measure approach to a more comprehensive evaluation of post-acute care quality. In **Exhibit 4.3**, we list measures that the SNF VBF adopted, along with measure status for federal fiscal years 2026 through 2029.

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[214] Improving Medicare Post-Acute Care Transformation Act of 2014, Pub. L. No. 113-185, 128 Stat. 1952 (2014). https://www.congress.gov/113/plaws/publ93/PLAW-113publ93.pdf.
[215] Improving Medicare Post-Acute Care Transformation Act of 2014, Pub. L. No. 113-185, 128 Stat. 1952 (2014).
[216] Centers for Medicare & Medicaid Services (CMS). (n.d.). *Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program*. https://www.cms.gov/medicare/quality/nursing-home-improvement/value-based-purchasing.
[217] CMS, *SNF VBP Program*, n.d.
[218] Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 1182 (2020). https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf.

Exhibit 4.3. SNF VBP program measures and status, FY2027–FY2029

Measure	FY2026	FY2027	FY2028	FY2029
Skilled Nursing Facility 30-Day All-Cause Readmission Measure	Included	Included	Not Included	Not Included
Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalizations Measure	Included	Included	Included	Included
Total Nurse Staffing Hours per Resident Day (Total Nurse Staffing) Measure	Included	Included	Included	Included
Total Nursing Staff Turnover (Nursing Staff Turnover) Measure	Included	Included	Included	Included
Discharge to Community - Post-Acute Care Measure for Skilled Nursing Facilities	Not Included	Included	Included	Included
Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) (Falls with Major Injury [Long-Stay]) Measure	Not Included	Included	Included	Included
Discharge Function Score for SNFs Measure	Not Included	Included	Included	Included
Number of Hospitalizations per 1,000 Long Stay Resident Days (Long-Stay Hospitalization) Measure	Not Included	Included	Included	Included
Skilled Nursing Facility Within-Stay Potentially Preventable Readmissions Measure	Not Included	Not Included	Included	Included

Source: https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf.

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

The SNF QRP is another core component of Medicare's quality oversight framework. Established under the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, the program requires nursing facilities to report standardized quality data to receive full Medicare payment updates.[219]

Under the SNF QRP, facilities must submit a series of standardized quality measures derived primarily from MDS assessments and claims data.[220] Facilities that fail to report the required data are subject to a two-percentage-point reduction in their annual Medicare payment update, creating a strong incentive for compliance with reporting requirements.[221]

The measures included in the SNF QRP focus on clinical outcomes, care transitions, and functional improvement among residents receiving post-acute care services.[222] Examples of measures include rates of successful discharge to the community, changes in mobility and self-care, and potentially preventable hospital readmissions.

A key objective of the SNF QRP is to standardize quality measurement across post-acute care settings, including skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals, and home health agencies.[223]

Medicaid quality programs national scan

Medicaid SNF quality incentive programs nationally

Federal programs such as SNF VBP and SNF QRP focus primarily on Medicare-covered nursing facility stays. Those programs aim to improve quality outcomes among the broader population of long-term care residents, many of whom rely on Medicaid as their primary source of coverage.

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[219] Improving Medicare Post-Acute Care Transformation Act of 2014, Pub. L. No. 113-185, 128 Stat. 1952 (2014).
[220] Centers for Medicare & Medicaid Services (CMS), *Skilled Nursing Facility Quality Reporting Program (SNF QRP)*, n.d.
[221] CMS, *SNF QRP*, n.d.
[222] CMS, (n.d.). *IMPACT Act of 2014 data standardization and cross-setting measures*. https://www.cms.gov/medicare/quality/initiatives/pac-quality-initiatives/impact-act-2014-data-standardization-cross-setting-measures.
[223] CMS. *IMPACT Act of 2014 data standardization and cross-setting measures*, n.d.

Many states, however, play a fundamental role in shaping nursing facility quality because Medicaid finances the majority of long-term nursing facility care in the United States.[224] National estimates indicate that Medicaid accounts for more than 63 percent of nursing facility residents and over half of total nursing home expenditures.[225] Even though Medicare provides limited coverage for short-term skilled nursing facility care following a qualifying hospital stay, the coverage is time-limited. Medicare fully covers the first 20 days and requires a copayment from days 21 through 100.[226] After the 100th day, or earlier if skilled nursing care is no longer needed, Medicare coverage ends, leaving either private pay or Medicaid as the primary payor for ongoing care. Accordingly, Medicaid is the dominant payor in financing long-term care services, giving Medicaid policy substantial influence over facility operations, staffing levels, and quality improvement initiatives.

In response to concerns about quality variation and workforce shortages within nursing facilities, many states have incorporated quality incentive programs into their Medicaid payment systems.[227] These programs typically allocate a portion of nursing facility payments based on performance on specified quality measures or participation in quality improvement activities. These approaches can take a range of forms, including:

- **Provider-facing pay for performance (P4P) incentives:** P4P incentives are designed to create financial incentives for improvement in areas such as quality of care, discharge practices, hospitalization rates, and person-centered care. Incentive programs might include provider-facing rate add-ons, quality bonus payments, or plan-level incentives.
- **Managed care incentives tied to post-acute outcomes:** Provides payments to MCPs rather than directly to nursing facilities. They are based on MCPs' performance on quality measures, such as community transitions or reduced avoidable utilization. The incentive payments do not reflect a direct financial impact on nursing facilities, but they can have an indirect effect. For example, plans can encourage improvements to discharge planning or enforce continuity-

[224] Chidambaram et al., *5 key facts about nursing facilities and Medicaid*. KFF, 2023.
[225] Chidambaram et al., *5 key facts about nursing facilities and Medicaid*. KFF, 2023.
[226] American Council on Aging. (2026). *Paying for nursing home care: Bridging the benefits of Medicare, Medigap & Medicaid*. https://www.medicaidplanningassistance.org/who-pays-for-nursing-homes/.
[227] American Health Care Association. (2022). *A review of nursing home Medicaid value-based purchasing programs*. Center for Health Policy Evaluation. https://www.ahcancal.org/Data-and-Research/Center-for-HPE/Documents/CHPE-Report-A%20Review%20of%20NH%20Medicaid%20VBP%20Programs%2002.23.2022.pdf.

of-care requirements by using tools such as network management or provider contracting that influence network adequacy.

- **Episode-based payment arrangements:** Payment is tied to the total cost and quality of care for a defined episode, which may include a range of providers and settings. Though not a common approach for states, the approach can encourage coordination at the federal level across hospitals, skilled nursing facilities, and other post-acute providers.
- **Shared savings models:** Payment is tied to the total cost and quality of care for a defined population or episode of care, which may include a range of providers and settings. Providers or provider organizations can be rewarded for reducing total cost of care while meeting quality standards. Skilled nursing facilities may participate directly or as part of a broader network, such as an Accountable Care Organization. Though not a common approach for states, Accountable Care Organizations under Medicare feature models that encourage coordination across hospitals, skilled nursing facilities, and other post-acute providers.

A national review of nursing facility value-based purchasing initiatives identified more than two dozen states that have implemented Medicaid quality incentive programs targeting nursing home performance (**Exhibit 4.4**). The programs vary in scope and design but generally share several common objectives, including encouraging improvements in staffing levels, reducing avoidable hospitalizations, and improving clinical outcomes for long-term care residents.[228]

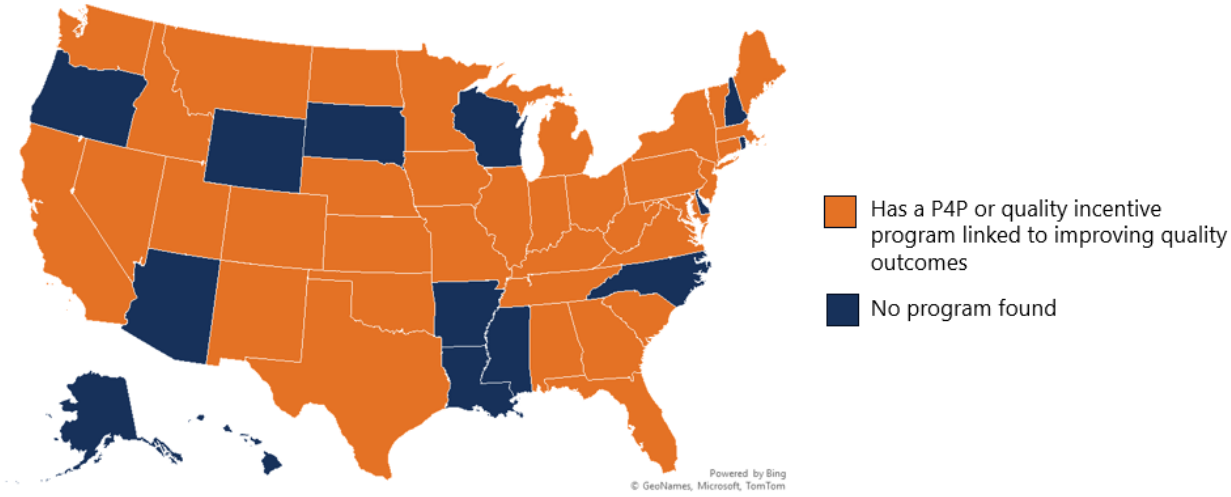
Many Medicaid quality incentive programs use payment adjustments or bonus payments tied to facility performance on selected quality indicators.[229] Some states structure these programs as P4P systems, whereby facilities earn additional payments if they achieve specified performance benchmarks. Other states use withhold and redistribution models, withholding a portion of payment and then redistributing it to higher-performing facilities.

Despite variation in program design, the overall objective of the above initiatives is the same. By linking a portion of payment to quality performance, states are creating financial incentives that reward facilities for achieving or maintaining higher standards of care while introducing accountability for underperformance. The various programs are

[228] American Health Care Association, *A review of nursing home Medicaid value-based purchasing programs*, 2022.
[229] American Health Care Association, *A review of nursing home Medicaid value-based purchasing programs*, 2022.

designed to shift the focus of nursing facility operations toward continuous quality improvement, with the ultimate goal of improving clinical outcomes, enhancing resident quality of life, and ensuring more consistent performance across providers.

Exhibit 4.4. States with Medicaid quality incentive programs



Source: Determined from review of publicly available State Plan or regulatory documentation nationwide as of January 1, 2026.

Elements of SNF quality incentive programs

Although Medicaid nursing facility quality programs vary across states, most programs incorporate a similar set of design elements. These elements determine how facilities are evaluated, how performance is measured, and how financial incentives are distributed.[230]

One common design feature involves the use of performance benchmarks derived from either statewide averages or national standards.[231] Facilities may be rewarded for exceeding benchmark thresholds or demonstrating improvement relative to their own historical performance. Some programs combine both approaches, rewarding facilities that both meet benchmarks and demonstrate measurable improvement.

Another key element involves the selection of quality measures used to evaluate facility performance. States typically rely on the same standardized data sources described

[230] American Health Care Association, *A review of nursing home Medicaid value-based purchasing programs*. 2022.
[231] American Health Care Association, *A review of nursing home Medicaid value-based purchasing programs*. Center for Health Policy Evaluation, 2022.

above such as the MDS, Medicare claims data, or staffing data reported through the PBJ system.[232] Use of standardized data sources allows states to measure performance consistently across facilities and align their programs with federal quality reporting systems.

Financial payment design also varies across states. Some programs provide direct bonus payments to high-performing facilities; others distribute incentive funds through competitive pools that reward top-performing providers. Still other programs include tiered payment structures that provide incremental incentives based on performance levels.

Many programs also incorporate mechanisms intended to ensure fairness across facilities serving different resident populations. Risk adjustment methodologies are frequently used to account for differences in resident acuity and clinical complexity. These adjustments are important because facilities serving more medically complex populations may face greater challenges in achieving certain quality benchmarks.

Finally, programs may also incorporate reporting and transparency components designed to monitor performance and track improvements over time. Facilities may be required to submit data on staffing levels, clinical outcomes, and quality improvement activities. State agencies then analyze these data to determine eligibility for incentive payments and evaluate program effectiveness.

Types of measures used in Medicaid SNF quality programs

Medicaid quality incentive programs for nursing facilities typically evaluate performance across several categories of measures that reflect both clinical outcomes and operational aspects of care delivery.[233] In designing these programs, states frequently seek to align quality measures with existing federal reporting systems. Such alignment can reduce duplicative reporting requirements and allow states to leverage standardized data sources that are already collected under Medicare and Medicaid participation requirements. In addition, alignment with federal reporting systems enhances transparency across the long-term care landscape, and payors' alignment of quality goals enhances the impact of financial incentives on quality improvement. Given that federally reported measures are publicly reported, providers, state agencies, and other

[232] American Health Care Association, *A review of nursing home Medicaid value-based purchasing programs* 2022.
[233] American Health Care Association, *A review of nursing home Medicaid value-based purchasing program*, 2022.

stakeholders have access to a common set of performance information that is updated on a consistent and predictable basis.

The selection of measures is therefore one of the most crucial design decisions in any quality incentive program. Measures must reflect aspects of care that are important to resident outcomes, must be supported by reliable and validated data sources, and must be sufficiently sensitive to detect meaningful differences in facility performance. Well-designed measure sets focus provider attention on high-priority areas such as staffing stability, clinical outcomes, and resident well-being, helping to ensure that financial incentives are aligned to encourage meaningful improvements in care delivery.

In practice, Medicaid nursing facility quality programs typically evaluate performance across several broad categories of measures. These often include:

- Gatekeeping measures that establish minimum standards for participation in incentive programs.
- Staffing measures that evaluate workforce capacity, staffing levels, and workforce stability.
- Health inspection survey results that are derived from regulatory inspection findings.
- Clinical quality measures that use MDS assessment data, administrative claims, and encounter data to assess clinical outcomes, health care, utilization, and resident health status over time.
- Resident and family experience measures that capture aspects of care quality related to resident satisfaction, engagement, and quality of life not reflected in clinical metrics.
- Equity-focused measures that evaluate disparities in care outcomes or access and assess how facilities serve residents with varying levels of clinical complexity or social risk factors.

Together, these categories of measures can provide a comprehensive view of facility performance across both clinical and operational dimensions of nursing facility care.

Gatekeeping measures

Medicaid nursing facility quality programs frequently rely on gatekeeping measures to establish minimum participation thresholds that facilities must meet to qualify for

quality incentive payments or participate fully in a program.[234] Rather than directly measuring clinical outcomes or care processes, gatekeeping measures function as baseline eligibility criteria designed to ensure that facilities meet fundamental standards of performance before receiving incentive payments.

Several state quality programs use gatekeeping measures to identify facilities with significant regulatory compliance issues or persistent quality concerns.[235] For example, facilities with serious survey deficiencies, immediate jeopardy citations, or enforcement actions such as denial of payment for new admissions may be excluded from receiving quality incentive payments during the performance period. These exclusions ensure that facilities with substantial compliance problems do not receive financial rewards intended to promote quality improvement. Gatekeeping measures may also incorporate performance thresholds tied to widely recognized quality indicators. For example, programs may require facilities to maintain minimum ratings on the Five-Star Quality Rating System or meet baseline performance levels on key clinical indicators before becoming eligible for incentive payments. In some cases, facilities must also demonstrate compliance with reporting requirements or participation in required quality monitoring programs as a condition of program eligibility.

The use of gatekeeping measures can also help strengthen program credibility by ensuring that limited financial resources are allocated to facilities that maintain acceptable standards of care. Without thresholds related to care standards, programs risk allocating incentive payments to facilities with poor performance simply because they demonstrate incremental improvement from a low baseline. Gatekeeping measures therefore help ensure that incentive structures reward facilities that both meet minimum quality expectations and demonstrate meaningful performance improvements.

At the same time, excessively restrictive eligibility criteria could limit participation in quality programs and reduce opportunities for facilities to receive funding intended to support quality improvement efforts. As a result, gatekeeping thresholds generally focus on serious compliance issues or extreme performance outliers, while allowing most facilities to remain eligible for improvement-based incentives.

When implemented effectively, gatekeeping measures provide an important structural component of Medicaid nursing facility quality programs. By establishing baseline performance expectations, the measures help ensure that incentive payments support

[234] Determined from review of publicly available MACPAC Compendium of state policies related to nursing facility staffing, 2022.
[235] MACPAC Compendium of state policies related to nursing facility staffing, 2022.

facilities that maintain acceptable standards of care even as they encourage broader participation in quality improvement initiatives.

Staffing measures

Given the well-established relationship between workforce capacity and resident outcomes, staffing measures are among the most frequently used indicators in Medicaid nursing facility quality programs.[236] Nursing facilities rely on direct care staff to provide assistance with daily activities, monitor changes in residents' conditions, administer medications, and coordinate care with physicians and other health care providers. As a result, the availability, stability, and skill mix of facility staff play a central role in determining the quality and safety of care delivered to residents.

Most staffing measures evaluate the amount of nursing care available to residents, typically expressed as hours per resident day.[237] These measures calculate the total number of hours worked by nursing staff relative to the number of residents in the facility over a given period. Staffing hours are often analyzed by staff type as each role contributes differently to resident care and clinical oversight. Many quality programs place particular emphasis on RN staffing levels because of RNs' role in clinical assessment, care planning, and supervision of other staff.

Data used for staffing measures are commonly derived from the PBJ reporting system. PBJ data provides a standardized method for tracking staffing levels across facilities and allow regulators to evaluate workforce patterns over time. Because PBJ reporting is tied to payroll records rather than to facility self-reported estimates, it is generally viewed as a reliable source of staffing data.

In addition to measuring total staffing hours, some quality programs incorporate indicators related to workforce stability and continuity of care.[238] Measures such as staff turnover rates, retention rates, and consistent staff assignment are used to evaluate how frequently staff members change positions or leave the facility. Staffing measures are particularly important within Medicaid quality incentive programs because workforce capacity is one of the most direct levers available for improving care quality in nursing facilities.

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[236] States that use staffing measures are California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Maryland, New Jersey, Ohio, Tennessee, and Virginia.

[237] MACPAC Compendium of state policies related to nursing facility staffing, 2022.

[238] MACPAC Compendium of state policies related to nursing facility staffing, 2022.

However, staffing needs may vary significantly with resident acuity, facility size, and the availability of specialized services. Facilities serving residents with higher clinical complexity may require greater staffing intensity than facilities serving lower-acuity populations. As a result, some programs incorporate risk adjustment or acuity-based staffing benchmarks into their measures to ensure fair comparisons across providers. In California, the WQIP incorporated several acuity-adjusted measures, including total nursing, RN, LVN, and CNA hours.

Despite these considerations, staffing measures remain a central component of most Medicaid nursing facility quality programs. By monitoring workforce capacity and stability, the measures provide policymakers with insight into whether facilities maintain the staffing resources necessary to support safe, high-quality resident care.

Health survey results measures

Health survey results represent another commonly used category of measures in Medicaid nursing facility quality programs.[239] Quality programs often rely on survey results in a variety of ways. In addition to serving as gatekeeping criteria for program eligibility, survey-based measures frequently find direct application within the scoring methodologies to evaluate facility performance.[240] Programs may assign points or apply performance adjustments based on the number, severity, or pattern of deficiencies identified during inspections. Facilities with fewer deficiencies or lower severity scores may receive higher performance ratings under quality incentive programs; facilities with significant or repeated regulatory violations may face reduced performance scores or find themselves excluded from participation in certain incentive programs. In some cases, particularly serious deficiencies may also trigger enforcement actions such as civil monetary penalties or denial of payment for new admissions.

One of the key strengths of survey-based measures is that they are derived from independent regulatory inspections, providing an external perspective on facility performance. Survey findings are standardized nationally through CMS survey protocols, allowing regulators to compare compliance across facilities and jurisdictions within a state. Because surveyors evaluate both documentation and direct observations of care delivery, survey results can capture operational and clinical issues that may not be reflected in administrative or clinical reporting systems.

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[239] States that use health survey results measures are Alabama, Colorado, Connecticut, District of Columbia, Florida, Georgia, Iowa, Illinois, Indiana, Kansas, Maryland, Michigan, New Jersey, Ohio, Tennessee, Utah, and Vermont.

[240] MACPAC Compendium of state policies related to nursing facility staffing, 2022.

Survey results remain an important component of many Medicaid nursing facility quality programs. By incorporating findings from independent regulatory inspections, the measures help ensure that incentive programs reinforce compliance with fundamental standards of care while also encouraging facilities to maintain strong operational and clinical practices between survey cycles. However, even though CMS provides standardized guidance, the survey process still involves a degree of subjective judgment that can lead to differences in how similar issues are cited or classified.

Clinical quality measures

Over 30 Medicaid nursing facility quality programs rely on MDS-based quality measures.[241] The measures capture a range of clinical outcomes commonly associated with nursing facility quality, including indicators such as the prevalence of pressure injuries, declines in functional status, use of antipsychotic medications, infection rates, falls, and other resident health outcomes. Because these measures reflect changes in resident health and functional status over time, they provide insight into how effectively facilities manage clinical care and support resident well-being.

The MDS provides a comprehensive and standardized data set that allows policymakers to evaluate performance across facilities by using consistent definitions and reporting structures. With assessments required for all residents in Medicare- and Medicaid-certified facilities, states use MDS data to analyze outcomes across large resident populations and to monitor trends in facility performance.

At the same time, the MDS assessment process relies largely on facility-reported information, meaning that nursing staff collect and submit the data; facilities do not rely on independent external reporting systems. Even though federal regulations require facilities to follow standardized assessment protocols and ensure the accuracy of submitted data, the system's self-reported nature can introduce potential variability in how assessments are conducted or coded across facilities and may increase the risk of inaccuracies.[242] Differences in staff training, documentation practices, and interpretation

[241] States that use MDS-based measures are Alabama, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Virginia, Washington, and West Virginia.

[242] Heid, A. R., Noble, M., Van Haisma, K., & Abbott, K. M. (2025). Alignment of Minimum Data Set 3.0 ratings with staff care partner reports of symptoms of distress for nursing home residents. *Journal of the American Medical Directors Association*, 26(12).

of assessment guidelines may influence how certain conditions or functional limitations are recorded.

For this reason, many quality monitoring systems incorporate MDS-based measures alongside other sources of information, such as claims-based utilization measures. Using several data sources helps provide a more complete view of facility performance and allows policymakers to identify potential discrepancies or patterns that may warrant further review. For example, California's WQIP included a combination of MDS and claims-based measures to evaluate and reward nursing facility performance. Measures such as use of antipsychotic medications and changes in resident functional status are derived from MDS assessments, but indicators such as ED visits, hospitalizations occasioned by health care-related infections, and potentially preventable 30-day post-discharge readmissions are based on claims data. By integrating data from both MDS and claims, WQIP provided a comprehensive framework for evaluating nursing facility quality and improving care outcomes.

A smaller number of Medicaid nursing facility quality programs incorporate measures derived from administrative claims data to evaluate aspects of care that extend beyond the facility itself.[243] Claims-based measures use billing and encounter data submitted for services covered under Medicare or Medicaid to track health care utilization patterns among nursing facility residents. Because these data points are generated through payment transactions rather than through facility self-reporting, they provide an external source of information that can be used to evaluate outcomes associated with care coordination, clinical monitoring, and transitions across care settings.

Claims-based measures commonly focus on outcomes that may reflect potential gaps in care delivery within the nursing facility environment. These measures often include rates of hospital admissions, potentially avoidable hospitalizations, emergency department visits, and readmissions following hospital discharge.[244] High rates of these events may indicate challenges related to early identification of changes in resident condition, medication management, infection prevention, or access to timely clinical interventions within the facility. As a result, many quality incentive programs incorporate claims-based indicators to assess how effectively nursing facilities manage residents' clinical needs and prevent avoidable acute care utilization.

[243] States that use claims-based measures are Arizona, California, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Maryland, Michigan, New Jersey, New Mexico, New York, Ohio, Oklahoma, Tennessee, Texas, and Washington.
[244] MACPAC Compendium of state policies related to nursing facility staffing, 2022.

Administrative claims data also allow policymakers to examine care patterns across a range of providers and care settings. Because residents frequently receive services from hospitals, physicians, pharmacies, and other providers outside the nursing facility, claims data can capture interactions that do not appear in facility-based reporting systems. This broader perspective associated with administrative claims data allows quality programs to evaluate outcomes related to care transitions, coordination between providers, and overall health care utilization among nursing facility residents.

Another advantage of claims-based measures is that they rely on externally generated administrative data rather than on information reported directly by nursing facilities. Such data reduce concerns related to reporting bias and accuracy and provide a standardized data set that can be used to compare outcomes across facilities and geographic regions. Claims-based measures are therefore often viewed as a complementary data source that can validate or supplement information derived from resident assessments or facility-reported measures.

Publicly reported claims-based measures, such as those displayed on CMS Care Compare, do not, however, capture the full scope of nursing facility residents. For example, the calculation of long-stay claims-based measures, including hospitalization and emergency department utilization, use Medicare fee-for-service data; as a result, only Medicaid members who are dually eligible for Medicare and enrolled in original Medicare are included in the calculation of claims-based measures used in CMS Care Compare.[245] As a result, these claims-based measures may not fully reflect facility-wide performance.

In addition, because claims data are generated primarily for billing purposes, they generally lack the clinical detail needed to explain fully why certain events occur. Further, claims data may be subject to reporting delays because of processing timelines, which can limit their usefulness for real-time quality monitoring and incentive program performance scoring and reconciliation.

Nonetheless, claims-based indicators remain an important component of many Medicaid nursing facility quality programs. By capturing health care utilization across care settings and providing an external perspective on resident outcomes, claims-based

[245] Approximately 33 percent of individuals dually eligible for Medicare and Medicaid were enrolled in Medicare Advantage in 2024, available at: https://www.kff.org/medicare/the-landscape-of-medicare-and-medicaid-coverage-arrangements-for-dual-eligible-individuals-across-states/

measures help policymakers evaluate how effectively nursing facilities manage resident health conditions and coordinate care with the broader health care system.

Quality-of-life and resident experience measures

About 15 state quality incentive programs incorporate measures designed to capture resident quality of life and experience.[246] The measures are designed to capture aspects of care that directly affect residents' daily experiences, dignity, autonomy, and overall well-being. Given that long-term care facilities function as both health care providers and residential environments, evaluating quality solely through clinical indicators may not fully reflect residents' lived experience.

Quality-of-life measures typically evaluate factors related to the social, emotional, and environmental aspects of care delivery. These indicators may assess residents' ability to participate in daily activities, maintain social relationships, exercise personal choice, and live in an environment that supports dignity and independence. Measures may also examine aspects of facility operations such as access to meaningful activities, opportunities for resident engagement, and the degree to which care practices support individualized preferences and routines.

Resident experience measures are often collected through resident and family satisfaction surveys or structured interviews conducted by independent organizations or state agencies. Two of the most widely used tools in nursing facility settings are the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Nursing Home Survey and the CoreQ Survey.[247,248] These surveys typically ask residents or their family members to report on their experiences with facility staff, communication with care teams, responsiveness to concerns, cleanliness of the environment, and overall satisfaction with care. Because these measures rely on direct feedback from residents and families, they provide insight into dimensions of care that clinical or administrative data sources might not capture.

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[246] States that use quality of life and resident experience measures are Alabama, Colorado, Connecticut, District of Columbia, Georgia, Iowa, Kansas, Maryland, Michigan, Minnesota, New Jersey, New Mexico, Tennessee, Utah, Vermont.

[247] CoreQ Overview, available at: https://www.ahcancal.org/Quality/Documents/CoreQ/CoreQ%20Overview%20Doc.pdf

[248] Centers for Medicare & Medicaid Services. (n.d.) CAHPS Home and Community-Based Services Survey, available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/cahps-home-and-community-based-services-survey

Incorporating resident experience measures into quality programs reflects a broader shift toward person-centered care within the long-term care sector. Person-centered care emphasizes the importance of respecting resident preferences, supporting autonomy, and ensuring that care delivery aligns with each resident's goals and values. Quality programs that include resident experience measures can encourage facilities to prioritize communication, responsiveness, and supportive living environments in addition to traditional clinical performance.

Measuring resident experience in nursing facilities can, however, present several challenges. Many residents have cognitive impairments that may affect their ability to participate in surveys or interviews and require the use of proxy responses from family members or caregivers. Residents' altered emotional state, health literacy, communication barriers, and concerns about retaliation may also present challenges to accurate measurement. In addition, differences in survey methodologies, response rates, and question design can complicate comparisons across facilities. Low response rates can limit the generalizability of responses.[249] Despite these challenges, resident experience measures provide valuable insights into the human aspects of care delivery and help ensure that quality monitoring efforts reflect the perspectives of those directly receiving services.

Health equity measures

A small but growing number of Medicaid quality incentive programs incorporate measures related to health equity and access to care.[250] These measures may evaluate disparities in outcomes across resident populations or examine facility performance in serving medically complex or socially disadvantaged residents.

One commonly used approach is to evaluate the proportion of residents covered by Medicaid or the degree to which a facility serves a disproportionate share of Medicaid beneficiaries. Notably, California incorporated the disproportionate share of Medicaid beneficiaries and completeness of race and ethnicity data reported through the MDS as equity-based measures within its WQIP.

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[249] Bland, C., Zuckerbraun, S., Lines, L., Kenyon, A., Hinsdale-Shouse, M., Hendershott, A., Sanchez, R., Allen, R., Djangali, A., Kinyara, E., Kline, T., Butler, J. 2022. *Challenges facing CAHPS surveys and opportunities for modernization*, available at https://doi.org/10.3768/rtipress.2022.op.0080.2211

[250] States that use equity measures are California, Colorado, Florida, Illinois, Kansas, Kentucky, Massachusetts, Michigan, Missouri, Nevada, and Wisconsin.

This approach can help ensure that facilities serving higher shares of Medicaid beneficiaries are not systematically disadvantaged when compared with facilities serving larger proportions of Medicare or private-pay residents; the latter facilities may have greater financial flexibility to invest in staffing, facility upgrades, or specialized services. By incorporating payor mix as a health equity measure in quality analysis, states can better understand how financial context influences facility performance. Facilities with high Medicaid census levels often care for residents with greater socioeconomic challenges, limited family support, and higher reliance on publicly funded services. Identifying these facilities allows states to evaluate whether additional investments or program supports may be needed to maintain access to care for vulnerable populations.

California skilled nursing facility quality overview

Against this federal and national Medicaid backdrop, California maintains a comprehensive oversight structure for nursing facility quality. California has implemented several state programs designed to monitor performance, strengthen workforce capacity, and encourage improvements in resident care outcomes. These initiatives operate alongside the federal survey and certification system and incorporate both regulatory oversight and financial incentives tied to quality performance.

In California, several state agencies share responsibility for nursing facility quality oversight. CDPH is the primary survey and certification authority responsible for enforcing federal nursing home regulations, conducting inspections, and investigating complaints. At the same time, DHCS plays a central role in shaping payment policy and quality incentive programs affecting nursing facilities. In addition, California's Department of Healthcare Access and Information (HCAI) supports the state's oversight framework through administration of cost reporting requirements, financial data collection, and select workforce-related initiatives that guide policy development and rate setting. The interaction among these agencies creates a regulatory and payment environment that influences how facilities approach quality improvement and workforce investment.

Current quality monitoring activities and reporting expectations

California has implemented several state programs that monitor nursing facility quality and strengthen accountability for care outcomes under Medi-Cal. The programs reflect a broader policy approach in which regulatory oversight complements targeted workforce investments, quality incentive programs, and accountability mechanisms tied to facility performance. The programs create a framework through which DHCS can track staffing

levels, monitor quality performance, and ensure that Medi-Cal funding supports improvements in resident care.

California's current oversight framework incorporates a variety of programmatic mechanisms that address several dimensions of nursing facility performance. These include:

- Minimum staffing requirement, which establishes baseline staffing expectations for facilities (see Chapter 3).
- WSP, which directs Medi-Cal funding to workforce investments and staffing improvements (see Chapter 3).
- WQIP, which provided performance-based payments tied to staffing and quality metrics.[251]
- Skilled Nursing Facility ASP, which establishes enforcement mechanisms for facilities that fail to meet required quality and workforce standards.
- Medi-Cal Accountability and Sanctions framework (MCAS), which provides additional oversight tools to ensure compliance with Medi-Cal program requirements and quality expectations for managed care plans in California.

In **Exhibit 4.5**, we list the quality measures used in California's current or recent programs that make up the SNF quality and oversight framework.

Exhibit 4.5. Quality measures used in California SNF quality and oversight framework

Measure Type	Measure	WSP[b]	WQIP[c]	ASP[d]	MCAS[e]
Pathway-based[a]	Maintain collective bargaining agreement	✓			
	Participate in multi-employer Labor Management Committee	✓			
	Meet basic wages and benefits standards benchmarks	✓			

[251] The WQIP ceased operation on December 31, 2025, pursuant to the 2025 Budget Act.

Measure Type	Measure	WSP[b]	WQIP[c]	ASP[d]	MCAS[e]
Staffing-based	Acuity-adjusted total nursing hours		✓		
	Acuity-adjusted weekend total nursing hours		✓		
	Acuity-adjusted RN hours		✓		
	Acuity-adjusted LVN hours		✓		
	Acuity-adjusted CNA hours		✓		
	Staffing turnover		✓		
Clinical Quality Measures	Percentage of residents who lose too much weight, long stay		✓	✓	
	Percentage of residents experiencing one or more falls with major injury, long stay		✓	✓	
	Percentage of residents who received an antipsychotic medication, long stay		✓	✓	
	Outpatient ED visits per 1,000 long-stay resident days		✓		✓**
	Health care–associated infections requiring hospitalization		✓		✓**
	Potentially preventable 30-day post-discharge readmission		✓		✓**
Equity-based	Medi-Cal disproportionate share		✓		

[a] Pathway-based measures refer to the specific pathway that facilities may choose to participate in the program.

[b] More information about WSP is available at https://www.dhcs.ca.gov/services/medi-cal/Pages/FFSRDD-LTC/SNFWSP.aspx.

[c] More information about WQIP is available at https://www.dhcs.ca.gov/services/Pages/SNF-WQIP.aspx.

[d] More information about ASP is available at https://www.dhcs.ca.gov/services/Pages/SNF-ASP.aspx.

[e] More information about MCAS is available at https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEAS.aspx.

** Long-term care measures have been retired from the MCAS for measure year 2026. Before retirement, these measures were "reporting only," with no accountability on performance.

Workforce Standards Program

WSP represents one of California's most significant recent initiatives aimed at improving nursing facility staffing capacity and workforce stability.[252] Administered by DHCS, the program incorporates workforce-related requirements into the Medi-Cal payment methodology by providing enhanced per diem rates to facilities that meet defined workforce investment and staffing requirements.[253] A full description of the program appears in Chapter 3.

The WSP's structure has several merits that can improve facility staffing and, in turn, affect quality. First, the pathway model creates flexibility by allowing facilities to qualify for participation in WSP through several options that accommodate variation in labor arrangements across the provider market. In addition, the program is designed to move beyond a narrow staffing-hour concept by linking payment to broader workforce conditions, particularly compensation and benefits, which are major factors in recruitment and retention. Finally, because the workforce rate adjustment is embedded in the Medi-Cal per diem structure and paired with opt-in, attestation, and compliance requirements, the WSP creates a formal accountability framework for workforce investment. All these design features make the WSP a notable example of how California has used payment policy to influence workforce conditions as part of its broader strategy for reforming the quality of nursing facilities.

Workforce & Quality Incentive Program

California's WQIP was a performance-based directed payment program designed to encourage facilities to improve quality of care, advance equity in health care outcomes, and invest in the workforce.[254] WQIP represented an evolution of California's earlier

[252] California Department of Health Care Services (DHCS). (n.d.). *Nursing Facility Financing Reform (AB 186)*. https://www.dhcs.ca.gov/services/medi-cal/Pages/Nursing-Facility-Financing-Reform-AB-186.aspx.
[253] California Department of Health Care Services. (n.d.). *Skilled Nursing Facility Workforce Stabilization Program (WSP)*. https://www.dhcs.ca.gov/services/medi-cal/Pages/FFSRDD-LTC/SNFWSP.aspx.
[254] California Department of Health Care Services. (n.d.). *Skilled Nursing Facility Workforce & Quality Incentive Program (WQIP)*. https://www.dhcs.ca.gov/services/Pages/SNF-WQIP.aspx.

QASP program. It expanded the scope of quality measurement by incorporating more granular workforce, clinical, and equity-focused measures.

Under the former WQIP, participating facilities underwent evaluation based on a standardized scoring methodology established by DHCS. The evaluation assessed performance across three domains: workforce, clinical quality, and health equity. For the calendar year 2025 program, 55 percent of the score was allocated to the workforce domain, 38 percent to the clinical quality domain, and 7 percent to the health equity domain. The workforce domain evaluated acuity-adjusted staffing hours and turnover, recognizing the impact of staffing levels and stability on resident care. The score for the workforce domain was also prorated for any days during the year that the facility did not meet minimum staffing requirements under state law. The clinical quality domain incorporated a combination of MDS-based and claims-based measures. Facilities could earn points for absolute achievement or for improvement over the previous year's performance. Achievement benchmarks for workforce and clinical quality measures were based on steps between the 25th and 90th percentile of California facilities. Scores for measures based on facility-reported MDS and PBJ data were prorated for incompleteness. The equity domain included measures related to disproportionate share and completeness of race and ethnicity data reported through the MDS. Facility performance across these measures was translated into incentive payments through the program's 100-point scoring methodology. A curve factor was applied to the score so that total projected WQIP payments across all facilities would target a budgetary funding amount. Facilities with one or more class AA citations issued by CDPH were disqualified from the program year. Facilities with one or more class A citations had a 40 percent penalty applied to the payment amount.

Several aspects of WQIP represented advances in California's approach to nursing facility quality. The program recognized that quality is influenced by several dimensions of facility performance rather than by any single indicator or metric. By incorporating the various domains into a singular framework, WQIP encouraged facilities to pursue improvements across staffing, resident outcomes, and organizational performance. Finally, by linking financial incentives directly to performance measurement, WQIP created accountability in supplemental Medicaid payments directly to resident care.

Fiscal constraints led to WQIP's sunset as an incentive program on December 31, 2025, pursuant to the 2025 Budget Act. DHCS remains interested in models that encourage SNF workforce and quality improvement in future payment models.

Accountability Sanctions Program

In addition to incentive-based initiatives, California administers ASP to support the objective of providing Medi-Cal members with the highest-quality care.[255] Unlike program structures that reward high performers through financial incentives, ASP's structure reflects a policy approach that uses financial penalties as an accountability mechanism to promote improvements in nursing facility performance. Programs such as WQIP provided positive financial incentives for achieving quality benchmarks, but ASP establishes consequences for facilities that fail to meet required standards.

Under ASP, participating facilities may receive a monetary sanction for failing to meet one or more quality or health equity measures established by DHCS on the basis of a per bed day. ASP sanctions may not exceed $5 per Medi-Cal bed day, capped at $150,000 per measurement year for each measure. ASP imposes monetary sanctions on SNFs failing to meet or exceed minimum performance benchmarks beginning for measurement year 2024.

The program provides a process for facilities to appeal the calculation of sanction amounts and establishes limited circumstances under which sanctions may be modified or waived. Pursuant to state law, waivers are available only to facilities that demonstrate both that they have taken sufficient corrective action to remediate the underlying deficiency and that imposition of the full amount of the sanction under ASP would in all likelihood create an undue financial hardship for that facility or create significant difficulty in providing services to Medi-Cal members.

Managed Care Accountability Set

In addition to the facility- and provider-focused programs described above, California's oversight framework includes quality reporting requirements for Medi-Cal MCPs through MCAS. This measure set includes several indicators related to long-term services and supports and care transitions, such as measures focused on care coordination, transitions between care settings, and utilization outcomes that are particularly relevant for nursing facility residents. These administrative measures were reporting only and not tied to performance. As of reporting year 2027, MCAS has retired measures related to long-term care.

[255] California Welfare and Institutions Code § 14126.026 (West, current through 2026). https://codes.findlaw.com/ca/welfare-and-institutions-code/wic-sect-14126-026/.

Civil Money Penalties and reinvestment grant program

CMPs, overseen by CDPH, represent one of the primary enforcement mechanisms used by federal and state regulators to address violations of nursing home quality standards.[256] Under federal law, CMP funds collected from nursing facilities must be reinvested in activities designed to improve nursing home quality and protect residents.[257] Facilities may not retain these funds as general revenue but instead must use them for programs that directly benefit nursing home residents.

CDPH administers CMP reinvestment funds through grant programs that support quality improvement initiatives throughout the long-term care sector.[258] The goal of the reinvestment initiatives is to convert regulatory enforcement resources into broader improvements in nursing home quality and resident safety. The grant programs may fund activities such as workforce training, infection prevention initiatives, technology adoption, and other resident-centered care programs. As of September 2025, California's estimate of total available funding was $17.6 million.[259]

Analysis of California and national SNF quality trends

California's overall quality profile appears mixed rather than uniformly high or low when compared with national averages. Drawing on Care Compare data, California performs relatively well on overall staffing capacity and many long-stay clinical quality measures, but the state performs less favorably on measures that reflect RN staffing levels, hospitalization, resident/family engagement, and certain oversight indicators favorably.

In Chapter 3, we compare California versus national average staffing measures. On many long-stay MDS-based clinical quality measures, California's performance exceeds the national average, including measures of residents whose need for help with daily activities increased (8.10 versus 14.87 nationally), residents who lose too much weight (4.78 versus 5.91), residents experiencing one or more falls with major injury (1.62 versus 3.53), and residents who received an antianxiety or hypnotic medication (13.60 versus

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[256] Centers for Medicare & Medicaid Services, *Nursing home enforcement*, n.d.
[257] Centers for Medicare & Medicaid Services. (n.d.). *Civil Money Penalty Reinvestment Program*. U.S. Department of Health and Human Services. https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/civil-money-penalty-reinvestment-program.
[258] California Grants Portal. (n.d.). *Civil Money Penalty Reinvestment Grant*. https://www.grants.ca.gov/grants/civil-money-penalty-reinvestment-grant/.
[259] California Grants Portal, *Civil Money Penalty Reinvestment Grant*, n.d.

19.14); for all of these measures, California ranks in the top ten in the nation. The results suggest that California facilities are generally performing well on most day-to-day long-stay care process and resident condition measures as demonstrated in **Exhibit 4.6**.

Exhibit 4.6. California versus national average quality measure comparison, long-stay measures

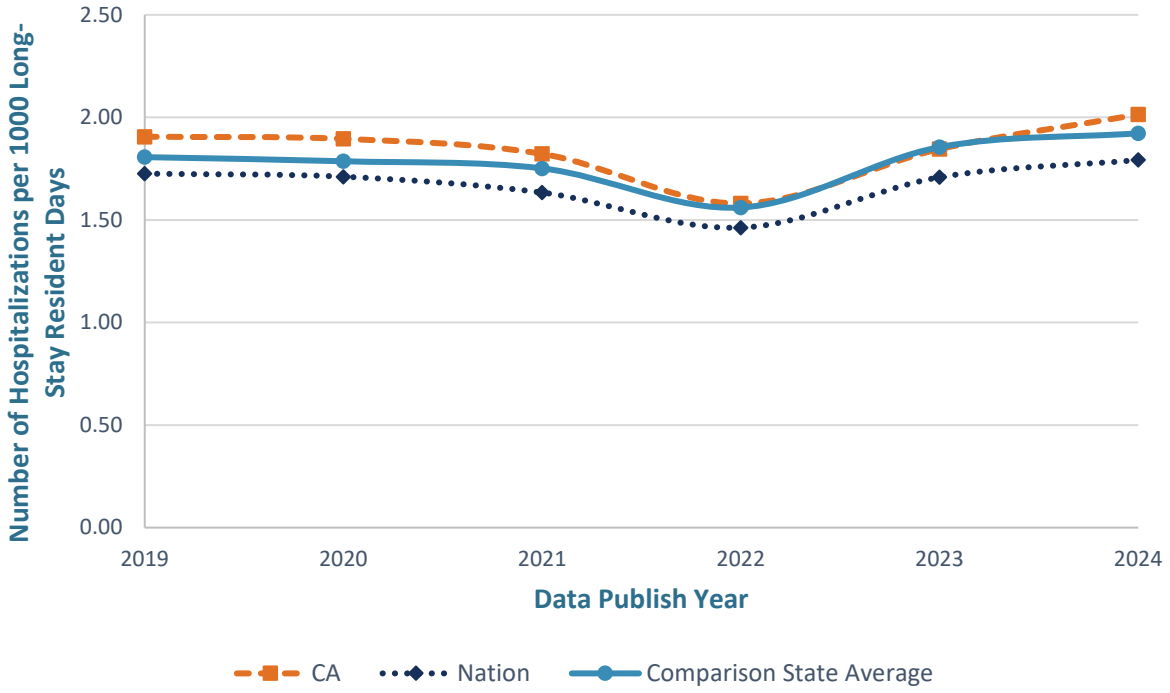
Measure	Preferred Quality Outcome	CA Average	National Average	National Ranking
Long-stay quality measure rating	Higher	4.37	3.36	2
Percentage of long-stay residents whose need for help with daily activities has increased	Lower	8.10	14.87	1
Percentage of long-stay residents who lose too much weight	Lower	4.78	5.91	5
Percentage of long-stay residents with a catheter inserted and left in bladder	Lower	1.28	1.44	25
Percentage of long-stay residents with a urinary tract infection	Lower	1.39	2.31	8
Percentage of long-stay residents who have depressive symptoms	Lower	6.10	7.68	31
Percentage of long-stay residents who were physically restrained	Lower	0.29	0.17	45
Percentage of long-stay residents experiencing one or more falls with major injury	Lower	1.62	3.53	1

Measure	Preferred Quality Outcome	CA Average	National Average	National Ranking
Percentage of long-stay residents assessed and appropriately given the pneumococcal vaccine	Higher	98.38	93.28	2
Percentage of long-stay residents who received an antipsychotic medication	Lower	11.06	16.02	6
Percentage of long-stay residents whose ability to walk independently worsened	Lower	10.63	16.91	3
Percentage of long-stay residents who received an antianxiety or hypnotic medication	Lower	13.60	19.14	8
Percentage of long-stay residents with pressure ulcers	Lower	7.35	7.74	19
Percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine	Higher	98.30	94.99	3
Number of hospitalizations per 1,000 long-stay resident days	Lower	2.03	1.59	47
Number of outpatient emergency department visits per 1,000 long-stay resident days	Lower	1.42	1.71	13

Source: CMS' archived data snapshot from October 2024 for nursing homes, including rehabilitation services, available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py.

However, this strength is not universal. California's claims-based utilization measures point to an area of opportunity for improvement. Although California performs in the top half of the nation on outpatient emergency department visits for long-stay residents (1.42 versus 1.71, ranking 13th), it performs substantially worse on long-stay hospitalizations (2.03 versus 1.59, ranking 47th). In **Exhibit 4.7**, we show that hospitalization rates in California followed the national decline in 2022 but then rose more sharply through 2024, ultimately exceeding both the national average and the comparison-state average. Despite the rate increase, a single measure such as the hospitalizations per 1,000 long-stay resident days measure is not indicative of the experience of all residents.

Exhibit 4.7. Number of hospitalizations per 1,000 long-stay resident days, 2019–2024



Source: CMS Care Compare Data by published year.

Notably, California's oversight and resident-experience indicators stand out among a generally high performance on quality measures. As shown in **Exhibit 4.8**, by quarter 4 of 2024, California was at the national average on the health inspection rating (2.76 versus 2.75, ranking 22nd) but performed worse than the nation on facility-reported incidents (5.50 versus 1.92, ranking 49th), substantiated complaints (11.57 versus 5.06, ranking 48th), infection control citations (1.03 versus 0.93, ranking 36th), payment denials

(0.18 versus 0.18, ranking 21st), and total penalties (2.32 versus 1.82, ranking 39th). California also lagged the nation on prevalence of resident and family councils (90.97 percent versus 94.70 percent, ranking 48th).

Exhibit 4.8. California versus national average quality measure comparison, resident-experience indicators

Measure	Preferred Quality Outcome	CA Average	National Average	National Ranking
With a resident and family council	Higher	90.97%	95.70%	48
Health inspection rating	Higher	2.76	2.83	22
Number of facility-reported incidents	Lower	5.50	1.92	49
Number of substantiated complaints	Lower	11.57	5.06	48
Number of citations from infection control inspections	Lower	1.03	0.93	36
Number of fines	Lower	2.14	1.64	40
Number of payment denials	Lower	0.18	0.18	31
Total number of penalties	Lower	2.32	1.82	39
Percentage of long-stay residents who were physically restrained	Lower	0.29	0.17	45
Number of hospitalizations per 1,000 long-stay resident days	Lower	2.03	1.59	47

Source: CMS' archived data snapshot from October 2024 for nursing homes, including rehabilitation services, available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py.

Taken together, these findings suggest that California's nursing facility sector has meaningful strengths in many long-stay clinical measures. Those strengths, however, have not translated into equally strong performance on hospitalization, complaint and incident burden, or resident/family engagement infrastructure.

Analysis of California SNF quality indicators and outcomes

Health inspection and complaint data

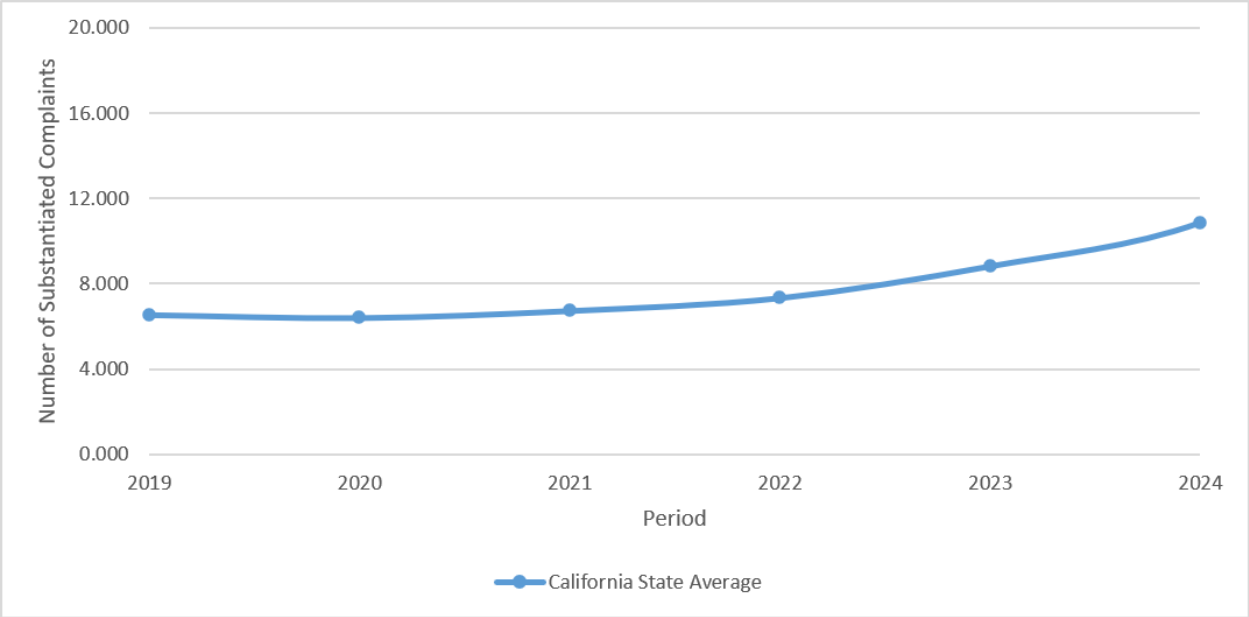
The average total weighted health survey score[260] varied greatly by FS/SNF-B peer group, with facilities in the Central Coast region scoring the lowest in quarter 4 of 2024, reflecting better performance, and facilities in Los Angeles Region 2 scoring the highest in quarter 4 of 2024, reflecting poorer performance (**Exhibit 4.11**). DP/SNF facilities also achieved a relatively low score, slightly above the score for the Central Coast region, reflecting better performance. These patterns by peer group were also reflected in the average health inspection rating, with better ratings among the peer groups with a lower average total weighted health survey score.

In **Exhibit 4.9**, we show a sharp rise in the number of complaints statewide between 2019 and 2024. A substantiated complaint occurs when a state or federal agency investigates an allegation against a nursing home and determines that the evidence is sufficient to prove that a regulatory violation has taken place. Substantiated complaints are significant because they indicate serious deficiencies in the quality of care or services provided by the facility. Complaints may involve issues such as neglect, abuse, inadequate staffing, medication errors, poor infection control practices, or violations of residents' rights.

The seriousness of substantiated complaints also underscores the importance of regulatory oversight in ensuring that nursing homes adhere to established standards of care and provide residents with a safe and supportive environment. Facilities with a higher number of substantiated complaints may face stricter scrutiny from state or federal agencies and be subject to corrective action plans to address identified deficiencies and prevent further harm to residents.

[260] The score is calculated based on deficiency points from the most recent surveys and complaint investigations over three years, with the most recent survey more heavily weighted to determine the score. Before July 2025, the three most recent surveys were used, but as of July 2025, the two most recent surveys are used as part of calculation of the score. State survey agencies conduct surveys at least every 15 months to ensure compliance with federal safety and care standards. Poorly performing facilities have increased the need for more frequent surveys.

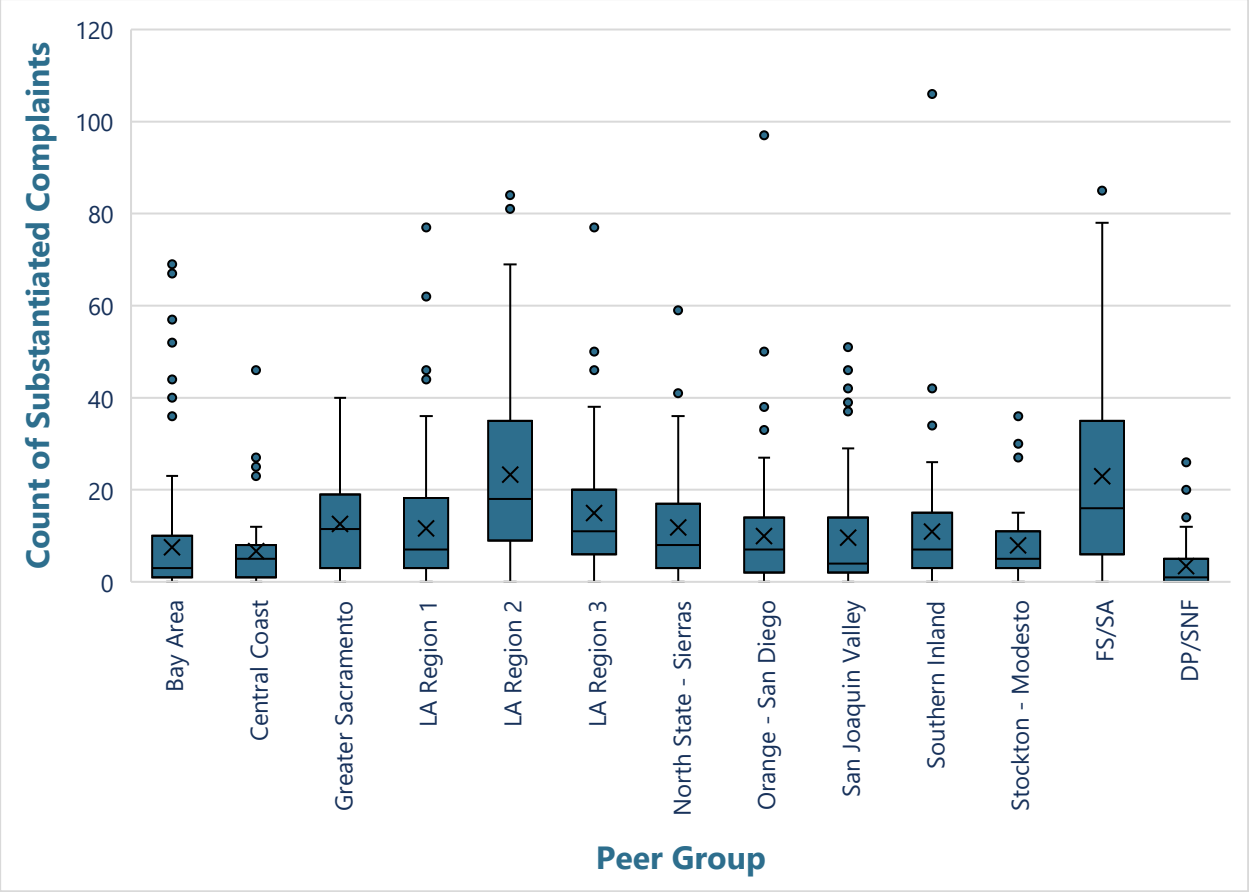
Exhibit 4.9. Number of substantiated complaints statewide, 2019–2024



Source: CMS' archived data snapshot from January 2019 through October 2024 for nursing homes, including rehabilitation services, available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py.

The average number of substantiated complaints across FS/SNF-B peer groups ranged from 7 to 23, with the highest average in Los Angeles Region 2 (23) and Greater Sacramento (13). FS/SA facilities also had an average of 23 substantiated complaints, similar to that of Los Angeles Region 2. Los Angeles Region 2 and FS/SA facilities also had the greatest variance across their respective facilities (**Exhibit 4.10**).

Exhibit 4.10. Count of substantiated complaints per facility among SNFs by peer group, quarter 4, 2024



Source: CMS' archived data snapshot from October 2024 for nursing homes, including rehabilitation services, available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py.
Note: The facility sample is based on a snapshot of active facilities as of October 2024 based on CMS' data for nursing homes, including rehabilitation services. Medicare-only facilities are not included. FS/SA facilities include FS/SA-only facilities and FS/SA + FS/SNF-Bs. The calculations reported in this exhibit exclude facilities with missing data. All averages reported by peer group are unweighted averages.
DP/SNF = distinct part skilled nursing facility; FS/SA = adult freestanding subacute facility; LA = Los Angeles.

Characteristics of high-performing facilities by peer group

We compared high-performing facilities in the sample to all facilities overall and within peer groups to account for some of the regional and peer group payment differences that could be a factor in performance.[261] In **Exhibit 4.11**, we show the results of this comparison for facility bed count, per diem rates, Medi-Cal Disproportionate Share, and performance for the three Five-Star Quality Rating System domains (health inspection rating, staffing rating, and quality measure rating).

The Bay Area, Central Coast, and Orange-San Diego had the highest proportion of four- and five-star facilities. Los Angeles regions 2 and 3 accounted for the lowest proportion of high-performing facilities. Across most peer groups, high-performing facilities had lower bed counts except for North State-Sierras and Central Coast. The North State Sierras high-performing facilities had a 7 percent higher average bed count compared with all facilities, and the Central Coast bed count rates for high-performing facilities were similar to all facilities. Across peer groups, higher-performing facilities' per diem rates[262] were overall 3 percent higher compared with all facilities.

Within the Five-Star Quality Rating System domains, higher-performing facilities scored better in the health inspection domain. Overall, facilities had an average score of 2.7 in the health inspection domain, but high-performing facilities had an average score of 3.9. Generally, facilities performed highest in the quality measure domain, with an average rating of 4.2 across all facilities in the sample.

[261] FS/SAs and DP/SNFs are excluded from regional peer groups and grouped into their own peer group. We used the publicly available 2024 California FS/SNF, FS/SA, and DP/SNF rate data updated in 2026 to identify FS/SA facilities as those found in the FS/SA rate data and DP/SNFs as those found in the distinct part rate data.

[262] The FS/SNF-B regular services rates are presented for county-based peer groups, DP/SNF regular services rates are presented for the DP/SNF group, and nonventilator-dependent rates are presented for the FS/SA group for each facility for 2024. Rates include WSP adjustments when applicable.

Exhibit 4.11. Characteristics of California SNFs by overall star rating and peer group, quarter 4, 2024

	Overall	Bay Area	Central Coast	DP/SNF	FS/SA[a]	Greater Sacramento	LA Region 1	LA Region 2	LA Region 3	North State-Sierras	Orange-San Diego	San Joaquin Valley	Southern Inland	Stockton-Modesto
Facility count														
All facilities[b]	1059	181	45	61	83	54	94	99	95	40	110	71	87	39
Four and five-star facilities[c]	429	102	27	31	26	18	29	19	22	15	62	20	40	18
Average bed count[d]														
All facilities	102.69	93.59	98.56	93.33	131.22	106.24	94.01	106.74	103.58	100.10	114.97	93.80	95.56	107.21
Four- and five-star facilities	89.73	83.58	96.96	80.97	110.12	97.72	83.31	88.16	75.27	107.33	96.60	84.05	84.28	101.22
Average per diem rate[e]														
All facilities	358.08	350.84	331.71	651.04	585.61	344.75	312.89	310.64	305.45	332.08	311.10	271.55	295.21	312.62
Four-and five-star facilities	368.89	361.64	326.38	674.74	578.34	352.91	326.47	308.33	313.06	338.16	315.78	277.65	300.57	322.67

	Overall	Bay Area	Central Coast	DP/SNF	FS/SA[a]	Greater Sacramento	LA Region 1	LA Region 2	LA Region 3	North State-Sierras	Orange-San Diego	San Joaquin Valley	Southern Inland	Stockton-Modesto
Average Medi-Cal Disproportionate Share[f]														
All facilities	0.62	0.59	0.60	No data[f]	0.73	0.52	0.67	0.70	0.70	0.66	0.53	0.58	0.59	0.62
Four-and five-star facilities	0.58	0.56	0.56	No data[e]	0.70	0.45	0.63	0.66	0.70	0.68	0.49	0.60	0.55	0.64
Average health inspection rating														
All facilities	2.71	3.18	3.53	3.32	2.31	2.65	2.33	1.95	2.11	2.45	3.20	2.45	2.82	2.90
Four- and five-star facilities	3.91	4.04	4.33	4.06	3.88	3.83	3.38	3.47	3.73	4.00	4.05	3.85	3.75	3.89
Average staffing rating														
All facilities	2.81	3.17	2.91	3.48	2.35	2.80	3.00	2.74	2.73	2.50	2.85	2.49	2.35	2.79
Four- and five-star facilities	3.30	3.53	3.26	4.23	2.80	3.00	3.41	3.42	3.27	2.93	3.15	2.95	2.80	3.39

	Overall	Bay Area	Central Coast	DP/SNF	FS/SA[a]	Greater Sacramento	LA Region 1	LA Region 2	LA Region 3	North State-Sierras	Orange-San Diego	San Joaquin Valley	Southern Inland	Stockton-Modesto
Average QM rating														
All facilities	4.19	4.18	4.44	3.71	4.11	4.02	4.31	4.31	4.23	4.05	4.53	3.93	4.21	3.90
Four- and five-star facilities	4.61	4.46	4.74	4.26	4.42	4.67	4.86	4.89	4.82	4.47	4.92	4.25	4.75	4.22

Source: CMS' archived data snapshot from October 2024 for nursing homes, including rehabilitation services, available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py; California Health and Human Services Open Data Portal Workforce & Quality Incentive Program Performance PY2 2024 WQIP Quarterly Performance Report #1, available at: https://data.chhs.ca.gov/dataset/workforce-quality-incentive-program-performance; publicly available 2024 California FS/SNF, FS/SA, and DP/SNF rate data updated in 2026, available at: https://www.dhcs.ca.gov/services/medi-cal-resources/freestanding-skilled-nursing-facilities-and-subacute-units/ and https://www.dhcs.ca.gov/services/medi-cal-resources/distinct-part-nursing-facilities-level-b-dp-nf-b/.

Note: The facility sample is based on a snapshot of active facilities as of October 2024 based on CMS' data for nursing homes, including rehabilitation services. Facilities in the CMS data, but not other California sources, are still included but have missing information for certain measures. Medicare-only facilities are not included. These calculations excluded facilities with missing data for any of the relevant characteristic reported in this exhibit.

The overall nursing home rating is a composite of the health inspection rating, staffing rating, and quality measure rating. The ratings take the form of "star" ratings for each nursing home, ranging from one to five stars, with five stars representing "much above average" and one star representing "much below average."

[a] FS/SA facilities include FS/SA-only facilities and FS/SA + FS/SNF-Bs.

[b] The rows labeled as "All facilities" include all facilities in the sample with any overall star rating (one through five).

[c] The rows labeled "Four- to five-star facilities" include facilities in the sample with either a four or five overall star rating.

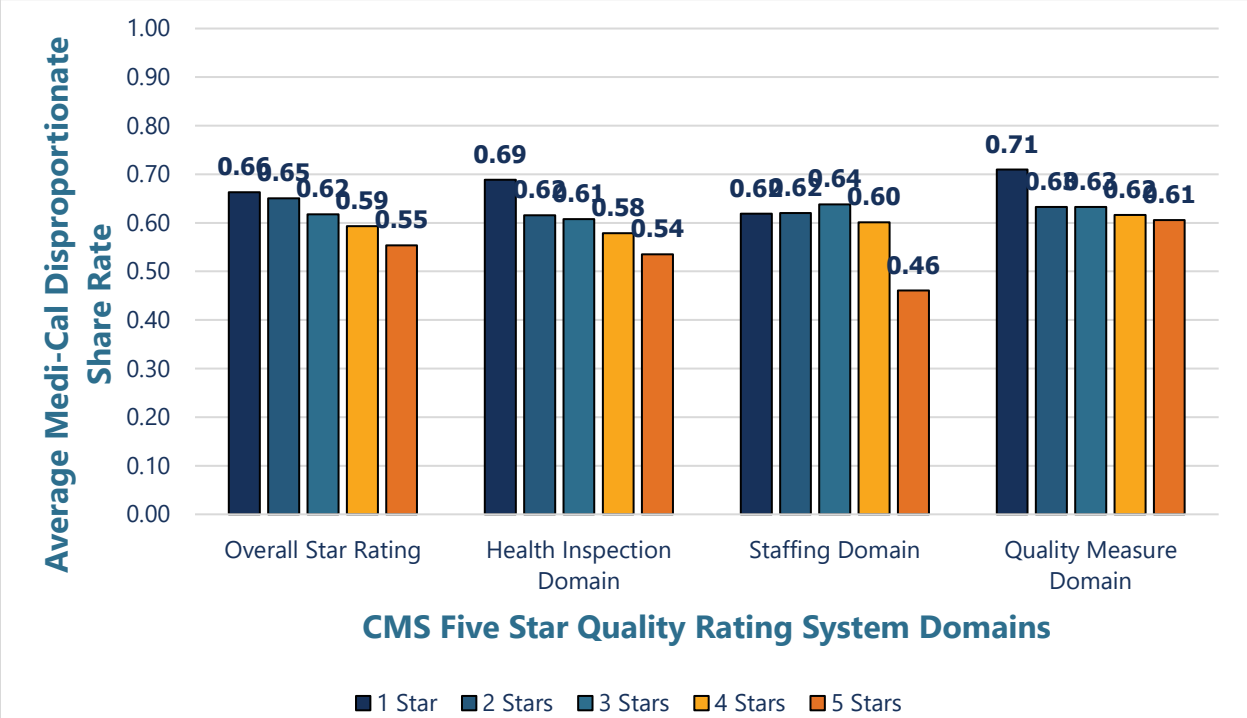
[d] All averages reported by peer group are unweighted averages.

[e] The FS/SNF-B regular services rates are presented for county-based peer groups, DP/SNF regular services rates are presented for the DP/SNF group, and nonventilator-dependent rates are presented for the FS/SA group for each facility for 2024. Rates include WSP adjustments when applicable.
[f] Medi-Cal disproportionate share is extracted from WQIP data and unavailable for distinct part facilities.
DP/SNF = distinct part skilled nursing facility FS/SA = adult freestanding subacute facility; FS/SNF-B = nursing facility level B;
QM = quality measure; WQIP = Skilled Nursing Facility Workforce and Quality Incentive Program.

Medi-Cal Disproportionate Share Rate by performance

The average Medi-Cal Disproportionate Share Rate was about 4 percentage points lower in high performing facilities compared to all facilities (58.0 percent for high performing facilities compared to 62.4 percent for all facilities) (**Exhibit 4.11**). In North State-Sierras, San Joaquin Valley, and Stockton-Modesto peer groups, high performing SNF facilities have slightly higher average Medi-Cal Disproportionate Share Rates (**Exhibit 4.11**). Among FS/SNF-Bs, as star ratings increased from 1 to 5 within the three domains and overall, the average Medi-Cal Disproportionate Share Rate decreased (**Exhibit 4.12**). The poorest performing FS/SNF-Bs, with one-star ratings overall and in each of the 3 domains, had an average Medi-Cal Disproportionate Share Rate that was 10 to 16 percentage points higher compared to FS/SNF-Bs that had 5five-star ratings. FS/SAs did not follow the same linear pattern except for the quality measure domain, where one-star facilities had an average Medi-Cal Disproportionate Share Rate that was 8 percentage points higher than the average for five-star facilities (**Exhibit 4.13**). FS/SA facilities with a one-star overall rating had a Medi-Cal Disproportionate Share Rate that was on average 11 percentage points higher than FS/SA facilities with a five-star overall rating. Medi-Cal Disproportionate Share Rate data were unavailable for distinct part nursing facilities.

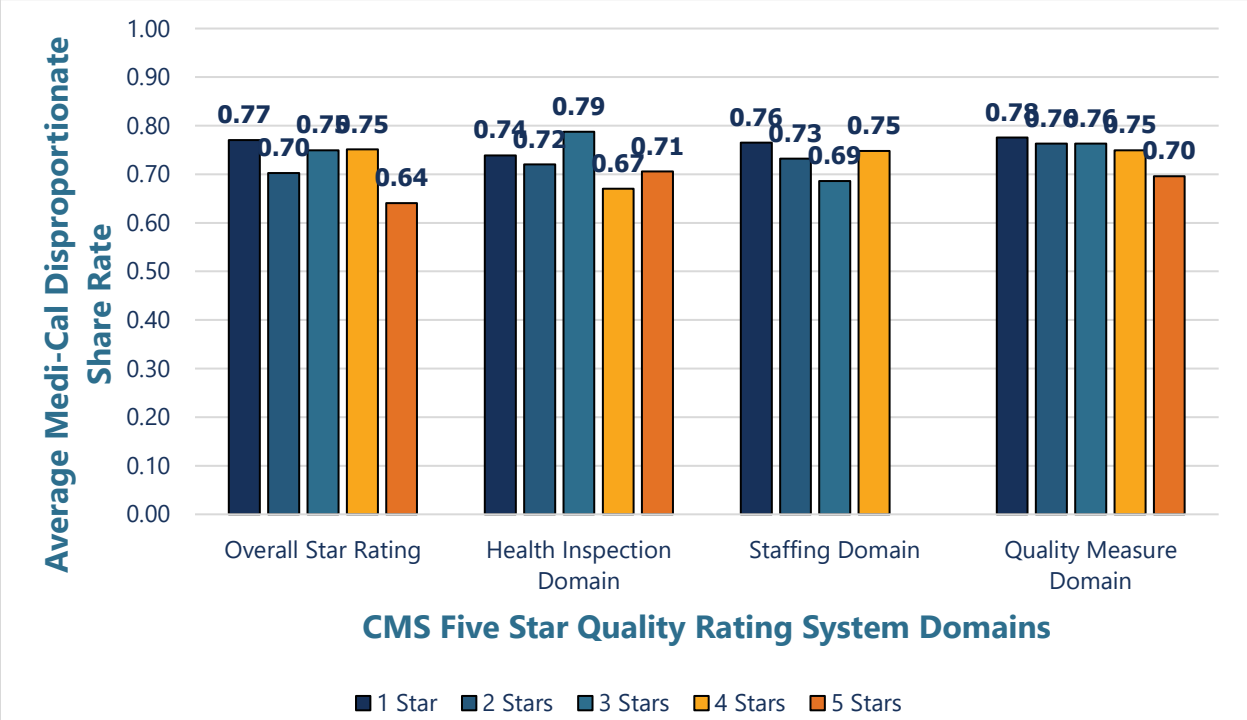
Exhibit 4.12. Average Medi-Cal Disproportionate Share Rate, FS/SNF-Bs, quarter 4, 2024



Source: CMS' archived data snapshot from October 2024 for nursing homes including rehabilitation services, available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py; California Health and Human Services Open Data Portal Workforce & Quality Incentive Program Performance PY2 2024 WQIP Quarterly Performance Report #1, available at: https://data.chhs.ca.gov/dataset/workforce-quality-incentive-program-performance; publicly available 2024 California FS/SNF-B rate data updated in 2026, available at: https://www.dhcs.ca.gov/services/medi-cal-resources/freestanding-skilled-nursing-facilities-and-subacute-units/.

Note: The facility sample is based on a snapshot of active facilities as of October 2024 based on the CMS data for nursing homes, including rehabilitation services. Facilities that were present in the CMS data, but not other California sources, are still included but have missing information for certain measures. The sample does not include Medicare-only facilities. The calculations excluded facilities with missing data for any of the relevant characteristics reported in this exhibit. The overall nursing home rating is a composite of the health inspection rating, staffing rating, and quality measure rating. The ratings take the form of "star" ratings for each nursing home, ranging from one to five stars, with five stars representing "much above average" and one star representing "much below average."

Exhibit 4.13. Average Medi-Cal Disproportionate Share Rate, FS/SA facilities, quarter 4, 2024



Source: CMS' archived data snapshot from October 2024 for nursing homes, including rehabilitation services, available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py; California Health and Human Services Open Data Portal Workforce & Quality Incentive Program Performance PY2 2024 WQIP Quarterly Performance Report #1, available at: https://data.chhs.ca.gov/dataset/workforce-quality-incentive-program-performance; publicly available 2024 California FS/SA facility rate data updated in 2026, available at: https://www.dhcs.ca.gov/services/medi-cal-resources/distinct-part-nursing-facilities-level-b-dp-nf-b/.

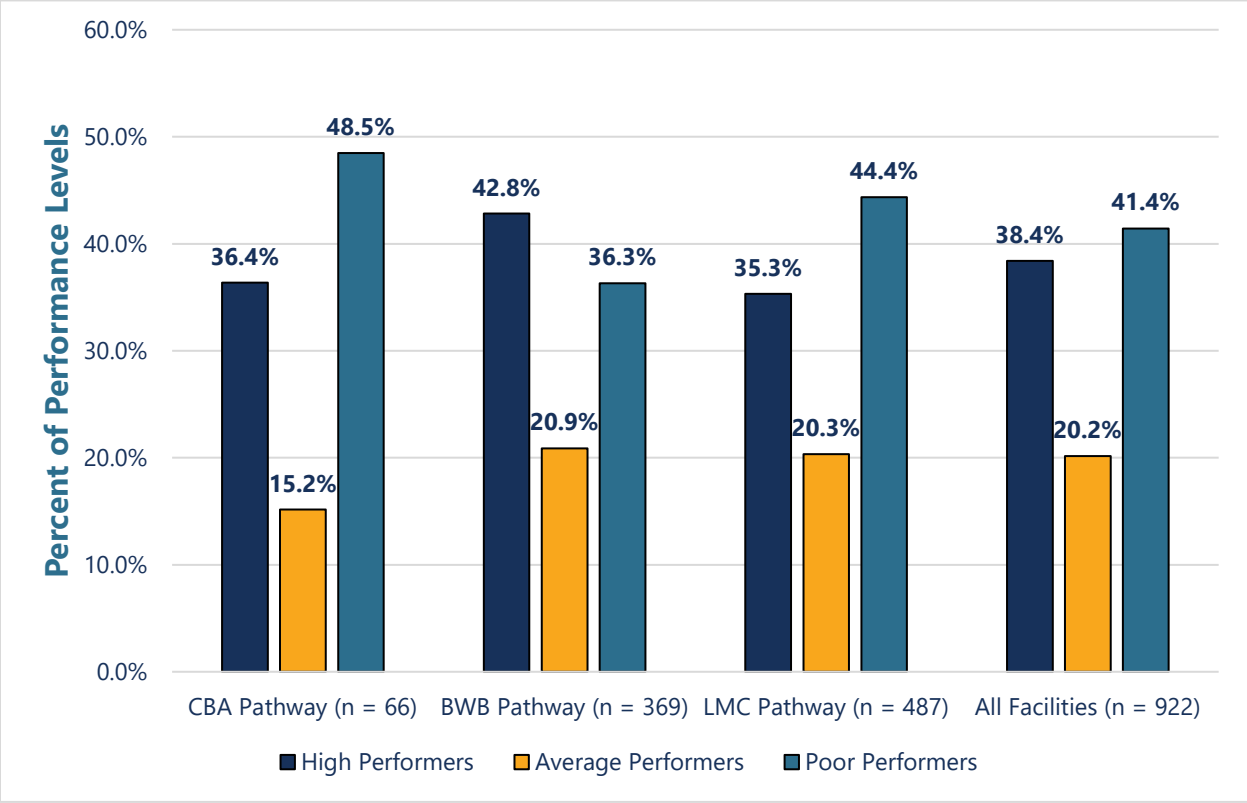
Note: The facility sample is based on a snapshot of active facilities as of October 2024 based on the CMS data for nursing homes, including rehabilitation services. Facilities that were present in the CMS data, but not other California sources, are still included but have missing information for certain measures. The sample does not include Medicare-only facilities. The calculations excluded facilities with missing data for any of the relevant characteristics reported in this exhibit. The overall nursing home rating is a composite of the health inspection rating, staffing rating, and quality measure rating. The ratings take the form of "star" ratings for each nursing home, ranging from one to five stars, with five stars representing "much above average" and one star representing "much below average."

While most of the facilities in the sample are for-profit facilities, high-performing facilities had a higher proportion of not-for-profit facilities compared to average and poor performing facilities. Among high performing facilities, 14.7 percent of facilities were not for profit, compared to 5.9 percent of poor performing facilities.

WSP pathways and performance

Among facilities that participated in WSP, the LMC pathway was the most common across high, average and low performing facilities. The proportion of high performing facilities was similar within each pathway, with a slightly higher rate of high performing facilities within the BWB pathway; 42.8 percent of facilities participating in the BWB pathway had an overall star rating of four or five compared to 38.4 percent of all facilities participating in the WSP (**Exhibit 4.14**).

Exhibit 4.14. Performance category by WSP pathway, quarter 4, 2024



Source: CMS' archived data snapshot from October 2024 for nursing homes, including rehabilitation services, available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py; California Workforce Standards Program indicator data.
Note: The facility sample is based on a snapshot of active facilities as of October 2024 based on the CMS data for nursing homes, including rehabilitation services, that participated in the WSP in 2024 and had WSP pathway data. The sample does not include Medicare-only facilities. Six

facilities with missing data for the CMS Five-Star Quality Rating System were excluded from this graph. Performance category is defined based on the overall star rating for the facility. Facilities with a four- or five-star rating are defined as "High performers," facilities with a three-star rating are defined as "Average performers," and facilities with a 1one- or two-star rating are defined as "Poor performers."
BWB = basic wage and benefit; CBA = collective bargaining agreement; LMC = labor management committee; WSP = Workforce Standards Program.

State approaches

A review of Medicaid nursing facility quality programs across states reveals several consistent design patterns that reflect both policy priorities and operational realities within the long-term care sector. Staffing capacity and workforce stability emerge as foundational elements of many quality incentive frameworks, with states frequently incorporating measures related to staffing levels, staff mix, and turnover or retention in performance methodologies.

In parallel, most programs are structured around the use of standardized and widely available data sources, including MDS assessments, survey deficiency data, and claims-based utilization measures. Reliance on these data sources enables states to evaluate facility performance in a consistent and scalable manner while aligning Medicaid quality initiatives with existing federal reporting systems.

Additionally, financial incentives serve as the primary mechanism through which these programs seek to influence provider behavior. By tying supplemental payments to measurable performance outcomes, states create a direct link between quality and payment, encouraging facilities to prioritize investments in staffing, care coordination, and operational improvements. These incentive structures are often designed to reward both achievement and improvement, recognizing variation in baseline performance while still promoting systemwide advancement in quality. Collectively, these elements reflect a broader shift toward integrating quality performance into the financial architecture of Medicaid nursing facility payment.[263]

[263] Determined from review of publicly available State-plan or Regulatory documentation nation-wide as of January 1, 2026.

Case study: Tennessee

Tennessee operates the QuILTSS program, a performance-based initiative developed by the Tennessee Division of TennCare to enhance the quality of care and services provided in long-term care facilities and other support settings.[264]

The QuILTSS program is designed to drive quality improvement in Tennessee's LTSS system by aligning financial incentives with measurable improvements in care quality. By incorporating principles of value-based care, the program motivates providers to deliver high-quality, person-centered services that enhance the lives of individuals who rely on LTSS. The program focuses on achieving four central goals, including improving the quality of care for TennCare beneficiaries in LTSS settings, supporting and retaining a high-performing LTSS workforce, encouraging innovation and evidence-based practices in long-term care delivery, and promoting the transition to VBP models.

Under the QuILTSS program, LTSS providers, including nursing facilities and HCBS providers, can participate in quality improvement initiatives. Providers are evaluated based on a range of metrics and benchmarks tied to resident outcomes, workforce stability, and other quality indicators. Key aspects of the program include:

- Quality measures: Facilities are assessed on metrics such as resident satisfaction, staff retention, reduction of adverse outcomes (e.g., falls or hospitalizations), and compliance with person-centered care practices.
- Incentive payments: Providers earn financial rewards for meeting or exceeding performance targets. These incentives are built into TennCare's Medicaid payment system.
- Workforce focus: Recognizing the role of professionals delivering direct support, the program includes specific measures and incentives aimed at improving recruitment, retention, and training of LTSS staff collected via PBJ.

A distinguishing feature of the QuILTSS program is that quality performance is not limited to a stand-alone incentive payment. In addition to offering performance-based adjustments, Tennessee integrates quality directly into core payment components. Elements of the Direct Care and Capital (FRV) rate component are adjusted based on a facility's composite quality score. This structure allows higher-performing facilities to receive enhanced payments through multiple components of the rate, rather than through a single supplemental payment.

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[264] Tennessee Division of TennCare. (n.d.). *Long-term services and supports (LTSS)*. https://www.tn.gov/tenncare/health-care-innovation/long-term-services-and-supports.html.

Case study: Kansas

Kansas operates the PEAK 2.0 program (Promoting Excellent Alternatives in Kansas), an initiative developed by the Kansas Department for Aging and Disability Services in partnership with Kansas State University.[265] The program is designed to improve the quality of life for residents in long-term care facilities by promoting person-centered care and fostering a culture of continuous improvement in nursing homes across the state.

Launched in 2012, PEAK 2.0 builds upon the foundation of the original PEAK program, which began in 2002. The program's primary goal is to enhance the experiences of nursing home residents by shifting the focus from traditional institutional care models to a more resident-centered approach. PEAK 2.0 encourages facilities to adopt practices that prioritize the preferences, dignity, and individuality of their residents while ensuring high-quality care and support. PEAK 2.0 is aligned with the Kansas Medicaid payment system, incentivizing nursing homes to participate in the program by offering financial rewards for demonstrating improvements in person-centered practices, including:

- Resident choice: Allowing residents to have a voice in decisions related to their daily routines, activities, and care plans.
- Staff empowerment: Encouraging staff to take ownership of care practices, foster relationships with residents, and make decisions that enhance the residents' quality of life.
- Homelike environment: Creating living spaces that feel less like institutions and more like home, with a focus on comfort, personalization, and community.
- Community engagement: Building connections between residents and the broader community to reduce isolation and increase social interaction.

Facilities are evaluated annually by the Center on Aging at Kansas State University under contract with the State to assess their progress in adopting these person-centered practices. A study of 349 participating facilities showed seven of thirteen clinical measures having meaningful improvement, including a 49 percent lower prevalence of major depressive symptoms.[266] PEAK 2.0 uses a dual focus on achievement-based and

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[265] Kansas Department for Aging and Disability Services. (n.d.). *PEAK 2.0: Person-centered care program*. https://www.kdads.ks.gov/partners-providers/nursing-facilities-adult-care-home-program/peak-person-centered-care.

[266] Hermer, L., Cornelison, L., Kaup, M., Poey, J., Drake, P., Stone, R., Doll, G. (2018). Person-Centered Care as Facilitated by Kansas' PEAK 2.0 Medicaid Pay-for-Performance Program and Nursing Home Resident Clinical Outcomes. https://pmc.ncbi.nlm.nih.gov/articles/PMC6304069/

improvement-based scoring. Facilities earn financial incentives through Kansas Medicaid based on their success in meeting goals. The program follows a structured framework to help facilities implement and sustain person-centered care practices. The program consists of five progressive levels, ranging from foundational improvements to mastery of person-centered care. Facilities move through the levels by meeting specific benchmarks and demonstrating ongoing progress in their practices.

- Entry level: Facilities begin with a baseline assessment and develop an initial action plan for person-centered care.
- Level 1 to level 4: Facilities work on implementing changes, documenting outcomes, and integrating resident-centered practices into all aspects of care.
- Mastery level (level 5): Facilities at this level have fully embraced person-centered care as a core component of their culture and operations.

Case study: Colorado

The Colorado Nursing Home Pay-for-Performance (P4P) program is designed to enhance the quality of care in nursing homes by linking financial incentives to measurable improvements in resident outcomes, satisfaction, and facility culture.[267] The program encourages facilities to go beyond basic regulatory compliance to prioritize resident-centered care and continuous quality improvement.

The Colorado P4P program evaluates nursing homes based on a broad set of performance metrics, encompassing clinical outcomes, resident and family satisfaction, workforce metrics, and emotional and social well-being of residents. Here nursing facilities are encouraged to create environments that feel less institutional and more like home, with efforts to improve daily experiences and build meaningful connections for residents. The P4P program includes resident and family satisfaction surveys[268] to gather direct feedback from those who receive care and their family members. Questions often touch on areas such as quality of life, safety, dignity, and communication with staff, providing a holistic view of how residents experience care. Colorado does not mandate the resident and family satisfaction survey instrument instead leaving that up to the

[267] Colorado Department of Health Care Policy and Financing. (n.d.). *Nursing facilities: Pay-for-performance (P4P)*. https://hcpf.colorado.gov/nursing-facilities-topics#P4P.

[268] Facilities may choose which survey to utilize, but must administer it using an independent third party. For more information, see Colorado Department of Health Care Policy and Financing. (n.d.). *Nursing facilities: Pay-for-performance (P4P)*. https://hcpf.colorado.gov/nursing-facilities-topics#P4P.

choice of each individual nursing facility. Regardless of instrument selected by each facility, they are required to be conducted by an independent third party.

Colorado's quality program framework also places significant emphasis on workforce development. The program evaluates measures of the strength and stability of a facility's workforce. Metrics such as person-directed care programing and training, daily schedules and care planning, consistent assignments, and staff engagement serve as proxies for organizational investments in recruitment, training, and professional development. Metrics like staff turnover rates and employee satisfaction are considered as well.

The Colorado Department of Health Care Policy and Financing manages the program and provides guidelines on how facilities can align their operations with the program's goals. Financial rewards in the P4P program are structured to recognize both high performance and incremental progress. Facilities that excel across key metrics or demonstrate significant year-over-year improvements are eligible for additional Medicaid funds.



CHAPTER V:
WHOLE PERSON CARE

CHAPTER V: WHOLE PERSON CARE

Whole person care addresses all services a person needs for positive health outcomes. Individuals with LTC needs require coordinated physical health, behavioral health, and social services to receive services in the least-restrictive setting of their choice.

Effective transitions between care settings enable the provision of whole person care and positive outcomes for this population. People who wish to transition from SNFs to community-based settings depend on the availability of HCBS programs and providers. Individuals with higher acuity levels—who cannot be safely served in community settings—require access to local SNFs to transition from higher levels of care, like hospitals. In both cases, the ability for people to transition to the least-restrictive care setting protects access to higher levels of care for those who need it. This section presents findings on the history and current state of whole person care in California, how current state policies shape incentives around care transitions and SNF access, and how the Medi-Cal SNF payment framework can support whole person care.

California policy context

Whole person care is the person-centered coordination of health, behavioral health, and social services to improve health outcomes. Whole person care plays an important role in the ongoing rebalancing of LTSS delivery taking place in California from institutional to home and community-based settings. In this section, we discuss the ongoing efforts and various programs in California designed to ensure long-term care is provided in the most integrated and least restrictive setting for a person's needs. We also discuss the care transition processes and care management programs under CalAIM that drive this change in care delivery.

Rebalancing institutional and home and community-based services

In 1999, a U.S. Supreme Court Case in *Olmstead v. LC* established that the Americans with Disabilities Act requires state Medicaid programs to provide services in the most integrated setting appropriate to a person's needs and avoid unnecessary institutional care.[269] The Olmstead decision set in motion a concerted effort for states to "rebalance" their Medicaid spending for individuals with disabilities away from institutions—

[269] Civil Rights: Community Living and Olmstead webpage, available at: https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html.

including SNFs—and toward more integrated community-based settings. States have implemented this rebalancing by expanding capacity for HCBS, diverting members from institutional settings, and supporting transitions from institutions to HCBS. Rebalancing supports Medi-Cal members' access to community-based options while preserving access to SNFs for those who need higher-level supports.

Exhibit 5.1. History of rebalancing in the U.S. and California

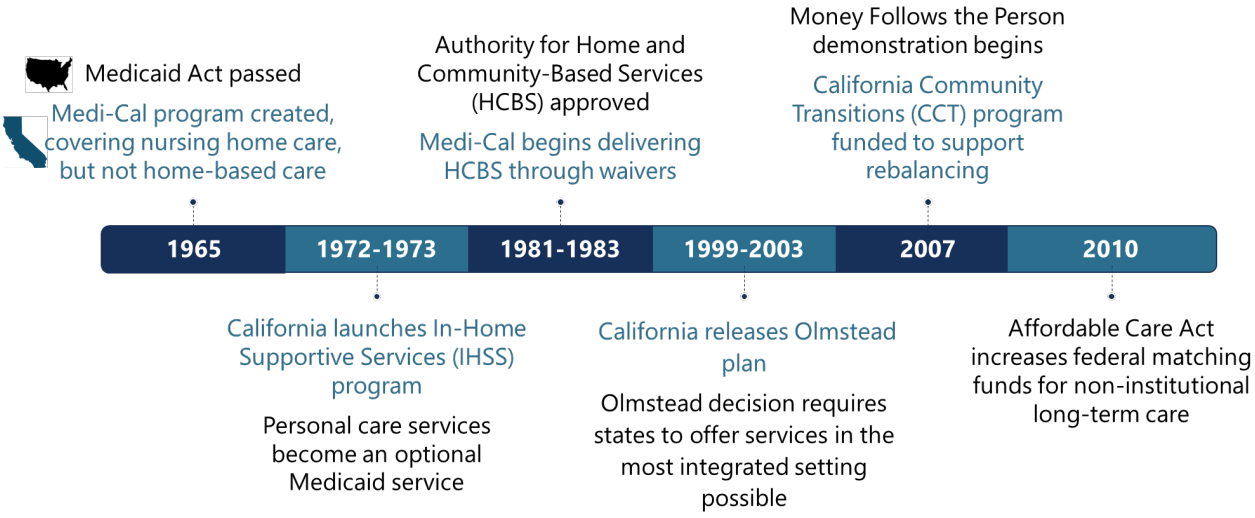


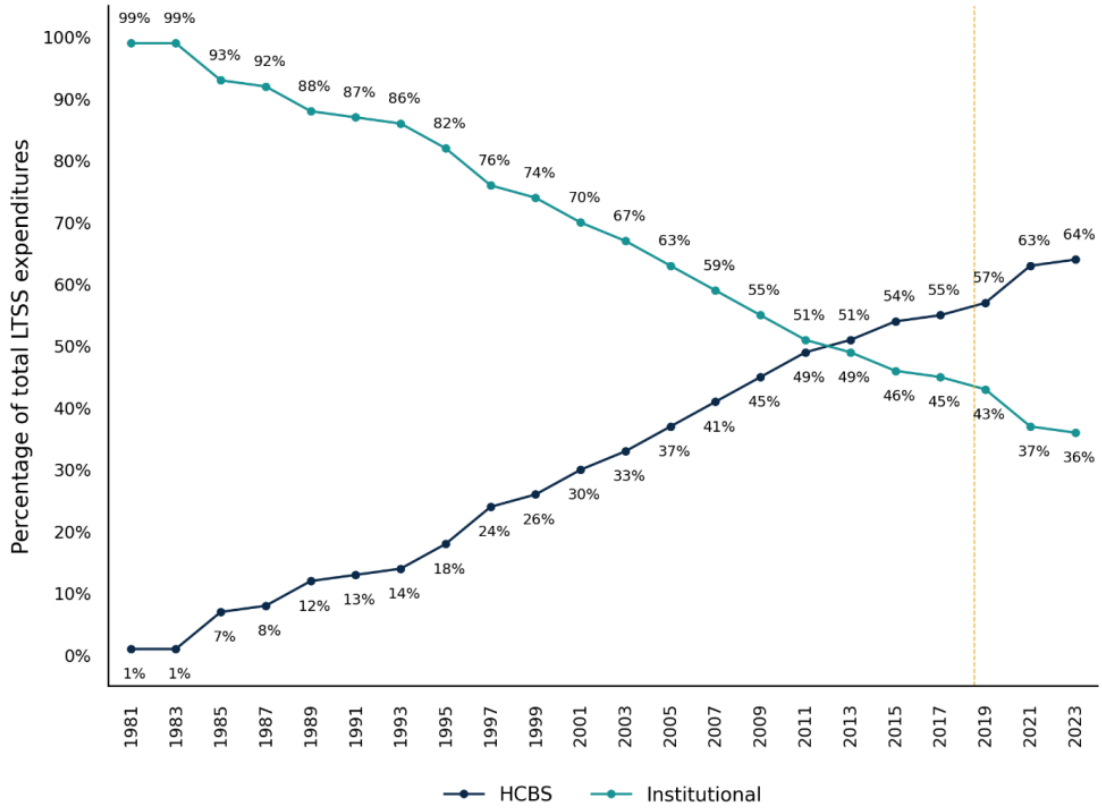
Exhibit 5.1 shows how California and national Medicaid policies have evolved to support rebalancing over time. Federal law requires states to cover institutional services in hospitals and SNFs as a mandatory Medicaid benefit. HCBS remains an optional benefit, but all states provide these services through one or more mechanisms that CMS has made available. CMS has supported state rebalancing efforts through specific initiatives, including the Money Follows the Person demonstration. This demonstration incentivizes transitions from institutional to community-based settings for long-stay residents by providing financial resources for transition specialists, one-time transition costs, and additional support in the first year of community living.[270]

Nationally, rebalancing has shifted spending significantly from institutional care to community-based care over time. **Exhibit 5.2** shows how national Medicaid expenditures have shifted as rebalancing efforts have expanded. Since the authority for HCBS was approved in 1981, the national percentage of Medicaid LTSS expenditures spent on institutional services has decreased from almost 100 percent to only 36

[270] Medicaid Money Follows the Person webpage, available at: https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person.

percent, while the national percentage of Medicaid LTSS expenditures on HCBS has increased from one percent to 64 percent in 2023.

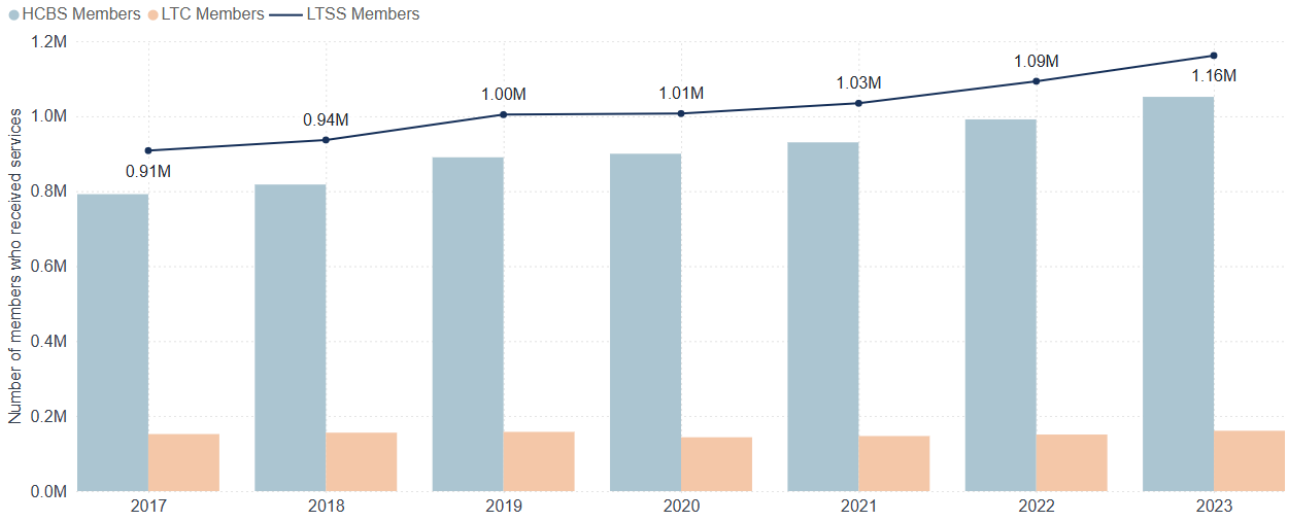
Exhibit 5.2. National Medicaid HCBS and institutional LTSS expenditures as a percentage of total Medicaid LTSS expenditures



Source: CMS 2023 LTSS Rebalancing Brief, available at: www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-brief-2023.pdf.
Note: Dotted yellow line indicates the data source changed between 2018 and 2019 from Medicaid CMS-64 expenditure reports to the TMSIS Analytic File.

California has made significant progress through rebalancing efforts, though the transition has been more nuanced than the national trends. **Exhibit 5.3** shows LTSS utilization in California over seven years (2017-2023), with the number of members using HCBS increasing while Medi-Cal members in long-term care facilities remained relatively flat.

Exhibit 5.3. Comparison of institutional to HCBS users of LTSS, 2017–2023



Source: DHCS Medi-Cal LTSS Dashboard, available at: https://www.dhcs.ca.gov/dataandstats/dashboards/Pages/LTSS-Dashboard.aspx.

However, utilization does not accurately represent total spending, as typically individuals in institutional settings have higher complexity and require more services and spending than those in the community.

California's community-based alternatives to institutional settings

California uses several pathways to provide HCBS as an alternative to institutional care, including Section 1915(c) waiver programs, State Plan benefits, the CalAIM Section 1115 demonstration, and other HCBS programs. These programs differ by community-based setting, eligibility requirements, level of care (LOC) needs, and other factors. **Exhibit 5.4** provides a summary of community-based alternatives available in California. In addition to these options, CalAIM allows MCPs to offer Community Supports to support community transitions and diversions from SNFs and Enhanced Care Management (ECM) to coordinate services for relevant populations.

Exhibit 5.4. California community-based long-term care programs

Section 1915(c) Waiver Programs These waiver programs provide community-based services to individuals who would otherwise qualify for institutional care. These programs may have waitlists due to a limited number of slots available to Medi-Cal members.	**Assisted Living Waiver (ALW):** Provides care for members in assisted living settings as an alternative to a SNF.
	Home and Community Based Alternatives (HCBA) Waiver: Provides care management and services to support members living in a community-based arrangement.
	Multipurpose Senior Services Program (MSSP) Waiver: Provides HCBS to Medi-Cal eligible individuals who are 65 years or older and disabled as an alternative to nursing facility placement.
	Medi-Cal Waiver Program (MCWP): Provides comprehensive case management and direct care services to persons living with HIV/AIDS as an alternative to nursing facility care or hospitalization.
	HCBS Waiver for the Developmentally Disabled (HCBS-DD): Provides services for Medi-Cal members with developmental disabilities who are also Regional Center consumers.
	Self Determination Program Waiver: Allows participants who are Regional Center consumers the opportunity to have more control in developing their service plans and selecting service providers to better meet their needs.
State Plan Benefits These State Plan benefits provide home-based care to individuals who have long-term care needs but whose needs fall below an institutional LOC.	**In-Home Support Services (IHSS):** Provides in-home assistance to eligible older, blind and disabled individuals as an alternative to out-of-home care and enables recipients to remain safely in their own homes.
	State Plan HCBS Benefit for the Developmentally Disabled: This program makes the services available through the 1915(c) HCBS-DD waiver to individuals with qualifying intellectual and developmental disability (I/DD) conditions that do not meet Nursing Facility LOC.
California Community Transitions (CCT)	CCT is a program funded through the Money Follows the Person federal demonstration that offers wraparound transition support to eligible Medi-Cal members who have

	continuously resided in state-licensed health care facilities for 60 days or longer.
Community Based Adult Services (CBAS)	CBAS is a community-based day health program that provides services to older adults and adults with chronic medical, cognitive, or behavioral health conditions and/or disabilities that make them at risk of needing institutional care. CBAS centers have health professionals who assess each participant to identify and plan services needed to meet the individual's specific health and social needs. Individuals can access daily care and activities through community-based centers.
Program for All-Inclusive Care for the Elderly (PACE)	The PACE model uses an interdisciplinary team approach in a PACE Center to provide and coordinate all needed preventive, primary, acute and long-term care services to older adults who would otherwise reside in nursing facilities. To be eligible, a person must be 55 years or older, reside in a PACE service area, be determined eligible at the nursing home LOC, and be able to live safely in their home or community at the time of enrollment.

Source: ECM Population of Focus Spotlight for Long-Term Care Populations, available at: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-POF-Spotlight-LongTermCarePopulation.pdf.

California policies influencing SNF access

While California is making progress on rebalancing LTSS spending toward HCBS, population growth and demographic projections indicate continuing—and potentially increasing—demand for SNF capacity by those with greater support needs.[271] SNF bed availability varies greatly across California's counties; the number of SNF beds available in each county ranges from 2.5 beds per 1,000 residents age 65 and older to 29.3 beds per 1,000 residents age 65 and older.[272] Policies such as network adequacy requirements

[271] California HCBS Gap Analysis Report, available at: https://www.dhcs.ca.gov/services/ltc/Documents/CA-HCBS-Gap-Analysis-Final-Report.pdf.

[272] Calculations performed based on count of certified beds from CMS' archived data snapshot from October 2024 for nursing homes including rehab services https://data.cms.gov/provider-data/archived-data/nursing-homes; population estimates age 65 and older from United States Census Bureau County Population by Characteristics Vintage 2024. https://www.census.gov/data/datasets/time-series/demo/popest/2020s-counties-detail.html.

and use of distinct part nursing facilities can influence equitable access to SNFs across California's diverse geographies.

Distinct part nursing facilities (DP/SNFs)

DP/SNFs are hospital-based SNF units which play a narrow but important role in supporting Medi-Cal SNF access, particularly in rural and underserved areas. In markets with limited FS/SNF capacity, DP/SNFs allow hospitals to retain and care for post-acute and long-stay residents locally, helping to reduce the need for long-distance transfers and mitigating access gaps. As such, DP/SNFs function as a critical access point within the broader LTSS system, especially where provider supply and transition infrastructure are constrained.

DP/SNF distribution is uneven and not limited to rural areas, resulting in variable impact on access across regions. DP/SNFs in rural areas tend to be smaller than nonrural DP/SNFs; in 2025, there were 26 DP/SNF facilities in rural counties with an average bed count of 60 and 35 DP/SNF facilities in nonrural counties with an average bed count of 118.[273]

From a financing and policy perspective, DP/SNFs receive substantially higher Medi-Cal per diem payments than FS/SNF-Bs, which may help sustain operations in low-volume or high-cost settings and preserve access in otherwise fragile markets. In 2025, the average DP/SNF per diem payment by county ranged from $487 to $771, an increase from $407 to $711 in 2024.[274] Overall, DP/SNFs had an average per diem payment of $705 compared to $325 for FS/SNF-Bs in 2025.[275] At the same time, these higher payments introduce variation across facility types and may influence provider participation and system dynamics. Within the current landscape, DP/SNFs represent a targeted mechanism that can help address localized access challenges but are not sufficient on their own to resolve broader, system-level constraints related to workforce, capacity, and care transitions.

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[273] Count of certified beds and facility counties based on CMS' archived data snapshot from October 2025 for nursing homes, including rehab services https://data.cms.gov/provider-data/archived-data/nursing-homes. DP/NF facilities identified based on rate information from rates available at: https://www.dhcs.ca.gov/services/medi-cal/Pages/DPNF_B.aspx.

[274] Calculations based on CY 2024 and 2025 DP/SNF rates, available at: https://www.dhcs.ca.gov/services/medi-cal/Pages/DPNF_B.aspx.

[275] Calculations based on CY 2025 DP/SNF rates on file, available at: https://www.dhcs.ca.gov/services/medi-cal/Pages/DPNF_B.aspx and CY 2025 FS/SNF-B rates on File, available at: https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx. These values reflect enhanced rates inclusive of WSP and QAF.

California network adequacy requirements

Medi-Cal MCPs are required to meet time-based network adequacy standards for SNF access, with requirements varying by county size and population density. In large counties, plans must ensure access to SNF services within five business days of a request, compared to seven business days in medium counties and up to 14 calendar days in rural and small counties.[276] When in-network capacity is insufficient, MCPs are required to arrange access through out-of-network providers to ensure members can obtain needed long-term care services. These standards are intended to maintain timely access across diverse geographic contexts, though longer allowable timeframes in rural areas reflect more limited provider capacity and may still contribute to delays in care.

Care transitions

Care transitions are a central component of the long-term care delivery system and play an important role in supporting whole person care for Medi-Cal members. For individuals with long-term care needs, transitions commonly occur between three main settings: hospitals, SNFs, and home or community-based settings. People move between these settings via admissions, discharges, and transfers, each of which requires coordination between MCPs and providers at different levels of care to ensure continuity of care is maintained and individuals are placed in the most appropriate, least restrictive setting.

Successful care transitions depend on timely exchange of clinical and administrative information, accessibility and availability of alternative care settings, and alignment of stakeholder incentives across the long-term care delivery system. Ineffective care transition processes place strain on the delivery system as well as the individual, leading to delays in care, inappropriate placements, and increased system costs from avoidable utilization.[277]

While there are multiple entities involved in the care transition process, Medi-Cal MCPs are ultimately accountable for ensuring Transitional Care Services (TCS) are rendered to Medi-Cal members across all settings and delivery systems. TCS are the services provided to a member transferring from one institutional care setting or LOC to another institution or lower LOC setting. The activities that make up TCS for a member differ in

[276] CY 2025 DHCS Managed Care Boilerplate Contract, available at: https://www.dhcs.ca.gov/provgovpart/Documents/Managed-Care-Boilerplate-Contract.pdf.
[277] Li, J., Young, R., & Williams, M. V. (2014). Optimizing transitions of care to reduce rehospitalizations. *Cleve Clin J Med, 81*(5), 312-320. https://www.ccjm.org/content/ccjom/81/5/312.full.pdf.

intensity according to the member's risk categorization.[278] For members already enrolled in higher-acuity levels of care management such as ECM or Complex Care Management, community-based care coordinators contracted with the plans are responsible for a range of TCS activities. However, MCPs always remain the accountable entity through a member's transition until that member has been successfully connected to all needed services and supports.[279]

Hospital to SNF transitions

There are several federal requirements providers must abide by when transitioning an individual with long-term care needs from a hospital to a SNF. Hospitals are responsible for leading the discharge planning process, including determining medical necessity for SNF placement, performing medication reconciliation, and transferring all clinical and behavioral health information to the SNF.[280] Hospitals work in coordination with SNFs and MCPs to confirm SNF placements.[281] Hospitals and SNFs must document all steps of this process for compliance, in addition to completing the federally required Preadmission Screening and Resident Review process (PASRR). Finally, admission must be confirmed by the hospital and SNF, and post-transfer follow-up must be completed by the MCP.

SNF to home or community transitions

Transitions of care from SNFs to HCBS are often led by SNF staff with MCP oversight and placement assistance. Federal requirements direct SNFs to establish discharge planning processes to facilitate effective transitions of care.[282] At admission and on a quarterly basis as part of the MDS clinical assessment process, facility staff ask residents about their interest in returning to the community or identify residents as appropriate candidates for home and community-based services.[283] A multidisciplinary care team will identify the residents' discharge needs and goals and develop a viable discharge

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[278] CalAIM Population Health Management Policy Guide, available at: https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf.

[279] For more information on MCPs role in transitions of care, see Graphics 1 and 2 on pages 26-27 of the Technical Assistance Resource on TCS for Medi-Cal Managed Care Plans, available at: https://www.dhcs.ca.gov/CalAIM/Documents/TCS-TA-Resource-for-LTSS-Transitions.pdf.

[280] 42 CFR § 482.43.

[281] 42 CFR § 482.43, 42 CFR § 438.208(b).

[282] 42 CFR § 483.21.

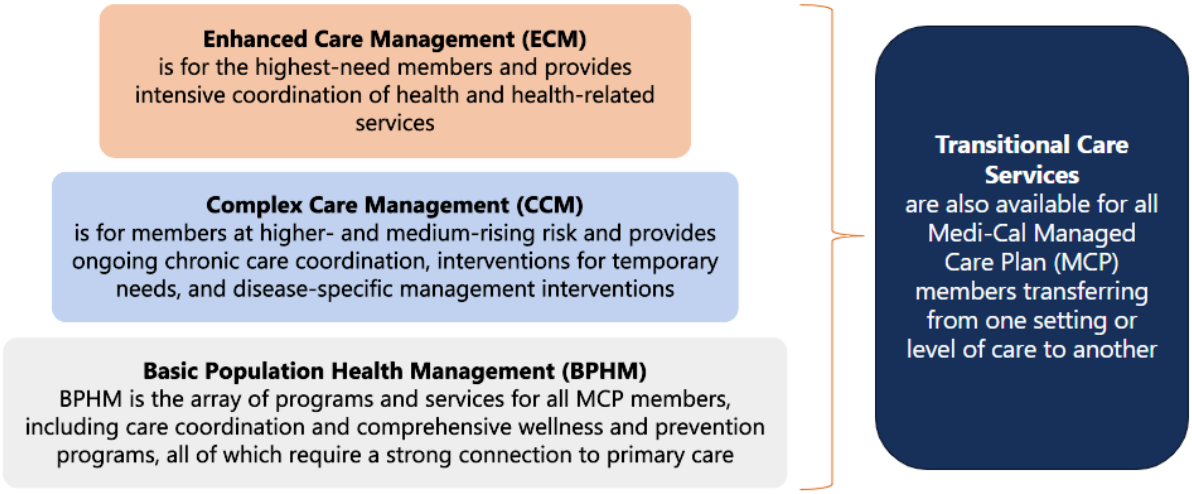
[283] For more information on Section Q, the component of the MDS addressing residents' interest in returning to the community, see: https://www.dhcs.ca.gov/services/long-term-care-alternatives-home-and-community-based-service-options/minimum-data-set-3-0-section-q/.

plan. Staff will make referrals to local agencies or other entities to coordinate the residents' transition of care and ensure that residents have the resources and support needed to avoid hospital or SNF readmission upon their transition.

Care management and Community Supports in CalAIM

Care management is one of the primary mechanisms in the CalAIM initiative for ensuring Medi-Cal members receive whole person care. Current care management practices under the CalAIM Population Health Management (PHM) Program have been developed from lessons learned, as well as MCP and provider experience, in the Whole Person Care Pilots and Health Homes Program. There are several tiers of care management within the CalAIM PHM program, detailed in **Exhibit 5.5** below.

Exhibit 5.5. CalAIM PHM program care management tiers



Source: CalAIM ECM Policy Guide, available at https://www.dhcs.ca.gov/CalAIM/ECM/Documents/CalAIM-ECM-Policy-Guide.pdf.

Basic Population Health Management is an approach to care that ensures needed programs and services are made available to each member, regardless of the member's risk tier or level of need Complex Care Management provides ongoing chronic care as well as temporary episodic coordination for medium and higher-rising risk members to avoid adverse outcomes. ECM is the most intensive LOC management in the CalAIM Care Management Continuum and takes a whole-person, interdisciplinary approach to coordinating all health and health-related services for the highest risk Medi-Cal members. Finally, TCS provides time-limited care management for members transitioning from one setting or level of care to another, and during pregnancy and the

post-partum period.[284] ECM is the most relevant care management program for discussion because it targets complex and high-acuity members which often overlap with the populations served by SNFs.

Enhanced Care Management (ECM)

ECM launched in 2022 and is a mandatory covered service for Medi-Cal MCPs to offer. MCPs contract with community-based providers to deliver ECM, connecting members with a single Lead Care Manager to provide comprehensive care management and coordinate all health and health related care and services. The ECM Core Service Components are: (1) Outreach and Engagement (2) Comprehensive Assessment and Care Management Plan (3) Enhanced Care Coordination (4) Health Promotion (5) Comprehensive Transitional Care (6) Member and Family Supports, and (7) Coordination of and Referral to Community and Social Support Services.[285]

To be eligible for ECM, a member must meet the inclusion criteria for at least one Population of Focus (POF). A POF is a defined group of Medi-Cal members with specific needs or risk profiles. There are ten distinct POFs which are eligible for ECM services, two of which are directly relevant to the long-term care population: (1) Adult Nursing Facility Residents Transitioning to the Community and (2) Adults Living in the Community and At Risk for Long-term Care Institutionalization.[286] The eligibility criteria for each of these POFs is listed in **Exhibit 5.6**. In the first nine months of launching ECM for the Long-term Care POFs, over 10,000 members at risk of or transitioning from institutional long-term care received ECM. Of those members, 92 percent were living in the community and at risk of needing institutional long-term care.[287]

[284] CalAIM Population Health Management Policy Guide, available at: https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf.
[285] CalAIM ECM Policy Guide, available at: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/CalAIM-ECM-Policy-Guide.pdf.
[286] CalAIM ECM Policy Guide, available at: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/CalAIM-ECM-Policy-Guide.pdf.
[287] ECM Population of Focus Spotlight for Long-Term Care Populations, available at: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-POF-Spotlight-LongTermCarePopulation.pdf.

Exhibit 5.6. Long-term care-related POF eligibility criteria

POF	Eligibility Criteria
Adult Nursing Facility Residents Transitioning to the Community	1. Are interested in moving out of the institution AND 2. Are candidates to do so successfully AND 3. Are able to reside continuously in the community
Adults Living in the Community and At Risk for Long-term Care Institutionalization	1. Are living in the community who meet the SNF LOC criteria or who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury AND 2. Are actively experiencing at least one complex social or environmental factor influencing their health AND 3. Are able to reside continuously in the community with wraparound supports

Source: CalAIM ECM Policy Guide, available at: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/CalAIM-ECM-Policy-Guide.pdf.

Members in these POFs can access ECM through community-based organizations and provider referrals, data driven referrals, or self-referrals. DHCS expects MCPs to source most ECM referrals through community-based partners and providers, but MCPs can also leverage data-driven referrals and self-referrals to identify eligible members. Example referral sources for each referral type are listed in **Exhibit 5.7**.

Exhibit 5.7. Common ECM referral sources for long-term care POFs

Referral Type	Example Source
Community-Based Organizations (CBO) and Provider Referrals	**CBOs and agencies:** Adult Protective Services Agencies, Alzheimer's Associations, Area Agencies on Aging, Centers for Independent Living, CBAS Centers, local Ombudsman offices, IHSS Providers, other HCBS Waiver Providers **Health care providers and Institutions:** Primary Care Physicians, federally qualified health centers, hospitals and acute care facilities, SNF case managers, county agencies, Home Health Agencies
Data Driven Referrals	1915(c) HCBS waiver program waitlists, previous SNF LOC determinations, MDS Section Q, Admissions, Discharged and Transfers data feeds
Self-Referrals	Families, caregivers, legal guardians, and adults may self-refer to the MCP

Source: ECM Population of Focus Spotlight for Long-Term Care Populations, available at: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-POF-Spotlight-LongTermCarePopulation.pdf.

Community Supports

Community Supports are services that help improve members' health and well-being by addressing health-related social needs, supporting healthier lives, and reducing the need for higher cost care. Community Supports are optional for MCPs to offer and for members to use, except for Transitional Rent, which is required for MCPs to offer as of January 1, 2026.[288] Available Community Supports vary by MCP and county.[289]

Members in the two ECM long-term care POFs will often need intensive planning and support to either transition to or remain in the community successfully. There are fifteen

[288] DHCS Community Supports Policy Guide, Volume 2: Community Supports to Support Members Experiencing or At Risk of Homelessness, available at: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf.

[289] CalAIM Community Supports - Managed Care Plan Elections (December 2025), available at: https://www.dhcs.ca.gov/Documents/MCQMD/Community-Supports-Elections-by-MCP-and-County.pdf.

Community Supports available under CalAIM, several of which are relevant to the long-term care population.[290] **Exhibit 5.8** lists these relevant Community Supports and what they provide for members.

Exhibit 5.8. Relevant Community Supports for long-term care populations

Community Support	Service Provided	12-month Member Utilization
Community Transition Services/Nursing Facility Transition to a Home	Covers nonrecurring set-up expenses (security deposits, air conditioners, etc.) to help members establish a basic household, along with transitional care coordination.	401
Nursing Facility Transition/Diversion to Assisted Living Facilities	Covers time-limited transition services and expenses (excluding room and board) that enable a person to establish a community facility residence in an assisted living facility/residential care facility for the elderly/adult residential facility, as well as ongoing assisted living expenses.	4,015
Environmental Accessibility Adaptations (Home Modifications)	Home modifications such as ramps and grab-bars, doorway widening for those who use a wheelchair, stair lifts, or making bathroom wheelchair accessible.	1,758
Respite Services	This provides short-term relief for member caregivers. Members may receive caregiver services in their home or in an approved facility on an hourly, daily, or nightly basis as needed.	4,403

[290] DHCS Transformation of Medi-Cal: Community Supports Fact Sheet, available at: https://www.dhcs.ca.gov/CalAIM/Documents/DHCS-Medi-Cal-Community-Supports-Supplemental-Fact-Sheet.pdf.

Community Support	Service Provided	12-month Member Utilization
Medically Supportive Food/Medically Tailored Meals	Members receive deliveries of nutritious, prepared meals and healthy groceries to support their health needs. Members also receive vouchers for healthy food and/or nutrition education.	95,267
Personal Care and Homemaker Services	Members who require assistance with ADLs or Instrumental ADLs receive in-home support, such as bathing or feeding, meal preparation, grocery shopping, and accompaniment to medical appointments.	5,253

Source: ECM Population of Focus Spotlight for Long-Term Care Populations, available at: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-POF-Spotlight-LongTermCarePopulation.pdf. ECM Community Support Data Tables for Quarterly Implementation Report (Quarter 4 2024-Q3 2025), Chart 3.5.2, available at: https://geohub-cadhcs.hub.arcgis.com/datasets/CADHCS::ecm-community-support-data-tables-for-quarterly-implementation-report/.

Efforts to improve whole person care: National scan

States have several levels available to promote whole person care in skilled nursing facilities. In the post-acute care setting, value-based payment strategies can encourage providers and payors to support care in the most appropriate setting, improve transitions across care settings, and reduce incentives for unnecessarily long stays.[291] Chapter IV provides an in-depth discussion of the value-based payment strategies states can use to improve quality. Below, we identify value-based payment strategies states have used to specifically address whole person care, including facilitating discharges and admissions.

Case study: Minnesota

Minnesota adopted the Nursing Facility Quality Improvement Incentive Payment program in 2013 to provide quality incentive payments to certified nursing facilities. The

[291] Value-Based Care Spotlight: Information for Providers webpage, available at: https://www.cms.gov/priorities/innovation-center/value-based-care-spotlight/providers.

program is intended to drive improvements in quality by providing financial rewards to facilities that show improvement on a single quality measure of their choosing. The Minnesota Department of Human Services compares a facility's performance during the improvement period (one year) against its baseline performance to calculate a one-year rate adjustment that is subject to renewal each year.[292]

Facilities have several options when selecting a quality measure. They can select a clinical quality indicator, quality of life domain, or care transitions quality indicator. Specifically, Minnesota tracks:

1. Hospital discharges within the first 30 days and during days 31–365
2. Community discharges within the first 30 days and during days 31–90

The community discharge methodology includes risk adjusters at the facility level to reflect the availability of HCBS to account for situations where community-based alternatives are limited; these adjusters include the rates of HCBS and institutional LTSS users in the population and HCBS and institutional LTSS spending per user.[293]

This program functions as a payment add-on and not as a rebasing mechanism and providers are not penalized for failing to show improvement on their selected quality measure. As of January 2026, facilities can earn a prorated payment up to $3.50 per resident per day.[294]

Case study: Massachusetts

Beginning January 15, 2022, Massachusetts established the Medicaid Transitional Add-On which functions as an add-on payment to nursing facilities who receive Medicaid members from an acute or nonacute inpatient hospital. Nursing facilities are eligible to receive an additional $200 per member per day for the first 60 days of admission. Importantly, the nursing facility admission may not include any leaves of absence, the member may not be returning from a medical leave of absence and Medicaid must be the primary payor at the time of admission.[295]

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[292] Quality Improvement Incentive Payment Program Instruction Manual, available at: https://nfportal.dhs.state.mn.us/Reports/QIIP%20Instructions%20for%201-1-2026.pdf.
[293] Minnesota Risk-Adjusted Transition Quality Indicator Guide, available at: https://nfportal.dhs.state.mn.us/Reports/Transitions%20-%20MN%20Hosp%20%26%20Comm%20Discharge%20QI%20guide.pdf.
[294] Quality Improvement Incentive Payment Program Instruction Manual, available at: https://nfportal.dhs.state.mn.us/Reports/QIIP%20Instructions%20for%201-1-2026.pdf.
[295] Code of Massachusetts Regulations, Title 101, chapter 206.00

Case study: Virginia

Beginning July 2019, Virginia implemented the Managed Care Discrete Incentive Transition Program which provides one-time payments of $7,500 to MCPs for each successful transition of a member from a SNF to a community setting. Successful transitions are defined as "the transition of a nursing facility resident that has received nursing services for at least one continuous year to a community setting for a period of at least nine consecutive months, during which the member does not receive more than thirty combined days of care in an inpatient hospital setting."[296]

To be eligible for the program a managed care member must have:

1. Continuous residence in a nursing facility for a period of at least twelve (12) consecutive months; and,
2. Continuous benefit package of indicator of one (1) or two (2); and
3. Are enrolled in the Managed Care Program in the month prior to their transition.

MCPs are only eligible to receive payment once for an eligible member within a 3-year period. The state Medicaid agency makes the final decisions on what constitutes an eligible member and a successful transition. In addition to providing an incentive for community discharges, Virginia also requires MCPs to develop inclusive and realistic transition plans for members that address a variety of transition-related needs. The transition plan might include assistance with setting up housing, nonmedical transportation, integration with the community, assistance with setting up volunteer opportunities, among others. MCPs are required to assist their members post-discharge for an entire year.[297]

[296] Cardinal Care Managed Care Contract (July 1, 2025 – June 30, 2026), available at: https://www.dmas.virginia.gov/media/jtujhlgt/sfy-2026-ccmc-contract-07-01-2025.pdf.
[297] Cardinal Care Managed Care Contract (July 1, 2025 – June 30, 2026), available at: https://www.dmas.virginia.gov/media/jtujhlgt/sfy-2026-ccmc-contract-07-01-2025.pdf.



CHAPTER VI: BEHAVIORAL HEALTH CAPACITY, INTEGRATION, AND PAYMENT IN SNFs

CHAPTER VI. BEHAVIORAL HEALTH CAPACITY, INTEGRATION, AND PAYMENT IN SNFs

SNFs in California serve individuals with LTSS needs who also have co-occurring behavioral health conditions, including serious mental illness (SMI), substance use disorders (SUD), and cognitive impairments. These individuals access care across a continuum of residential settings, from community-based housing to institutional environments such as SNFs, Special Treatment Programs (STPs), and psychiatric facilities. Placement within this continuum is shaped by clinical need, legal frameworks including conservatorship, and system capacity, with non-STP SNFs serving as one of the most common settings for these individuals.

Despite this role, SNFs are not fully integrated into the broader behavioral health delivery system in California. Capacity for Medi-Cal members to receive specialized behavioral health services within SNFs is limited, with STPs representing a small, geographically concentrated subset of facilities. As a result, most nursing facility residents with behavioral health needs are served in nonspecialized SNFs, where behavioral health staffing, infrastructure, and payments are not consistently aligned with resident complexity. These structural constraints contribute to challenges in access, placement, and care delivery for individuals requiring both SNF-level care and behavioral health services.

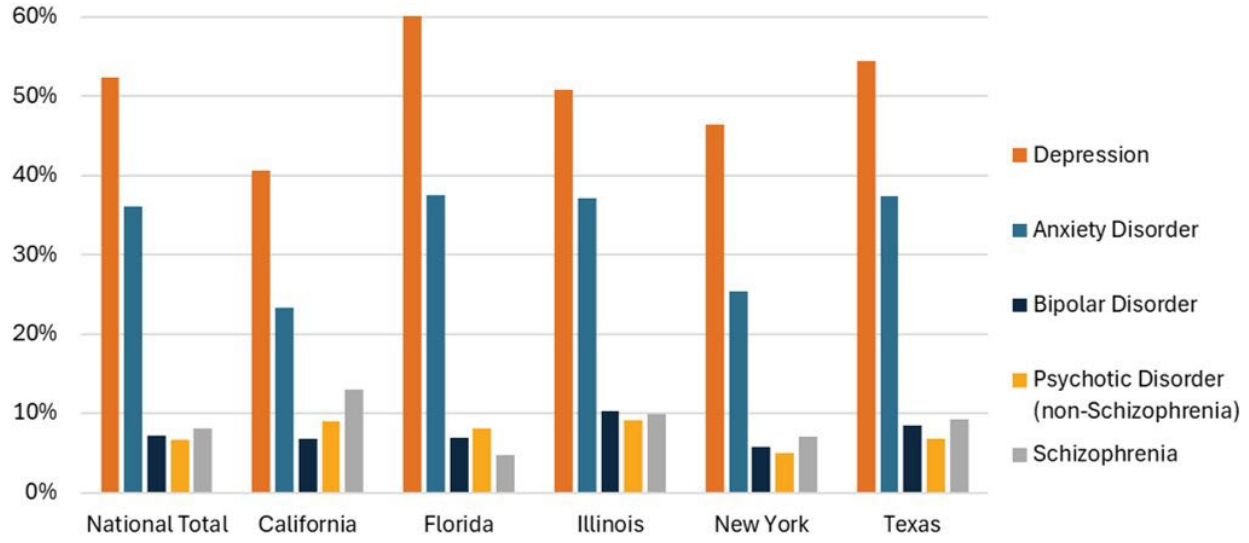
The renewal of the Medi-Cal LTC Reimbursement Act presents an opportunity to use the SNF payment framework to better incentivize the delivery of high-quality LTSS for individuals with behavioral health conditions who require the level of care provided in SNFs. This chapter summarizes key challenges related to providing SNF services to individuals with behavioral health needs and potential approaches for using Medi-Cal SNF payments to address some of these challenges.

Population with LTSS and behavioral health needs

For the purposes of this report, individuals with behavioral health needs are those diagnosed with chronic psychiatric diagnoses that cause long-term impairment. This includes diagnoses such as bipolar disorder, major depressive disorder, and schizophrenia. However, this chapter also discusses the needs of and services for individuals with SUD, cognitive disabilities like Alzheimer's Disease and Related Dementias, traumatic brain injuries, or other disabilities and impairments that can result in needs that are similar to those of individuals with psychiatric diagnoses.

Exhibit 6.1 shows the prevalence of select psychiatric disorders among SNF residents in California, nationally, and in select comparison states, as reported in MDS data in quarter 4 2025. Among comparison states, California reports slightly lower rates of depression (40 percent) and anxiety (23 percent) among SNF residents, but slightly higher rates of schizophrenia (13 percent).

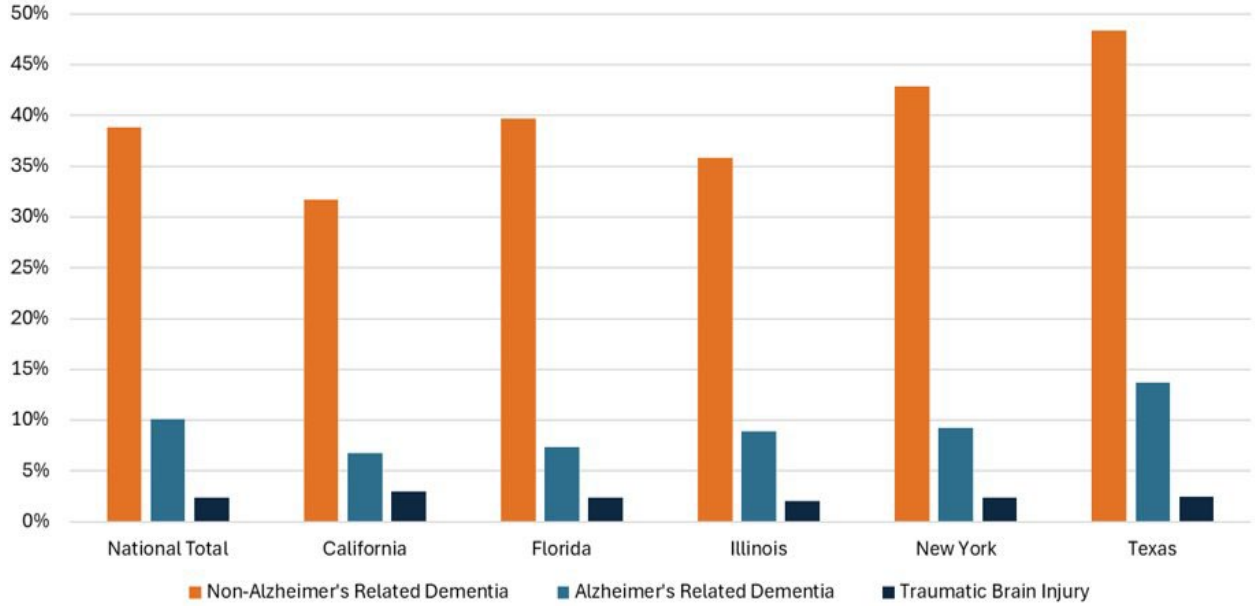
Exhibit 6.1. Prevalence of psychiatric diagnoses in SNFs, quarter 4, 2025



Source: Analysis of the MDS Frequency data published by CMS at https://data.cms.gov/quality-of-care/minimum-data-set-frequency.
Note: Prevalence of each reported diagnosis is not mutually exclusive, and it is possible that representation of some individuals is repeated across several psychiatric diagnostic categories.

Exhibit 6.2 shows the prevalence of dementias and TBI among SNF residents in California and other comparison states in quarter 4, 2025. California reported slightly lower rates of Alzheimer's Related (7 percent) and Non-Alzheimer's Related Dementias (32 percent) among SNF residents, but slightly higher rates of TBI (3 percent) relative to comparison states. As noted earlier, sometimes the needs of individuals with dementias can overlap those with other behavioral health conditions, such as the need for a secure unit. Looking at these conditions together can help show why payment and care delivery discussions often overlap across behavioral health and cognitive support needs.

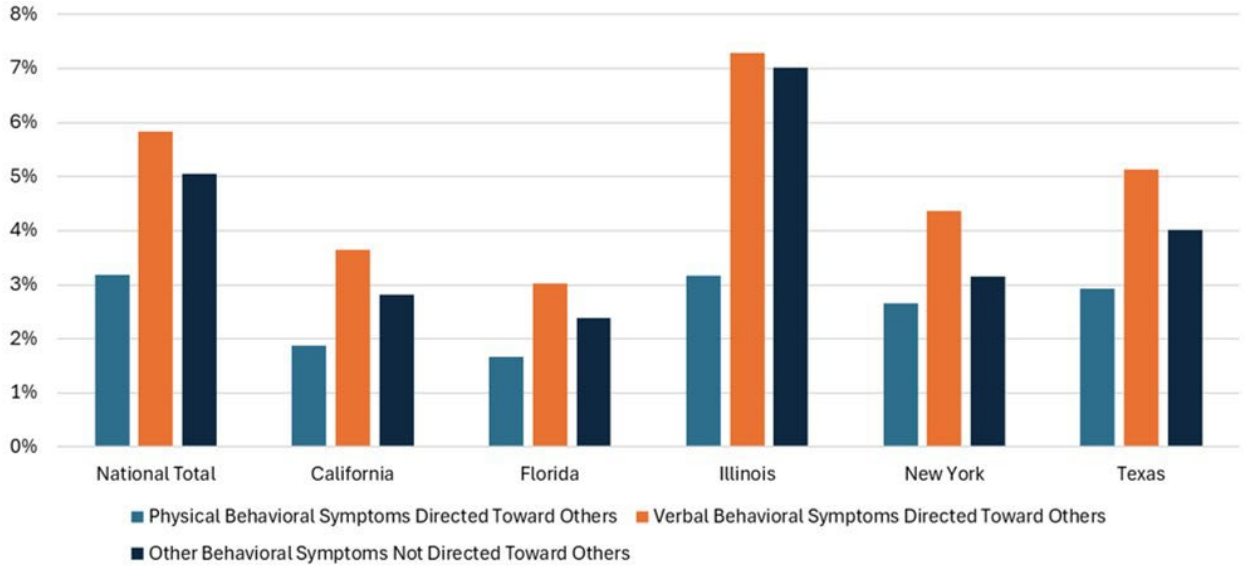
Exhibit 6.2. Prevalence of dementias and traumatic brain injuries among SNF residents, quarter 4, 2025



Source: Analysis of the MDS Frequency data published by CMS at https://data.cms.gov/quality-of-care/minimum-data-set-frequency.
Note: Prevalence of each reported diagnosis is not mutually exclusive, and it is possible that representation of some individuals is repeated across cognitive impairment categories.

Exhibit 6.3 shows the prevalence of facility-reported physical and verbal behavioral symptoms among SNF residents in quarter 4, 2025. This statistic is included to examine the behavioral presentations that facilities need to respond to in practice that might accompany residents with behavioral health conditions. While a small percentage of SNF residents in California have documented verbal and physical behavioral symptoms directed toward others, these actions can still have a significant impact on residents and staff.

Exhibit 6.3. Prevalence of physical and verbal behavioral symptoms among SNF residents, quarter 4, 2025



Source: Analysis of the MDS Frequency data published by CMS at https://data.cms.gov/quality-of-care/minimum-data-set-frequency.
Note: Prevalence of each reported diagnosis is not mutually exclusive, and it is possible that representation of some individuals is repeated across behavioral symptoms.

Background on California's behavioral health settings and programs

Individuals with behavioral health conditions who also require LTSS reside in a broad range of residential settings in California, spanning from community-based environments to highly structured institutional care. These settings include permanent housing (such as single-family homes and apartments), interim and congregate settings (such as recuperative care), community residential treatment programs (including substance use disorder facilities), assisted living settings (such as adult residential facilities and residential care facilities for the elderly), and more intensive clinical environments such as SNFs, STPs, mental health rehabilitation centers (MHRCs), and acute psychiatric hospitals.[298] Some individuals also reside in Institutions for Mental Diseases (IMDs), which are a federal financing-related designation that excludes federal Medicaid funding for specific age groups in settings that may include some of the

[298] For more information on California's behavioral health settings, see "Behavioral Health Settings, Services, and Funding Sources", available at: https://www.dhcs.ca.gov/ru/BHT/Documents/Behavioral-Health-Settings-Infographic.pdf.

residential settings listed above, including STPs. This continuum of settings includes varying levels of medical and behavioral health supports, as well as differences in regulatory oversight, staffing, and service delivery models.

As the number of residents with behavioral health conditions grows, SNFs remain largely siloed from the broader behavioral health continuum of care. Capacity in behavioral health-specific settings (such as STPs or MHRCs), both in terms of facilities and beds, is limited relative to the population of residents with behavioral health needs in non-STP SNFs. Many residents with behavioral health conditions are served in non-STP SNFs, where access to behavioral health services is more variable, and staff may have less specialized training in behavioral health care. There are approximately 12,800 nursing facility residents with schizophrenia diagnoses, and 9,000 nursing facility residents with some other psychotic disorder diagnoses whose need for specialty behavioral health services may vary.[299] At present, the majority of these individuals reside in non-STP SNFs. Additional information would be needed to help determine how many of these individuals would be best served by placement in a behavioral health setting.

Select California behavioral health residential settings and payment structures

Payment for Medi-Cal members receiving behavioral health services differs depending on the type of services a member receives and the setting in which the service is delivered. Behavioral health services in California are generally classified as either specialty or non-specialty. Non-specialty mental health services are available to adult members with behavioral health needs that can be treated in non-specialty settings, such as mild-to-moderate anxiety and depression, and are covered by Medi-Cal managed care plans (MCPs). Specialty mental health services for more significant or complex mental health needs and substance use disorder services are available to members who meet access criteria and are covered by county behavioral health plans.[300,301]

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[299] Calculations performed based on [MDS 3.0 Data Frequency for Quarter 4, 2025], published by CMS, available at: https://data.cms.gov/quality-of-care/minimum-data-set-frequency.

[300] For more information about different types of Medi-Cal behavioral health services, see DHCS's "Guide to Behavioral Health Coverage", available at: https://www.dhcs.ca.gov/services/MH/Documents/BH-Brochure-Eng.pdf.

[301] For more information about Medi-Cal specialty mental health services, see DHCS webpage, available at: https://www.dhcs.ca.gov/services/Pages/Medi-cal_SMHS.aspx.

Payment for services in IMDs

Federal law defines an IMD as a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases.[302] SNF IMD facilities have more than 50 percent of their residents in the facility to receive specialized treatment for serious mental illness (as defined in federal regulation).[303] A SNF could be considered an IMD facility if it meets this definition. Per federal statute, IMDs generally cannot receive federal financial participation (FFP) for services provided to adults ages 21 to 64.[304] In SNF IMDs, FFP is typically only available for adults 65 years of age and older.[305]

In California, SNFs that are considered IMDs are reimbursed by counties under the Bronzan McCorquodale Act (1991 Realignment) and are not subject to the Medi-Cal Long-Term Care Reimbursement Act.[306] As a result, neither the facility-specific base rate methodology nor the AB 186 rate structure (including WSP) applies to IMD-designated SNF-STPs. While federal waivers are utilized by California and other states to receive FFP

[302] 42 CFR § 435.1010.

[303] For additional guidelines that states are expected to use to determine that SNFs or other facilities are IMDs, see Sections 4390 and 4390.1 of the State Medicaid Manual, available at: https://www.dhcs.ca.gov/wp-content/uploads/2025/10/MH-Ltr02-06_Attach1.pdf

[304] The IMD exclusion originates in Section 1905(a)(B) of the Social Security Act, which prohibits federal financial participation for Medicaid services furnished to individuals aged 21 through 64 who are patients in an IMD. The federal definition of an IMD, codified at 42 CFR § 435.1010, identifies a facility of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Additionally, WIC Section 14126.02(b) expressly excludes facilities designated as IMDs from the Medi-Cal Long-Term Care Reimbursement Act methodology. As a result, neither the facility-specific base rate methodology nor the AB 186 rate structure (including the Workforce Standards Program and the Workforce & Quality Incentive Program) applies to IMD-designated SNF-STPs. For more information about Medicaid's IMD exclusion, see the Library of Congress, available at: https://www.congress.gov/crs-product/IF10222.

[305] Federal statute and regulation creates an exception to the Medicaid IMD exclusion known as the "psych under 21" benefit (see 42 U.S.C. § 1396d(a)(16)); however, regulation and additional federal guidance restrict this to facilities/settings that meet additional, specific criteria (42 CFR § 440.160; 42 CFR Part 441, Subpart D).

[306] For more information about the impacts of the 1991 realignment, see California's Budget & Policy Center, available at: https://calbudgetcenter.org/resources/understanding-realignment-californias-shifts-in-state-and-county-responsibilities/#h-part-2-key-facts-about-the-1991-realignment.

for select IMD services, these waivers generally only apply to short-stay facilities and not long-term care.[307]

Special Treatment Programs (STPs)

The Special Treatment Program (STP) is a Medi-Cal program under which SNFs, as approved by DHCS, provide specialized mental health services to Medi-Cal members with a diagnosed chronic psychiatric impairment and moderately impaired adaptive functioning.[308]

To qualify as an STP, facilities must provide at least 2.3 nursing HPRD, have staff with mental health training or experience, and initially have a minimum of 30 residents whose need for STP services has been reviewed and approved by the local county mental health director or designee.[309] The intent of the regulations is to require a specialized workforce, a dedicated treatment unit or facility structure, and ongoing regulatory compliance for a difficult to treat behavioral health population.

STP payment structure

Payment for STP services takes the form of a per diem add-on payment applied to the facility's base FS/SNF per diem rate. The STP supplemental payment is set at $5.72 per STP patient day and has remained at this level since 1985.[310] The supplement is paid only for days on which the STP resident receives STP services within a DHCS-approved STP unit; it does not modify the underlying base FS/SNF-B per diem rate, which continues to be established under the facility-specific, cost-based methodology applicable to the facility's rate classification as described in Chapter 1.

STP-approved beds exist in two distinct facility populations, which are reimbursed under two distinct financing frameworks. This landscape analysis addresses only the first of

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[307] California Department of Health Care Services, Behavioral Health Information Notice 26-026, available at: https://www.dhcs.ca.gov/wp-content/uploads/2026/08/BHIN-26-026-BH-CONNECT.pdf.

[308] Programmatic authority is established in Title 22, California Code of Regulations (CCR), Section 72443 et seq. and Section 51335 et seq., which set staffing, therapeutic programming, and certification requirements; reimbursement authority is established in Title 22 CCR Section 51511.1 and the California Medicaid State Plan.

[309] California Code of Regulations (CCR), Title 22, Division 5, Chapter 3, § 72443–72475.

[310] For more information about the last update on the STP supplemental payment, see "California's Department of Mental Health Information Notice 05-11", available at: https://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice05-11.pdf.

those populations as the second population is outside of the scope of the Medi-Cal LTC Reimbursement Act.

- **Non-IMD FS/SNF-Bs with STP beds.** Facilities certified to operate STP distinct part units while retaining their primary character as general FS/SNF-B providers are reimbursed under the Medi-Cal LTC Reimbursement Act methodology for their base per diem rate, with the $5.72 STP supplement added for STP resident days. These facilities remain subject to the facility-specific, cost-based rate methodology, the WSP, and the aggregate growth limits established under AB 186 and described in Chapter 1.[311]
- **IMD-designated facilities with STP beds.** Facilities meeting the federal definition of an IMD, generally, SNFs at which STP-designated beds exceed 50 percent of total beds, or which otherwise meet the IMD definition described above, are statutorily excluded from the Medi-Cal LTC Reimbursement Act methodology.[312] These facilities are financed through a separate set of payment mechanisms.

STP rate analysis

Under the 2026 rate study, 16 non-IMD California SNFs operate DHCS-approved STP beds.[313, 314] The analytical cohort to review rates and their impacts comprises the twelve continuing rate California SNFs certified by DHCS for STP services and classified as FS/SNF-B providers under the Medi-Cal LTC Reimbursement Act methodology for rate year 2026. Rate, rate growth, and cost coverage results for the STP cohort are compared against the population of all freestanding skilled nursing facilities statewide operating

[311] For more information about California's Nursing Facility Financing Reform (AB 186), see the DHCS webpage at: https://www.dhcs.ca.gov/services/medi-cal/Pages/Nursing-Facility-Financing-Reform-AB-186.aspx.

[312] Welfare and Institutions Code (WIC) Section 14126.02(b).

[313] California FS/SNF-B rate studies, available at: https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx.

[314] Twelve of the 16 California SNFs operating DHCS-approved STP beds operate under the continuing rate methodology, and four operate under the newly established rate methodology (the other 20 STP designated facilities operate as IMDs and are excluded from DHCS rate setting). The 12 continuing rate facilities constitute the analytical cohort for the quantitative analyses presented in this section. STPs operating under newly established rates do not follow all the growth limit restrictions that impact continuing rates and were excluded to prevent undue influence on quantitative analysis. In addition, the IMD-designated SNF-STP population is excluded from analyses, consistent with its statutory exclusion from the FS/SNF-B methodology and the established scope of the landscape analysis.

under the FS/SNF-B methodology, regardless of STP certification status. This framing positions the STP subset within the broader universe of Medi-Cal FS/SNF rate setting outcomes. Rate and cost data reflect DHCS-published facility-specific rates for rate year 2023 through rate year 2026.[315] The $5.72 STP supplemental payment is included in per diem payment totals for the cost coverage analysis, reflecting the facility-wide comparison of total Medi-Cal payment to total Medi-Cal allowable cost.

Medi-Cal cost reports filed by FS/SNF-B facilities do not separately report STP program costs from general FS/SNF-B operational costs. Direct care staffing, therapeutic programming, and indirect costs associated with the STP distinct part are reported on an aggregated basis together with non-STP FS/SNF-B costs. As a result, an STP-specific cost coverage analysis, that is, an isolated comparison of the $5.72 STP supplement to the incremental per diem cost of STP service delivery, is not feasible using currently filed cost report data. The cost coverage metric presented below therefore reflects a facility-wide comparison of total Medi-Cal per diem payment (inclusive of both base per diem rates and STP supplements) to total Medi-Cal allowable per diem cost, consistent with the approach applied to non-STP FS/SNF-B facilities.

STP rate analysis: rate year 2026

For rate year 2026, facilities in the STP cohort have per diem base rates that, on a weighted average basis, are materially higher than the average for relevant FS/SNF-B facilities statewide (**Exhibit 6.4**).

Several structural features of the AB 186 methodology are consistent with the observed positioning. The FS/SNF-B rate methodology projects facility-specific rates from audited historical costs, subject to peer-group cost caps and split aggregate growth limits. Facilities operating STP distinct parts carry the embedded cost of STP-required staffing ratios, therapeutic activity programming, and related infrastructure within their audited cost bases. To the extent those costs flow through the facility-specific projection, they may contribute to higher rate positioning relative to non-STP peers. Participation in the WSP, authorized under AB 186 for calendar years 2024 through 2026, provides an additional facility-specific workforce rate adjustment to WSP participating facilities and further influences cohort positioning as the twelve noted facilities all received enhanced rates due to WSP participation in rate year 2026.

[315] For more information, see California FS/SNF-B rate studies, available at: https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx.

Exhibit 6.4. Comparison of STP facility final enhanced per diem rates to final enhanced per diem rates

STP Medicaid Day-Weighted Average Final Per Diem: Rate Year 2026	All Facility Medicaid Day-Weighted Average Final Per Diem: Rate Year 2026
$406.96	$322.63

Source: Calculations performed based on DHCS published rate studies for rate year 2026. The California FS/SNF-B rate studies are available at: https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx.

STP rate growth analysis: rate year 2023 through rate year 2026

Over the four-year period from rate year 2023 to rate year 2026, cumulative per diem rate growth for facilities in the STP cohort has been higher than the all-facility average (**Exhibit 6.5**).

Exhibit 6.5. Comparison of STP facility final enhanced rate growth from rate year 2023–2026 compared to final enhanced rate growth from rate year 2023–2026 (percentage)

STP Medicaid Day-Weighted Average Facility Percentage Growth 2023-2026	All Facility Medicaid Day-Weighted Average Facility Percentage Growth 2023-2026
16.31	8.72

Source: Calculations performed based on DHCS published rate studies for rate years 2023-2026. The California FS/SNF-B rate studies are available at https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx.

Rate year 2023 represents the final rate year under the pre-AB 186 methodology framework, and rate year 2024 through rate year 2026 reflects rates established under AB 186 and its accompanying structural elements: the split of 5 percent labor / 1 percent nonlabor aggregate growth limits and the Workforce Standards Program. The analysis period therefore captures the initial implementation arc of the current methodology.

STP cost coverage analysis: Cost report year 2023

Cost coverage is calculated as the ratio of Medi-Cal allowable cost to Medi-Cal payment. We calculated total Medi-Cal per diem payments as the facility-specific FS/SNF-B base rate plus the $5.72 STP supplement (**Exhibit 6.6**) and without the $5.72 STP supplement (**Exhibit 6.7**) to total Medi-Cal allowable per diem cost as reported on the facility's 2023 cost report and compare to rate year 2026 rate information. A ratio of 1.00 reflects full cost coverage on a Medi-Cal basis; ratios below 1.00 reflect Medi-Cal per diem payments below Medi-Cal allowable per diem cost; ratios above 1.00 reflect Medi-Cal per diem payments exceeding Medi-Cal allowable per diem cost.

Exhibit 6.6. Comparison of STP facility allowable cost coverage compared to applicable peer group allowable cost coverage for cost report year 2023 utilizing rate year 2026 rates, inclusive of the $5.72 STP add-on (percentage)

STP Facility Weighted-Average Allowable Cost Coverage With STP Add-on Rate Year 2026	All Facility Weighted-Average Allowable Cost Coverage Rate Year 2026
84.68	86.63

Source: Calculations performed based on DHCS published rate studies for rate year 2026. The California FS/SNF-B rate studies are available at: https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx.

To more accurately review cost coverage for STP facilities, it would be necessary to weight the application of the $5.72 supplemental add-on based on the billed occurrence of STP days within a given facility. Unfortunately, this information is not available at the time of the writing of this landscape analysis, and so comparable cost coverage is shown in **Exhibit 6.7** without the impact of the $5.72 supplemental.

From the data, the cost coverage impact of the $5.72 supplemental add-on ranges does increase total cost coverage. While impactful, the materiality of this add-on to facility operations may be muted when compared to larger considerations regarding ongoing facility cost containment.

Exhibit 6.7. Comparison of STP facility allowable cost coverage compared to allowable cost coverage for cost report year 2023 utilizing rate year 2026 rates, exclusive of the $5.72 STP add-on (percentage)

STP Facility Weighted-Average Allowable Cost Coverage Without STP Add-on Rate Year 2026	All Facility Weighted-Average Allowable Cost Coverage Rate Year 2026
83.48	86.63

Source: Calculations performed based on DHCS published rate studies for rate year 2026. California FS/SNF-B rate studies are available at: https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTC.aspx.

For cost report year 2023 and rate year 2026, the STP facility cohort exhibits cost coverage ratios that are generally comparable to, or slightly below, the peer group average for all FS/SNF-B facilities statewide, both with and without the $5.72 supplemental add-on.

As noted, the cost coverage ratio presented above is calculated on a facility-wide basis because STP-specific costs are co-mingled with general FS/SNF-B costs on the Medi-Cal LTC cost report. The analysis measures the aggregate relationship between Medi-Cal payment and Medi-Cal allowable costs for the cohort facilities, without attempting to isolate the economics of the STP distinct part. A program-isolated STP cost coverage analysis of comparing the $5.72 STP supplement alone to the incremental per diem cost of STP-specific service delivery would require program-specific cost segregation not captured in the existing cost reporting framework.

Taken together, these analyses are consistent with an STP cohort whose facility-specific cost bases produce both higher rates and higher underlying costs under the facility-specific, cost-based AB 186 methodology, with aggregate cost coverage ratios that generally track with the systemwide pattern. While the STP facility rates and rate growth exceed similar facilities, the comparable cost coverage analysis indicates that facilities that operate STP programs do not see payments that exceed their operating costs.

Patch payments to SNFs from county behavioral health agencies

Some county behavioral health agencies make supplemental "patch" payments to SNFs for the admission of county residents with behavioral health conditions. A patch payment is an extra daily or monthly payment made to a SNF to cover the cost of extra services to a resident or to support admission of a resident with a behavioral health

condition who may be difficult to place. To better understand the ways in which each county behavioral health agency is or is not making these types of supplemental payments to SNFs, we administered a survey to county behavioral health agencies about their use of these payments. Twenty-nine out of California's 58 counties responded to the survey.

Twenty-seven counties (93 percent of respondents) reported providing patch payments to SNFs serving individuals from their county with behavioral health conditions. Of these, 25 counties (93 percent of counties making patch payments) reported providing patch payments for members residing in STPs, 20 counties (74 percent) reported providing patch payments for members residing in non-STP SNFs, and 19 counties (70 percent) reported providing patch payments to facilities that are classified as IMDs. **Exhibit 6.8** summarizes the number of counties that make patch payments by facility type.

Exhibit 6.8. Number of responding counties that provide patch payments for members with behavioral health conditions by facility type

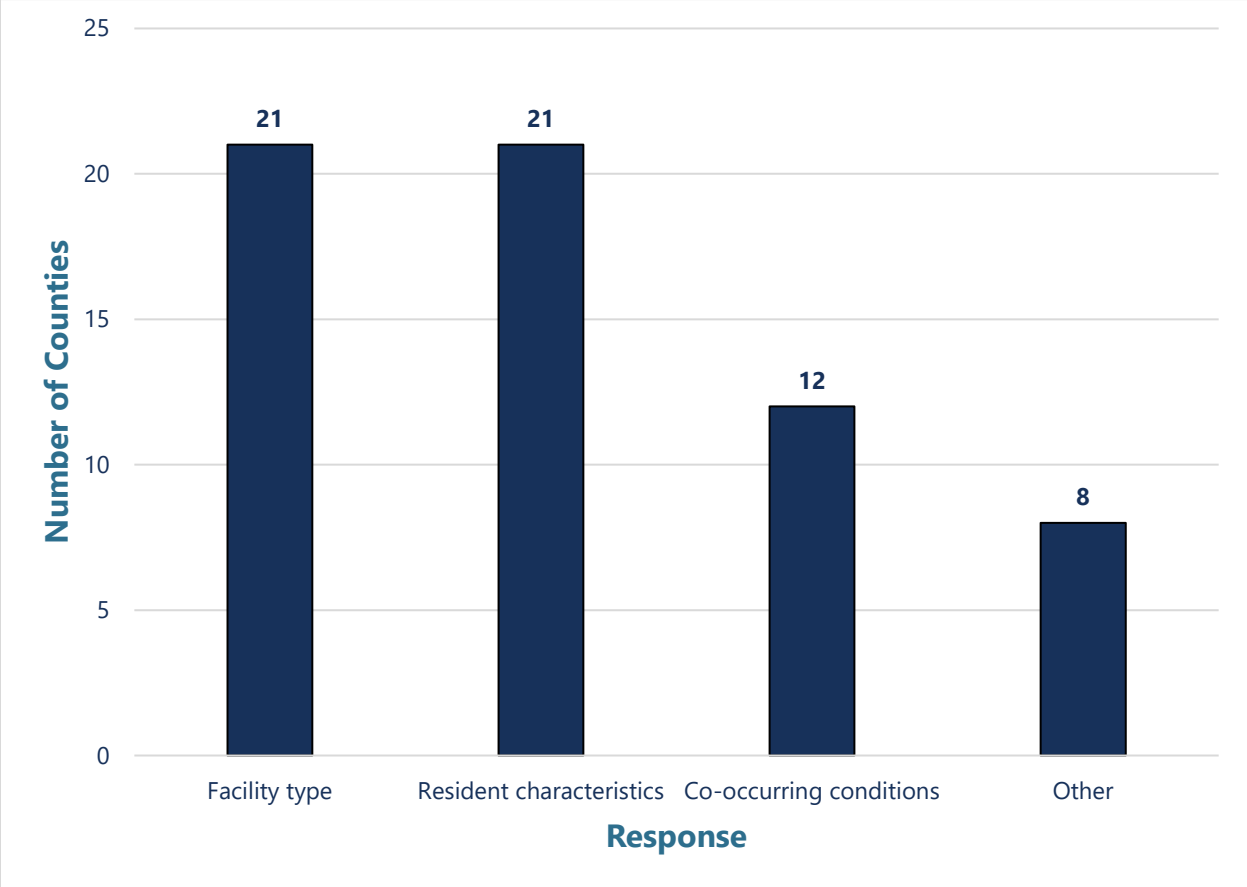
Facility Type	Number of Responding Counties (n=29)
Both STPs and non-STP SNFs	19
STPs only	4
Non-STP SNFs only	1
Facility type not specified	3
Does not make patch payments	2
Facilities classified as IMDs	19

Source: Analysis of DHCS survey administered to county behavioral health agencies, Spring 2026.

Twenty-one of the 27 responding counties that make patch payments (78 percent) indicated that the amount of patch payments vary based on facility type, resident characteristics, co-occurring conditions, and other factors. **Exhibit 6.9** shows the most common factors affecting the amount of county patch payments to facilities. Facility-related factors that might impact payment amount include whether a facility is an STP or non-STP SNF, whether the facility is locked or secured, whether there is specialized programming, and the staffing model used by the facility. Resident-related factors include the acuity of a resident's behavioral health condition, medical complexity, the

need for a private room or one-to-one supervision, elopement risk, and other factors. Other factors include bed scarcity and facility location.

Exhibit 6.9. Factors that impact amount of supplemental patch payments

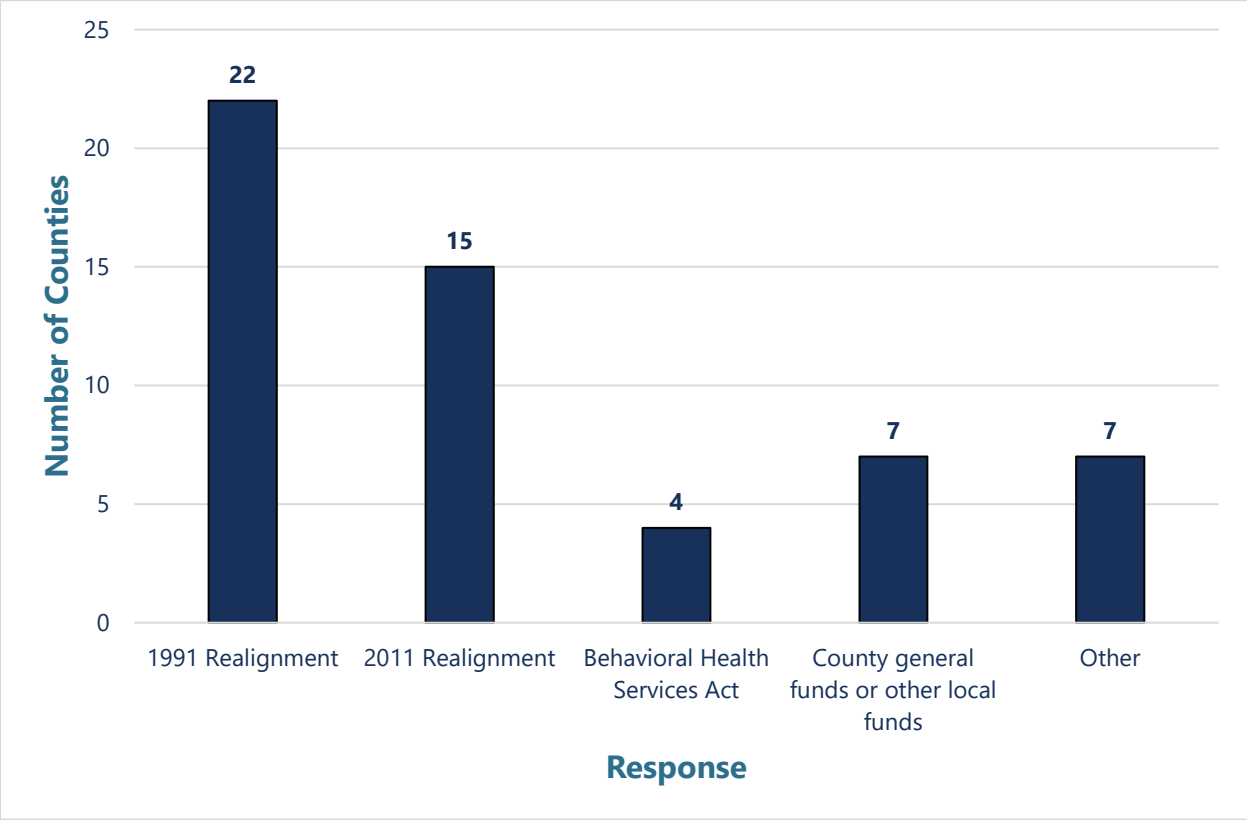


Source: Analysis of DHCS survey administered to county behavioral health agencies, Spring 2026.

When asked about the source of funding for supplemental patch payments to facilities (**Exhibit 6.10**), 22 of the 27 counties providing patch payments (81 percent) use 1991 Realignment funding, 15 counties (56 percent) use 2011 Realignment funding,[316] 7 counties (26 percent) use local funds, 4 counties (15 percent) use Behavioral Health Services Act funds, and 6 counties (22 percent) use other funding sources, including combinations of county, state and federal funds; and Behavioral Health Bridge Housing funds.

[316] For more information about California's 1991 and 2011 Realignments, visit: https://www.counties.org/ongoing-issue/1991-and-2011-realignment/.

Exhibit 6.10. Funding sources used for patch payments to facilities.



Source: Analysis of DHCS survey administered to county behavioral health agencies, Spring 2026.

Separate from making patch payments, we also asked counties about operational support, training, behavioral health services, or other resources that they provide to SNFs.

- Twenty-seven of the 29 responding counties (93 percent) shared that they provide resources to contracted SNFs to assist in serving individuals with behavioral health conditions from their county.
- Twelve of the 29 responding counties (41 percent) provide operational support or behavioral health services in STPs, and 11 counties (40 percent) provide operational support or behavioral health services in non-STP SNFs. These supports include case management, treatment team participation, resident monitoring, assessment, therapy, rehabilitation, psychoeducation, care coordination, medication access coordination, technical assistance, utilization management, site visits, and discharge planning.

The results of this survey indicate that, separate from the current Medi-Cal reimbursement framework for SNFs, STPs and non-STP SNFs in California are receiving both financial and operational support from county behavioral health agencies for the care of residents with behavioral health diagnoses.

Behavioral health staffing and scope constraints of settings

Behavioral health staffing models and scope limitations can also play a central role in shaping the capacity of different care settings that serve individuals with complex behavioral health needs.

Behavioral health staffing across settings

The availability and composition of behavioral health trained direct care staff can vary across care settings, shaping each setting's ability to serve individuals with complex behavioral health needs. These differences are particularly important when comparing non-STP SNFs to other residential and community-based care settings, as they can have important implications for care capacity, access, and admission decisions.

Behavioral health training can cover a broad spectrum of competencies, from applied care skills for direct care staff to clinical licensure. Typical training options include awareness training, which supports staff in recognizing psychiatric symptoms and substance use disorders. Trainings can also focus on applied care skills, such as trauma-informed care, de-escalation, medication monitoring, and nonpharmacologic interventions. And finally, training may include clinical support from specialized behavioral health professionals, such as access to consultations and case review processes.

Non-STP SNFs are primarily staffed by CNAs and licensed nursing personnel (including RNs and LVNs). While these staff play key roles in supporting residents with a range of medical and functional needs, they are not typically trained or deployed as specialized behavioral health providers. Psychiatric services are often provided offsite or through consultants, limiting real-time access. In a national survey, 47 percent of SNF administrators reported that staff's limited behavioral health training impacted the provision of behavioral health services and 33 percent reported they could not adequately meet resident's behavioral health needs.[317]

[317] Orth, J., Li, Y., Simning, A. and Temkin-Greener, H. (2019), Providing Behavioral Health Services in Nursing Homes Is Difficult: Findings From a National Survey. *J Am Geriatr Soc,* 67: 1713-1717. https://doi.org/10.1111/jgs.16017.

In contrast, other care settings such as psychiatric health facilities and mental health rehabilitation centers are more likely to employ multidisciplinary teams with dedicated behavioral health expertise that include psychiatrists, therapists, and non-licensed professionals with specialized training or credentials such as mental health rehabilitation specialists or substance use disorder counselors. The presence of embedded behavioral health professionals allows for more integrated care planning, continuous clinical oversight, and consistent treatment for behavioral health needs.

National evidence suggests that a lack of behavioral health staffing or training limits SNF's willingness to admit individuals with behavioral health needs. In a national survey, SNF administrators and directors of nursing cited both difficulty accessing psychiatric support and inadequate staff training as important considerations for whether to admit residents with psychiatric or behavioral problems.[318] In a qualitative study on SNF admissions for people with opioid use disorder, SNF administrators described limited onsite behavioral health services, staff capacity, and lack of clinicians certified to prescribe medication assisted treatment as reasons for rejecting patients.[319] Taken together, these differences in staffing models and training frameworks contribute to a structural gap in capacity across settings.

California behavioral health staffing regulations

Required behavioral health training and staffing levels across settings in California further reinforce differences in behavioral staff capacity and experience. Settings vary in the amount of training or experience required for supervisors or direct care staff in behavioral health, if any; for example, STPs do not require most direct care staff to have behavioral health training or experience,[320] while short-term crisis residential treatment programs require one year of experience. The way staffing ratios are defined also shapes how different settings employ direct care staff and behavioral health professionals. STPs and MHRCs focus on hours of interdisciplinary staff time (including psychologists and therapists) per week—provided in many cases by consultants—while psychiatric health

[318] Orth, J., Li, Y., Simning, A. and Temkin-Greener, H. (2019), Providing Behavioral Health Services in Nursing Homes Is Difficult: Findings From a National Survey. *J Am Geriatr Soc,* 67: 1713-1717. https://doi.org/10.1111/jgs.16017.

[319] Moyo P, Nishar S, Merrick C, et al. Perspectives on Admissions and Care for Residents With Opioid Use Disorder in Skilled Nursing Facilities. *JAMA Netw Open.* 2024;7(2):e2354746. doi:10.1001/jamanetworkopen.2023.54746.

[320] Cal. Code Regs. Tit. 22, § 72465.

facilities define full-time staff to census ratios for multiple behavioral health roles. STP staffing requirements are summarized in **Exhibit 6.11**.

Exhibit 6.11. STP staffing requirements

More detailed behavioral health staffing requirements for STPs include:

- Nursing charge personnel must have one year experience or training relevant to STP
- Interdisciplinary staff must have one year training or experience in mental health setting
- STPs must provide interdisciplinary staff from at least two disciplines, such as a psychologist, occupational therapist, art therapist
- Staff to census ratio must be maintained at 1 direct care staff per 10 residents (day shifts) or 1 direct care staff to 15 residents (night shifts)
- Depending on census, required to provide 24-72 hours of interdisciplinary staff time per week

Source: Cal. Code Regs. Tit. 22, § 72465, § 72329.1.

In addition to staffing constraints, regulatory and operational constraints related to treatment further limit SNF capacity to serve residents with behavioral health needs, particularly for individuals with SUD and those requiring psychotropic medications. For residents in need of medications for opioid use disorder, SNFs may not be prepared to provide treatment directly, and may instead coordinate with external providers, creating additional administrative and care coordination burdens. The elimination of federal requirements for practitioners to obtain specialized "x-waivers" to prescribe buprenorphine (effective January 2023) [321]and the enactment of AB 2115 (Haney, Chapter 634, Statutes of 2024) expanded access options to medication-assisted treatment for SNFs. However, logistical challenges and limited onsite prescribing capacity may still restrict admissions for these residents. At the same time, federal oversight of psychotropic medication use, including quality measures tied to antipsychotic prescribing, may influence facility prescribing and documentation practices. These policies can lead to unintended consequences, such as shifts to

[321] The statutory repeal of 21 U.S.C. 823(h)(2) ended the federal requirement for providers to apply for a special waiver (an "x-waiver") to prescribe buprenorphine for the treatment of opioid use disorder. For more information, visit: https://www.deadiversion.usdoj.gov/faq/buprenorphine-faq.html.

alternative medications, changes in diagnostic coding, or potential undertreatment, all of which can affect how SNFs manage residents with behavioral health conditions and potentially disincentivize admissions.

Policies influencing placement for individuals with behavioral health conditions

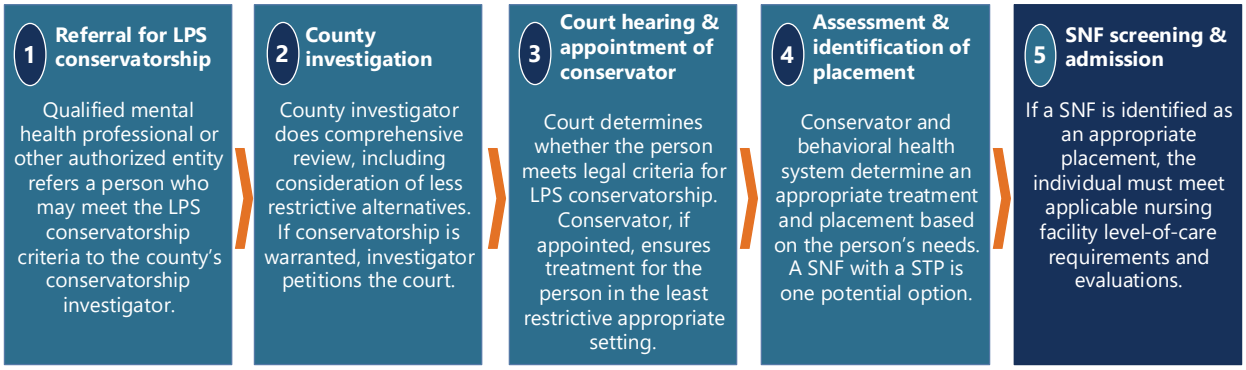
Lanterman-Petris-Short (LPS) conservatorship

In some cases, an individual's mental illness or substance use disorder rises to a level of impairment where a court may appoint a conservator to make certain treatment and placement decisions for the individual; in other words, the individual may receive involuntary behavioral health treatment. Conservatorship, as governed by California's Lanterman-Petris-Short (LPS) Act, is relevant to SNF access and care delivery. While LPS conservatees can be placed in many treatment settings, STPs are a common placement setting for LPS conservatees with co-occurring LTSS and behavioral health needs who require treatment in a residential setting.[322] According to operators of STPs, nearly all STP residents are LPS conservatees.

LPS conservatorships are indicated when a court finds that a person is "gravely disabled" as a result of their behavioral health condition. "Gravely disabled", under WIC 5008(h)(1)(a) means that the person is unable to provide for their basic personal needs for food, clothing, shelter, personal safety, or medical care.[323] LPS conservatorship involves a structured process that includes referral, county investigation, and court review. The decision typically follows an acute psychiatric hospitalization and/or repeated attempts over time to engage the individual in voluntary behavioral health services in the community. **Exhibit 6.12** outlines the pathway that an individual who is deemed "gravely disabled" takes to be designated under LPS conservatorship and placed in a SNF.

[322] For more information about LPS Conservatorship, see DHCS' website, available at: https://www.dhcs.ca.gov/services/Pages/Behavioral-Health-Conservatorship.aspx.
[323] WIC 5008(h)(1)(a) creates a second standard for "gravely disabled" with a public safety dimension, but individuals conserved under this "Murphy" standard are rarely placed in SNFs.

Exhibit 6.12. LPS pathway to SNFs



Source: Developed in consultation with the County Behavioral Health Directors Association of California.

LPS conservatees can be placed in SNFs by their conservator if the SNF is considered the least restrictive appropriate placement and the conservatorship court order allows placement in a nursing facility. Placement depends on the individual's clinical and functional needs, applicable SNF admission and level of care requirements, the availability of an appropriate facility, and the requirements of the particular treatment setting.

Preadmission Screening and Resident Review

Another primary pathway through which individuals with severe behavioral health conditions may be placed in institutional settings is the Preadmission Screening and Resident Review (PASRR) process, which is a federally mandated process for any individual seeking admission to a Medicaid-certified nursing facility, regardless of that individual's payor source.[324] This process is used to determine, prior to SNF admission, whether an individual has a SMI or intellectual or developmental disability (I/DD). If the individual meets the criteria for SMI or I/DD, the process also identifies where in the continuum of behavioral health settings that individual should be placed to ensure they are receiving care in the least restrictive setting that best meets their needs while providing specialized services if deemed necessary.[325] The PASRR process is intended to divert inappropriate SNF placements and ensure that individuals with a SMI or I/DD that

[324] For more information about SNFs' responsibilities in the PASRR process, visit the DHCS memorandum at: PASRR IN 23-002 Final.pdf.
[325] For more information about the PASRR level 2 screening process, visit the DHCS webpage at: https://www.dhcs.ca.gov/services/MH/Pages/PASRR_faq_level2.aspx.

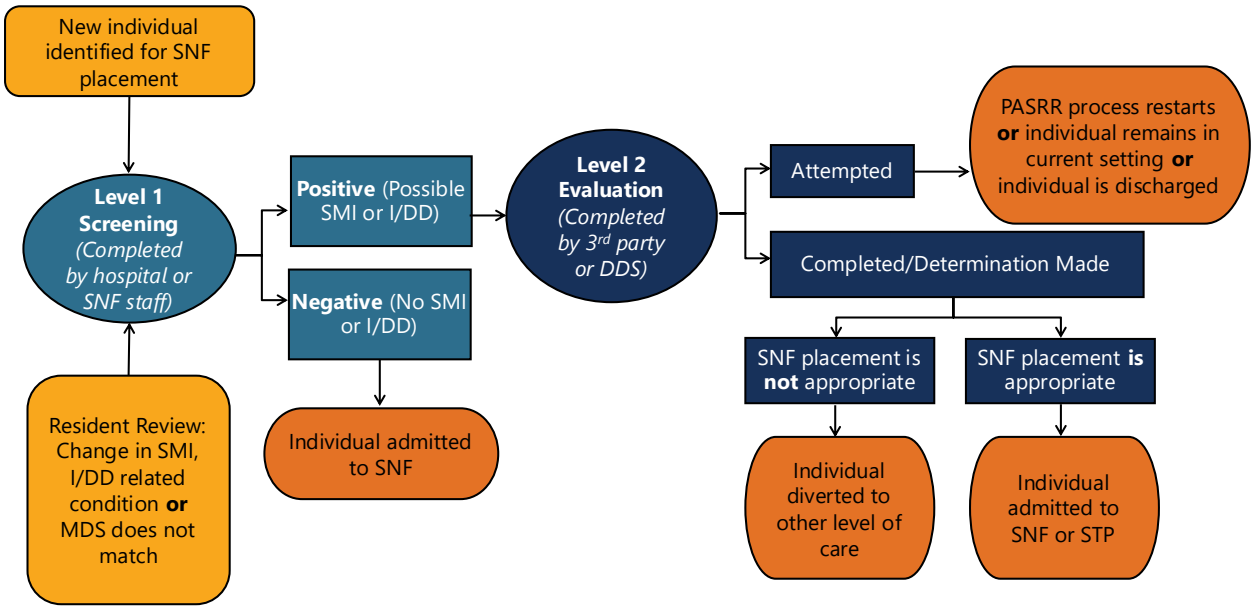
are placed in a SNF can receive specialized behavioral health services.[326] Crucially, FFP for services rendered in a SNF are only available after the PASRR process is complete.[327]

The PASRR process presents several challenges and highlights system constraints that SNFs encounter. When the PASRR process is initiated for a given individual, the state's designated contractors attempt to contact the SNF or hospital where the individual is within 48 hours to obtain medical records and ask preliminary questions. If the facility fails to answer the contractors' calls or supply the requested documentation necessary to begin a Level II Evaluation within 24 hours of contact, the case may be closed as "Attempted," which either extends an individual's time in the hospital while a new Level I Screening is performed or results in the individual being discharged elsewhere, with or without the support or housing stability they may need. Another challenge is SNFs must often coordinate with external providers to deliver specialized services that are recommended through the PASRR process. A final challenge is the PASRR process may determine a placement or specialized services are necessary (for example, placement in a STP), but facilities may not have the availability or infrastructure to provide these services.

The PASRR process consists of a Level I Screening and a Level II Evaluation. The Level I Screening determines if an individual may have a SMI or I/DD and is performed by hospital staff if the individual is entering the SNF from a hospital or SNF staff if the individual is entering from the community. A resident review is completed when there is a significant change in condition relating to the individual's SMI or I/DD or when the MDS does not match the Level I Screening from the hospital. The SNF must initiate the resident review as a Level I Screening within 72 hours of identification of a significant change in condition or identification of variance between the MDS and Level I Screening. If the Level I Screening is positive, the individual then receives a Level II Evaluation, which helps determine the most appropriate placement for the individual and whether specialized behavioral health services are needed. In California, third-party contractors perform the Level II Evaluation, and the Department of Developmental Services (DDS) is responsible for the I/DD Level 2 evaluations. The screening and evaluation process is shown below in **Exhibit 6.13**.

[326] For more information about the national PASRR process intent and requirements, visit the Medicaid.gov website at: https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/preadmission-screening-and-resident-review.
[327] 42 CFR § 483.122.

Exhibit 6.13. PASRR screening and evaluation process



Source: Chart based on the process described in PASRR IN 23-002, available at: https://www.dhcs.ca.gov/es/services/MH/Documents/PASRR-IN-23-002.pdf.

California initiatives to expand behavioral health capacity

California has launched various initiatives aimed at expanding behavioral health capacity through both infrastructure investments and workforce development. These programs have some implications for the provision of behavioral health services in SNFs and other long-term care settings.

On the infrastructure side, DHCS established the Behavioral Health Continuum Infrastructure Program (BHCIP) in 2021 to expand California's behavioral health facility capacity. DHCS awarded $1.7 billion through multiple funding cycles to purchase, build, and renovate facilities and invest in mobile crisis infrastructure. This work was expanded in 2024 through Proposition 1 (2024) which included AB 531 (Irwin, Chapter 789, Statutes of 2023), the Behavioral Health Infrastructure Bond Act (BHIBA), which authorized up to $4.4 billion in additional BHCIP grants, which have already been awarded. The BHIBA also earmarked additional money for investment in physical infrastructure for permanent supportive housing.[328]

[328] For more information on the Behavioral Health Continuum Infrastructure Program, see the DHCS webpage, available at: https://www.dhcs.ca.gov/behavioral-health-continuum-infrastructure-program/.

In parallel, California is advancing workforce and system capacity through other policy reforms occurring via Proposition 1, such as SB 326, the Behavioral Health Services Act (BHSA) (Eggman, Chapter 790, Statutes of 2023). This Act directs the state to prioritize services for populations with the highest behavioral health needs, increases state and local oversight, and increases the emphasis on housing and substance use disorder treatment.[329]

Another complementary effort, Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT), strengthens California's behavioral health delivery system by adding Medi-Cal coverage for additional community-based, evidence-based practices for individuals with significant behavioral health needs, while also supporting behavioral health workforce development. The workforce component includes loan repayment, scholarships, recruitment and retention initiatives, training, and fellowships for behavioral health professionals who commit to working in Medi-Cal safety net settings. These settings, which may include STPs, serve a high proportion of Medi-Cal or uninsured residents.[330]

SNF behavioral health integration payment approach models in other states

This section presents a review of SNF behavioral health payment models across state Medicaid programs nationwide, organized around available payment models. **Exhibit 6.14** summarizes common payment models.

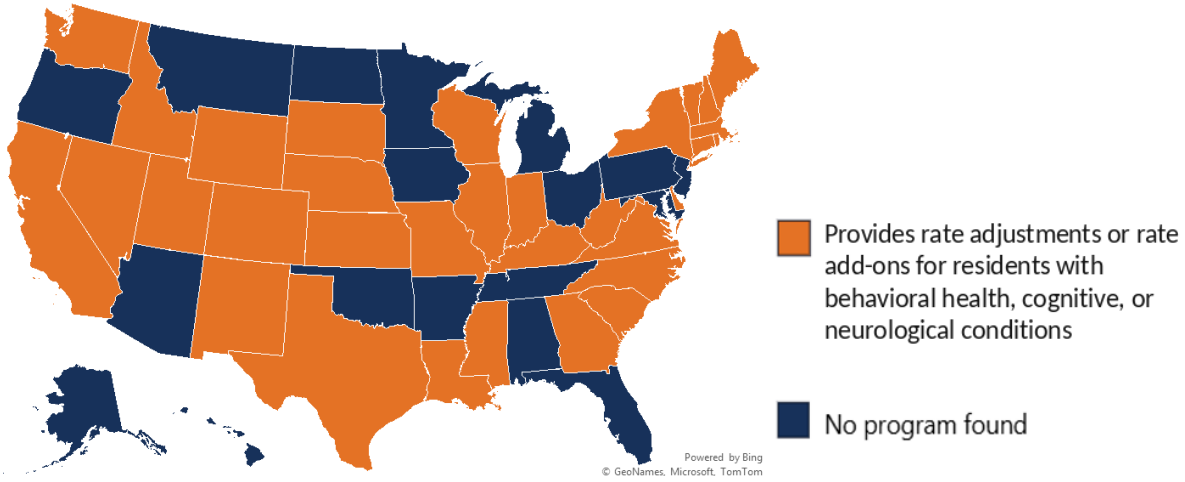
[329] For more information about Behavioral Health Services Act, see DHCS webpage, available at: https://www.dhcs.ca.gov/behavioral-health-transformation/behavioral-health-services-act/.
[330] For more information about BH-CONNECT, see the California Department of Health Care Access and Information website, available at: https://hcai.ca.gov/workforce/initiatives/behavioral-health-bh-connect/.

Exhibit 6.14. Payment models available for SNF residents with behavioral health needs

Payment Approach	Definition
Flat rate add-on	A fixed amount added to the standard daily rate
Tiered payment	A structured payment model where facilities receive different payment amounts based on condition severity or other factors
Quality incentive payments	Additional payments or rate adjustments linked to behavioral health related performance metrics
Adjusted rate components	Modifications to specific elements of the base rate to account for higher resource needs

At least 32 states and District of Columbia provide specified rates or add-on payments for SNFs serving residents with mental, behavioral, or cognitive conditions, including TBI, dementia, and Alzheimer's disease (**Exhibit 6.15**).

Exhibit 6.15. State use of Medicaid payment models for residents with behavioral health, cognitive, or neurological conditions



Source: Map created based on the MACPAC Compendium of State Policies Related to Nursing Facility Staffing, published March 2022, available at: https://www.macpac.gov/publication/state-policies-related-to-nursing-facility-staffing/ and from review of publicly available State-plan or regulatory documentation nation-wide as of January 1, 2026.

Eligibility indicators for payments related to behavioral health, cognitive, and neurological conditions

States typically incorporate some form of eligibility criteria to determine when a facility qualifies to receive supplemental payments for serving residents with behavioral, cognitive, or neurological conditions. These criteria are designed to direct funding toward residents and facilities with elevated needs related to their diagnosis. There are four primary approaches: diagnosis-based triggers, behavior-based triggers, service-based triggers, and facility-level criteria.

- Diagnosis-based triggers tie payment to resident diagnoses or functional cognitive thresholds (e.g., diagnosis of schizophrenia, dementia, or score on Cognitive Performance Scale [CPS] or BIMS).
- Behavior based triggers link payment to behavioral complexity or intervention needs, such as aggression, wandering, need for supervision, or tiered severity levels.
- Service-based triggers tie payment to the provision of specific services or programs, such as therapy, rehabilitation, counseling, or structured treatment plans.
- Facility-level criteria base eligibility on facility characteristics, such as minimum share of high-need residents or designation as a specialized unit.

Comparing state payment approaches for behavioral health, cognitive, and neurological conditions

Across states, supplemental payment approaches in SNFs reflect a common recognition that traditional case-mix based payment systems may not fully capture the resource intensity associated with residents with certain behavioral, cognitive, and neurological conditions. While the specific structures vary, there are several consistent themes. Over half of states nationally rely on some form of targeted payment adjustment whether through add-ons, tiered payments, or specialized rates, to account for increased staffing needs, care coordination, and programmatic requirements.[331] Additionally, states differ in how their payment approaches consider resident acuity and payment, with simpler flat add-on payment models offering administrative ease but less differentiation between residents, and tiered or negotiated rate models providing greater alignment

[331] Determined from review of publicly available *MACPAC Compendium of State Policies Related to Nursing Facility Staffing,* published March 2022.

with resident complexity at the cost of increased program administrative complexity. In addition, some states are increasingly incorporating programmatic expectations and accountability mechanisms into payment designs. These include staffing requirements as well as performance-based elements tied to quality.

Supplemental payment types: flat rate add-ons and tiered payments

Flat rate add-on models provide a standardized supplemental payment layered onto the base SNF rate. States structure these add-ons in several ways, including fixed per diem payments, percentage-based adjustments to the base rate, and facility-level rate increases tied to case mix. While the structure and magnitude vary, these models apply a consistent payment adjustment and are designed to account for additional costs associated with serving residents with behavioral health, cognitive, and neurological conditions.

Tiered payment models vary payments based on defined levels of need, allowing payments to increase incrementally as resident acuity or service intensity rises. States operationalize tiers using different methodologies, including variation from statewide CPS benchmarks,[332] condition severity levels, and behavior-based intervention needs.

State approaches

Case study: Massachusetts (flat rate add-on)

Massachusetts provides a per diem add-on of $45 for behavioral health and $50 for substance use disorder for residents with "severe mental or neurological disorders", including traumatic brain injuries, who are receiving specialized rehabilitation services. Eligibility requires that at least 50 percent of annual resident days are attributed to individuals with mental or neurological conditions, including brain injury. Facilities must also deliver state-specified specialized rehabilitation services to qualify for payment.[333]

Case study: Colorado (tiered payment)

Colorado provides tiered supplemental payments to SNFs, with payment determined annually using MDS data. Payment tiers are based on a facility's CPS percentage relative to the statewide average. The state measures how far a facility's CPS percentage exceeds the average using standard deviations. Per diem multipliers are applied at defined

[332] For more information on the CPS, see the original publication of the "MDS Cognitive Performance Scale", available at: https://pubmed.ncbi.nlm.nih.gov/8014392/.
[333] Code of Massachusetts regulations, 101 CMR 206.

thresholds, with higher payments assigned as facilities exceed each level. The per diem rate is calculated by applying the assigned multiplier to a fixed percentage of the base nursing facility rate and scaling by Medicaid days. Colorado also includes a PASRR Level II per diem add-on, equal to 4 percent of the base rate, for residents with severe mental illness, with additional payments available for facilities offering specialized behavioral health programs.[334]

Case study: Wisconsin (flat rate add on)

Wisconsin provides a Specialized Psychiatric Rehabilitative Services add-on for residents with mental illness identified through the PASRR Level II Evaluation. The add-on payment provides $25.49 per diem for residents receiving qualifying services and requires a care plan with measurable goals. Eligibility is reassessed every two years through PASRR, and payment is adjusted annually based on the inflation factor applied to direct care wages.[335]

Case study: Idaho (flat rate add on)

Idaho's Behavioral Care Unit rate adjustment provides a per diem rate enhancement to SNFs that operate state-approved Behavioral Care Units meeting specified program and utilization requirements for residents with complex behavioral health needs.[336] The adjustment is designed to address the additional resources required for providing specialized care to individuals with conditions such as dementia, psychiatric disorders, and other behavioral health challenges. Facilities are eligible for the enhanced rate by applying for Behavioral Care Unit status and meeting specific criteria, including specially trained staff, individualized interventions, weekly Behavioral Care Unit team meetings, and providing at least 20 percent of their total Medicaid days to individuals with qualifying behaviors.

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[334] Code of Colorado Regulations, tit. 10 CCR 2505-10 § 8.443.10.

[335] For more information see: Wisconsin Department of Health Services. (2025). *Methods of implementation for Wisconsin Medicaid nursing home payment rates* (Attachment 4.19-D). Forward Health. Available at: https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/medicaid/nursingfacility/MethodsOfImplementation.pdf.spage.

[336] For more information about Idaho's Behavioral Care Units, see Idaho's Medicaid Nursing Facilities webpage, available at: https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/medicaid-nursing-facilities.

Supplemental payment types: Quality incentives and rate adjustments

Some states incorporate behavioral health considerations into broader quality incentive programs. These quality incentive programs provide mechanisms for rate adjustments or incentives tied to behavioral health-related factors. States structure these adjustments based on defined measures, and may include resident cognitive status, the prevalence of residents with behavioral health conditions or related behaviors, and facility participation in behavioral health training.

Alternatively, states may adjust specific components of the base rate rather than applying add-ons. This may include increasing allowable cost limits within rate components or modifying capital-related payments. For example, states may recognize higher capital costs for specialized units, such as those for Alzheimer's care. These adjustments are incorporated directly into the rate structure.

State approaches

Case study: Kentucky (training-based quality incentive)

Kentucky's Medicaid Nursing Facility Quality Program provides a per diem add-on to the prospective rate based on performance across defined quality measures. The program includes seven measures, each equally weighed at 100 points, for a total of 700 points. One measure focuses on behavioral health and is based on facility attestation of participation in the Center of Excellence for Behavioral Health in Nursing Facilities. This measure is scored across four tiers, with payment tied to the level of participation.[337]

[337] Kentucky Administrative Regulations, Title 907. Chapter 001. Regulation 065.

CONCLUSION AND NEXT STEPS

The renewal of the Medi-Cal LTC Reimbursement Act creates a historic opportunity for California to modernize its SNF payment framework to support DHCS's policy goals and ensure sustainability for nursing facility providers, managed care plans, and the state. This report's overview of payment approaches used in California, other state Medicaid programs, and Medicare provides DHCS and stakeholders with a comprehensive understanding of policy levers that can be used to achieve the guiding principles of the SNF Value Strategy.

Throughout the drafting of this Landscape Analysis Report, DHCS has been convening the SNF Value Strategy Stakeholder Advisory Workgroup to provide input on the report's findings and inform the Department's future planning. DHCS thanks the members of the Stakeholder Advisory Workgroup for their participation and commitment to serving Medi-Cal members.

DHCS is developing the SNF Value Strategy Multi-Year Roadmap, planned for release in early 2027, which will outline a path for system transformation to the Medi-Cal SNF payment framework over a five-year time horizon from 2028 to 2032. DHCS will continue to engage stakeholders throughout the implementation of its SNF Value Strategy.

ACRONYMS

Acronym	Definition
AB 186	Assembly Bill 186 (2022 Amendment to Medi-Cal Long-Term Care Reimbursement Act)
AB 531	Assembly Bill 531 (Behavioral Health Infrastructure Bond Act of 2024)
AB 1629	Assembly Bill 1629 (Medi-Cal Long-Term Care Reimbursement Act)
ADL	Activities of Daily Living
AHCA	American Health Care Association
ALW	Assisted Living Waiver
APM	Alternative Payment Model
ASP	Accountability Sanctions Program
BIMS	Brief Interview for Mental Status
BH-CONNECT	Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
BHCIP	Behavioral Health Continuum Infrastructure Program
BHP	Behavioral Health Plan
BHSA	Behavioral Health Services Act
BWB	Basic Wage and Benefit
CalAIM	California Advancing and Innovating Medi-Cal
CalHHS	California Health and Human Services Agency
CBA	Collective Bargaining Agreement
CBAS	Community Based Adult Services
CCT	California Community Transitions
CDPH	California Department of Public Health
CMI	Case-Mix Index
CMP	Civil Money Penalties

Acronym	Definition
CMS	Centers for Medicare & Medicaid Services
CNA	Certified Nursing Assistant
CPS	Cognitive Performance Scale
CY	Calendar Year
DHCS	Department of Health Care Services
DHPPD	Direct Care Hours Per Patient Day
DON	Director of Nursing
DP/SNF	Distinct Part Skilled Nursing Facility
DP/PSA	Distinct Part Pediatric Subacute Facility
DP/SA	Distinct Part Subacute Facility
ECM	Enhanced Care Management
FFP	Federal Financial Participation
FRV	Fair Rental Value
FRVS	Fair Rental Value System
FS/SNF-B	Freestanding Skilled Nursing Facility (Level-B)
FS/PSA	Freestanding Pediatric Subacute
FS/SA	Adult Freestanding Subacute Facility
HCAI	Health Care Access and Information
HCBA	Home and Community Based Alternatives
HCBS	Home and Community-Based Services
HCBS-DD	HCBS Waiver for the Developmentally Disabled
HCRIS	Healthcare Provider Cost Reporting Information System
HPRD	Hours Per Resident Day
I/DD	Intellectual and Developmental Disability
ICF/DD	Intermediate Care Facility for the Developmentally Disabled
IHSS	In-Home Support Services

Acronym	Definition
IMD	Institution for Mental Disease
IMPACT	Medicare Post-Acute Care Transformation Act of 2014
iQIES	Internet Quality Improvement & Evaluation System
LMC	Labor Management Committee
LOC	Level of Care
LPN	Licensed Practical Nurse
LPS	Lanterman-Petris-Short
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
LVN	Licensed Vocational Nurse
MA	Medicare Advantage
MACPAC	Medicaid and CHIP Payment and Access Commission
MCAS	Medi-Cal Accountability and Sanctions
MCP	Managed Care Plan
MCWP	Medi-Cal Waiver Program
MDS	Minimum Data Set
MHRC	Mental Health Rehabilitation Center
MLTSS	Managed Long-Term Services and Supports
MSSP	Multipurpose Senior Services Program
NF-A	Nursing Facility Level A
NTA	Non-Therapy Ancillary
OBRA '87	Omnibus Budget Reconciliation Act of 1987
OT	Occupational Therapy
P4P	Pay-for-Performance
PACE	Program for All-Inclusive Care for the Elderly
PASRR	Preadmission Screening and Resident Review Process

Acronym	Definition
PDPM	Patient Driven Payment Model
PHM	Population Health Management
POF	Population of Focus
PPS	Prospective Payment System
PT	Physical Therapy
QAF	Quality Assurance Fee
QAPI	Quality Assurance and Performance Improvement
QASP	Quality and Accountability Supplemental Payment Program
QuILTSS	Tennessee's Quality Improvement in Long-Term Services and Supports Program
RN	Registered Nurse
RUG	Resource Utilization Group
SDP	State Directed Payment
SLP	Speech-Language Pathology
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SNF QRP	SNF Quality Reporting Program
SNF VBP	SNF Value Based Purchasing
STRIVE	Staff Time and Resource Intensity Verification
SUD	Substance Use Disorder
TBI	Traumatic Brain Injury
TCS	Transitional Care Services
UPL	Upper Payment Limit
VBP	Value-Based Payment
WQIP	Workforce & Quality Incentive Program
WSP	Workforce Standards Program

APPENDIX A: GLOSSARY

Term	Definition
Distinct Part Skilled Nursing Facility (DP/SNF)	A licensed long-term care unit that is a distinct part of an acute care hospital, physically separated and licensed as a nursing facility within that hospital.
Distinct Part Pediatric Subacute Unit (DP/PSA)	A pediatric subacute program integrated as a distinct part of a hospital's skilled nursing unit, under contract with DHCS to deliver specialized subacute care for medically complex pediatric patients who require intensive but nonacute care.
Distinct Part Adult Subacute Unit	A subunit of an acute care hospital licensed as a distinct part skilled nursing facility, contracted with DHCS to provide adult subacute care to Medi-Cal beneficiaries who do not require acute hospital care but need more intensive skilled nursing care than standard SNFs provide.
Freestanding Pediatric Subacute	A freestanding certified nursing facility (not part of a general acute care hospital) contracted with DHCS to provide pediatric subacute services—specialized skilled nursing care for patients under 21 who require medically complex support but do not need acute hospital care.
Freestanding Adult Subacute Facility (FS/SA)	An independent facility licensed to provide subacute care (which is a step below hospital-level intensive care, but more complex than regular nursing home care) for adults 18 and over that is not embedded within a hospital.
Freestanding Skilled Nursing Facility (FS/SNF-B)	An independent facility licensed to provide full long-term skilled nursing care that is not embedded within a hospital.
Intermediate Care Facility for the Developmentally Disabled (ICF/DD)	A facility that provides specialized 24-hour-per-day residential services to individuals with intellectual or developmental disabilities.

Term	Definition
Nursing Facility Level A (NF-A)	A licensed facility that does not provide skilled nursing care or participate in the Medicare program.
Special Treatment Program (STP)	A licensed SNF that includes a mental health program for people with diagnosed chronic psychiatric impairment whose adaptive functioning is moderately impaired.

APPENDIX B: PEER GROUPS

County Name	Peer Group
Alameda	Bay Area
Alpine	North State-Sierras
Amador	North State-Sierras
Butte	North State-Sierras
Calaveras	North State-Sierras
Colusa	North State-Sierras
Contra Costa	Bay Area
Del Norte	North State-Sierras
El Dorado	Greater Sacramento
Fresno	San Joaquin Valley
Glenn	North State-Sierras
Humboldt	North State-Sierras
Imperial	Southern Inland
Inyo	North State-Sierras
Kern	San Joaquin Valley
Kings	San Joaquin Valley
Lake	North State-Sierras
Lassen	North State-Sierras
Los Angeles[a]	Los Angeles Region 1, Los Angeles Region 2, Los Angeles Region 3
Madera	San Joaquin Valley
Marin	Bay Area
Mariposa	North State-Sierras
Mendocino	North State-Sierras

County Name	Peer Group
Merced	San Joaquin Valley
Modoc	North State-Sierras
Mono	North State-Sierras
Monterey	Central Coast
Napa	Bay Area
Nevada	North State-Sierras
Orange	Orange-San Diego
Placer	Greater Sacramento
Plumas	North State-Sierras
Riverside	Southern Inland
Sacramento	Greater Sacramento
San Benito	Central Coast
San Bernardino	Southern Inland
San Diego	Orange-San Diego
San Francisco	Bay Areas
San Joaquin	Stockton-Modesto
San Luis Obispo	Central Coast
San Mateo	Bay Area
Santa Barbara	Central Coast
Santa Clara	Bay Area
Santa Cruz	Central Coast
Shasta	North State-Sierras
Sierra	North State-Sierras
Siskiyou	North State-Sierras
Solano	Bay Area
Sonoma	Bay Area

County Name	Peer Group
Stanislaus	Stockton-Modesto
Sutter	Greater Sacramento
Tehama	North State-Sierras
Trinity	North State-Sierras
Tulare	San Joaquin Valley
Tuolumne	North State-Sierras
Ventura	Central Coast
Yolo	Greater Sacramento
Yuba	Greater Sacramento

[a] Because of its large number of facilities, Los Angeles County is currently split into three peer groups, grouped by CDPH office.