

**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.

II. General Provisions

- A. Within the provisions of this Supplement, the following abbreviation will apply:
FS/NF-8 meaning freestanding level-B nursing facility.
- B. Reimbursement to FS/NF-Bs (excluding those with FS/NF-8 subacute beds) will be for routine per diem services, exclusive of ancillary services. The reimbursement rate for these ancillary services are reviewed and audited by the Department and are reimbursed separately.
- C. The routine service per diem reimbursement rate will be consistent with Medicare Reimbursement Principles as specified in Title 42, Code of Federal Regulations, Part 413. Aggregate Medi-Cal payments may not exceed the aggregate payments that the state would pay for the same or similar services under the Medicare Prospective Payment System:
- D. The FS/NF-8 routine service per diem payment includes all equipment, supplies and services necessary to provide appropriate nursing care to long-term care residents, except those items listed as separately payable, as described in the California Code of Regulations, Title 22, section 51511(c), as that section reads as of July 1, 2015, or personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shaves or shampoos performed by the facility and periodic haircuts performed as part of resident care), and television rental.
- E. For subacute care units of FS/NF-Bs the per diem payment includes all services, equipment and supplies necessary for the administration of the treatment procedures for residents determined to need subacute care services. Items included in the reimbursement rate are specified in the California Code of Regulations, Title 22, section 51511.5(d), as that section reads as of July 1, 2015.
- F. Notwithstanding any other provisions of this State Plan, the per diem payment will be limited to the usual charges made to the general public, as described in the California Code of Regulations, Title 22, section 51501, as that section reads as of July 1, 2015.
- G. All long-term care providers must be licensed and certified to participate in the Medi-Cal program and must meet the requirements of the California Code of Regulations, Title 22, section 51200, as that section reads as of July 1, 2015. In order to ensure that reimbursement rates take into account the cost of compliance with statutory requirements, FS/NF-Bs will be reimbursed according to this Supplement based on the following resident acuity levels:
 - 1. Freestanding NF-8 residents;
 - 2. Freestanding subacute ventilator-dependent residents;
 - 3. Freestanding subacute non-ventilator-dependent residents.

- H. FS/NF-B subacute care facilities provide medically necessary services of varying degrees of higher intensity care, as provided in the California Code of Regulations, title 22, section 51124.5.

III. Cost Reporting

- A. All long-term care FS/NF-Bs participating in the Medi-Cal Program will maintain, according to generally accepted accounting principles, the uniform accounting systems as described in California Code of Regulations, title 22, section 51511.2 and will submit cost reports in the manner approved by the state.
- B. Cost reports are due to the state no later than 120 days after the close of each facility's fiscal year, in accordance with Medi-Cal cost reporting requirements.
- C. Each FS/NF-B will retain its supporting financial and statistical records for a period of not less than three years following the date of submission of its cost report and will make such records available upon request to authorized state or federal representatives, as described in Welfare and Institutions Code section 14124.1.
- D. All cost reports will be prepared according to the Office of Statewide Health Planning and Development (OSHPD) Reporting Requirements and Instructions. These cost reports will be maintained by the state for a period of not less than five • years following the date of electronic submission of reports, in accordance with Title 42, Code of Federal Regulations, section 433.32.
- E. The reimbursement rate methodology for FS/NF-Bs may include more or less than twelve months and/or more than one cost report, as long as the fiscal periods all end within the timeframe specified for rate-setting. Only cost reports accepted by the OSHPD will be included in the calculation of the facility-specific reimbursement rates, except as specified in Section VIII of this Supplement.
- F. For FS/NF-Bs providing subacute care services, only cost reports with twelve or more months of subacute costs which have been formally accepted by the state will be used in the rate study to determine the facility-specific reimbursement rate.
- G. Supplemental schedules may be used to augment and/or update cost reports and other source data used to develop facility-specific rates. Supplemental schedules will be subject to audit or review prior to use in the facility-specific rate-setting process.

- 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

care: additional labor costs attributable to the COVID-19 Public Health Emergency including, but not limited to, increased wages or benefits, shift incentive payments, staff retention bonuses, pay differential for workers employed by more than one facility, and overtime payments to nonmanagerial workers, and other appropriate costs that support the delivery of patient care. Other appropriate costs that support delivery of patient care include, but is not limited to, personal protective equipment, COVID-19 testing, infection control measures and equipment, and staff training.

- J. For calendar year 2023, the audit conducted pursuant to paragraph I of this Section shall include an audit of 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, and amounts equivalent to the COVID-19 10% per diem rate increase authorized in paragraph R.2 on page 17a, that are received by a facility that were spent on additional labor costs attributable to the COVID-19 Public Health Emergency. Additional labor costs attributable to the COVID-19 Public Health Emergency may include, but is not limited to, increased wages or benefits, shift incentive payments, staff retention bonuses, pay differential for workers employed by more than one facility, and overtime payments to nonmanagerial workers.

Increased wages or benefits, shift incentive payments, staff retention bonuses, pay differential for workers employed by more than one facility, overtime payments to nonmanagerial workers or other additional labor costs shall qualify for purposes of this paragraph if they were either of the following:

1. Implemented prior to January 1, 2023, and continued during the 2023 calendar year, or
2. Implemented on or after January 1, 2023.

If the Department finds that a facility spent less than 85 percent of revenues associated with the COVID-19 Public Health Emergency on additional labor costs during calendar year 2023, the Department will recoup the difference between the amount spent on additional labor costs and 85 percent of Medi-Cal payments received by the facility associated with the COVID-19 10% per diem rate increase authorized in Section 7.4 of the State Plan and amounts equivalent to the COVID-19 10% per diem rate increase authorized in paragraph R.2 on page 17a.

V. Methods and Standards for Establishing FS/NF-B Reimbursement Rates

- A. Effective August 1, 2005, a FS/NF-B's actual reimbursement rate (per diem payment) is the amount the Department will reimburse to a FS/NF-B for services rendered to an eligible resident for one resident day. The per diem payment is calculated prospectively on a facility-specific per resident day basis using facility-specific data from the FS/NF-B's most recent cost report period (audited or adjusted), supplemental schedules, and/or other data determined necessary by the Department.
- B.1 Each facility-specific per diem rate consists of the sum of the following rate components:
 - a. Final labor rate component calculated pursuant to Section V, paragraph B.3.
 - b. Final non-labor rate component calculated pursuant to Section V, paragraph B.3.
 - c. State-mandated prospective licensing and quality assurance fees described in Section V, paragraph C.6.f.
 - d. One-time state or federal mandates for the applicable rate year as defined in Section V, paragraph B.5.a.
- B.2 Pre-growth limit rate components:
 - a. The pre-growth limit labor rate component consists of the sum of the cost categories described in Section V, paragraph C.1, subject to any peer group ceilings applicable to the cost components, plus the projected per diem cost of complying with new ongoing state or federal mandates attributable to cost categories in the labor rate component as defined in Section V, paragraph B.5.b.
 - b. The pre-growth limit non-labor rate component consists of the sum of the cost categories described in Section V, paragraph C.2 through paragraph C.6.e, subject to any peer group ceilings applicable to the cost components and the limitations described in Section V, paragraph C.4.e for the capital cost component, plus the projected per diem cost of complying with new ongoing state or federal mandates attributable to cost categories in the non-labor rate component as defined in Section V, paragraph B.5.b.

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- 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.

B.4 Notwithstanding Section V, paragraph B.3, for facilities with newly established rates pursuant to Section VIII, the final labor and non-labor rate components shall be computed by multiplying the following two factors:

- i. The respective pre-growth limit 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 final amounts of the respective rate component.
 - b. The Medi-Cal utilization weighted average pre-growth limit amounts of the respective rate component.

B.5 State and federal mandates shall be categorized as follows:

- a. One-time state or federal mandates are those that increase facility costs on a one-time or limited-term basis but do not permanently increase ongoing facility costs (e.g. a one-time facility improvement). Projected costs associated with one-time state or federal mandates are reimbursed through an additional rate component added to the facility-specific per diem rate in the applicable rate year. The projected per diem cost associated with one-time state or federal mandates may be reimbursed over multiple rate years through a reasonable cost recovery period. Costs associated with one-time state or federal mandates are not considered in the calculation of the growth limit for the labor and non-labor rate components in future rate years. In subsequent rate years, cost reports utilized in rate-setting will be adjusted to remove costs associated with one-time state or federal mandates.
- b. Ongoing state or federal mandates are those that increase facility costs on an ongoing basis (e.g. a minimum wage increase). Pursuant to Section V, paragraph B.2, the pre-growth limit labor and non-labor rate components shall be adjusted for the projected per diem costs associated with new state or federal mandates that are not included in cost report used to set rates or in cost inflation factors that may otherwise be applied during the rate-setting process, until those costs are reflected in cost reports used to set rates. Additionally, pursuant to paragraph B.3, the growth limit applicable to the labor and non-labor rate components in a rate year is increased for the projected per diem costs of new state and federal mandates that have not been reflected in the calculation of the final per diem rate in a previous rate year.

C. Cost Categories. The facility-specific cost-based per diem payment for FS/NF-Bs is based on the projected costs of the major cost categories, each subject to ceilings described in this Section. Costs within a specific cost category may not be shifted to any other cost category. In addition, per diem payments will be subject to overall limitations described in Sections V, paragraphs B.1-4 and VI of this Supplement.

1. The labor cost category is comprised of a direct resident care labor cost component and an indirect care labor cost component. These components are comprised of more specific elements described below:
 - a. Direct resident care labor costs include salaries, wages, and benefits related to routine nursing services personnel, defined as nursing, social services, and activities personnel. Direct resident care labor costs include labor expenditures associated with a FS/NF-B's permanent direct care employees, as well as expenditures associated with temporary agency staffing.
 - i. For the rate year beginning August 1, 2005, and for subsequent rate years, the direct resident care labor per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report, as adjusted for audit findings. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 90th percentile of each FS/NF-B's peer-grouped allowable Medi-Cal direct resident care labor cost per diems. FS/NF-B's will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.
 - ii. For the rate period beginning August 1, 2020, and for subsequent rate years, the direct resident care labor cost component will be limited to the 95th percentile of each facility's respective peer group, as described in Section VII of this Supplement. FS/NF-B's will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

- iii. A labor inflation index, will be applied to the FS/NF-B's allowable direct resident care labor per diem costs. Each facility's direct resident care labor costs will be inflated from the mid-point of the cost reporting period or supplemental schedule reporting period to the mid-point of the rate year. The labor inflation index will be annually updated by the Department based upon appropriate data sources and forecasts, which may include, but are not limited to, historical wage data from facility cost reports, US Bureau of Labor Statistics surveys and indexes, the Centers for Medicare and Medicaid Services indexes and market baskets, and the California Department of Finance Economic Forecast.
- b. Indirect care labor costs include all labor costs related to staff supporting the delivery of resident care including housekeeping, laundry and linen, dietary, medical records, in-service education, and plant operations and maintenance costs.
 - i. In-service education activities are defined as education conducted within the FS/NF-B for facility nursing personnel. Salaries, wages and payroll-related benefits of time spent in such classes by those instructing and administering the programs will be included as in-service education labor costs. If instructors do not work full-time in the in-service education program, only the cost of the portion of time they spend working in the in-service education program is allowable. In-service education does not include the cost of time spent by nursing personnel as students in such classes or costs of orientation for new employees. The costs of nursing in-service education supplies and outside lecturers will be reflected in the in-service education non-labor costs of the indirect care non-labor cost category.
 - ii. For the rate year beginning August 1, 2005, and for subsequent rate years, the indirect resident care labor per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the facility's most recently available cost report, as adjusted for audit findings. Each facility's per diem payment will be limited to a ceiling amount, identified as the 90th percentile of each facility's peer-grouped allowable Medi-Cal indirect. Resident care labor cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.
 - iii. For the rate period beginning August 1, 2020, and for subsequent rate years, the indirect resident care labor cost component will be limited to the 95th percentile of each facility's respective peer group, as described in Section VII of this Supplement. FS/NF-B's will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

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- iv. A labor inflation index will be applied to the FS/NF-B's allowable indirect resident care labor per diem costs. Each facility's indirect resident care labor costs will be inflated from the mid-point of the cost reporting period or supplemental schedule reporting period to the mid-point of the rate period or rate year. The labor inflation index will be annually updated by the Department based upon appropriate data sources and forecasts, which may include, but are not limited to, historical wage data from facility cost reports, US Bureau of Labor Statistics surveys and indexes, the Centers for Medicare and Medicaid Services indexes and market baskets, and the California Department of Finance Economic Forecast.
2. Indirect care non-labor costs include the non-labor costs related to services supporting the delivery of resident care, including the non-labor portion of nursing, housekeeping, laundry and linen, dietary, in-service education and plant operations and maintenance costs. These costs are limited to the 75th percentile of each facility's respective peer-group, as described in Section VII of this Supplement.
- a. For the rate year beginning August 1, 2005, and for subsequent rate periods or rate years, the indirect care non-labor per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report, as adjusted for audit findings. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 75th percentile of each FS/NF-B's peer-grouped allowable Medi-Cal indirect care non-labor cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.
 - b. The California Consumer Price Index for All-Urban Consumers, as determined by the State Department of Finance, will be applied to the FS/NF-B's allowable indirect care non-labor per diem costs to inflate costs from the mid-point of the cost reporting period to the mid-point of the rate period or rate year.

3. Administrative costs include allowable administrative and general expenses of operating the facility, including a FS/NF-B's allocated expenditures related to allowable home office costs. The administrative cost category will include allowable property insurance costs, and exclude expenditures associated with caregiver training, liability insurance, facility license fees, and medical records. For the rate year beginning August 1, 2010, and subsequent rate periods or rate years, legal and consultant fees are excluded as stated below.
 - a. For the rate year beginning August 1, 2005, and for subsequent rate periods or rate years, the administrative per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report or supplemental schedule, as adjusted for audit findings. For purposes of establishing reimbursement ceilings, each FS/NF-B will be peer-grouped as described in Section VII of this Supplement. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 50th percentile of the allowable Medi-Cal administrative cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.
 - b. The California Consumer Price Index for All-Urban Consumers, as determined by the State Department of Finance, will be applied to the FS/NF-B's allowable administrative per diem costs to inflate costs from the mid-point of the cost reporting period to the mid-point of the rate period or rate year.
 - c. For the rate year beginning August 1, 2010, and for subsequent rate periods or rate years, the administrative cost category will exclude any legal or consultant fees in connection with a fair hearing or other litigation against or involving any government agency or department until all issues related to the fair hearing or litigation issues are ultimately decided or resolved in favor of the FS/NF-B's.
4. For the rate year beginning August 1, 2010, and for subsequent rate periods or rate years, the professional liability per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report or supplemental schedule, as adjusted for audit findings. For purposes of establishing reimbursement ceilings, each FS/NF-B will be peer-grouped as described in Section VII of this Supplement. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 75th percentile of the allowable Medi-Cal cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount. FS/NF-Bs must report the insurance deductibles in a format and by the deadline determined by the Department, or the deductibles will be reimbursed at the 50th percentile in the administrative cost category.

5. Capital costs. For the rate year beginning August 1, 2005, and for subsequent rate periods or rate years, a Fair Rental Value System (FRVS) will be used to reimburse FS/NF-B's property (capital) costs. Under the FRVS, the Department reimburses a facility based on the estimated current value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest, rent or lease payments. The FRVS establishes a facility's value based on the age of the facility. For rate periods or rate years subsequent to 2005/06, additions and renovations (subject to a minimum per-bed limit) will be recognized by lowering the age of the facility. The facility's value will not be affected by sale or change of ownership. Capital costs, limited as specified below in Section V.C.4.e. of this Supplement, are derived from the FRVS parameters as follows:
- a. The initial age of each facility is determined as of the mid-point of the 2005/06 rate year, using each facility's original license date, year of construction, initial loan documentation, or similar documentation. For the 2005/06 rate year, all FS/NF-Bs with an original license date of February 1, 1976, or prior, will have five years subtracted from their facility age to compensate for any improvements, renovations or modifications that have occurred in the past. The age of each facility will be adjusted every rate period or rate year, to reflect the facility's age, as appropriate, up to a maximum age of 34 years.
 - b. Beginning with the rate year of August 1, 2006, and for subsequent rate periods or rate years costs incurred for major capital improvements, modifications or renovations equal to or greater than \$500 per bed on a total licensed-bed basis will be converted into an equivalent number of new beds, effectively lowering the age of the facility on a proportional basis. If a facility adds or replaces beds, these new beds will be averaged in with the age of the original beds, and the weighted average age of all beds will represent the facility's age. If a facility performs a major renovation or replacement project (defined as a project with capitalized cost equal to or greater than \$500 per bed, on a total bed basis), the cost of the renovation project will be converted to an equivalent number of new beds. The equivalent number of new beds would then be used to determine the weighted average age of all beds for the facility.
 - i. Beginning in the 2018-19 rate year, if a facility is at the maximum depreciation age of 34 years, the weighted average age calculation for effective facility age after improvements will be based on a base facility age of 34 years rather than the actual facility age to determine the new effective facility age.
 - c. The FRVS per diem calculation, subject to the limitations identified in Section V.C.4.e. of this Supplement, is calculated as follows:

1. An estimated building value will be determined based on a standard facility size of 400 square feet per bed, each facility's licensed beds, and the R.S. Means Building Construction Cost Data, adjusted by the location index for each locale in the State of California. The estimated building value will be trended forward annually to the mid- point of the rate year using the percentage change in the R.S. Means Construction Cost index.
 - a. Beginning in the 2018-19 rate year, any FS/NF-B or FSSA/NF-B facility built on or after January 1, 2016 will have all- estimated building value based on a standard facility size of 500 square feet per bed; each facility's licensed beds; and the R.S. Means Building Construction Cost Data, increased by 20 percent.
11. An estimate of equipment value will be added to the estimated building value in the amount of \$4,000 per bed.
 - iii. The greater of the estimated building and equipment value or the fully depreciated building and equipment value will be determined for each facility (hereinafter, the "current facility value"). The fully depreciated building and equipment value is based on a 1.8 percent annual depreciation rate for a full 34 years.
 - iv. An estimate of land value will be added to the current facility value based on ten percent of the estimated building value as calculated in Section V.4.C.c.i. of this Supplement.
 - v. A facility's fair rental value is calculated by multiplying the facility's current value plus the estimated land value, times a rental factor. The rental factor will be based on the average 20-year U.S. Treasury Bond yield for the calendar year preceding the rate year plus a two percent risk premium, subject to a floor of seven percent and a ceiling of ten percent.
 - vi. The facility's fair rental value is divided by the greater of actual resident days for the cost reporting period, or occupancy-adjusted resident days, based on the statewide average occupancy rate. Days from partial year cost reports will be annualized in the FRVS per diem payment calculation.
- d. Continued explanation and examples of the FRVS per diem calculations follow:

Example of FRVS Per Diem Calculation

Example Assumptions

Building License Date= 2/1/1976

Actual Age on 2/1/2006 (mid-point of 2005/06 rate year) = 30 years Effective Age
for FRVS = 25 years (subtract 5 years for improvements)

Rental Factor = 7 percent

Construction Cost = \$123 per square foot

Occupancy= 90% = 30,715 resident days

Licensed Beds = 99

Facility Location= San Diego= 1.061 location index

Base Value Computation

Estimated Building Value (99 beds x 400 square feet x \$123 x 1.061) Add:	\$5,167,919
Equipment Value at \$4,000 per bed	<u>\$ 396,000</u>
Gross Value	\$5,563,919
Depreciation (1.8% x 25 years)	<u>\$ 2,503,764</u>
Net Value (undepreciated current facility value)	\$3,060,155
Add: Land Value at 10% of Undepreciated Building Value	<u>\$ 516,792</u>
Total Base Value	<u>\$ 3,576,947</u>

FRVS Per Diem Calculation

	\$ 250,386
Fair Rental Value (rental factor x total base value)	
	<u>\$ 8.15</u>
FRVS per diem (Fair Rental Value+ occupancy adjusted resident days)	

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Example of FRVS Per Diem Calculation With Improvement Modification

Example Assumptions

Original Building Assumptions Remain Static	
Cost of Remodel	\$ 500,000
Remodel Cost Per Bed (\$500,000 ÷ 99 beds)	\$ 5,051
Base Value Per New Bed Prior to Improvement Modification (gross value ÷ 99 beds)	\$ 56,201

Modified Facility Age Calculation

Equivalent Number New Beds (cost of remodel ÷ base value/bed before improvement)	8.9
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Weighted Average Age

Prior to Improvement - 99 Beds x 25 years	2,475
Resulting from Improvement - 8.9 Beds x 0 years	<u>0</u>
Total = 107.9 Beds	2,475
Weighted Average Age = 2,475 / 107.9	22.9 Years

Modified Base Value Computation

Gross Value (Building and Equipment)	\$ 5,563,919
Adjusted Depreciation = 1.8% x 22.9 years x gross value	<u>\$ 2,293,447</u>
Modified Net Value	\$3,270,472
Add: Land Value	<u>\$ 516,792</u>
Modified Total Base Value	<u>\$ 3,787,264</u>

Modified FRVS Per Diem Calculation

FRVS Per Diem (rental factor x modified base value) / (total resident days)	<u>\$ 8.63</u>
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- e. The capital costs based on FRVS will be limited as follows:
 - i. For the 2005/06 rate year, the capital cost category for all FS/NF-Bs in the aggregate will not exceed the Department's estimate of FS/NF-B's capital reimbursement for the 2004/05 rate year, based on the methodology in effect as of July 31, 2005.
 - ii. Beginning with the rate year of August 1, 2006, and for subsequent rate periods or rate years, the maximum annual increase for the capital cost category for all FS/NF-Bs in the aggregate will not exceed eight percent of the prior rate year's FRVS aggregate payment.
 - iii. If the total capital cost category for all FS/NF-Bs in the aggregate for the 2005/06 rate year exceeds the value of the capital cost category for all FS/NF-Bs in the aggregate for the 2004/05 rate year, the Department will reduce the capital cost category for each and every FS/NF-B in equal proportion.
 - iv. If the capital cost category for all FS/NF-Bs in the aggregate, beginning with the rate year of August 1, 2006, and for subsequent rate periods or rate years exceeds eight percent of the prior rate year's cost category, the Department will reduce the capital FRVS cost category for each and every FS/NF-B in equal proportion.
 - v. For the 2018/19 and subsequent rate years, if the aggregate maximum annual increase for the capital cost category calculated without the application of Section 5(b)(i) on page 10 and Section 5(c)(i)(a) on page 11, is less than the aggregate maximum annual increase for the capital cost category applying Section 5(b)(i) and Section 5(c)(i)(a), the Department will reduce the capital FRVS cost category for all FS/NF-Bs by an equal proportion, so that the aggregate maximum annual increase for the capital cost category will be equal to the aggregate maximum annual increase without the application of Section 5(b)(i) and Section 5(c)(i)(a).

6. Direct pass-through costs are comprised of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, liability insurance costs, and the Medi-Cal portion of the skilled nursing facility quality assurance fee. For the rate year beginning August 1, 2010, and for subsequent rate periods or rate years, liability insurance costs are excluded from the direct-pass-through cost category.

- a. For the rate year beginning August 1, 2005, and for subsequent rate periods or rate years, the Medi-Cal proportional share of the pass-through per diem costs will be calculated as the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report and/or supplemental schedule(s), as adjusted for audit findings.
- b. Caregiver training costs are defined as a formal program of education that is organized to train students to enter a caregiver.

occupational specialty. Eligible caregiver training costs include any and all trainings that enhance the skills, education, or career advancement for nursing facility workers. Until the Medi-Cal cost report is revised to specifically identify these costs, FS/NF-Bs will be required to complete an annual supplemental report detailing these expenditures. These supplemental reports may be audited or reviewed prior to use in rate-setting.

- c. The Medicare reimbursement principles consistent with Title 42, Code of Federal Regulations, Part 413 will be used to determine reasonable allowable pass through costs for professional liability insurance. FS/NF-Bs will be required to complete an annual supplemental report detailing these expenditures. These supplemental reports may be audited or reviewed prior to use in rate-setting. For the rate year beginning August 1, 2010, and for subsequent rate periods or rate years, liability insurance costs are excluded from the direct pass-through cost category.
 - d. The California Consumer Price Index for All-Urban Consumers, as determined by the State Department of Finance, will be applied to update caregiver training costs and liability insurance costs from the mid-point of the cost report period or supplemental report period to the mid-point of the rate year. For the rate year beginning August 1, 2010, and for subsequent rate periods or rate years, liability insurance costs are excluded from the direct pass-through cost category.
 - e. Property tax pass-through costs will be updated at a rate of two percent annually from the mid-point of the cost report period to the mid-point of the rate period or rate year.
 - f. Facility-license fee pass-through costs and the Medi-Cal portion of the skilled nursing facility quality assurance fee will be applied on a prospective basis for each rate period or rate year, and will not require an inflation adjustment.
- D. For the 2005/06 and 2006/07 rate years, the facility-specific Medi-Cal reimbursement rate calculated under the methodology set forth in Section V of this Supplement will not be less than the Medi-Cal reimbursement rate that the FS/NF-B would have received under the rate methodology in effect as of July 31, 2005, plus Medi-Cal's projected proportional costs for new state or federal mandates for rate years 2005/06 and 2006/07, respectively.
- E. Pursuant to AB 81, the details, definitions and formulas may be set forth in regulations and provider bulletins or similar instructions.
- F. The Department will establish reimbursement rates pursuant to AB 81 on the basis of facility cost data reported in the Integrated Long-Term Care Disclosure and Medi-Cal Cost Report required by Health and Safety Code section 128730 for the most recent

reporting period available and cost data reported in other facility financial disclosure reports, supplemental reports, or surveys required by the Department.

- G. The percentiles in labor costs, indirect care non-labor costs, and administrative costs will be based on annualized costs divided by total resident days and computed on a geographic peer-group basis. For the rate year beginning August 1, 2010, and for subsequent rate periods or rate years, professional liability costs will be based on annualized costs divided by total resident days and computed on a geographic peer-group basis.

VI. Limitations on the Medi-Cal Facility-Specific Reimbursement Rate Calculation

In addition to limitations described in Section V.C.4.e. of this Supplement (FRVS reimbursement limitations), the aggregate facility-specific Medi-Cal payments calculated in accordance with the methodology set forth in Section V of this Supplement will be limited by the following:

- A. For the 2005/06 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed eight percent of the weighted average reimbursement rate for the 2004/05 rate year, as adjusted for the change in the cost to the FS/NF-B to comply with the skilled nursing facility quality assurance fee for the 2005/06 rate year, plus the total projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.
- B. For the 2006/07 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed five percent of the weighted average Medi-Cal rate for the 2005/06 rate year, as adjusted for the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.
- C. For the 2007/08 and 2008/09 rate years, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 5.5 percent of the weighted average Medi-Cal rate for the 2006/07 rate year, as adjusted for the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.
- D. For the 2009/10 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not be increased over the weighted average Medi-Cal rate for the 2008-09 rate year, as adjusted for the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.
- E. For the 2010/11 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 3.93 percent of the maximum annual increase in the weighted average rate from the 2009/10 rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.
- F. For the 2011/12 rate year, the maximum annual increase of each FS/NF-Bs Medi-Cal reimbursement rate will not exceed 2.4 percent from the rate effective May 31, 2011, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

- G. For services provided on and after June 1, 2011 through July 31, 2012, Medi-Cal payments will equally be reduced by 10 percent. Specifically, for the period June 1, 2011 through July 31, 2011, the payment is based on the 2010-11 rate that would otherwise be paid to each FS/NF-B, reduced by 10 percent. Accordingly, for the period August 1, 2011 through July 31, 2012, the payment is based on the 2011-12 rate that otherwise would be paid to each FS/NF-B, reduced by 10 percent. The Department will determine the amount of reduced payments for each FS/NF-B, equivalent to the 10 percent payment reduction for the period beginning June 1, 2011, through July 31, 2012, and provide a supplemental payment to each FS/NF-B no later than December 31, 2012.
- H. To the extent that the prospective facility-specific reimbursement rates are projected to exceed the adjusted limits calculated pursuant to VI.A, VI.B, VI.C, VI.D, VI.E, and VI.F of this Supplement, the Department will adjust the increase to each FS/NF-B's projected reimbursement rate for the applicable rate period or rate year by an equal percentage.
- I. The payment reductions in the previous section(s) will be monitored in accordance with the monitoring plan at Attachment 4.19-F, entitled "Monitoring Access to Medi-Cal Covered Healthcare Services.
- J. For the 2012/13 rate year, FS/NF-Bs will be reimbursed the facility specific Medi-Cal reimbursement rate effective on August 1, 2011, excluding the reductions specified in VI.G, plus the cost of complying with new state or federal mandates.
- K. For the 2013/14 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 3 percent of the maximum annual increase in the weighted average rate from the 2012/13 rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.
- L. For the 2014/15 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 3 percent of the maximum annual increase in the weighted average rate from the 2013/14 rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.
- M. Beginning with the 2015/16 rate year through July 31, 2017, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 3.62 percent of the maximum annual increase in the weighted average rate from the previous rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.
- N. Beginning with the 2017/18 rate year through July 31, 2020, the annual increase in the weighted average Medi-Cal reimbursement rate shall be 3.62 percent of the weighted average rate from the previous rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates. Total Medi-Cal reimbursement shall not exceed any applicable federal upper payment limit.

- O. Beginning with the rate period of August 1, 2020, through December 31, 2020, the increase in the weighted average Medi-Cal reimbursement rate shall be 3.62 percent of the weighted average rate from the previous rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates. Total Medi-Cal reimbursement shall not exceed any applicable federal upper payment limit.
- P. For the calendar year 2021 rate year, the increase in the weighted average Medi-Cal reimbursement rate shall be 3.5 percent of the weighted average rate from the previous rate period, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates. Total Medi-Cal reimbursement shall not exceed any applicable federal upper payment limit.
- Q. For the calendar year 2022 rate year, the increase in the weighted average Medi-Cal reimbursement rate shall be 2.4 percent of the weighted average rate from the previous rate period, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates. Total Medi-Cal reimbursement shall not exceed any applicable federal upper payment limit.
- R. For the calendar year 2023 rate year, the increase in the weighted average Medi-Cal reimbursement rate shall be calculated separately for labor and non-labor costs, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates. For the labor cost category, the annual aggregate increase shall be 5 percent of the weighted average rate attributed to labor costs from the previous year. For the non-labor cost categories, including indirect care non-labor cost, administrative cost, professional liability insurance, capital cost, and direct pass through categories, as specified in Section V, paragraph B on page 6 of this Supplement, the annual aggregate increase shall be 2 percent of the weighted average rate attributed to non-labor costs from the previous year. Total Medi-Cal reimbursement shall not exceed any applicable federal upper payment limit.
1. For purposes of this calculation, the labor cost categories are summed to calculate the labor rate component, and the non-labor cost categories are summed to calculate the non-labor rate component. For each of the labor and non-labor rate components, a facility's rate component will not decrease for calendar year 2023 relative to calendar year 2022, unless the facility's sum of projected costs for calendar year 2023 decreased compared to the facility's sum of projected costs for calendar year 2022 for that rate component.
 2. The facility-specific rate will include the COVID-19 10% per diem rate increase authorized on pages 90g – 90l of Section 7.4 of the State Plan. In the event the COVID-19 Public Health Emergency expires prior to December 31, 2023, the rates established for the calendar year 2023 rate year, including the COVID-19 10% rate increase, will not be decreased and will continue for the duration of calendar year 2023.

3. The COVID-19 10% per diem rate increase authorized on pages 90g – 90l of Section 7.4, or the amounts equivalent to the COVID-19 10% per diem rate increase authorized in paragraph 2 above, whichever remains in effect on December 31, 2023, shall be discontinued for dates of service on or after January 1, 2024.
4. To apply this growth limit to facilities with newly established rates pursuant to Section VIII, the final labor and non-labor rate components shall be computed by multiplying the following two factors:
 - a. The respective rate component projected pursuant to Section V, including applicable peer group limits, before applying the rate growth limit described in this section.
 - b. The ratio of the following two factors, calculated using data from all facilities with available rates at the time of the rate study:
 - i. The Medi-Cal utilization weighted average amounts of the respective rate component after applying the rate growth limit described in this section.
 - ii. The Medi-Cal utilization weighted average limit amounts of the respective rate component before applying the rate growth limit described in this section.

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VII. Peer-Grouping

A. The percentile caps for FS/NF-B facility labor, indirect care non-labor, administrative, and professional liability costs will be computed on a geographic peer-grouped basis as defined in the following table

County	Peer Group	County	Peer Group
Alameda	Bay Area	Orange	Orange - San Diego
Alpine	North State - Sierras	Placer	Greater Sacramento
Amador	North State - Sierras	Plumas	North State - Sierras
Butte	North State - Sierras	Riverside	Southern Inland
Calaveras	North State - Sierras	Sacramento	Greater Sacramento
Colusa	North State - Sierras	San Benito	Central Coast
Contra Costa	Bay Area	San Bernardino	Southern Inland
Del Norte	North State - Sierras	San Diego	Orange - San Diego
El Dorado	Greater Sacramento	San Francisco	Bay Area
Fresno	San Joaquin Valley	San Joaquin	Stockton-Modesto
Glenn	North State - Sierras	San Luis Obispo	Central Coast
Humboldt	North State - Sierras	San Mateo	Bay Area
Imperial	Southern Inland	Santa Barbara	Central Coast
Inyo	North State - Sierras	Santa Clara	Bay Area
Kern	San Joaquin Valley	Santa Cruz	Central Coast
Kings	San Joaquin Valley	Shasta	North State - Sierras
Lake	North State - Sierras	Sierra	North State - Sierras
Lassen	North State - Sierras	Siskiyou	North State - Sierras
Los Angeles	Los Angeles	Solano	Bay Area
Madera	San Joaquin Valley	Sonoma	Bay Area
Marin	Bay Area	Stanislaus	Stockton-Modesto
Mariposa	North State - Sierras	Sutter	Greater Sacramento
Mendocino	North State - Sierras	Tehama	North State - Sierras
Merced	San Joaquin Valley	Trinity	North State - Sierras
Modoc	North State - Sierras	Tulare	San Joaquin Valley
Mono	North State - Sierras	Tuolumne	North State - Sierras
Monterey	Central Coast	Ventura	Central Coast
Napa	Bay Area	Yolo	Greater Sacramento
Nevada	North State - Sierras	Yuba	Greater Sacramento

B. Los Angeles County shall be subdivided into three peer groups by California Department of Public Health Skilled Nursing Facility District Office as defined at <https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/DistrictOffices.aspx> .

C. Subacute care units of FS/NF-B facilities shall constitute one state-wide peer group.

VIII. Determination of FS/NF-B Rates for State-Owned Facilities, Newly Certified Providers or Changes of Ownership

- A. State-owned and operated FS/NF-Bs will receive a prospective payment rate based on the peer-group weighted average Medi-Cal reimbursement rate.
- B. New FS/NF-Bs with no cost history in a newly constructed facility, in a location not previously licensed as a FS/NF-B, or an existing facility newly certified to participate in the Medi-Cal program will receive a reimbursement rate based on the peer-group weighted average Medi-Cal reimbursement rate. The Department will calculate a newly established rate for the facility once a minimum of six months (12 months for subacute care units) of Medi-Cal cost data has been audited. The Department will calculate the rate prospectively and it will be effective at the beginning of each rate period or rate year, as applicable.
- C. FS/NF-Bs that have a change of ownership or changes of the licensed operator where the previous provider participated in the Medi-Cal program, the new owner or operator will continue to receive the reimbursement rate of the previous provider. The reimbursement rate of the previous owner will continue to be updated annually pursuant to Section V of this Attachment using the most recent available audited cost report data until a newly established rate is calculated for the facility. The Department will calculate a newly established rate for the facility once a minimum of six months (12 months for subacute care units) of Medi-Cal cost data has been audited for a reporting period beginning after completion of the change of ownership or change of the licensed operator. The Department will calculate the rate prospectively and it will be effective at the beginning of each rate period or rate year, as applicable.
- D.
 - 1. FS/NF-Bs decertified for less than six months and upon recertification will continue to receive the reimbursement rate in effect prior to decertification. The Department will calculate the facility-specific rate when a minimum of six months (12 months for subacute care units) of Medi-Cal cost data has been audited. The Department will calculate the rate prospectively and it will be effective at the beginning of each rate period or rate year, as applicable.
 - 2. FS/NF-Bs decertified for six months or longer and upon recertification will receive a reimbursement rate based on the peer-group weighted average Medi-Cal reimbursement rate. The Department will calculate a newly established rate for the facility once a minimum of six months (12 months for subacute care units) of Medi-Cal cost data has been audited. The Department will calculate the rate prospectively and it will be effective at the beginning of each rate period or rate year, as applicable.

IX. Quality and Accountability Supplemental Payment

- A. For the rate periods January 1, 2021 through December 31, 2021 and January 1, 2022 through December 31, 2022 the Department will develop and implement the Skilled Nursing Facility Quality and Accountability Supplemental Payment (QASP) System. This program provides supplemental reimbursement for FS/NF-Bs, including FS/adult subacute facilities, that improve the quality of care rendered to its residents and would be in addition to the rate of payment FS/NF-Bs receive under the current reimbursement methodology.
- B. The Department, in consultation with California Department of Public Health (CDPH) and representatives from the long-term care industry; organized labor; and consumers; has developed a three tiered scoring methodology, with improvement scoring, for supplemental payments. The Minimum Data Set data file is obtained from the Centers for Medicare & Medicaid Services (CMS). The Department has a data use agreement with the Health Services Advisory Group for such purposes.
1. 100 points are divided among the measurements with point values distributed for each quality indicator.

Measurement Area/Indicator	Possible Points:
Minimum Data Set Clinical	100.00
Physical Restraints: Long Stay	Monitor-only, not scored
Facility Acquired Pressure Ulcer: Long Stay	10.55600
Influenza Vaccination: Short Stay	10.55600
Pneumococcal Vaccination: Short Stay	5.27700
Urinary Tract Infection: Long Stay	5.27700
Control of Bowel/Bladder: Long Stay	10.55600
Self-Report Pain: Short Stay	10.55600
Self-Report Pain: Long Stay	5.27700
Activities of Daily Living: Long Stay	5.27700
California-specific Antipsychotic Medication: Long Stay	10.55600
Direct Care Staff Retention	10.55600
30 Day All-Cause Readmission	10.55600
Infection Preventionist	5
Total	100

2. Except for the infection preventionist measure, a facility's score for each indicator is as follows: a facility's performance is less than statewide average: zero points; at or above statewide average, up to but not including 75th percentile: half points; at or above the 75th percentile: full points. Indicators may be added or removed in the future, subject to state and CMS approval.

In determining the statewide average and the 75th percentile for each indicator, the performance of all facilities, including ineligible facilities as defined in paragraph C below, are included.

For the infection preventionist measure, facilities will receive a pass/fail score.

If a facility cannot be scored on any measure, as determined by CDPH, they may receive an N/A for that measure.

3. Facilities receive an overall quality of care score when points from each of the quality measures are totaled.
4. Facilities that score at least 50.00 points are eligible for QASP payments.
5. For the clinical quality measures, the prior state fiscal year (July 1 to June 30) performance is used for current rate year payment as well as determination of the 75th percentile and statewide average, except for the staff retention measure. For example, MDS data from the performance period of July 1, 2016 to June 30, 2017 will be used to make rate year 2017/18 payments.

For the clinical quality measures, CDPH, in collaboration with the Department, computes each facility's score based on the MDS data. In using the MDS data file, the Long Stay Pressure Ulcer measure is adjusted so that unhealed pressure ulcers are not added back into the performance calculation.

For the direct care staff retention measure, cost reports available from the Office of Statewide Health Planning and Development (OSHPD) for the audit period will be used. The measure will rank facilities based on the amount of direct nursing staff turnover during the reporting period, calculated by dividing "Number of Continuously Employed Direct Nursing Staff During the Report Period" by "Number of Direct Nursing Staff at the Beginning of the Report Period," with less turnover scoring higher.

For the infection preventionist measure, CDPH inspections for compliance with Health and Safety Code section 1255.9, subdivisions (a) and (b), as these subdivisions were effective on January 1, 2022, will be used. If a facility passes all inspections for the infection preventionist measure during the performance period, it will receive the full 5 points for this measure. If a facility does not receive an inspection for this measure during the performance period, it may receive an N/A.

6. Except as provided in subsection (a) of this paragraph, when a facility receives an N/A in any quality measure(s), the points available for the quality measure(s) that receive an N/A will be redistributed across all other quality measures that are scored for that facility.

(a) The infection preventionist measure is limited to a score of 5 points. The infection preventionist measure will not gain points redistributed from other quality measures. However, if a facility receives an N/A in the infection preventionist measure, the 5 points for the infection preventionist measure will be redistributed across all other quality measures that are scored for that facility.

7. Eligible facilities are grouped into three payment tiers based on their overall quality of care score. Facilities with scores from 0 to 49.99 points are grouped as Tier 1. Facilities with scores from 50.00 to 66.66 points are grouped into Tier 2. And facilities with scores from 66.67 to 100 points are grouped into Tier 3. Ineligible facilities, as defined in paragraph C, are grouped into Tier 0.

Tier 0 and Tier 1 facilities will not receive any supplemental payments under this QASP program component. The total pool amount for this component is converted into a Tier 2 per diem and a Tier 3 per diem. The Tier 3 per diem is set at 1.5 times the Tier 2 per diem. Each facility within Tier 2 and Tier 3 will receive a supplemental payment equal to the respective tier per diem times the facility's number of Medi-Cal bed days (including Fee-For-Service and managed care days) for the audit period.

The formula for determining the Tier 2 and Tier 3 per diems is as follows:

$$\text{Total pool} = (\text{Aggregate Tier 2 Medi-Cal bed days} * \text{Tier 2 per diem}) + (\text{Aggregate Tier 3 Medi-Cal bed days} * 1.5 * \text{Tier 2 per diem})$$

$$\text{Tier 3 per diem} = \text{Tier 2 per diem} * 1.5$$

* Medi-Cal bed days total for the audit period includes Fee-For-Service and managed care days

The Department will utilize audited skilled nursing Medi-Cal Fee-For-Service and managed care bed days for determining payment amounts. For the QASP rate period ending December 31, 2022, the audited skilled nursing bed days are drawn from the audit reports used to establish the calendar year 2022 Fee-For-Service per diem rates. Note that any facility that does not have any Medi-Cal Fee-For-Service days from the audit period would not be included in the above computation and will not receive this payment.

Below is an example of a three tiered payment methodology:

Total Payout \$90M

Payment Tier	Point Range	# of SNFs	Payout per MCB	Total MCBs per Tier	Total Payout per Tier	Ave Payout per SNF
Tier 0		346	\$0.00	5,811,700	\$0	\$0
Tier 1	0 - 49.99	419	\$0.00	10,280,958	\$0	\$0
Tier 2	50.00 - 66.66	211	\$12.15	4,381,696	\$53,237,607	\$252,310
Tier 3	66.67 - 100	119	\$18.23	2,019,628	\$36,807,720	\$309,307
Total Receiving Payment		330				\$272,865
		30.14%				

- An additional component of the QASP program is the improvement scoring, where 10% of the payment allocation is set aside for facility improvements from the baseline year.

A facility's overall quality of care score as determined in paragraph B during a performance period is compared to the facility's score from the immediate prior performance period (base period). For example, for rate year 14/15 payment purposes, the facility's score for its performance in the 13/14 period is compared to its score for performance in the 12/13 base period. The difference is the improvement score. The improvement score for all facilities are ranked. Tier O facilities in the performance period are not included in the ranking as they are ineligible and not assigned a score. Additionally, a Tier 1/2/3 facility in the performance period would not be included in the Improvement ranking if the facility: 1) did not have any Medi-Cal bed days in the base period; 2) did not have any MDS clinical measure data in the base period; or 3) is a new facility in the performance period. Facilities in the top 20th percentile in the improvement score ranking will receive a supplemental payment under the improvement component.

The total improvement pool amount specified in paragraph B.8 below is divided by the total number of Medi-Cal bed days (including both Fee-For-Service and managed care days) for all facilities qualifying for an improvement component payment. The result is an improvement per diem. Each facility qualifying for an improvement component supplement payment

will receive a supplement payment equal to the improvement per diem times its number of Medi-Cal days (including Fee-For-Service and managed care).

The Medi-Cal days are derived from the same source as Medi-Cal days in paragraph B.6. Note that any facility that does not have any Medi-Cal Fee-For-Service days in the audit period would not be included in the above computation and will not receive this payment.

8. The aggregate supplemental payment amount for the rate period of August 1, 2020 – December 31, 2020, and calendar year 2021 will be funded by a pool of \$84,000,000, of which \$6,000,000 will be used to fund the delayed payment pool. The pool will be divided in the amounts shown below for the applicable payment periods.

Primary Payment Pool Pay By Date (or soon after SPA approval date, if later)	Service Period	Primary Payment Pool	Delayed Payment Pool
4/30/2021	8/1/20 - 6/30/21	\$50,500,000	\$4,000,000
7/30/2021	7/1/21 - 9/30/21	\$13,750,000	\$1,000,000
10/31/2021	10/1/21 - 12/31/21	\$13,750,000	\$1,000,000

The aggregate supplemental payment amount for the rate period of January 1, 2022 through December 31, 2022 will be funded by a pool of \$84,000,000, of which \$6,000,000 will be used to fund the delayed payment pool. The pool will be divided in the amounts shown below for the applicable payment periods.

Primary Payment Pool Pay By Date (or soon after SPA approval date, if later)	Service Period	Primary Payment Pool	Delayed Payment Pool
4/30/2022 (but no earlier than 4/1/2022)	1/1/22 - 6/30/22	\$39,000,000	\$3,000,000
9/30/2022 (but no earlier than 7/1/2022)	7/1/22 - 9/30/22	\$19,500,000	\$1,500,000
12/31/2022 (but no earlier than 10/1/2022)	10/1/22 - 12/31/22	\$19,500,000	\$1,500,000

Ninety (90) percent of the primary payment pool remaining amount will be used to compute the Tier 2 and 3 per diems in paragraph B.6, and the remaining ten (10) percent will be used to compute the improvement per diem in paragraph B.7. Annually, the pool amounts will be updated in the state plan and will be based on funds derived from the general fund related to setting aside 1% of the weighted average Medi-Cal per diem rate, plus the savings from the Professional Liability Insurance being applied at the 75th percentile and the administrative penalties collected for facilities' failure to meet the nursing hours per patient day requirement, minus administration costs.

9. For the rate periods beginning on or after August 1, 2020, the delayed payment pool for each service period will be available for two years after the first day of the respective service period and will be used to fund delayed QASP payments made after the respective primary lump sum supplemental payment.

An example of a delayed payment would be where a facility was originally determined to be ineligible in accordance with paragraph C.a, at the time of primary payment, but such determination was later successfully appealed by the facility within the above timeline. Delayed supplemental or improvement payments will be made on a per diem basis at the respective per diem rate established by the respective rate year or rate period calculation, as applicable. No rate year or rate period's per diem calculations will be altered by delayed payments, and no payments originally made to other facilities will be affected by delayed payments. A facility eligible for a delayed payment will receive the established Tier 2 or Tier 3 per diem, based on its own quality of care score. A facility eligible for a delayed payment will receive the established improvement per diem, if its improvement score ranks in the top 20th percentile when included in the ranking of all eligible facilities. Any remaining funds from the delayed payment pool will be applied to the following rate year or rate period's aggregate supplemental payments amount. If the amount in the delayed pool is insufficient to pay all computed delayed payments for the current rate year or rate period, additional funds will be made available by deducting from next rate year or rate period's total payment pool so that all facilities eligible for a delayed payment will be paid their computed payments in full.

C. For the service periods provided in paragraph B.8, the Department will pay a lump sum Medi-Cal supplemental payment (as computed in paragraphs B.6 and B.7 above), by the respective pay by dates provided in paragraph B.8, (and delayed payments as provided in paragraph B.9), to eligible skilled nursing facilities. These payments will be based on the following performance measures as specified in W&I Code Section 14126.022 (i), as effective on January 1, 2022, and developed by the Department in coordination with CDPH:

1. Facility Acquired Pressure Ulcer: Long Stay
2. Influenza Vaccination: Short Stay
3. Pneumococcal Vaccination: Short Stay
4. Urinary Tract Infection: Long Stay
5. Control of Bowel/Bladder: Long Stay
6. Self-Reported Pain: Short Stay
7. Self-Reported Pain: Long Stay
8. Activities of Daily Living: Long Stay
9. California-specific Antipsychotic Medication: Long Stay
10. Direct Care Staff Retention
11. 30 Day All-Cause Readmission
12. Infection Preventionist

a. The Department will determine a facility ineligible to receive supplemental payments if the facility fails to meet the following minimum qualifying criteria:

- i. A facility fails to timely provide supplemental data as requested by the Department.
- ii. CDPH determines that a skilled nursing facility fails to meet the nursing hours per patient per day requirements pursuant to Section 1276.5 or 1276.65 of the Health and Safety Code, as applicable.
- iii. For the performance period, facility has Class AA/A citations. These citations are issued due to serious harm or death of a resident.
- iv. For the audit period, facility does not have any Medi-Cal bed days. Furthermore, facility must have Medi-Cal Fee-For-Service bed days in the payment period in order to receive a Medi-Cal Fee-For-Service supplemental payment.

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.

- c) "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).
- d) "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).
- e) "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.
- f) "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.
- g) "Rate year" means a given rate year is based upon the calendar year. For example, rate year 2024 corresponds with the 2024 calendar year.
- h) "Rate on file" means the facility's per diem rate published on the DHCS internet website.
- i) "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.
- j) "Enhanced per diem rate" means the facility's basic per diem rate plus the workforce rate adjustment calculated pursuant to section 2.2.

Section 2.1 Workforce Standards

A facility will be considered to meet the workforce standards if for an applicable rate year, the facility meets the requirements of paragraphs a, b, c, d, and e of Section 2.1.

- a) From the first day of the rate year through the last day of the rate year, the facility meets at least one of the following requirements:
 - i. The facility is a member of a statewide, multi-employer labor-management committee certified by the Department, as defined in Section 4.
 - ii. At least a majority of the facility's applicable direct care workers are covered by a collective bargaining agreement that recognizes one or more labor unions certified by the National Labor Relations Board (NLRB) or Public Employment Relations Board (PERB) as the exclusive bargaining representative of those workers, as defined in Section 5.
 - iii. Each of the facility's applicable workers receives at least the basic wage and benefits defined in Sections 6 through 6.4.
- b) For the duration of the rate year, the facility and the facility's related employer entities comply with all applicable federal, state, and local laws regarding wages, overtime, paid leave, and wage passthrough requirements (including Welfare and Institutions Code 14110.6 and Health and Safety Code 1338) with respect to applicable workers. Only a final disposition or judgment of a violation issued by the applicable local, state or federal agency or court against the facility or the facility's related employer, following any and all available appeals, shall be used to determine non-compliance. A facility that resolves an alleged violation made by an individual, or the applicable local, state or federal agency and complies with such resolution, or that complies with or remediates, as applicable, any judgment or other disposition, within the timeframe specified by the judgment or other disposition, shall be deemed to be in compliance with this paragraph.

- c) The facility and the facility's related employers report wage, benefit, and collective bargaining information regarding the applicable rate year, at the time and in the manner specified by the Department, and in accordance with Sections 4 through 6.4.
- d) The facility provides notice to applicable workers regarding the Workforce Standards Program, at the time and in a manner specified by the Department.
- e) The facility and the facility's related employers do not subject any employee to retaliation due to reporting noncompliance with any of the workforce standards applicable to the facility under the Workforce Standards Program.

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.

Section 3. Opt-in Process

- a) To opt-into the Workforce Standards Program for each rate year, facilities must submit a completed opt-in application, at the time and in the manner specified by the department.
- b) The facility's rate on file effective as of the last day of the previous rate year shall remain the rate on file until the later of:
 - i. The first day of the applicable rate year;
 - ii. 60 days after the Department provides notice of the opt-in period beginning;
or
 - iii. If the facility has submitted an opt-in agreement, the date the Department processes the facility's opt-in agreement.
- c) If the facility opts into the workforce standards program by the applicable deadline, the department shall update the facility's rate on file to the enhanced per diem rate retroactive to the beginning of the rate year. If a facility fails to opt into the workforce standards program by the applicable 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.
- d) To opt into the Workforce Standards Program, facilities must execute an agreement specified by the Department. The opt-in agreement shall specify which pathway described in paragraph (a) of Section 2.1 the facility will comply with.

- e) If a facility opted into the workforce standards program via the collective bargaining or labor-management committee pathway but ceases to meet the pathway's requirements during the rate year, the facility must notify the department within 30 days of ceasing to meet the pathway's requirements. The facility shall have a special opt-in period lasting 30 days from the date the facility ceased to qualify via the collective bargaining or labor-management committee standard during which the facility may opt to continue in the Workforce Standards Program via another qualifying pathway.
- f) If a facility opted into the Workforce Standards Program via the basic wage and benefit pathways but during the rate year becomes eligible through the collective bargaining or labor-management committee pathway as described in Section 4.e and Section 5.c, the facility shall notify the department within 30 days.
- g) A facility may opt-out of the Workforce Standards Program by providing written notice to the Department. Upon receipt of an opt-out notice, the Department shall retroactively adjust the facility's rate to the basic per diem rate for the entire duration of the applicable rate year.

Section 4. Statewide Multi-Employer Labor-Management Committee Standard

- a) "Statewide multi-employer labor-management committee" or "LMC" means a committee that meets all of the following criteria:
- i. The LMC is established to develop industry-wide workforce standards, with the aim of improving labor-management relationships, job security, organizational effectiveness, and/or enhancing economic development.
 - ii. The LMC's membership is composed of at least 200 facilities in California, and one or more labor organizations that are certified or recognized as the exclusive bargaining representative of applicable workers at a combined total of 100 facilities in California.
 - iii. The LMC's governing body is composed of an equal number of representatives of participating facilities and labor organizations.
 - iv. The LMC establishes a process for seeking input from workers at participating facilities regarding subjects of mutual interest and concern discussed by the LMC.
 - v. The LMC does not interfere with the protected rights of workers under state and federal law, including the rights of workers to freely organize and bargain collectively.
 - vi. The LMC does not engage in any anticompetitive practices in violation in state or federal law.
 - vii. The LMC's membership policies do not discriminate against any person in violation of state or federal law.
- b) To qualify for the Statewide Multi-Employer Labor-Management Committee (LMC) Standard, a LMC must be certified by the Department to meet all of the requirements in paragraph (a). The certification will be effective for the duration of one rate year and must be renewed annually.

- c) The LMC must provide the Department with a list of all member facilities and labor organizations as part of the certification process or a renewal of the certification process. The LMC must notify the Department within 30 days of any changes to the member facilities or labor organizations participating in the LMC.
- d) The Department may periodically require the LMC to provide additional information regarding its governance and activities as a condition of continued certification, at the time and in the manner specified by the Department.
- e) To opt-in via the LMC pathway, the facility must be a member of a certified LMC as of the time of opting into the program (or, if applicable, as of the time of switching pathways via a special opt-in period pursuant to Section 3. The Department may consider the facility to be a member of the LMC from the beginning of the rate year for purposes of the Workforce Standards Program if the LMC applies such retroactive membership to the facility.
- f) If the Department determines that an LMC has failed to comply with any of requirements of this section, the Department may decertify the LMC. The Department shall give the LMC at least 30 days' notice of its findings and intent to deem the LMC out of compliance.

Section 5. Collective Bargaining Agreement Standard

- a) To opt-in through the collective bargaining pathway, the facility must demonstrate that as of the time of opting-in (or, if applicable, as of the time of switching pathways via a special opt-in period pursuant to Section 3, at least a majority of the facility's applicable direct care workers are covered by a collective bargaining agreement compliant with the requirements of Section 2.1(a)(ii).
- b) After opting in, a facility shall notify the Department of any revised, extended, or new collective bargaining agreements that cover applicable workers within 30 days of such agreement taking effect .
- c) A collective bargaining agreement that is entered into or extended after the beginning of a rate year, and includes terms making it retroactively effective to an earlier date, may be considered effective retroactively to that earlier date for purposes of meeting the collective bargaining agreement standard.
- d) The Department may require a facility participating through the collective bargaining pathway to provide additional information regarding the collective bargaining agreement, at the time and in the manner specified by the Department.

Section 6: Basic Wage and Benefits Standard

- a) To comply with the basic wage and benefit pathway, the 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.
- b) "Applicable date" means the latter of:
 - i. The first day of the rate year.
 - ii. For the 2024 rate year, the date the Department publishes the facility's updated rate on file for facilities that initially opt-in through the basic wage and benefit standards.
 - iii. If a facility initially opted-in through the collective bargaining or labor-management committee standard but ceases to be eligible for this pathway during the rate year, the last day of the facility's special opt-in period.
- c) A facility must begin paying and providing basic wages and benefits prospectively within 30 days of the applicable date.
- d) A facility must provide payment and credit of the basic wages and benefits retroactive to the first day of the rate year within 90 days of the applicable date. The facility shall not be responsible for retroactive payments for days during the rate year that the facility was eligible under the collective bargaining or labor-management committee standards. The facility shall not be responsible for retroactive payments for employees who are no longer employed by the facility or any of the facility's related corporate entities as of the applicable date.

- 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.

Section 6.1 Basic Wage Standard

- a) A facility shall pay each applicable worker at least the regular hourly wage standard applicable to the class of worker required by the State and county in which the facility is located.
- b) A facility shall pay any applicable worker who, pursuant to any applicable law or regulation is due a premium wage that is a multiple of the regular hourly wage, at a wage that is at least the required multiple of the applicable regular hourly wage standard.
- c) The regular hourly wage standard applicable in each county to each class of workers effective January 1, 2024, is listed in Table 1.
- d) Effective January 1, 2025 and on each January 1 thereafter, the Department shall increase each regular hourly wage standard specified in Table 1 by the lesser of 5 percent or the rate of change in the averages of the most recent July 1 to June 30, inclusive, period over the preceding July 1 to June 30, inclusive, period for the United States Bureau of Labor Statistics non-seasonally adjusted United States Consumer Price Index for Urban Wage Earners and Clerical Workers (U.S. CPI-W). The result shall be rounded to the nearest ten cents (\$0.10). If the rate of change in the averages of the most recent July 1 to June 30, inclusive, period over the preceding July 1 to June 30, inclusive, period for the United States Bureau of Labor Statistics non-seasonally adjusted U.S. CPI-W is negative, there shall be no increase or decrease in the regular hourly wage standard pursuant to this section on the following January 1.
- e) If a facility opts into the Workforce Standards Program after the beginning of the rate year (or opts to switch compliance to the Basic Wage & Benefit Standards during a rate year pursuant to paragraph (e) of Section 3), the facility shall retroactively credit each applicable worker, pursuant to paragraph (d) of Section 6, for any increased wages required by this Section for all hours worked on days during the rate year in which the facility did not meet the requirements of paragraphs (i) or (ii) of paragraph (a) of Section 2.1.

Section 6.2. Health Benefit Standard

a) Definitions:

- i. "Actuarial Value" or "AV" means the actuarial value of a health benefit calculated as determined pursuant to the Actuarial Standard of Practice No. 50 "Determining Minimum Value and Actuarial Value under the Affordable Care Act" adopted by the Actuarial Standards Board September 2015.
- ii. "Benchmark plan" means the employee-only health benefit plan offered by the facility to a full-time applicable worker with an actuarial value of at least 80 with the lowest cost gross premium. For health benefit years prior to the first health benefit year beginning on or after July 1, 2024, if the facility does not offer a plan with an actuarial value of at least 80 to a full-time applicable worker, the benchmark plan shall be the employee-only health benefit plan offered by the facility to the full-time applicable worker with the highest gross premium.
- iii. "Gross premium" means the premium for the health benefit before the employer contribution.

iv. "Required employer contribution" means:

- A. For the 2024 calendar year, the gross premium of the benchmark health benefit, times 70 percent, times the sum of one plus the quotient of the difference of eighty minus the actuarial value of the benchmark plan divided by the actuarial value of the benchmark plan, as described in this formula:

$$\text{Benchmark Plan Gross Premium} \times 70\% \times (1 + (80 - \text{Benchmark Plan AV}) / \text{Benchmark Plan AV})$$

- B. For the 2025 calendar year, the gross premium of the benchmark health benefit, times 75 percent, times the sum of one plus the quotient of the difference of eighty minus the actuarial value of the benchmark plan divided by the actuarial value of the benchmark plan, as described in this formula:

$$\text{Benchmark Plan Gross Premium} \times 75\% \times (1 + (80 - \text{Benchmark Plan AV}) / \text{Benchmark Plan AV})$$

- C. For the 2026 calendar year and each subsequent year, the gross premium of the benchmark health benefit, times 80 percent, times the sum of one plus the quotient of the difference of eighty minus the actuarial value of the benchmark plan divided by the actuarial value of the benchmark plan, as described in this formula:

$$\text{Benchmark Plan Gross Premium} \times 80\% \times (1 + (80 - \text{Benchmark Plan AV}) / \text{Benchmark Plan AV})$$

- v. "Health benefit account" means a health savings account, flexible spending account, health reimbursement arrangement, or other similar benefit that allows the applicable worker to be reimbursed for medical expenses with funds deposited in the account.
 - vi. "Essential Health Benefits" means the essential health benefits package applicable to California pursuant to 42 U.S. Code § 18022 and 45 CFR 156.100 – 156.155.
 - vii. "Stipend" means a payment to an employee made on at least a monthly basis.
 - viii. "Health benefit year" means a 12-month period of benefits coverage under an employer health benefit plan.
- b) Effective January 1, 2024, the facility shall offer a health benefit to all full-time applicable workers and shall make at least the required employer contribution towards the health benefit premium cost of each full-time applicable worker enrolled in an employer-sponsored health benefit.
- i. Effective with the facility's first health benefit year beginning on or after July 1, 2024, if the required employer contribution exceeds the gross premium cost for an applicable worker, the facility shall pay the difference to the applicable worker as a stipend or shall deposit an equivalent amount in a health benefit account.
 - ii. Prior to the facility's first health benefit year beginning on or after July 1, 2024, if increasing the employer contribution within the current health benefit year would require the facility to hold a new open enrollment period, the facility may meet this standard by paying the difference between the actual employer contribution and the required employer contribution as a stipend or by depositing an equivalent amount in a health benefit account.
 - iii. If a facility opts into the Workforce Standards Program after the beginning of the rate year (or opts to switch compliance to the Basic Wage & Benefit Standards during a rate year pursuant to paragraph (e) of Section 3), the facility shall retroactively credit each full-time applicable worker, pursuant to paragraph (d) of Section 6, for any increased employer contribution or equivalent for all months worked full-time during the rate year during which the facility did not meet the requirements of paragraphs (i) or (ii) of paragraph (a) of Section 2.1.

- c) Effective with the facility's first health benefit year beginning on or after July 1, 2024, a facility shall offer a health benefit with a minimum actuarial value of 80 including all essential health benefits to all full-time applicable workers.
- d) Notwithstanding paragraphs (b) and (c), a facility shall not be required to offer health benefit enrollment prior to 90 days after the first day of employment pursuant to state and federal law.

Section 6.3. Paid Sick Leave Standard

- a) "Paid sick leave" means time that is compensated at the same wage as the applicable worker normally earns during regular work hours, and is provided to an applicable worker for the purposes described in Section 246.5 of the California Labor Code.
- b) The facility shall provide each applicable worker with paid sick leave at the rate of not less than one hour per every 26 hours worked during the rate year. If a facility opts into the Workforce Standards Program after the beginning of the rate year (or opts to switch compliance to the Basic Wage & Benefit Standards during a rate year pursuant to paragraph (e) of Section 3), the facility shall retroactively credit each applicable worker, pursuant to paragraph (d) of Section 6, for all hours worked on days during the rate year in which the facility did not meet the requirements of paragraphs (i) or (ii) of paragraph (a) of Section 2.1.
- c) Accrued paid sick leave shall carry over to the following year of employment. However, the facility may limit an applicable worker's total accrued paid sick leave to a total of ten days or 80 hours.
- d) This standard shall be satisfied, and no accrual or carryover is required, if ten days or 80 hours of paid sick leave is available to the employee at the beginning of each year of employment, calendar year, or 12-month period.
- e) Paid leave provided pursuant to state law, local ordinance, or employer paid time off policy is credited towards the facility's obligation contained this section if the paid leave or paid time off may be used for the same purposes and under the same conditions as specified in this section, and satisfies the accrual, carryover, and use requirements of this section.
- f) The requirements of subdivisions (c) (g), (h), (i), (k), (l), (m), (n) of California Labor Code section 246 shall apply to paid sick leave required by this standard.

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Section 6.4. Training and Education Standard

- a) For the period consisting of the duration of the rate year and the following 12 months, a facility shall provide each applicable worker who is employed as a certified nursing assistant with paid time and tuition expenses for 48 hours of in-service training that meets the requirements of Health and Safety Code section 1337.6.

Section 7. Compliance

- a) Facilities are required to report any failure to comply with the any of the workforce standards applicable to the facility under the Workforce Standards Program within 15 days of becoming aware of the failure to comply.
- b) If the Department determines that a facility has failed to comply with any of the workforce standards applicable to the facility under the Workforce Standards Program during a rate year in which the facility has opted into the Workforce Standards Program, the Department shall retroactively adjust the facility's rate to the basic per diem rate for the entire duration of the applicable rate year. The Department shall give the facility at least 30 days' notice of its findings and intent to deem the facility out of compliance.
- c) The Department may, in its sole discretion, waive noncompliance with any of the workforce standards applicable to the facility under the Workforce Standards Program for either of the following reasons:
 - i. Non-willful noncompliance if the facility promptly notifies the department upon becoming aware of the noncompliance and makes a prompt good faith effort to remediate the noncompliance. Non-willful noncompliance includes conduct that is due to negligence, inadvertence, or mistake or conduct that is the result of a good faith misunderstanding of the requirement of the law.
 - ii. As otherwise necessary to preserve the health and safety of facility residents.
- d) As a term of a waiver granted pursuant to paragraph (c), the Department may require the facility to:
 - i. Make retroactive and/or prospective payments to applicable workers.
 - ii. Take other appropriate actions to identify, remediate, or prevent noncompliance.
- e) Prior to granting a waiver pursuant to paragraph (c), the Department will post the request for the waiver and the proposed terms of the waiver on its internet website for at least 30 days.

Table 1: CY 2024 Basic Wage Standards

County	Direct Care Worker	Indirect Care Worker	County	Direct Care Worker	Indirect Care Worker
Alameda	\$23.80	\$20.80	Orange	\$20.40	\$18.40
Alpine	\$20.10	\$18.30	Placer	\$20.90	\$18.30
Amador	\$20.10	\$18.30	Plumas	\$20.40	\$18.80
Butte	\$20.30	\$18.20	Riverside	\$19.50	\$18.50
Calaveras	\$20.10	\$18.30	Sacramento	\$20.90	\$18.30
Colusa	\$20.40	\$18.80	San Benito	\$24.50	\$20.70
Contra Costa	\$23.80	\$20.80	San Bernardino	\$19.50	\$18.50
Del Norte	\$20.10	\$18.60	San Diego	\$20.30	\$18.40
El Dorado	\$20.90	\$18.30	San Francisco	\$23.80	\$20.80
Fresno	\$19.10	\$17.50	San Joaquin	\$20.20	\$18.70
Glenn	\$20.40	\$18.80	San Luis Obispo	\$19.70	\$17.80
Humboldt	\$20.10	\$18.60	San Mateo	\$23.80	\$20.80
Imperial	\$19.00	\$18.50	Santa Barbara	\$20.50	\$18.60
Inyo	\$20.10	\$18.30	Santa Clara	\$24.50	\$20.70
Kern	\$19.30	\$18.10	Santa Cruz	\$21.90	\$18.20
Kings	\$18.90	\$18.30	Shasta	\$19.50	\$17.50
Lake	\$20.10	\$18.60	Sierra	\$20.40	\$18.80
Lassen	\$20.40	\$18.80	Siskiyou	\$20.40	\$18.80
Los Angeles	\$20.40	\$18.40	Solano	\$20.90	\$18.80
Madera	\$20.30	\$18.30	Sonoma	\$22.00	\$18.50
Marin	\$23.80	\$20.80	Stanislaus	\$19.60	\$18.50
Mariposa	\$20.10	\$18.30	Sutter	\$19.80	\$18.30
Mendocino	\$20.10	\$18.60	Tehama	\$20.40	\$18.80
Merced	\$19.20	\$18.70	Trinity	\$20.40	\$18.80
Modoc	\$20.40	\$18.80	Tulare	\$19.30	\$17.70
Mono	\$20.10	\$18.30	Tuolumne	\$20.10	\$18.30
Monterey	\$21.10	\$19.30	Ventura	\$19.90	\$18.40
Napa	\$22.80	\$19.20	Yolo	\$20.90	\$18.30
Nevada	\$20.40	\$18.80	Yuba	\$19.80	\$18.30

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