CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: March 30, 2026

ALL PLAN LETTER 26-006
SUPERSEDES ALL PLAN LETTER 25-002

TO: ALL MEDI-CAL MANAGED CARE PLANS[1]

SUBJECT: SKILLED NURSING FACILITY WORKFORCE QUALITY INCENTIVE PROGRAM

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with instructions on the payment and data sharing process required for the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) for Rating Periods between January 1, 2023, and December 31, 2025. The Calendar Year (CY) 2023 Rating Period is referred to as Program Year (PY) 1, CY 2024 Rating Period as PY 2, and so forth.

BACKGROUND:

Assembly Bill (AB) 186 (Committee on Budget, Chapter 46, Statutes of 2022) amended the Medi-Cal Long-Term Care Reimbursement Act to reform the financing methodology applicable to Freestanding SNFs Level-B and Adult Freestanding Subacute Facilities Level-B.[2] In addition, AB 186 added Welfare & Institutions Code (W&I) section 14126.024 authorizing the state to implement SNF WQIP, which will provide performance-based directed payments to facilities to incentivize workforce and quality improvements. AB 116 (Committee on Budget, Chapter 21, Statutes of 2025) amended W&I section 14126.024 to change the end date of SNF WQIP to December 31, 2025. SNF WQIP succeeds the former Fee-For-Service (FFS) delivery system's Quality and Accountability Supplemental Payment (QASP) program.

As of January 1, 2023, all MCPs are responsible for SNF Long-Term Care (LTC) services pursuant to W&I section 14184.201. Prior to January 1, 2023, only MCPs operating in County Organized Health Systems or Cal MediConnect (Coordinated Care Initiative)

[1] This APL does not apply to Prepaid Ambulatory Health Plans.
[2] State law is searchable at: https://leginfo.legislature.ca.gov/.

counties were responsible for LTC services on a long-term basis, and other MCPs covered those services only for the initial month of admission and subsequent month, after which those Members were disenrolled from Medi-Cal managed care and covered through Medi-Cal FFS.

POLICY:

SNF WQIP-Eligible Network Providers and Bed Days

Qualifying facilities include Freestanding SNF Level-B and Adult Freestanding Subacute Facility Level-B that are eligible to participate in the Medi-Cal program and furnish services under a Network Provider Agreement.[3] Pursuant to W&I sections 14126.024 subdivisions (d), (e), and (l)(3), Freestanding Pediatric Subacute Care Facilities, Intermediate Care Facilities for the Developmentally Disabled Homes, Distinct Part Facilities, and SNFs with 100% designated special treatment program beds are not eligible for SNF WQIP. MCPs are responsible for determining if a Network Provider is eligible to participate in SNF WQIP.

SNF WQIP qualifying bed days are calendar days during which a Member receives SNF Level-B services inclusive of the first day of a Member's stay and excluding the day of discharge unless it is also the first day of stay, rendered during the PY and billed under a Network Provider Agreement with an MCP pursuant to applicable state and federal laws, regulations, and contractual terms for which Medi-Cal is the primary payer and where Medicare is no longer covering any portion of the bed day. SNF Level-B services are defined in California Code of Regulations (CCR) sections 51123(a), 51511(b), 51535, and 51535.1 as applicable and include:[4]

- SNF services as set forth in 22 CCR section 51123(a):
  - Room and board.
  - Nursing and related care services.
  - Commonly used items of equipment, supplies, and services as set forth in 22 CCR section 51511(b).
- Leave-of-absence days as set forth in 22 CCR section 51535.

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[3] For more information on evaluating Network Provider status, see APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status. APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

[4] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.

- Bed holds as set forth in 22 CCR section 51535.1.

Pursuant to W&I section 14126.024(e), bed days receiving reimbursement for special treatment program (STP) services for the mentally disordered are not qualified for SNF WQIP payments. Furthermore, hospice bed days are not qualified for SNF WQIP. Facilities in which all beds are designated for STP and/or hospice services thus are not qualified for SNF WQIP.

Bed days reimbursed outside of a Network Provider Agreement, bed days for which Medi-Cal is a secondary payer, and bed days reimbursed through the Medi-Cal FFS delivery system are not qualified for SNF WQIP.

Payments to SNF WQIP-Eligible Network Providers

SNF WQIP payments will be made by MCPs to SNF WQIP-eligible Network Providers based on an interim and final per diem amount calculated by the Department of Health Care Services (DHCS) in accordance with the preprint approved by the Centers for Medicare & Medicaid Services (CMS) and DHCS' SNF WQIP Technical Program Guide.[5] For each PY, DHCS will aim to calculate quality scores and provide payment exhibits directing MCPs to pay the interim per diem amount during the first part of the CY following the Rating Period, and the final per diem amount during the second part of the CY following the Rating Period.

MCPs are responsible for calculating the number of SNF WQIP qualifying bed days and paying the directed per diem amount for all Clean Claims for SNF WQIP qualifying bed days without regard to when these bed days are reported to DHCS, consistent with any reporting requirements applicable to the SNF.

MCPs are responsible for netting out any previously directed interim payment amounts from the final payment. MCPs are responsible for recouping or withholding any amounts related to Class AA or A citations from interim and final payments as described below.

[5] The SNF WQIP Technical Program Guide for PY1 is available at: https://www.dhcs.ca.gov/services/Documents/WQIP-PY1-TechnicalProgramGuide-F3.pdf.

MCPs must make payments to SNF WQIP-eligible Network Providers for qualifying bed days within 45 calendar days of receiving payment exhibits from DHCS or within 30 calendar days of receiving a Clean Claim from the Provider, whichever is later.

MCPs must designate that payment is for the SNF WQIP (including the PY) when sending payment to SNF Providers.

Interest for Late Payment

Requirements for Timely Payment of Claims, the amount of the SNF WQIP payment owed in accordance with this APL is considered a portion of a claim as defined in H&S section 1371. For any payment exhibits issued for SNF WQIP after March 30, 2026, an MCP owes the Provider interest on any unpaid amount owed at the rate of 15 percent per annum beginning on the first calendar day after the latter of either:

1. 45 calendar days after receipt of payment exhibits from DHCS applicable to the claim, as described above; or
2. 45 Working Days after receipt of claims, if on or before December 31, 2025, or 30 calendar days of receipt of claims, if on or after January 1, 2026.

The MCP must automatically include all accrued interest in any late payment. This paragraph does not relieve the MCP of any other interest that may be owed on any other portion of a claim under APL 23-020 or applicable state and federal law.

Class AA and A Citations

In accordance with SNF WQIP's requirements, MCPs must withhold SNF WQIP payments for facilities with one or more Class AA or A citations issued by the California Department of Public Health (CDPH) for violations that occur wholly or in part during the PY.

- Class AA citations are issued to facilities for actions that are the proximate cause of resident death. Facilities with one or more class AA citations partly or wholly in the PY are disqualified from payments for that PY.
    - Class A citations are issued to facilities for actions where there is imminent danger of death or serious harm to a resident or a substantial probability of death or serious physical harm. Facilities with one or more class A citations partly or wholly in the PY receive a 40 percent penalty in addition to the per diem payment amount for that PY.

CDPH publishes state enforcement action data, including Class AA and A citations, on the CDPH State Enforcement Actions Dashboard.6 If an MCP becomes aware of an applicable citation for a PY after the time of an interim or final payment, the MCP must recoup and withhold the applicable payments retroactively for the respective PY.

For citations that are appealed, MCPs must withhold the applicable payments until all appeals are exhausted and, if applicable, release the applicable payments based on the final disposition of the citation, without regard to the length of the appeals process.

Separate Payment Term

For PY 1, DHCS calculated the final separate payment term made by DHCS to MCPs based on qualifying bed days that were reported by MCPs to the Post-Adjudicated Claims and Encounters System (PACES) by October 15, 2024, and that were accepted by DHCS. For PY 2 and subsequent PYs, DHCS will calculate the final separate payment term made by DHCS to MCPs based on qualifying bed days that are reported by MCPs to PACES by June 30 following the PY and that are accepted by DHCS.

Because Providers generally have up to 12 months to report claims to MCPs, DHCS may make actuarially appropriate adjustments to reflect claims run out past the reporting deadline. However, the inclusion, or lack thereof, of SNF WQIP qualifying bed days in the data reported to DHCS does not impact the MCP's obligation to make payments for all SNF WQIP qualifying bed days.

WQIP Score & Quality Metrics

DHCS will calculate each SNF WQIP-eligible Network Provider's performance metrics, WQIP score, and resulting interim and final per diem payment amounts. For PY 1, PY 2, and PY 3, SNF WQIP includes several quality metrics across workforce, clinical, and equity domains. An aggregate curve factor is applied to all facilities' WQIP scores based on projected qualifying bed days to calculate the interim and final per diem payment amounts. Because a single facility may have bed days billed to multiple MCPs, DHCS will calculate the aggregate performance on each metric and the curve factor across all MCPs.

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[6] The CDPH State Enforcement Actions Dashboard is available at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/StateEnforcementActionsDashboard.aspx.

SNF WQIP includes three claims-based clinical quality metrics that MCPs must calculate on behalf of SNF WQIP-eligible Network Providers. These metrics are the three LTC report only metrics in Measurement Year 2023, 2024, and 2025 of the Medi-Cal Accountability Set (MCAS).[7] The specifications for the SNF WQIP versions of these metrics are provided in the SNF WQIP Technical Program Guide. The SNF WQIP versions of these LTC metrics are sub-sets of the MCP's overall performance on these measures (e.g., the MCP reports their overall performance through MCAS and a sub-rate for each SNF WQIP-eligible facility that is a Network Provider). MCPs must submit the SNF WQIP versions of these LTC metrics at the same time MCAS data are due for each MCAS Measurement Year as described in APL 24-004: Quality Improvement and Health Equity Transformation Requirements.

Additionally, for PY 1, PY 2, and PY 3, the Medi-Cal Disproportionate Share metric counts all Medi-Cal bed days including contracted and non-contracted bed days in the managed care delivery system and bed days in the FFS delivery system.

DHCS will calculate the interim curve factor based on qualifying bed days that are reported by MCPs to PACES by December 31 of the PY and that are accepted by DHCS. DHCS will calculate the Medi-Cal Disproportionate Share metric and final curve factor based on qualifying bed days that are reported by MCPs to PACES by June 30 following the PY and that are accepted by DHCS.

Bed Days Data Sharing

DHCS will provide MCPs with data reflecting all SNF bed days reported by MCPs to PACES on a quarterly basis as described in Appendix A below. MCPs must reconcile the data against the MCP's records and provide each SNF WQIP-eligible Network Provider with a summary level reporting including the specified data fields in Appendix A. These summary level reports must be sent to all SNF WQIP-eligible Network Providers in a manipulatable digital format within 30 calendar days of receiving the data from DHCS. If a SNF WQIP-eligible Network Provider reports a possible discrepancy in the summary level report, the MCP must confirm receipt of the inquiry within three Working Days and work with the Network Provider to reconcile the data, which must include providing

[7] The MCAS measures for each Measurement Year are available at: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEAS.aspx.

Member-level data and claims, in a machine-readable format, to the Network Provider upon request.

MCPs are responsible for publishing SNF WQIP-eligible Network Provider's contracted bed days (by CY for date of service) and payment totals (by PY) on a SNF WQIP public website maintained by each MCP. Data must be published for all prior CYs. For the immediate prior CY, data must be updated by September 1 and February 15. For example, for 2025, bed days and payments must be posted by September 1, 2026, and then updated again by February 15, 2027. Each SNF should be listed individually with National Provider Identifier(s) (NPI) and Health Care Access and Information (HCAI) ID. MCPs must use and publish data with a template Excel document provided as an attachment to this APL. Additionally, MCPs must provide the website URL to the SNF WQIP Inbox at SNFWQIP@dhcs.ca.gov within seven calendar days of publishing this data.

General Provisions

MCPs must have a formal procedure to accept, acknowledge, and resolve Network Provider grievances related to the processing or non-payment of SNF WQIP directed payments including the calculation of SNF WQIP qualifying bed days. DHCS may request information regarding the Network Provider grievances and how they were resolved. MCPs must maintain records to respond to DHCS's request for information regarding Network Provider grievances.

MCPs must communicate the payment processes to SNF WQIP-eligible Network Providers and maintain a SNF WQIP public internet website. The communication and website must, at a minimum, include a description of how payments will be processed, how to file a Provider grievance, how to determine the responsible payer, and a hyperlink to the DHCS SNF WQIP website.[8]

MCPs must ensure that Long-Term Services and Supports (LTSS) liaisons (described pursuant to APL 24-009: Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care) are trained and able to assist Network Providers with questions and technical assistance related to SNF WQIP.

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[8] The DHCS SNF WQIP website is available at: https://www.dhcs.ca.gov/services/Pages/SNF-WQIP.aspx.

Liaisons must acknowledge receipt of communications from Network Providers within three business days. MCPs with more than one LTSS liaison must designate at least one of the LTSS liaisons to act as the point of contact for SNF WQIP. MCPs must publish this LTSS liaison's name, title, email address, and telephone number on the MCP's SNF WQIP public internet website.

Each MCP must hold a webinar twice per year for all SNF WQIP-eligible Network Providers. The webinar must allow these Network Providers to participate virtually via telephone and optionally via an online teleconference service. The webinar must provide the capability and opportunity for Network Providers to ask live questions. If an MCP covers multiple counties, a single webinar can be held for all counties. If a single county/region has multiple MCPs, the MCPs may hold joint webinars to satisfy this requirement, though each individual MCP must answer questions from Network Providers about issues specific to that individual MCP. At least 30 days before the webinar, each MCP must publish, on its SNF WQIP public internet website, the date and time of the webinar and instructions to join and notify DHCS and all SNF WQIP-eligible Network Providers. DHCS may provide additional guidance to MCPs regarding the required timing, content, and duration of webinars.

MCP Responsibilities for Policies and Procedures, Subcontractors, Downstream Subcontractors, and Enforcement Actions

MCPs must review their contractually required policies and procedures (P&Ps) to determine if amendments are needed to comply with this APL. If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required P&Ps, the MCP must submit its updated P&Ps to the Managed Care Operations Division (MCOD)-MCP Submission Portal[9] within 90 calendar days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must attach an attestation to the Portal within 90 calendar days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The attestation must include the title of this APL as well as the applicable APL release date in the subject line.

[9] The MCOD-MCP Submission Portal is located at: https://cadhcs.sharepoint.com/sites/MCOD-MCPSubmissionPortal/SitePages/Home.aspx.

MCPs are responsible for ensuring that all Subcontractors, Downstream Subcontractors, and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all Subcontractors, Downstream Subcontractors, and Network Providers. DHCS may impose enforcement actions, including corrective action plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. MCPs should review their Subcontractor, Downstream Subcontractor, and Network Provider Agreements to ensure compliance with this APL. For additional information regarding enforcement actions, see APL 25-007: Enforcement Actions: Corrective Action Plans, Administrative and Monetary Sanctions. Any failure to meet the requirements of this APL may result in enforcement actions.

For MCPs that have any questions regarding this APL, please contact your MCOD Contract Manager and Capitated Rates Development Division Rate Liaison. For SNFs that have any questions regarding this APL, please contact SNFWQIP@dhcs.ca.gov.

Sincerely,

Original Signed by Shaun Garcia

Shaun Garcia, Chief

Quality and Health Equity Division

Appendix A

Data Sharing:

DHCS will provide a dataset containing the below data elements to each MCP. Each MCP must reconcile the data against the MCP's records and provide each of their SNF WQIP-eligible Network Provider with summary-level reporting containing at least the following data fields:

- Plan_Name
- PLAN_CD
- Facility_Name
- NPI
- PROV_274
- MEDICARE_IND
- Medicare_Status
- Remove_Days
- Remove_Note
- WQIP_Days

Data Description:

The data reflects claims that fall under the LTC category of service, based on Mercer's Rate Development Template (RDT) logic.

SNF WQIP qualifying bed days are calculated as follows (using CY 2024 as an example):

> **SNF WQIP Bed Days** = (minimum of SVC_TO_DT or 12/31/2024) - (max of SVC_FROM_DT or 1/1/2024) + 1 (only if LTC claim is non-discharge)

As shown above, bed days are only counted if they fall within the PY.

1 bed day is counted in instances where SVC_FROM_DT = SVC_TO_DT

Otherwise, the discharge date does not count towards payable days.

Additionally, bed days for Medicare crossover claims (MEDICARE_IND = "1") where the beneficiary has Medicare Part A coverage are not qualified for SNF WQIP.

Data Fields:

Field Name	Description
Plan_Name	health plan name
PLAN_CD	health plan code
Facility_Name	facility name
NPI	billing Provider's National Provider Identifier number
PROV_274	DHCS derived field indicating whether Provider (based on NPI) is a Network Provider identified in the health plan's Network Provider file
RECORD_ID	record identification number, provides a unique number for each claim header record
MAIN_SGMNT_ID_NO	claim line number
AKA_CIN	beneficiary's client index number
ENCRYPTED_AKA_CIN	encrypted client index number
BENE_FIRST_NAME	beneficiary's first name
BENE_LAST_NAME	beneficiary's last name
AGE	beneficiary's age
BIRTH_DT	beneficiary's birth date
CLAIM_FORM_IND	indicates whether claim form used is a UB-04 or a HCFA-1500 form
FI_CLAIM_TYPE_CD	claim type code
FI_PROV_TYPE_CD	Provider type code
PROV_TAXON	billing Provider taxonomy
SVC_FROM_DT	header level service from date
SVC_TO_DT	header level service to date

Field Name	Description
INPAT_DISCHARGE_DT	date the patient was discharged (inpatient/LTC claims only), equals SVC_TO_DT when not blank
INPAT_DISCHARGE_CD	value of 6 indicates non-discharge claim
Day_DIFF	day difference = (minimum of SVC_TO _DT or program phase end date) - (max of SVC_FROM_DT or program phase start date) + 1 (only if LTC claim is non-discharge) 1 bed day is counted when SVC_FROM_DT = SVC_TO_DT
DTL_SVC_FROM_DT	detail level service from date
DTL_SVC_TO_DT	detail level service to date
ORIG_POS_CD	place of service code
PROC_CD	procedure code
REND_OPERATING_PROV_TAXON	rendering Provider taxonomy
REVENUE_CD	revenue code
MEDICARE_IND	value of 1 indicates Medicare crossover claim
MC_STAT_A	code indicating status and funding source for beneficiary's Medicare Part A coverage
MC_STAT_B	code indicating status and funding source for beneficiary's Medicare Part B coverage
Medicare_Status	field derived from eligibility data indicating beneficiary's Medicare coverage status
Remove_Days	indicates how many days have been zeroed out due to Medicare Part A exclusion

Field Name	Description
Remove_Note	indicates if days were not qualified for SNF WQIP due to being for Medicare crossover claims where the beneficiary has Medicare Part A coverage
WQIP_Days	set equal to Day_DIFF on the first claim line of each LTC claim