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State/Territory Name: CA

State Plan Amendment (SPA) #: CA-24-0004

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

November 7, 2024

Tyler Sadwith
State Medicaid Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

RE: California State Plan Amendment Transmittal Number 24-0004

Dear State Medicaid Director Sadwith:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed California state plan amendment (SPA) to Attachment 4.19-D CA-24-0004, which was submitted to CMS on March 29, 2024. This plan amendment renews and modifies the reimbursement rate methodology for Freestanding Skilled Nursing/Subacute Facilities Level-B, by authorizing aggregate increases to the weighted average Medi-Cal reimbursement rate components for labor and non-labor costs and authorizing a new Workforce Standards Program rate augmentation.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of January 1, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Mark Wong at 415-744-3561 or via email at mark.wong@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0004

2. STATE: CA

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

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

4. PROPOSED EFFECTIVE DATE
January 1, 2024

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

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023-24 $ 97,000,000
b. FFY 2024-25 $ ~~32,350,000~~ 213,800,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D, page 12
Supplement 4 to Attachment 4.19-D, pages 5b, 5c (new), 5d (new), 6-8, 14, 18, ~~18a, and 19~~ 18a (new), and 19
Supplement 6 to Attachment 4.19-D pages ~~1-21 (new)~~ 1-22 (new)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D, page 12
Supplement 4 to Attachment 4.19-D, pages 5b, ~~i~~6-8, 14, 18, ~~18a,~~ and 19

9. SUBJECT OF AMENDMENT
Continue the existing facility-specific reimbursement methodology for Freestanding Skilled Nursing/Subacute Facilities Level-B, authorizing rate increases for Calendar Years (CY) 2024 through 2026 and authorize a new Workforce Standards Program rate augmentation.

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

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Tyler Sadwith

13. TITLE
State Medicaid Director

14. DATE SUBMITTED
March 29, 2024

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

FOR CMS USE ONLY

16. DATE RECEIVED
March 29, 2024

17. DATE APPROVED
November 7, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS
Pen-and-ink changes made to Boxes 6, 7, and 8 by CMS with state concurrence.

Instructions on Back

requirements of state or federal laws or regulations including the costs of special programs,

C. Change in service provided since cost report period.

Adjustments to reported costs of facilities will be made to reflect changes in state or federal laws and regulations which would impact upon such costs. The adjustments are necessary to account for costs associated with changes in state or federal laws and regulations which are not included in cost reports used to set rates nor in cost inflation factors that may be otherwise applied during the rate setting process pursuant to the State Plan. These adjustments will be reflected as an "add-on" to the rates for these costs. To the extent not prohibited by federal law or regulations, "add-ons" to the rate may continue until such time as those costs are included in cost reports used to set rates under this state plan.
For example, state or federal mandates may include such costs as changes to the minimum wage or increases in nurse staffing requirements. An example of other extraordinary costs might include unexpected increases in workers compensation costs or other costs which would impact facilities ability to continue to provide patient care.

D. Updates.

Updates to reported costs will reflect economic conditions of the industry. The following economic indicators will be considered where the Department has not developed other indicators of cost:

1. California Consumer Price Index, as determined by the State Department of Finance.

2. A labor inflation index, which will be updated annually 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.

The update factors used by the Department shall be applied to all classes from the midpoint of each facility's fiscal period to the midpoint of the State's rate year in which the rates are effective. For the rate period of August 1, 2023 through December 31, 2023, the midpoint will be October 15, 2023. For calendar rate year beginning January 1, 2024 and each calendar rate year thereafter, the midpoint of the State’s rate year will be July 1st.

E. Cost-of-Living Update

Adjusted costs for each facility are updated from the midpoint of the facility's report period through the midpoint of the State's Medi-Cal rate year. For the rate period of August 1, 2023 through December 31, 2023, the midpoint will be October 15, 2023. For calendar rate year beginning January 1, 2024 and each calendar rate year thereafter, the midpoint of the State’s rate year will be July 1st. Adjusted costs are divided into categories and treated as follows:

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.

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, 2026, 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.

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.

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.

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 l, 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.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: California

SKILLED NURSING FACILITY WORKFORCE STANDARDS PROGRAM

For the 2024 through 2026 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.

   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) The workforce rate adjustment shall not be provided for rate years beginning on or after January 1, 2027.

f) 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.

g) 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) 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:

Benchmark Plan Gross Premium × 70% × (1 + (80 – Benchmark Plan AV) / 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:

Benchmark Plan Gross Premium × 75% × (1 + (80 – Benchmark Plan AV) / 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:

Benchmark Plan Gross Premium × 80% × (1 + (80 – Benchmark Plan AV) / 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.

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