CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

August 11, 2026

THIS LETTER SENT VIA EMAIL

Ms. Courtney Miller, Director
Division of Program Operations
Medicaid and CHIP Operations Group
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 355
Kansas City, MO 64106

STATE PLAN AMENDMENT 26-0010: EXTEND THE REIMBURSEMENT METHODOLOGY FOR FREESTANDING SKILLED NURSING/SUBACUTE FACILITIES LEVEL-B AND WORKFORCE STANDARDS PROGRAM THROUGH CALENDAR YEAR 2027

Dear Ms. Miller:

The Department of Health Care Services (DHCS) is submitting State Plan Amendment (SPA) 26-0010 for your review and approval. This SPA proposes to extend the rate methodology for Freestanding Skilled Nursing/Subacute Facilities Level-B and the Workforce Standards Program through Calendar Year (CY) 2027 and makes additional technical edits. DHCS seeks an effective date of January 1, 2027, for this SPA.

SPA 26-0010 proposes to provide annual aggregate increases in the weighted average Medi-Cal reimbursement calculated separately for labor and non-labor costs, plus the projected cost of complying with new state of federal mandates, in accordance with California Welfare & Institutions Code (WIC) section 14126.033(c)(16) by extending the existing reimbursement methodology through CY 2027. In addition, the proposed SPA 26-0010 extends the Workforce Standards Program for Freestanding Skilled Nursing/Subacute Facilities Level-B.

Public notice was released on July 13, 2026. At the time of SPA submission, no comments were received. DHCS has determined that a Tribal notice is not necessary for this proposal. DHCS has determined that this SPA does not reduce or restructure rates.

DHCS is submitting the following SPA documents for review and approval:

- CMS 179 – Transmittal and Notice of Approval of State Plan Material
- Attachment 4.19-D, Supplement 4, pages 1, 4, 5, 5c (Clean and Redline)
- Attachment 4.19-D, Supplement 6, pages 1-2, 5-6, 13 (Clean and Redline)
- Standard Funding Questions
- Federal Budget Impact Methodology
- Public Notice (Posted July 13, 2026)

If you have any questions or need additional information, please contact Aditya Voleti, Chief of Provider Rates Division, at (916) 345-8717 or by email at Aditya.Voleti@dhcs.ca.gov.

Sincerely,

[redacted]

Tyler Sadwith
State Medicaid Director
Chief Deputy Director, Health Care Programs
California Department of Health Care Services

Enclosures

cc: Saralyn M. Ang-Olson, JD, MPP
Chief Compliance Officer
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 26-0010

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2027

5. FEDERAL STATUTE/REGULATION CITATION
Title 42 § CFR 447 Subpart B & C

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ 13,850,000
b. FFY 2027 $ 4,600,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D, Supplement 4, pages 1, 4, 5, 5c
Attachment 4.19-D, Supplement 6, pages 1-2, 5-6, 13

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D, Supplement 4, pages 1, 4, 5, 5c
Attachment 4.19-D, Supplement 6, pages 1-2, 5-6, 13

9. SUBJECT OF AMENDMENT
Continue the existing facility-specific reimbursement methodology and Workforce Standards Program for Freestanding Skilled Nursing/Subacute Facilities Level-B through Calendar Year 2027.

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:
Please note: The Governor's Office does not wish to review the State Plan Amendment.

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Tyler Sadwith

13. TITLE
State Medicaid Director and Chief Deputy Director

14. DATE SUBMITTED
August 11, 2026

15. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Instructions on Back

METHODS AND STANDARDS FOR ESTABLISHING FACILITY-SPECIFIC REIMBURSEMENT RATES FOR FREESTANDING SKILLED NURSING FACILITIES LEVEL-B AND SUBACUTE CARE UNITS OF FREESTANDING SKILLED NURSING FACILITIES

I. Introduction

A. This document, labeled Supplement 4 to Attachment 4.19-D, describes the overall reimbursement rate methodology for skilled nursing facility services provided to Medi-Cal recipients by: freestanding skilled nursing facilities level-B (FS/NF-B), both publicly and privately operated, and (2) subacute care units of FS/NF-Bs as defined in California Code of Regulations, title 22, section 51124.5.

B. This Supplement is submitted by the single State Medicaid (Medi-Cal) Agency, the State of California Department of Health Care Services (hereinafter "Department"). This Supplement is necessary to describe changes to the FS/NF-B reimbursement rate methodology adopted by the 2004 State Legislature in Assembly Bill (AB) 1629, signed into law on September 29, 2004, as Chapter 875 of the Statutes of 2004.

C. AB 1629 establishes the Medi-Cal Long-Term Care Reimbursement Act, which mandates a facility- specific rate-setting methodology effective on August 1, 2005; and which will cease to be operative on and after July 31, 2008. This statute requires the Department to develop and implement a Medi-Cal cost-based facility-specific reimbursement rate methodology for Medi-Cal participating FS/NF-Bs, including FS/NF-Bs with subacute care beds. AB 203, signed into law on August 24, 2007, as Chapter 188 of the Statutes of 2007, extends the operative date to July 31, 2009. AB 1183, signed into law on September 30, 2008, as Chapter 758 of the Statutes of 2008, extends the operative date to July 31, 2011. SB 853, signed into law on October 19, 2010, as Chapter 717 of the Statutes of 2010, extends the operative date to July 31, 2012. ABX 119, signed into law on June 28, 2011, as Chapter 4 of the Statutes of 2011, extends the operative date to July 31, 2013. AB 1489, signed into law on September 27, 2012, as Chapter 631 of the Statutes of 2012, extends the operative date to July 31, 2015. AB 119 (Chapter 17, Statutes of 2015) extends the operative date to July 31, 2020. Assembly Bill 81 (Chapter 13, Statutes of 2020) extends the operative date to December 31, 2022, and directs the department to make various revisions to the methodology. AB 186 (Chapter 46, Statutes of 2022) reformed the financing methodology applicable to long-term care freestanding nursing facilities level-B and subacute facilities. The financing methodology authorized by AB 186 is effective January 1, 2023 through December 31, 2026. SB 165 (Chapter 61, Statutes of 2026) extended the financing methodology authorized by AB 186 through December 31, 2027.

D. The cost-based reimbursement rate methodology is intended to reflect the costs and staffing levels associated with the quality of care for residents in FS/NF-Bs. This methodology will be effective August 1, 2005, and will be implemented the first day of the month following federal approval. A retroactive increase in reimbursement rates to August 1, 2005, to FS/NF-Bs will be provided in the event that federal approval occurs after the effective date of the methodology.

E. August 1, 2020 through December 31, 2020 shall be a rate period, effective August 1, 2020. Beginning January 1, 2021, the rate year shall be the calendar year.

F. The reimbursement rates established will be based on methods and standards described in Section V of this Supplement.

H. The Department reserves the right to exclude any cost report or supplemental schedule or portion thereof that it deems inaccurate, incomplete or unrepresentative.

I. FS/NF-Bs that no longer participate in the Medi-Cal program will be excluded from the rate-setting process.

J. For purposes of calculating reasonable compensation of facility administrators, the Department will adhere to the standards established under Chapter 9 of the Centers for Medicare & Medicaid Services Provider Reimbursement Manual (HIM 15), reproduced in full in Volume 2 at Paragraph 5577 of the Commerce Clearing House Medicare and Medicaid Guide. The Department will conduct its own compensation survey for calculating reasonable compensation for facility administrators. Based on the data collected from such surveys, the state will develop compensation range tables for the purpose of evaluating facility administrator compensation during audits of those FS/NF-Bs, and adjust the costs accordingly.

IV. Audits and Audit Adjustments

A. The Department will conduct financial audits of FS/NF-Bs participating in the Medi-Cal program a minimum of once every three years. These audits may be full-scope field audits, limited scope reviews, or desk reviews. Limited scope or desk reviews will be conducted at intervening periods, as necessary. All subacute care units of FS/NF-Bs will be subject to audit or review on an annual basis.

B. The Department will adjust or reclassify reported cost and statistical information submitted by the FS/NF-Bs for the purposes of calculating facility-specific Medi-Cal rates consistent with applicable requirements of this Supplement and as required by Title 42, Code of Federal Regulations, Part 413.

C. Audited or reviewed cost data and/or prospective audit adjustments will be used and/or applied to develop facility-specific reimbursement rates.

1. On an annual basis, the Department will use FS/NF-B audited cost reports with Fiscal Years Ending (FYE) three years prior to the rate year, or the most recent audited cost reports available at the time of the Department’s prospective ratesetting for the rate year, as required by the Medi-Cal Long-Term Care Reimbursement Act, including supplemental reports as required by the Department, and the results of any state or federal audits to determine if there is any difference between the reported costs used to calculate a FS/NF-B's reimbursement rate and the FS/NF-B's audited expenditures in the rate period or rate year.

2. If the Department determines that there is a difference between reported costs used to calculate a FS/NF-B's reimbursement rate and the audited facility expenditures, the Department will adjust the FS/NF-B's

reimbursement rate prospectively over the intervening year(s) between audits. The amount a cost category is adjusted will be determined by an error factor that reflects a ratio of the difference between the reported cost and the audited expenditures for each cost category, consistent with the methodology specified in this Supplement.

D. In the event that the FS/NF-B's labor costs are incorrectly reported on facility cost reports or supplemental schedules, the Department will prospectively adjust the facility's reimbursement rate, in the same manner as described in Section IV.C.2. of this Supplement. Those adjustments received after computation of the annual labor study will be excluded from that study.

E. Compliance by each FS/NF-B with state laws and regulations regarding staffing levels will be documented annually, either through supplemental reports or through the annual licensing inspection process specified in Health and Safety Code section 1422.

F. Overpayments to any FS/NF-B will be recovered in a manner consistent with applicable recovery procedures and requirements of state and federal laws and regulations. Overpayment recovery regulations are described in the California Code of Regulations, title 22, section 51047. Overpayments referred to in this Section do not include those situations described above in Paragraphs IV.C.2. or IV.D.

G. Providers have the right to appeal final audit or examination findings that result in an adjustment to Medi-Cal reimbursement rates. Specific appeal procedures are contained in Welfare and Institutions Code, section 14171, and in Division 3, Subdivision 1, Chapter 3, Article 1.5 (Provider Audit Appeals) of the California Code of Regulations, title 22, sections 51016 through 51048.

H. For FS/NF-Bs that obtain an audit appeal decision that results in revision of the facility's allowable costs used to calculate a facility's reimbursement rate, the Department will make a retroactive adjustment in the facility-specific reimbursement rate.

I. Beginning January 1, 2022, the Department's financial audits, including any relevant supplemental schedules, of FS/NF-Bs and subacute care units of FS/NF-Bs pursuant to this Section, may include audits of facility costs and revenues associated with the COVID-19 Public Health Emergency declared pursuant to Section 247d of Title 42 of the United States Code on January 30, 2020, and any renewal of that declaration. The Department will recoup amounts of Medi-Cal payments associated with the COVID-19 10% per diem rate increase authorized in Section 7.4 of the State Plan that the Department finds were not adequately used by the facility for allowable costs. Allowable costs include those for patient

B.3 For each rate year, the final labor and non-labor rate components shall be computed to be the lesser of:

a. The respective pre-growth limit rate component.

b. For rate years beginning January 1, 2024 through January 1, 2027, the respective final rate component calculated for the preceding rate year, increased by:

i. For the labor rate component, five percent plus the projected per diem cost of complying with new ongoing state or federal mandates (as defined in Section V, paragraph B.5.b) attributable to cost categories in the labor rate component for the applicable rate year that have not been reflected in the calculation of the final per diem rate in a previous rate year.

ii. For the non-labor cost component, the non-labor growth factor plus the projected per diem cost of complying with new ongoing state or federal mandates (as defined in Section V, paragraph B.5.b) attributable to cost categories in the non-labor rate component for the applicable rate year that are being reflected in the calculation of the per diem rate for the first time in the applicable rate year. The non-labor growth factor shall be prospectively calculated by the department so that projected annual aggregate average increase in the final non-labor rate component, weighted by projected Medi-Cal utilization, does not exceed one percent.

c. For each rate year beginning on or after January 1, 2028, the respective final rate component calculated for the preceding rate year increased by the projected per diem cost of complying with new ongoing new state or federal mandates attributable to cost categories in the respective rate component for the applicable rate year that have not been reflected in the calculation of the final per diem rate in a previous rate year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: California

SKILLED NURSING FACILITY WORKFORCE STANDARDS PROGRAM

For the 2024 through 2027 rate years, a facility that opts-into the Workforce Standards Program and meets the workforce standards will receive an enhanced per diem rate during the applicable rate year pursuant to the requirements and provisions of this Supplement.

Section 1. Definitions

For purposes of this Supplement, the following definitions apply:

a) "Applicable worker" means, with respect to a facility, an employee of the facility or an employee of a related employer of the facility who meets all the following criteria:

   i. Is a direct care or indirect care worker,

   ii. Is not exempt from an overtime rate of compensation pursuant to state or federal law,

   iii. Primarily works on the premises of the licensed facility,

   iv. Is not primarily employed by a non-related entity for the provision of services on the premises of the licensed facility.

b) "Facility" means a freestanding skilled nursing facilities level-B (FS/NF-B) and subacute care units of FS/NF-Bs eligible to receive reimbursement pursuant to Supplement 4 to Attachment 4.19-D of this State Plan. With respect to standards applying to a facility's applicable workers, the term "facility" also includes each of the facility's related employers. With respect to participation in a labor-management committee, the term "facility" also means a related entity duly authorized to act on behalf of the facility.

a) "Direct care worker" means a worker at a facility who is primarily responsible for any of the following: nursing services, social services, or activities, and other duties related to direct care, as described in the direct resident care labor cost category at Welfare and Institutions Code section 14126.023, subdivision (d), paragraph (1).

b) "Indirect care worker" means a worker at a facility who is primarily responsible for any of the following: housekeeping, laundry and linen, dietary, medical records, in-service education, plant operations, or maintenance, and other duties related to supporting the delivery of patient care, as described in the indirect resident care labor cost category at Welfare and Institutions Code section 14126.023, subdivision (d), paragraph (2).

c) "Full time worker" means a worker who is employed an average of at least 30 hours per week within a calendar month, or at least 130 hours per calendar month.

d) "Related employer" means a person who both:

   i. Directly or indirectly, or through an agent or any other person, employs or exercises control over the wages, hours, or working conditions of any person primarily working on the premises of a facility. "Primarily" means more than 50 percent of the applicable metric.

   ii. Is related to the facility as defined in Section 413.17(b) of Title 42 of the Code of Federal Regulations.

e) "Rate year" means a given rate year is based upon the calendar year. For example, rate year 2024 corresponds with the 2024 calendar year.

f) "Rate on file" means the facility's per diem rate published on the DHCS internet website.

g) "Basic per diem rate" means the facility's per diem rate calculated pursuant to Supplement 4 to Attachment 4.19-D of this State Plan.

h) "Enhanced per diem rate" means the facility's basic per diem rate plus the workforce rate adjustment calculated pursuant to section 2.2.

Section 2.2 Workforce Rate Adjustment

a) The amount of the workforce rate adjustment is calculated on a facility-specific per diem basis.

b) For the 2024 rate year, the amount of each facility-specific workforce rate adjustment is equal to the difference between the pre-growth limit labor rate component, described in Supplement 4 to Attachment 4.19-D, Section V, paragraph B.2, and the final labor rate component, described in paragraph B.3.

c) For 2025 rate year, the amount of each facility-specific workforce rate adjustment is equal to the workforce rate adjustment calculated for the 2024 rate year, increased by 5 percent.

d) For the 2026 rate year, the amount of each facility-specific workforce rate adjustment is equal to the workforce rate adjustment calculated for the 2025 rate year, increased by 5 percent.

e) For the 2027 rate year, the amount of each facility-specific workforce rate adjustment is equal to the workforce rate adjustment calculated for the 2026 rate year, increased by 5 percent.

f) The workforce rate adjustment shall not be provided for rate years beginning on or after January 1, 2028.

g) In any rate year, the amount of the workforce rate adjustment shall be reduced so that the sum of the workforce rate adjustment and the final labor rate component for the applicable rate year does not exceed the pre-growth limit labor rate component calculated for the applicable rate year.

h) For facilities with newly established rates pursuant to Supplement 4 to Attachment 4.19-D, Section VIII, the amount of the workforce rate adjustment in the first rate year that the facility has a newly established rate will be calculated by multiplying the following two factors:

   i. The facility's pre-growth limit labor rate component, less the final labor rate component.

   ii. The ratio of the following two factors, calculated using data from all facilities with existing rates in the facility's peer group:

      a. The Medi-Cal utilization weighted average workforce rate adjustment.

      b. The Medi-Cal utilization weighted average pre-growth limit labor rate component less the weighted average final labor rate component.

e) A facility qualifying through the basic wages and benefits must notify the department and attest to meeting the requirements of paragraph (c) and (d) within 105 days of the applicable date. If the facility fails to provide this notice and attestation by the required deadline, the Department shall update the facility's rate on file to the basic per diem rate retroactive to the beginning of the rate year.

f) If an Applicable Worker is terminated during a rate year, a facility must pay or provide the basic wages and benefits described in section 6.1 through 6.4 for all days during the rate year that the facility is not eligible for under another qualifying pathway, up to the termination date.

g) The Department may, in its sole discretion, waive any deadline in this section for good cause.