Is Medi-Cal Paying Its Fair Share for Mandated Infection Prevention Services?

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DHCS cost reclassifications can reduce both labor-based reimbursement and workforce-related rate factors

The COVID-19 pandemic exposed the devastating consequences that infectious disease outbreaks can have in skilled nursing facilities. California responded by requiring facilities to devote dedicated clinical resources to infection prevention. Beginning in 2021, the State required a full-time, dedicated Infection Preventionist who was a registered nurse or licensed vocational nurse. That mandate reflected a clear policy judgment: trained clinical oversight of infection prevention was essential to resident safety.

Years later, however, the Department of Health Care Services (DHCS) may reclassify Infection Preventionist nursing costs from direct or indirect care labor to administration when auditing Medi-Cal cost reports. Under DHCS's reimbursement methodology, moving the same costs from one category to another can materially reduce reimbursement for services California required facilities to provide. In practical terms, the State recognized the need for infection prevention services, imposed the cost, and now risks leaving facilities to bear that cost without Medi-Cal paying its fair share.

California's Infection Preventionist Requirement

Federal regulations require nursing facilities to maintain an infection prevention and control program and designate a qualified Infection Preventionist. The federal rule did not require the Infection Preventionist to be a nurse or to serve in a full-time position. California went further in 2021 by requiring a full-time, dedicated Infection Preventionist who was an RN or LVN. The State later broadened the professions eligible to fill the role while retaining the full-time requirement.

California imposed this facility-level staffing requirement after COVID-19 demonstrated the need for focused infection surveillance, outbreak response, staff education, and resident care coordination. The mandate treated infection prevention as part of the clinical infrastructure needed to protect residents, not as ordinary corporate overhead.

DHCS Reclassification of Infection Preventionist Costs

Infection Preventionists commonly monitor infections, investigate outbreaks, review laboratory and surveillance data, coordinate isolation precautions, participate in care planning, educate nursing staff, and work with Directors of

Nursing and resident care teams. When an RN or LVN performs these duties, providers reasonably view the expense as a nursing cost that supports resident care.

DHCS reclassification can produce the opposite result. If DHCS moves the expense into administration, Medi-Cal may recognize less of the cost in the direct or indirect care labor categories used to establish facility reimbursement. The facility still employs the same clinician, pays the same salary, and provides the same resident care services. The reclassification changes only how that expense is reimbursed.

The consequences may extend beyond the initial cost classification. First, the reclassified expense may no longer contribute in the same manner to the facility's direct or indirect care labor calculation, causing the underlying rate to decline. Second, the reduced amount of recognized qualifying labor may lower workforce-based rate factors or adjustments, including amounts under the Workforce Standards Program (WSP). A single reclassification may therefore affect both the base labor reimbursement rate and an additional workforce incentive intended to support staffing.

Implications for Providers

The reimbursement policy is difficult to reconcile with California's staffing mandate. The State requires facilities to maintain dedicated infection prevention resources because those services are essential to safe resident care. Yet DHCS may classify the resulting clinical expense in a manner that limits Medi-Cal reimbursement and weakens workforce incentives. That approach risks discouraging investment in the very clinical infrastructure California requires.

The issue may extend beyond Infection Preventionists. Similar concerns can arise when DHCS reclassifies home-office or regional nurses who provide clinical consulting, Minimum Data Set support, quality assurance, outbreak management, or nursing oversight. Providers should focus on the services actually performed, the residents and facilities benefited, and the governing cost classification standards rather than job location or generalized labels such as oversight.

Providers facing these reclassifications should preserve job descriptions, schedules, clinical reports, training records, outbreak documentation, care-planning materials, and other evidence showing the services actually performed. They should also quantify both components of the reimbursement impact: the change to labor-related rate calculations and any corresponding change to WSP or other workforce factors. Providers should consider challenging unsupported reclassifications through the applicable audit and rate appeal processes while preserving broader legal and policy objections.

Medi-Cal's treatment of these costs has significant implications for providers that were required to increase clinical staffing in response to a public health crisis. If facilities remain obligated to provide dedicated infection prevention services, the reimbursement system should recognize those services for what they are: part of the nursing and clinical infrastructure necessary to protect residents. Reclassifying the expense as administration, particularly when that change also depresses workforce-related rate factors, risks shifting the cost of the State's mandate back to providers and undermining the policy the mandate was intended to advance.

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