SKILLED NURSING FACILITY WORKFORCE & QUALITY INCENTIVE PROGRAM: 2024 FINAL TECHNICAL PROGRAM GUIDE

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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Please provide any comments regarding to the WQIP Technical Program Guide to DHCS' email: AB186Comments@DHCS.ca.gov.

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DEFINITIONS

Acronym	Definition
AB	Assembly Bill
AFL	All Facilities Letter
CalHHS	California Health and Human Services
CBE	Consensus-Based Entity
CDPH	California Department of Public Health
CMS	Centers for Medicare & Medicaid Services
CNA	Certified Nursing Assistant
COHS	County Organized Health Systems
DHCS	Department of Health Care Services
DON	Directors of Nursing
ED	Emergency Department
EQR	External Quality Review
FFS	Fee-For-Service
HAI	Healthcare-Associated Infections
HPPD	Hours Per Patient Day
HSAG	Health Services Advisory Group, Inc.
HSC	Health & Safety Code
ID	Identification
LTC	Long Term Care
LVN	Licensed Vocational Nurse
MCAS	Managed Care Accountability Set
MCP	Managed Care Health Plans
MDS	Minimum Data Set
MCBD	Medi-Cal Bed Day
PBJ	Payroll Based Journal
PPR	Potentially Preventable Readmission
PY 1	Program Year 1 (2023)
PY 2	Program Year 2 (2024)
QASP	Quality and Accountability Supplemental Payment
RFA	Reason for Assessment
RN	Registered Nurse
SNF	Skilled Nursing Facility
STP	Special Treatment Program
WQIP	Workforce and Quality Incentive Program

OVERVIEW

Introduction

Assembly Bill (AB) 186 (Chapter 46, Statutes of 2022)[1] amended the Medi-Cal Long-Term Care Reimbursement Act to reform the financing methodology applicable to Freestanding Skilled Nursing Facilities (SNFs) Level-B and Adult Freestanding Subacute Facilities Level-B. AB 186 authorizes the State to implement the SNF Workforce & Quality Incentive Program (WQIP), which will provide performance-based directed payments to facilities to incentivize workforce and quality for Medi-Cal Certified SNFs. WQIP succeeds the former Quality and Accountability Supplemental Payment (QASP) program.

As of January 1, 2023, all Medi-Cal managed care health plans (MCPs) are responsible for long-term care (LTC) services. Prior to January 1, 2023, only MCPs operating in County Organized Health Systems (COHS) or Cal MediConnect (Coordinated Care Initiative [CCI]) counties were responsible for LTC services beyond the month of admission and subsequent month.

For program year (PY) 2 (i.e., January 1–December 31, 2024), MCPs will make directed payments to eligible SNFs based on utilization during the PY. Directed payments will be determined based on how SNFs perform on WQIP metrics. WQIP payments will also be reduced for facilities that receive class A or AA citations from the California Department of Public Health (CDPH) for violations that occurred wholly or in part during PY 2.

As part of WQIP, Health Services Advisory Group, Inc. (HSAG) developed this Technical Program Guide for the Department of Health Care Services (DHCS). This Technical Program Guide outlines how each facility will be scored on the WQIP metrics and how the WQIP directed payments will be determined.

[1] State of California Legislative Counsel Bureau. Assembly Bill No. 186, Chapter 46. Available at: https://leginfo.legislature.ca.gov/faces/billPdf.xhtml?bill_id=202120220AB186&version=20210AB18695CHP

WQIP-Qualifying Bed Days

Freestanding SNF Level-B bed days that are rendered by a network provider during the program year and reimbursed by a MCP where Medi-Cal is the primary payer are eligible to earn WQIP payments. Bed days reimbursed outside of a network agreement, days where Medi-Cal is a secondary payer, and bed days reimbursed through the Medi-Cal Fee-For-Service (FFS) Delivery System are not eligible for WQIP payments.

Freestanding pediatric subacute care facilities, distinct part facilities, and SNFs with 100 percent designated special treatment program (STP) beds are not eligible for WQIP payments.

WQIP Metrics

To evaluate the quality of care within SNFs, DHCS established the following domains and measurement areas:

- Workforce Metrics Domain
  - Acuity-Adjusted Staffing Hour Metrics Measurement Area
  - Staffing Turnover Metric Measurement Area
- Clinical Metrics Domain
  - Minimum Data Set (MDS) Clinical Metrics Measurement Area
  - Claims-Based Clinical Metrics Measurement Area
- Equity Metrics Domain
  - Medi-Cal Disproportionate Share Measurement Area
  - MDS Racial and Ethnic Data Completeness Measurement Area

Table 1 presents the metrics included in each domain and measurement area, including the Centers for Medicare & Medicaid Services (CMS) Consensus-Based Entity (CBE) identification (ID) (if applicable), that will be evaluated as part of PY 2 of the WQIP.

Table 1—WQIP Metrics

N/A indicates *there is no applicable CBE ID.*

Metric	CBE ID
Workforce Metrics Domain	
Acuity-Adjusted Staffing Hour Metrics Measurement Area	
Acuity-Adjusted Total Nursing Hours	N/A
Acuity-Adjusted Weekend Total Nursing Hours	N/A
Acuity-Adjusted RN Hours	N/A
Acuity-Adjusted LVN Hours	N/A
Acuity-Adjusted CNA Hours	N/A
Staffing Turnover Metric Measurement Area	
Staffing Turnover	N/A
Clinical Metrics Domain	
MDS Clinical Metrics Measurement Area	
Percent of Residents Who Lose Too Much Weight, Long Stay	0689
Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	0674
Percent of Residents Who Received an Antipsychotic Medication, Long Stay	N/A
Claims-Based Clinical Metrics Measurement Area	
Outpatient ED Visits per 1,000 Long-Stay Resident Days	N/A
Healthcare-Associated Infections Requiring Hospitalization	N/A
Potentially Preventable 30-Day Post-Discharge Readmission	N/A
Equity Metrics Domain	
Medi-Cal Disproportionate Share Measurement Area	
Medi-Cal Disproportionate Share	N/A
MDS Racial and Ethnic Data Completeness Measurement Area	
MDS Racial and Ethnic Data Completeness	N/A

Data Sources

The following section discusses the data sources and how each will be used for the WQIP scoring calculations.

Payroll Based Journal (PBJ) Data

CMS developed PBJ as a system for collecting daily staffing information.[2] WQIP utilizes the PBJ Public Use File for nursing staff from the CMS PBJ system to assess staffing within California SNFs. These data are collected from facilities that electronically submit the number of hours facility staff are paid to work each day. Staffing data are collected for each day in the quarter for directors of nursing (DONs), RNs, LVNs, CNAs, and Nurse Aides in training. Additionally, the daily resident census information derived from the MDS data is reported. These data are submitted quarterly and are audited to ensure data accuracy.[3] HSAG will use these data to calculate the staffing data completeness for use in scoring the Acuity-Adjusted Staffing Hour Metrics Measurement Area. In addition, the daily MDS census information will be used to calculate the denominator for the *Medi-Cal Disproportionate Share* Metric.

Care Compare Metrics Data

The Care Compare tool was developed by CMS as a way for individuals to make informed decisions when choosing a provider (e.g., physician, hospital, SNF).[4] As part of the CMS Care Compare public reporting site, CMS calculates a set of quality ratings and staffing rates for nursing homes. As part of these calculations, CMS uses the reported staffing hours from the PBJ data to calculate the staffing hours per resident day for each quarter along with the daily resident census information from the MDS assessments. Additionally, CMS calculates case-mix adjusted staffing levels based on information

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[2] CMS. Staffing data submission payroll-based journal. Available at: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/staffing-data-submission-pbj. Accessed on: Sep 12, 2024.

[3] Submissions must be received by the end of the 45th calendar day after the last day in each fiscal quarter to be considered timely.

[4] CMS. About this tool. Available at: https://www.medicare.gov/care-compare/resources/about-this-tool. Accessed on: Sep 12, 2024.

derived from the MDS assessments. These data are submitted quarterly and are due 45 days after the end of each reporting period.[5]

To calculate the Workforce Metrics Domain, HSAG will obtain data from the Provider Information file from CMS' Care Compare public data catalog. This file contains general information on currently active nursing homes, including staffing information, used as part of CMS' quality rating system. For PY 2, HSAG will use the most up-to-date data from the July 2024, October 2024, January 2025, and April 2025 Care Compare refresh to calculate the Acuity-Adjusted Staffing Hour Metrics Measurement Area for January 1, 2024, to December 31, 2024. Additionally, HSAG will use data from the April 2025 Care Compare refresh to calculate the Staffing Turnover Metric Measurement Area for PY 2.

MDS 3.0 Data

Data from the MDS 3.0 national database will be used to evaluate facility performance on select measures. MDS is a core set of screening, clinical, and function status items used by CMS to facilitate care management in SNFs and was designed to improve data reliability, accuracy, and usefulness by including the resident in the assessment process.[6] HSAG will obtain MDS 3.0 data from CMS, allowing access to all MDS 3.0 data submitted by California facilities. In addition to the MDS 3.0 data, HSAG will also obtain a facility file containing identifying information for all facilities included in the MDS 3.0 data (e.g., facility name, facility address). These data will be used to calculate the metric rates and the MDS Data Completeness for the MDS Clinical Metrics Measurement Area and the MDS Racial and Ethnic Data Completeness Metric Measurement Area as displayed in Table 1. For further details about the MDS data, please see the LTC Facility Resident Assessment Instrument 3.0 User Manual.[7]

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[5] CMS. Design for care compare nursing home five-star quality rating system: Technical users' guide. 2023. Available at: https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf. Accessed on: Sep 12, 2024.

[6] CMS. MDS 3.0 for nursing homes and swing bed providers. Available at: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/nhqimds30. Accessed on: Sep 12, 2024.

[7] CMS. LTC facility resident assessment instrument 3.0 user's manual V1.18.11. 2023. Available at: https://www.cms.gov/files/document/draftmds-30-rai-manual-v11811october2023.pdf. Accessed on: Sep 12, 2024.

Audited Claims-Based Metrics Data

As part of the measurement year 2024 Medi-Cal Managed Care Accountability Set (MCAS), MCPs are required to submit audited claims-based metrics to DHCS in June 2025 for use in WQIP.[8] MCPs will be required to calculate and report a rate for each facility it has residents residing in. For all metrics within the Claims-Based Clinical Metrics Measurement Area, the MCPs will provide audited results containing facility-level numerators, denominators, and rates. Please note, MCPs will be audited in alignment with the HEDIS Compliance Audit™, [9] timeline and in accordance with the methods outlined in CMS' publication, *CMS External Quality Review (EQR) Protocols: Protocol 2. Validation of Performance Measures, February 2023*.[10]

Medi-Cal Bed Day (MCBD) Data

DHCS will provide MCBD counts, by facility, from the data in DHCS' data warehouse. The MCBDs will be based on claims/encounter data submitted by the MCPs to DHCS by June 30, 2025. If a facility does not have MCBD data, its MCBD count will be considered zero. These data will be used to calculate the numerator for *the Medi-Cal Disproportionate Share* Metric and to calculate the linear curve application for the final WQIP score. A more detailed discussion of the *Medi-Cal Disproportionate Share* Metric may be found in the Metrics Calculations section and a discussion of the WQIP payment eligibility requirements and payment determinations may be found in the WQIP Scoring Methodology section.

WQIP-Qualifying Days

DHCS will calculate the WQIP curve factor for the interim and final WQIP scores based on WQIP-qualifying days reported in encounter data submitted by the MCPs to DHCS' data warehouse by the specified reporting deadlines.

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[8] DHCS. MCAS for MCPs Measurement Year 2023. Available at: https://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal-Accountability-Set-Reporting-Year-2024.pdf. Accessed on: Sep 12, 2024.

[9] HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

[10] CMS. CMS External Quality Review (EQR) Protocols. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Sep 12, 2024.

WQIP-qualifying days are SNF services as defined in 22 CCR sections 51123(a), 51511(b), 51535, and 51535.1, as applicable, starting on the first day of a Member's stay, which include:

- SNF services as set forth in 22 CCR section 51123(a) to include:
  - Room and board.
  - Nursing and related care services.
  - Commonly used items of equipment, supplies and services as set forth in 22 CCR section 51511(b).
  - Leave-of-absence days as set forth in 22 CCR section 51535.
  - Bed holds as set forth in 22 CCR section 51535.1.

Table 2—Interim and Final Payment Reporting Deadlines

Payment	Reporting Deadline
Interim Payment	December 31, 2024
Final Payment	June 30, 2025

California Health and Human Services (CalHHS) Data

HSAG will obtain from the CalHHS Open Data Portal the Licensed and Certified Healthcare Facility Listing File, which includes all California health care facilities that are operational and have a current license issued by CDPH and/or has another U.S. Department of Health and Human Services' CMS certification.[11] HSAG will use this file to determine the number of licensed beds for each SNF to identify facilities with 59 or fewer licensed beds for the staffing data completeness calculations. A more detailed discussion of the staffing data completeness calculation is provided in the Metrics Calculations section.

A/AA Citation Data

DHCS will direct MCPs to withhold SNF WQIP payments, partially or wholly depending on citation, for facilities with one or more Class AA or A citations issued by CDPH for violations that were issued wholly or in part during PY 2.

[11] CDPH. Licensed and certified healthcare facility listing. Available at: https://data.chhs.ca.gov/dataset/healthcare-facility-locations. Accessed on: Sep 12, 2024.

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

See the A/AA Citations section for more details.

METRICS CALCULATIONS

As part of WQIP PY 2, HSAG will evaluate 14 metrics across three domains (i.e., Workforce Metrics, Clinical Metrics, and Equity Metrics). Table 3 presents the PY 2 WQIP metric domains, measurement areas, metrics, measure steward, data sources, and each domains' percentage of the total WQIP score. DHCS will re-evaluate the metrics, data sources, and measurement periods for future WQIP PYs.

Table 3—WQIP Domains, Metrics, Measure Steward, and Data Source

N/A indicates there is no applicable CBE ID.

Metric	CBE ID
Workforce Metrics Domain	
Acuity-Adjusted Staffing Hour Metrics Measurement Area	
Acuity-Adjusted Total Nursing Hours	N/A
Acuity-Adjusted Weekend Total Nursing Hours	N/A
Acuity-Adjusted RN Hours	N/A
Acuity-Adjusted LVN Hours	N/A
Acuity-Adjusted CNA Hours	N/A
Staffing Turnover Metric Measurement Area	
Staffing Turnover	N/A
Clinical Metrics Domain	
MDS Clinical Metrics Measurement Area	
Percent of Residents Who Lose Too Much Weight, Long Stay	0689
Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	0674
Percent of Residents Who Received an Antipsychotic Medication, Long Stay	N/A
Claims-Based Clinical Metrics Measurement Area	
Outpatient ED Visits per 1,000 Long-Stay Resident Days	N/A
Healthcare-Associated Infections Requiring Hospitalization	N/A
Potentially Preventable 30-Day Post-Discharge Readmission	N/A

Metric	CBE ID
Equity Metrics Domain	
Medi-Cal Disproportionate Share Measurement Area	
Medi-Cal Disproportionate Share	N/A
MDS Racial and Ethnic Data Completeness Measurement Area	
MDS Racial and Ethnic Data Completeness	N/A

Table 4 displays the PY 2 measurement areas, measurement periods, and measurement populations.

Table 4—PY 2 Measurement Areas, Measurement Periods, and Measurement Population

**For this measurement area, performance is assessed for two separate measurement periods from January 1, 2024–September 30, 2024, and from October 1, 2024–December 31, 2024.*

***For this metric, performance is assessed from October 1, 2023–September 30, 2024; however, the metric uses data from July 1, 2023–December 31, 2024, to calculate results (i.e., there is a one quarter look-back and look-forward period for calculation).*

Measurement Area	Measurement Period	Measurement Population
Acuity-Adjusted Staffing Hour Metrics*	January 1–December 31, 2024	All direct care staff
Staffing Turnover Metric**	October 1, 2023–September 30, 2024	All direct care staff
MDS Clinical Metrics	July 1, 2023–June 30, 2024	All long-stay patients
Claims-Based Clinical Metrics	January 1–December 31, 2024	Patients enrolled in Medi-Cal managed care, including Medi-Cal/Medicare dual eligible members
Medi-Cal Disproportionate Share Metric	January 1–December 31, 2024	All patients
MDS Racial and Ethnic Data Completeness Metric	January 1–December 31, 2024	All patients

Workforce Metrics Domain

Acuity-Adjusted Staffing Hour Metrics Measurement Area

For each of the Acuity-Adjusted Staffing Hour Metrics, HSAG will use the publicly available data from Care Compare for the measurement period of January 1, 2024, to December 31, 2024. Because the number of hours needed for nursing staff to care for a patient's needs may vary based on each facility's patient population, CMS applies a case-mix adjustment to account for the differences in the levels of patient acuity. Please refer to the CMS Five Star Quality Rating System Technical Users' Guide[12] for more detailed specifications on how CMS calculates the Acuity-Adjusted Staffing Metrics Measurement Area rates and the specific adjustment tables. For WQIP, HSAG will derive the metrics within the Acuity-Adjusted Staffing Hour Metrics Measurement Area from the CMS-calculated adjusted nursing hours per resident day rates.
Table 5 provides a crosswalk of the rates included in the Care Compare data to those that will be used for WQIP.

Table 5—CMS Care Compare Staffing Rates and Associated WQIP Metrics

Care Compare Staffing Rates	WQIP Metric
Adjusted Total Nurse Staffing Hours per Resident per Day	*Acuity-Adjusted Total Nursing Hours*
Adjusted Weekend Total Nurse Staffing Hours per Resident per Day	*Acuity-Adjusted Weekend Total Nursing Hours*
Adjusted RN Staffing Hours per Resident per Day	*Acuity-Adjusted RN Hours*
Adjusted LVN Staffing Hours per Resident per Day	*Acuity-Adjusted LVN Hours*
Adjusted Nurse Aide Staffing Hours per Resident per Day	*Acuity-Adjusted CNA Hours*

HSAG will calculate and score the measurement area using two measurement periods within the overall PY 2 measurement period (January 1–December 31, 2024). The facility

[12] CMS. Design for *Care Compare* Nursing Home Five-Star Quality Rating System: Technical Users' Guide. Available at: https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf. Accessed on: Sep 12, 2024.

rates for the first measurement period (January 1, 2024–September 30, 2024) will be calculated by averaging each facility's rates for the first three quarters of the overall PY 2 measurement period. The second measurement period (October 1, 2024–December 31, 2024) will use the reported rates in the April 2025 Care Compare data refresh to determine the metric rates for each facility. Each measurement period will have a rate and a score calculated separately. Because all facilities are required to submit staffing data to CMS, facilities that are missing data for all metrics within the Acuity-Adjusted Staffing Hour Metrics Measurement Area will receive a score of 0 points for this measurement area. Further details may be found in the WQIP Scoring section.

Staffing Data Completeness

As part of the WQIP calculations, scores for each of the metrics within the Acuity-Adjusted Staffing Hour Metrics Measurement Area will be adjusted based on staffing data completeness calculated from the daily PBJ data. For each of the metrics within the Acuity-Adjusted Staffing Hour Metrics Measurement Area, HSAG will use the daily PBJ data to calculate a completeness score equal to the percentage of days during the date span used to calculate each acuity-adjusted staffing metric rate (e.g., for the January 1, 2024–September 30, 2024 measurement period, the completeness score will be determined for the same date span) that the facility met the minimum performance benchmark applicable to the metric. Details into how the staffing data completeness will be calculated for each metric is included below.

Acuity-Adjusted Total Nursing Hours

The *Acuity-Adjusted Total Nursing Hours* data completeness minimum performance benchmark requires that the facility reports PBJ data daily and that the daily non-administrative nursing staff hours per patient day (HPPD) meets a 3.5 HPPD minimum staffing standard for each day in the measurement period. For facilities with 59 or fewer licensed beds, HSAG will align with the CDPH All Facilities Letter (AFL) 21-11[13] and will credit up to 40 hours per week for work performed by a DON to determine daily compliance with the 3.5 HPPD staffing standard. To calculate the percentage of days in the measurement period that met the minimum performance benchmark, the following specifications will be used:

- Denominator: The total number of days in the measurement period.
- Numerator: The total number of days in the measurement period that meet the minimum performance benchmark. A day is considered to have not met the

[13] CDPH. AFL 21-11. Available at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-11.aspx. Accessed on: Sep 12, 2024.

minimum performance benchmark if the total nursing staff non-adjusted HPPD is below the 3.5 HPPD minimum staffing standard or if the day did not have reported PBJ data. To identify the numerator, the following logic will be used:

- Step 1: For each day included in the PBJ data, sum the RN, LVN, CNA, and Nurse Aides in Training hours from the PBJ data (Hrs_RN + Hrs_LPN + Hrs_CNA + Hrs_Natrn) to get the total staffing hours for the day.
- Step 2: For each day included in the PBJ data, divide the total staffing hours for the day by the MDS Census for the day as reported in the PBJ data (MDScensus) to get the total nursing HPPD for that day.
- Step 3: For each day, compare the calculated Total Nursing HPPD to the 3.5 HPPD minimum staffing standard. If the HPPD is below 3.5 then the day is below the minimum performance benchmark.
- Step 4: For facilities with 59 or less certified beds, as determined by the CalHHS data, up to 40 DON hours per week may be used for compliance with the 3.5 HPPD minimum staffing standard. To assign DON hours for these facilities, the following logic will be used:
    - Identify the number of certified beds using the capacity listed for the facility in the CalHHS data. If the capacity is 60 or higher or the facility is missing its capacity data, end this step here and move on to step 5. If the facility capacity is 59 or less, continue with the logic to assign DON hours.
    - Identify the beginning and end of each week during the measurement period. For the purposes of DON hour allocation, the week starts on Monday and ends on Sunday. If the measurement period does not begin on a Monday, then the first week will start on the first day of the measurement period and end on the first Sunday.
    - Beginning with the first day of the week, identify if the facility did not meet the 3.5 HPPD minimum staffing standard. If the facility did not meet the 3.5 HPPD minimum staffing standard and has PBJ data for the day, add the necessary amount of DON hours to the total staffing hours to meet the 3.5 HPPD standard. If the number of DON hours is insufficient to meet the 3.5 HPPD standard, all DON hours will still be counted for the day.

- Repeat the previous step for each subsequent day until 40 DON hours have been assigned or until the end of the week. If the number of DON hours necessary to meet the 3.5 HPPD standard would results in more than 40 DON hours being assigned, then only assign the number of DON hours available to exactly reach 40, even if that is insufficient to meet the 3.5 HPPD standard.
- Please see Table 6 for an example of how the DON hours will be credited towards the calculation of the Total Nursing Staffing Data Completeness.

- Step 5: Identify the number of days missing from the PBJ data. If a day is missing from the PBJ data, then that day is considered below the minimum performance benchmark.
- Step 6: All days that were not below the minimum performance benchmark are considered to have met the minimum performance benchmark.
- Step 7: Sum the total number of days that met the minimum performance benchmark to determine the numerator.

» Rate: Divide the numerator by the denominator to calculate the Total Nursing Hours Data Completeness rate.

Table 6—*Acuity-Adjusted Total Nursing Hours* Completeness Score Calculation

Facility Name	Day of Week	Minimum Performance Benchmark	Licensed Beds	Daily MDS Census	Total Nursing Hours (Excluding DON Hours)	Total Nursing HPPD (Excluding DON Hours)	DON Hours	DON Hours Credited as HPPD	Total Nursing Hours (Including DON Hours, if Eligible)	Total Nursing HPPD (Including DON Hours, if Eligible)
Facility 1	Mon	3.5	51	48	170	3.54	8	0	170	3.54
	Tues	3.5	51	47	162	3.45	8	2.5	164.5	3.50
	Weds	3.5	51	47	160	3.40	8	4.5	164.5	3.50
	Thurs	3.5	51	47	150	3.19	8	8	158	3.36
	Fri	3.5	51	48	165	3.44	8	3	168	3.50
	Sat	3.5	51	48	170	3.54	0	0	170	3.54
	Sun	3.5	51	48	170	3.54	0	0	170	3.54
Facility 2	Mon	3.5	120	105	400	3.81	8	0	400	3.81
	Tues	3.5	120	106	396	3.74	8	0	396	3.74
	Weds	3.5	120	106	396	3.74	8	0	396	3.74
	Thurs	3.5	120	106	392	3.70	8	0	392	3.70
	Fri	3.5	120	107	396	3.70	8	0	396	3.70
	Sat	3.5	120	107	366	3.42	8	0	366	3.42

Facility Name	Day of Week	Minimum Performance Benchmark	Licensed Beds	Daily MDS Census	Total Nursing Hours (Excluding DON Hours)	Total Nursing HPPD (Excluding DON Hours)	DON Hours	DON Hours Credited as HPPD	Total Nursing Hours (Including DON Hours, if Eligible)	Total Nursing HPPD (Including DON Hours, if Eligible)
	Sun	3.5	120	107	370	3.46	8	0	370	3.46
Facility 3	Mon	3.5	35	34	117	3.44	10	2	119	3.50
	Tues	3.5	35	34	115	3.38	12	4	119	3.50
	Weds	3.5	35	34	117	3.44	10	2	119	3.50
	Thurs	3.5	35	34	119	3.50	8	0	119	3.50
	Fri	3.5	35	34	117	3.44	10	2	119	3.50
	Sat	3.5	35	34	114	3.35	8	5	119	3.50
	Sun	3.5	35	34	108	3.18	8	8	116	3.41
Facility 4	Mon	3.5	18	16	50	3.13	8	6	56	3.50
	Tues	3.5	18	16	48	3.00	10	8	56	3.50
	Weds	3.5	18	16	46	2.88	10	10	56	3.50
	Thurs	3.5	18	16	46	2.88	10	10	56	3.50
	Fri	3.5	18	16	48	3.00	10	6	54	3.38
	Sat	3.5	18	16	46	2.88	10	0	46	2.88
	Sun	3.5	18	16	46	2.88	10	0	46	2.88

Acuity-Adjusted Weekend Total Nursing Hours

The *Acuity-Adjusted Weekend Total Nursing Hours* Metric data completeness minimum performance benchmark requires that the facility reports PBJ data on all weekend days and that the daily weekend non-administrative nursing staff HPPD meets a 3.5 HPPD minimum staffing standard for each weekend day in the measurement period. Additionally, HSAG will credit all hours performed by a DON on a weekend day when determining daily compliance with the 3.5 HPPD staffing standard to align with the CDPH AFL 21-11.[14] To calculate the percentage of weekend days in the measurement period that met the minimum performance benchmark, the following specifications are used:

- Denominator: The total number of weekend days in the measurement period.
- Numerator: The total number of weekend days in the measurement period that meet the minimum performance benchmark. A weekend day is considered to have not met the minimum performance benchmark if the non-adjusted HPPD is

[14] CDPH. AFL 21-11. Available at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-11.aspx. Accessed on: Sep 12, 2024.

below the 3.5 HPPD minimum staffing standard or if the day did not have reported PBJ data. To identify the numerator, use the following logic:

- Step 1: For each weekend day included in the PBJ data, sum the RN, LVN, CNA, and Nurse Aides in Training hours from the PBJ data (Hrs_RN + Hrs_LPN + Hrs_CNA + Hrs_Natrn) to get the total staffing hours for the day.
- Step 2: For each weekend day included in the PBJ data, divide the total staffing hours for the day by the MDS Census for the day as reported in the PBJ data (MDScensus) to get the total nursing HPPD for that day.
- Step 3: For each weekend day, compare the calculated Total Nursing HPPD to the 3.5 HPPD minimum staffing standard. If the HPPD is below 3.5 then the day is below the minimum performance benchmark.
- Step 4: For facilities with less than 59 certified beds as determined by the CalHHS data, DON hours may be assigned to determine compliance with the 3.5 standard for weekend days. To assign DON hours for these facilities, the following logic will be used:
    - Identify the number of certified beds using the capacity listed for the facility in the CalHHS data. If the capacity is 60 or higher or the facility is missing its capacity data end this step here and move on to step 5. If the facility capacity is 59 or less, continue with the logic to assign DON hours.
    - If a weekend day has PBJ data and does not meet the 3.5 HPPD minimum staffing standard, add all DON hours to the total staffing hours for the day and recalculate the HPPD for the day. If the HPPD is now above the 3.5 HPPD minimum staffing standard, then the day meets the minimum performance benchmark.
- Step 5: Identify the number of weekend days missing from the PBJ. If a day is missing from the PBJ data, then that day is below the minimum performance benchmark.
- Step 6: All weekend days that were not below the minimum performance benchmark are considered to have met the minimum performance benchmark.
- Step 7: Sum the total number of weekend days that met the minimum performance benchmark to determine the numerator.

- Rate: Divide the numerator by the denominator to calculate the Weekend Total Nursing Hours Data Completeness rate.

Acuity-Adjusted CNA Hours

The *Acuity-Adjusted CNA Hours* metric data completeness minimum performance benchmark requires that the facility reports PBJ data daily and the total CNA and nursing aides in training HPPD meets a 2.4 HPPD minimum staffing standard for each day in the measurement period. To calculate the percentage of days in the measurement period that met the minimum performance benchmark, the following specifications are used:

- Denominator: The total number of days in the measurement period.
- Numerator: The total number of days in the measurement period that met the minimum performance benchmark. A day is considered to have not met the minimum performance benchmark if the combined non-adjusted CNA and nursing aides in training HPPD is below the 2.4 HPPD minimum staffing standard for CNAs or if the day did not have reported PBJ data. To identify the numerator, use the following logic:
  - Step 1: For each day included in the PBJ data, sum the CNA and nurse aides in training hours from the PBJ data (Hrs_CNA + Hrs_Natrn) to get the CNA staffing hours for the day.
  - Step 2: For each day included in the PBJ data, divide the CNA staffing hours for the day by the MDS Census for the day as reported in the PBJ data (MDScensus) to get the CNA HPPD for that day.
  - Step 3: For each day, compare the calculated CNA HPPD to the 2.4 HPPD minimum staffing standard for CNAs. If the HPPD is below 2.4 then the day is below the minimum performance benchmark.
  - Step 4: Identify the number of days missing from the PBJ. If a day is missing from the PBJ data, then that day is below the minimum performance benchmark.
  - Step 5: All days that were not below the minimum performance benchmark are considered to have met the minimum performance benchmark.
  - Step 6: Sum the total number of days that met the minimum performance benchmark to determine the numerator.
- Rate: Divide the numerator by the denominator to calculate the CNA Hours Data Completeness rate.

Acuity-Adjusted RN Hours and Acuity-Adjusted LVN Hours

The *Acuity-Adjusted RN Hours* Metric and *Acuity-Adjusted LVN Hours* Metric data completeness minimum performance benchmark requires that the facility reports PBJ data daily. Because both metrics do not have a minimum staffing standard, the process to calculate the data completeness is the same for both metrics. To calculate the percentage of days in the measurement period that met the minimum performance benchmark, the following specifications are used:

- Denominator: The total number of days in the measurement period.
- Numerator: The total number of days in the measurement period that have reported PBJ data. To identify the numerator, count the number of days that the facility had reported PBJ data in the measurement period.
- Rate: Divide the numerator by the denominator to calculate the RN and LVN Hours Data Completeness rate

Background and Caveats

The minimum performance benchmarks are designed to align with the state law minimum staffing requirements in the California Health & Safety Code (HSC) 1276.65. The exclusion of administrative hours and medication aides/technicians is designed to approximate the definition of direct care hours used by CDPH to enforce HSC 1276.65. While the PBJ data does not allow an exact cross walk with the definition of direct care hours used by the CDPH to enforce HSC 1276.65, PBJ is the best data source available to measure year-round compliance with the minimum performance benchmarks. However, AB 186 does not require that WQIP use the same definitions as HSC 1276.65 to define direct care service hours. Additionally, DHCS will not consider any patient needs or workforce waivers issued by CDPH when assessing daily compliance with the minimum performance benchmarks.

Staffing Turnover Metric

HSAG will use the CMS-calculated *Staffing Turnover* Metric rate as reported in the publicly available Care Compare data which is derived from PBJ data. The *Staffing Turnover* Metric reflects the percentage of nursing staff that stopped working at a nursing home over a 12-month period. To calculate this metric, CMS uses a measurement period of six consecutive quarters (i.e., a baseline quarter prior to the 12-month period covered by the turnover measure and a quarter after the 12-month period). The baseline quarter along with the first two quarters covered by the *Staffing Turnover* Metric is used to identify the eligible population which are individuals who worked at least 120 hours over a 90-day period across those three quarters. The

numerator includes individuals with a period of at least 60 consecutive days in which they do not work at all. This 60 consecutive days must start during the 12-month period covered by the *Staffing Turnover* Metric. The additional quarter after the 12-month period is used to verify if gaps that started within the 12-month period continued for 60 consecutive days, even if those days extend beyond the 12-month period. For PY 2, HSAG will use the *Staffing Turnover* Metric rates reported in the April 2025 Care Compare refresh for nursing staff. Please refer to the CMS Five Star Users' Guide[15] for detailed specifications for the *Staffing Turnover* Metric.

MDS Clinical Metrics Measurement Area

For the MDS Clinical Metrics Measurement Area, HSAG will calculate three long-stay MDS clinical metrics: *Percent of Residents Who Lose Too Much Weight, Long Stay; Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay;* and *Percent of Residents Who Received an Antipsychotic Medication, Long Stay*. These metrics will be calculated for all four quarters of the measurement period (i.e., July 1, 2023–June 30, 2024) for each facility. Additionally, HSAG will use the metric results for the PY 1 measurement period (i.e., July 1, 2022–June 30, 2023) for the purposes of evaluating the improvement score. A detailed discussion of the improvement score calculations may be found in the WQIP Scoring section.

HSAG will identify the long-stay population for the MDS Clinical Metrics Measurement Area in alignment with CMS' stay logic for a well-constructed data stream presented in the MDS 3.0 Quality Measures User's Manual Version 16.0.[16] Based on the stay logic, HSAG will identify three types of assessments for the purposes of metric calculation: target assessments, prior assessments, and look-back scan assessments.

Target Assessment

HSAG will use the target assessment criteria to identify the assessment that will be used to calculate the *Percent of Residents Who Lose Too Much Weight, Long Stay* and the P*ercent of Residents Who Received an Antipsychotic Medication, Long Stay* Metrics. The

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[15] CMS. Design for *Care Compare* Nursing Home Five-Star Quality Rating System: Technical Users' Guide. Available at: https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf. Accessed on: Sep 12, 2024.

[16] CMS. MDS 3.0 Quality Measures User's Manual V16.0. Available at: https://www.cms.gov/files/zip/mds-qm-users-manual-v160-effective-10-1-2023-and-associated-user-manual-files.zip. Accessed on: Sep 12, 2024.

target assessment for long stay metrics include a selection period of the most recent three months, a qualifying reason for assessment (RFA) (A0310A = [01,02,03,04,05,06], or A0310B = [01], or A0310F = [10,11]), and is the latest assessment that meets the above criteria in the most recent episode and has a target date that is no more than 120 days before the end of the episode. To ensure MDS assessments are submitted timely, HSAG will only use MDS assessments that had a submission date within 60 days of the target date for the purposes of metric calculation. If an original version of the assessment is received within 60 days after the target date, but a modified assessment is submitted more than 60 days after the target date, only the modified assessment will be excluded and the originally submitted assessment will be used for metric calculation.

Prior Assessment

Prior assessment refers to the latest assessment that is 46 to 165 days before the target assessment with a qualifying RFA. The prior assessment is required to calculate the exclusion criteria for the *Percent of Residents Who Received an Antipsychotic Medication, Long Stay* Metric. A full description of the criteria for prior assessment includes: (a) contained within the resident's episode, (b) has a qualifying RFA (A0310A = [01,02,03,04,05,06] or A0310B = [01] or A0310F = [10, 11]), and (c) target date is 46 to 165 days preceding the target date of the target assessment. Similar to the target assessments, HSAG will only use MDS assessments that had a submission date within 60 days of the target date.

Look-Back Scan

The look-back scan refers to all assessments with a qualifying RFA within the current episode that have a target date no more than 275 days prior to the target assessment. The look-back scan will be used to determine whether events or conditions of interest occurred at any time during a one year look back period and is required to calculate the *Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay* Metric. Assessments included in the look-back scan includes the target assessment and all earlier assessments that meet all the following criteria: (a) contained within the resident's episode, (b) has a qualifying RFA (A0310A = [01,02,03,04,05,06] or A0310B = [01] or A0310F = [10, 11]), (c) target date is on or before the target date for the target assessment, and (d) its target date is no more than 275 days prior to the target date of the target assessment. Please note that for the look-back assessments, the 60-day submission requirement will not be applied.

MDS Clinical Metric Description

This section describes the metrics included within the MDS Clinical Metrics Measurement Area for the WQIP PY 2 calculations. HSAG will calculate an annual rate for each metric within the MDS Clinical Metrics Measurement Area using the MDS measure specifications provided in the MDS 3.0 Quality Measures User's Manual Version 16.0. Please note, due to the updated labels for items used in the *Percent of Residents Who Lose Too Much Weight, Long Stay* and the *Percent of Residents Who Received an Antipsychotic Medication, Long Stay* metrics on October 1, 2023, assessments prior to October 2023 will follow the specifications provided in the MDS 3.0 Quality Measures User's Manual Version 15.0. However, the measure specifications remained intact or had minimal changes and reporting of the measures was not interrupted. Because the MDS quality measures are calculated on a quarterly basis, the target period for the purposes of measure calculations will be the four calendar quarters. HSAG will then calculate a final annual rate for each facility for each metric by summing the numerators and denominator across the four quarters of the measurement period. To have a reportable rate for the metrics in the MDS Clinical Metrics Measurement Area, a minimum denominator size of 30 will be required. If a metric has a denominator less than 30, that metric will not be included for the purposes of score calculations. Please refer to the WQIP Scoring section for further details on how missing rates will be accounted for in the MDS Clinical Metrics Measurement Area. Please note that a lower rate indicates better performance for all MDS Clinical Metrics. Detailed metric specifications may be found in Appendix A: Clinical Metrics Domain Metric Specifications

Percent of Residents Who Lose Too Much Weight, Long Stay

The *Percent of Residents Who Lose Too Much Weight* Metric is defined as the percentage of long-stay residents who had a weight loss of 5 percent or more in the last month or 10 percent or more in the last six months who were not on a physician prescribed weight-loss regimen noted in an MDS assessment during the selected quarter. The denominator of the metric includes all long-stay residents with a selected target assessment, except for those with exclusions. The numerator includes all long-stay residents with a selected target assessment that indicates a weight loss of 5 percent or more in the last month or 10 percent or more in the last six months who were not on a physician prescribed weight-loss regimen.

Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay

The *Percent of Residents Experiencing One or More Falls with Major Injury* Metric is defined as the percentage of long-stay residents who have experienced one or more falls with major injury reported in the target period or the look-back period. The

denominator of the metric includes all long-stay residents with one or more look-back scan assessments except for those that did not have the number of falls with major injury coded for all look-back scan assessments. The numerator includes long-stay residents with look-back assessments that indicate one or more falls that resulted in major injury.

Percent of Residents Who Received an Antipsychotic Medication, Long Stay

The *Percent of Residents Who Received an Antipsychotic Medication* Metric is defined as the percentage of long-stay residents who are receiving antipsychotic medication in the target period. The denominator for the metric includes long-stay residents with a selected target assessment except those who have any of the following conditions: schizophrenia, Tourette's syndrome on the target or prior assessment, or Huntington's disease. The numerator includes long-stay residents who received an antipsychotic medication. Residents who do not qualify for the numerator and do not report information on the number of antipsychotic medications received will be excluded from the metric.

MDS Data Completeness

To ensure facilities submit the appropriate MDS assessments, DHCS will require facilities to meet a 90 percent MDS data completeness threshold to receive points for the MDS clinical metrics. The data completeness methodology is designed to reflect the percentage of residents who had an assessment with a qualifying RFA submitted for each quarter they resided in a facility. Based on the MDS guidelines for assessment submissions (i.e., frequency and timing), facilities should submit at least one assessment with a qualifying RFA that can be used as a target assessment in each quarter the resident is in the facility. The MDS data completeness will be defined as the percentage of patients who have an assessment submitted for each quarter they resided in a facility. For this metric, HSAG will only use MDS assessments that had a submission date within 60 days of the target date and will be limited to long-stay residents to reflect the population of the MDS Clinical Metrics Measurement Area. The data completeness rate will be calculated for each quarter and aggregated into an annual rate by summing the quarterly numerators and dividing it by the sum of the quarterly denominators. To calculate the MDS data completeness, the following criteria will be used:

- Numerator: The numerator criteria for the data completeness metric includes long-stay residents who had an assessment submitted with a qualifying RFA (A0310A = [01,02,03,04,05,06], or A0310B = [01], or A0310F = [10,11]) during the quarter.

- Denominator: The denominator will include the long-stay residents who are identified for each facility during the quarter. To determine the long-stay residents in each quarter, HSAG will use the stay definitions and instructions for a well-constructed data stream provided by CMS in the MDS 3.0 Quality Measures User's Manual Version 16.0. Based on this, a resident stay is considered ongoing until either a discharge or death assessment (A0310F = [10, 12]) is reported, a discharge assessment with return anticipated (A0310F = [11]) is reported but the resident did not return, or the end of the reporting period (i.e., the end of each quarter). If a resident does not have a reported discharge assessment, the stay logic considers the stay ongoing, and the resident will be included in the denominator if their cumulative days in the facility are greater than or equal to 101 days as of the end of the quarter. To account for residents who did not have a discharge assessment and residents who were recorded as deceased, HSAG will incorporate the following exclusion criteria:
    - For any resident who does not have a discharge assessment and stopped receiving assessments, HSAG will consider them to be in the facility for 150 days after their latest assessment. Once 150 days or more with no assessments have passed, HSAG will consider them to no longer be in the facility starting on the 150th day after their latest assessment and they will not be included in the denominator population for the following quarters. Please note, a resident will be included in the denominator of the facility for all quarters that fall between their latest assessment and the 150th day after (e.g., if a resident's latest assessment is in quarter 1 and the 150-day period ends in quarter 3, they will be included in the denominator for quarters 1-3). However, if the facility submits a non-admission assessment for the resident at a later date that is not the start of a new episode (i.e., the new assessment is not an admission assessment that indicates the beginning of a new episode (A0310F = [01] and A1700 = [1]) as defined by CMS' stay logic), then the resident will be considered to still be in the facility and will included in the denominator for all prior quarters. For example, if a resident's latest assessment was in quarter 1 and received no assessments for the following 150 days, but then receives an assessment in quarter 4 that does not indicate the start of a new episode (i.e., it is not a new admission assessment), then this resident will be included in the denominator for all four quarters.

- Additionally, the following optional exclusion will be applied if the resident is not eligible for the numerator: The resident had a death in a facility assessment (A0310F = [12]) during the selection period. This optional exclusion is applied to not penalize facilities for residents who were deceased during the selection period before an assessment with a qualifying RFA can be performed.

HSAG will use assessments with a target date up to one year prior to the start of the PY 2 measurement period for the purposes of determining resident stays and calculating the MDS data completeness rate (i.e., for PY 2, this will include assessments with a target date on or after July 1, 2022). These calculations will include assessments submitted up until two months after the end of the measurement period (i.e., for PY 2, HSAG will use assessments submitted by the end of August 2024 for the purposes of the measure calculations). Additionally, HSAG will include one additional look forward quarter of data (i.e., Q3 2024 for PY 2) to determine if residents have any additional assessments after the 150-day exclusion period. For PY 2, this look forward period will include assessments with a target date on or before September 30, 2024 that were submitted by the end of November 2024. This additional look forward quarter will be used for the purposes of evaluating the 150-day exclusion criteria and will not be included in the MDS data completeness rate.

Claims-Based Clinical Metrics

For the claims-based clinical metrics, MCPs will calculate facility-level rates in accordance with the modified specifications provided by DHCS. Once MCPs submit facility-level rates for the measurement period, HSAG will calculate a single facility-level rate for each metric by summing the numerators and denominators reported by each MCP as described in the following section. Please note that for all claims based clinical metrics, a lower rate indicates better performance. For the purposes of reporting, the *Outpatient ED Visits per 1,000 Long-Stay Resident Days* Metric, requires a minimum denominator of 360 long-stay days. For the *SNF Healthcare-Associated Infections Requiring Hospitalization* Metric and the *Potentially Preventable 30-Day Post-Discharge Readmission* Metric a minimum denominator of 25 stays will be used. If a metric does not meet the minimum denominator, that metric will not be included for the purposes of score calculations. Additionally, HSAG will use the metric results for the PY 1 measurement period (i.e., January 1, 2023–December 31, 2023) for the purposes of calculating the improvement score. Please refer to the WQIP Scoring section for further details on the improvement score calculations and how the missing rates will be accounted for in the Claims-Based Clinical Metrics Measurement Area. Please refer to

Appendix A: Clinical Metrics Domain Metric Specifications for the detailed specifications, and exclusion criteria.

Outpatient ED Visits per 1,000 Long-Stay Resident Days

The *Outpatient ED Visits per 1,000 Long-Stay Resident Days* Metric is defined as the number of outpatient ED visits occurring in the measurement period while the individual is a long-term nursing home resident. The eligible population includes all long-stay Medi-Cal members or dually eligible members who resided in a SNF during the measurement period. The denominator is the total number of days during the measurement period that all long-stay residents were in a nursing home after they obtained long-stay resident status (i.e., after 100 cumulative days at a facility). The numerator for the metric is the number of visits to an ED that occurred while the patient was a long-term nursing home resident.

A minimum denominator of 360 long-stay days is required to have a reportable rate.

Healthcare-Associated Infections Requiring Hospitalization

The *SNF Healthcare-Associated Infections Requiring Hospitalization* Metric is defined as the rate of healthcare-associated infections (HAIs) which were acquired during SNF care and resulted in hospitalization. The denominator is the number of Medi-Cal and dually eligible SNF stays during the measurement period that do not meet an exclusion criterion. The numerator is the number of eligible SNF stays where a resident acquired an HAI during SNF care and resulted in hospitalization and was not a pre-existing infection. A minimum denominator of 25 eligible stays is required to have a reportable rate.

Potentially Preventable 30-Day Post-Discharge Readmission

The *Potentially Preventable 30-Day Post-Discharge Readmission* metric for SNFs measures the rate of unplanned, potentially preventable readmissions for SNF patients who are readmitted to a short-stay acute-care hospital within 30 days following discharge from a SNF. The denominator includes all SNF stays for Medi-Cal and dually eligible members during the measurement period that do not meet an exclusion criterion. The numerator for the metric is the number of eligible SNF stays that had an unplanned potentially preventable readmission (PPR) within 30 days after discharge. A minimum denominator of 25 eligible stays is required to have a reportable rate.

Equity Metrics

DHCS developed the equity metrics to align with state quality strategy goals, including eliminating health disparities through anti-racism and community-based partnerships. The *Medi-Cal Disproportionate Share* Metric recognizes that Medi-Cal members face greater socioeconomic/racial inequities and that facilities with a disproportionately higher share of Medi-Cal patients face challenges related to those of their patients. This measure aims to incentivize the acceptance of Medi-Cal members into SNFs. Given that historically underserved communities are more likely to rely on Medi-Cal, the metric aims to support equitable access to care. Additionally, the *MDS Racial and Ethnic Data Completeness* Metric is a step towards collecting the necessary data to construct metrics that assess gap closure between the care and experience of the general population and marginalized populations.

Medi-Cal Disproportionate Share Metric

The Medi-Cal Disproportionate Share Measurement Area uses the proportion of Medi-Cal patients within each facility during the measurement year and compares each facility's Medi-Cal share to the other facilities within its peer group. Facilities with a higher proportion of Medi-Cal residents within each peer group will receive a higher score. If a facility has an MCBD count of zero, then the facility will receive a rate of zero for this metric. Please refer to the WQIP Scoring section for further details on the peer groups and the scoring for the Medi-Cal Disproportionate Share Measurement Area. To calculate the proportion of Medi-Cal patients for each facility the following specifications are used:

- Numerator: The total MCBDs during the measurement year for each facility based on the MCBD Data. For this metric, MCBDs include bed days for Medi-Cal fee-for-service and managed care, where Medi-Cal is the primary payor, regardless of network provider status.
- Denominator: The total patients for each facility derived from the daily MDS Census field in the PBJ data (represents all payor bed days within the facility). The daily MDS census field will be aggregated for each facility for each day during the measurement period to derive the total bed days for the measurement year. For any day with missing daily MDS Census data, HSAG will impute the daily MDS Census data using the maximum MDS census value for that facility during the measurement year. If a facility does not have reported PBJ data during the measurement period, then the rate will not be reported.

Please note that due to differences between the claims data used to determine the MCBDs and the MDS data used to determine the daily MDS census, the *Medi-Cal Disproportionate Share* Metric rate may exceed 100 percent in some cases. Where this occurs, the metric will be capped at 100 percent to prevent skewing of the score calculations.

MDS Racial and Ethnic Data Completeness Metric

The *MDS Racial and Ethnic Data Completeness* Metric assesses the completeness of the race and ethnicity fields for each resident. The metric will be calculated for each quarter of the measurement period. HSAG will calculating a final annual rate by summing the numerators and denominators for all quarters and calculating a final aggregate rate.

- Numerator: The numerator criteria for this metric include all patients with any assessment during the quarter with completed race and ethnicity data fields. Residents are defined as having completed race and ethnicity data if any assessment in the quarter meet the following criteria:
  - An assessment is considered completed if it meets both of the following criteria:
    - Ethnicity field is populated (A1005A = [1] or A1005B = [1] or A1005C = [1] or A1005D = [1] or A1005E = [1] or A1005X = [1] or A1005Y = [1])
    - Race field is populated (A1010A = [1] or A1010B = [1] or A1010C = [1] or A1010D = [1] or A1010E = [1] or A1010F = [1] or A1010G = [1] or A1010H = [1] or A1010I = [1] or A1010J = [1] or A1010K = [1] or A1010L = [1] or A1010M = [1] or A1010N = [1] or A1010X = [1] or A1010Y = [1] or A1010Z = [1])
- Denominator: The denominator includes all patients with at least one assessment submitted with a qualifying RFA (A0310A = [01,02,03,04,05,06], or A0310B = [01], or A0310F = [10,11]) during the quarter.

WQIP SCORING

Overview

This section describes the facility scoring methodology, the performance targets/benchmarking, the quality scoring methodology, and payment calculations.

WQIP Scoring Methodology

HSAG will calculate a WQIP score for each facility based on performance on the metrics within three domains (i.e., Workforce Metrics, Clinical Metrics, and Equity Metrics). Within each domain, there are two measurement areas, each of which includes between one to five metrics, as shown in Table 7.

Table 7—WQIP Metrics

N/A indicates there is no applicable CBE ID.

Metric	CBE ID
Workforce Metrics Domain	
Acuity-Adjusted Staffing Hour Metrics Measurement Area	
Acuity-Adjusted Total Nursing Hours	N/A
Acuity-Adjusted Weekend Total Nursing Hours	N/A
Acuity-Adjusted RN Hours	N/A
Acuity-Adjusted LVN Hours	N/A
Acuity-Adjusted CNA Hours	N/A
Staffing Turnover Metric Measurement Area	
Staffing Turnover	N/A
Clinical Metrics Domain	
MDS Clinical Metrics Measurement Area	
Percent of Residents Who Lose Too Much Weight, Long Stay	0689
Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	0674
Percent of Residents Who Received an Antipsychotic Medication, Long Stay	N/A
Claims-Based Clinical Metrics Measurement Area	
Outpatient ED Visits per 1,000 Long-Stay Resident Days	N/A

Metric	CBE ID
Healthcare-Associated Infections Requiring Hospitalization	N/A
Potentially Preventable 30-Day Post-Discharge Readmission	N/A
Equity Metrics Domain	
Medi-Cal Disproportionate Share Measurement Area	
Medi-Cal Disproportionate Share	N/A
MDS Racial and Ethnic Data Completeness Measurement Area	
MDS Racial and Ethnic Data Completeness	N/A

Each WQIP metric will be scored based on facility performance and the score for each measurement area will be calculated as a percentage by summing the points for each metric within the measurement area and dividing by the measurement area's total possible points. To derive an overall WQIP score for each facility, the score for each measurement area will be weighted by the percentage of the total score that the measurement area contributes to the total WQIP score as displayed in Table 8 (e.g., the Acuity-Adjusted Staffing Hour Metrics Measurement Area accounts for 35 percent of the total WQIP score). Table 8 displays the overall points and weights by measurement area for PY 2. Additionally, the individual measurement domain sections below provide a detailed description of how scores will be calculated for each domain.

Table 8—Points and Weighting by Measurement Area for PY 2

**The Acuity-Adjusted Staffing Hour Metrics will be split into two measurement periods with the first measurement period (January 1, 2024–September 30, 2024) worth 75 percent of the 35 Weighted Possible Points for Measurement Area and the second measurement period (October 1, 2024–December 31, 2024) worth 25 percent of the 35 Weighted Possible Points for the Measurement Area.*

***Within the MDS Clinical Metrics Measurement Area, the maximum number of unweighted points possible points for the Percent of Residents Who Received an Antipsychotic Medication, Long Stay Metric is 5 points and the maximum number of possible points for all other metrics in the MDS Clinical Metrics Measurement Area is 6 points.*

Domain	Measurement Area	Number of Metrics	Possible Points per Metric	Possible Points for Measurement Area	Percent of Total Score
Workforce Metrics	Acuity-Adjusted Staffing Hour Metrics (January 1, 2024–September 30, 2024)*	5	6	30	26.25%
	Acuity-Adjusted Staffing Hour Metrics (October 1, 2024–December 31, 2024)*	5	6	30	8.75%
	Staffing Turnover Metric	1	6	6	15%
Clinical Metrics	MDS Clinical Metrics**	3	5 or 6	17	20%
	Claims-Based Clinical Metrics	3	6	18	20%
Equity Metrics	Medi-Cal Disproportionate Share Metric	1	5	5	7%

Domain	Measurement Area	Number of Metrics	Possible Points per Metric	Possible Points for Measurement Area	Percent of Total Score
	MDS Racial and Ethnic Data Completeness Metric	1	10	10	3%
Total		**14**	**NA**	**NA**	**100%**

Performance Targets/Benchmarking

To evaluate performance and to calculate scores for each facility for WQIP, HSAG will use performance benchmarks based on the percentiles calculated for each individual metric. For the Staffing Turnover Metric Measurement Area, the MDS Clinical Metrics Measurement Area, and the MDS Racial and Ethnic Data Completeness Metric Measurement Area, benchmarks were set prospectively based on a baseline period prior to the measurement period. However, benchmarks for the Acuity-Adjusted Staffing Hour Metrics Measurement Area, Claims-Based Metrics Measurement Area and Medi-Cal Disproportionate Share Metric Measurement Area will be set retrospectively for PY 2 due to data availability. Additionally, DHCS will assess whether all benchmarks can be set prospectively based on the availability of data in future years. Additional details regarding the benchmarks may be found in the individual measurement domain sections below.

Workforce Metrics Domain Scoring

The following section describes the metric scoring for the Acuity-Adjusted Staffing Hour Metrics Measurement Area and Staffing Turnover Metric Measurement Area that will be used for the PY 2 Annual Report.

Acuity-Adjusted Staffing Hour Metric Measurement Area and Staffing Turnover Metric Measurement Area

In October 2023, CMS elected to transition the staffing case-mix adjustment methodology used to calculate the acuity-adjusted staffing hour metrics reported on Care Compare to a model based on the Patient-Driven Payment Model which will be

used starting in the 2024 calendar year.[17] Because this change in the staffing case-mix adjustment methodology for the Acuity-Adjusted Staffing Hour metrics for calendar year 2024 differs from the methodology used in PY 1, HSAG will determine the benchmarks retrospectively for PY 2. The benchmarks will be based on the calculated percentile distributions for each metric and limited to facilities included in WQIP for PY 2. Retrospective benchmarks will be calculated separately for both measurement periods (i.e., January 1, 2024–September 30, 2024, and October 1, 2024–December 31, 2024). For the Staffing Turnover Metric Measurement Area, HSAG established prospective benchmarks using publicly available Care Compare data. The *Staffing Turnover* Metric rate from the October 2023 refresh of the Care Compare data, limited to facilities eligible for WQIP in PY 1, was used for each facility. The percentile distribution was then calculated for the *Staffing Turnover* Metric to establish the baseline benchmarks for PY 2.

The PY 2 benchmarks based on baseline Care Compare data for the Staffing Turnover Metric Measurement Area are displayed in Table 9.

Table 9—Workforce Metric Domain Benchmarks for PY 2

Metric	Baseline Period	Number of Facilities	25th Percentile	37.5th Percentile	50th Percentile	62.5th Percentile	75th Percentile	90th Percentile
Staffing Turnover Metric Measurement Area								
Staffing Turnover	4/1/22–3/31/23	951	55.600%	50.500%	46.200%	41.500%	36.800%	28.300%

As part of the WQIP calculations, HSAG will download the publicly available data from Care Compare for the applicable measurement period and will limit the data to the WQIP facilities for each of the metrics in the Acuity-Adjusted Staffing Hour Metrics Measurement Area and the Staffing Turnover Metric Measurement Area. For the Acuity-Adjusted Staffing Hour Metrics Measurement Area, HSAG will calculate the rates and scores using two measurement periods. The rate for the first measurement period (January 1, 2024–September 30, 2024) will be calculated by averaging each facility's rates for the first three quarters of the overall PY 2 measurement period. This measurement period will account for 75 percent of each facility's final measurement

[17] Centers for Medicare & Medicaid Services. Updates to Nursing Home Care Compare Staffing and Quality Measures. Sep 20, 2023. Available at: https://www.cms.gov/files/document/qso-23-21-nh.pdf. Accessed on: Sep 12, 2024.

area score. The second measurement period (October 1, 2024–December 31, 2024) will use the reported rates in the April 2025 Care Compare data refresh to determine the rates and scores for each facility. This will account for 25 percent of the facility's final measurement area score. Please note that each measurement period will be compared to retrospective benchmarks based on the same date span used for each period. The final weighted score for the Acuity-Adjusted Staffing Hour Metrics Measurement Area will be the sum of the weighted scores of both measurement periods. For the Staffing Turnover Metric Measurement Area, the final rate for each facility will be the rate reported in the April 2025 Care Compare data, representing data for the October 1, 2023–September 30, 2024 measurement period. As outlined in Table 10 facilities will receive a score based on how the final rate compares to the percentiles for each metric in Table 9. Please note, the Acuity-Adjusted Staffing Hour Metrics Measurement Area and Staffing Turnover Metric Measurement Area are not eligible for improvement points.

Table 10—Acuity-Adjusted Staffing Hour Metrics Measurement Area and Staffing Turnover Metric Measurement Area Scoring

Points	Achievement Benchmark
6	90th Percentile
5	75th Percentile
4	62.5th Percentile
3	50th Percentile
2	37.5th Percentile
1	25th Percentile
0	Below the 25th Percentile or Data Are Missing

For each of the metrics in the Acuity-Adjusted Staffing Hour Metrics Measurement Area, HSAG will use PBJ data to calculate a completeness score equal to the percentage of days during the measurement period the facility either failed to report data in the PBJ or did not meet the non-acuity adjusted HPPD minimum performance benchmark applicable to the metric. For each measurement period, HSAG will multiply the raw score for each metric by the completeness score for the same date span to calculate the score for each metric. Further details regarding the calculation of the HPPD minimum performance benchmark for each metric may be found in the Metrics Calculations section.

Table 11 provides examples of how the scores for the Acuity-Adjusted Staffing Hour Metrics Measurement Area will be calculated based on the achievement benchmarks displayed in Table 10. Please note that all the facility rates for the examples presented in the document are based on mock data and may not reflect actual WQIP performance. Additionally, due to the retrospective benchmarks used for the Acuity-Adjusted Staffing Hour measurement area, all example calculations are for illustrative purposes only. Because the scoring methodology is identical for both measurement periods (i.e., January 1, 2024–September 30, 2024, and October 1, 2024–December 31, 2024), the below examples can be used as a reference for both periods. Based on a facility's performance, the facility will be assigned a raw score ranging from 0 to 6 points.

Table 11—Acuity-Adjusted Staffing Hour Metrics Measurement Area Scoring Example

NR indicates the facility does not have a reported rate.

Facility	Metric	Rate	Achievement Benchmark	Raw Score	Staffing Data Completeness	Score
Facility 1	*Acuity-Adjusted Total Nursing Hours*	4.550	75th Percentile	5	72.0%	3.600
	Acuity-Adjusted Weekend Total Nursing Hours	3.981	62.5th Percentile	4	68.0%	2.720
	Acuity-Adjusted RN Hours	0.654	75th Percentile	5	89.5%	4.475
	Acuity-Adjusted LVN Hours	2.111	90th Percentile	6	89.5%	5.370
	Acuity-Adjusted CNA Hours	2.654	62.5th Percentile	4	78.6%	3.144

Facility	Metric	Rate	Achievement Benchmark	Raw Score	Staffing Data Completeness	Score
Facility 2	*Acuity-Adjusted Total Nursing Hours*	4.331	62.5th Percentile	4	95.0%	3.800
	Acuity-Adjusted Weekend Total Nursing Hours	4.385	75th Percentile	5	92.5%	4.625
	Acuity-Adjusted RN Hours	0.555	50th Percentile	3	100%	3.000
	Acuity-Adjusted LVN Hours	1.312	62.5th Percentile	4	100%	4.000
	Acuity-Adjusted CNA Hours	2.425	37.5th Percentile	2	90.6%	1.812
Facility 3	*Acuity-Adjusted Total Nursing Hours*	4.120	37.5th Percentile	2	100%	2.000
	Acuity-Adjusted Weekend Total Nursing Hours	3.512	25th Percentile	1	100%	1.000
	Acuity-Adjusted RN Hours	0.478	37.5th Percentile	2	100%	2.000
	Acuity-Adjusted LVN Hours	1.212	50th Percentile	3	100%	3.000
	Acuity-Adjusted CNA Hours	1.850	Below the 25th Percentile	0	100%	0.000
Facility 4	*Acuity-Adjusted Total Nursing Hours*	NR	Data Are Missing	0	NR	0.000
	Acuity-Adjusted Weekend Total Nursing Hours	NR	Data Are Missing	0	NR	0.000
	Acuity-Adjusted RN Hours	NR	Data Are Missing	0	NR	0.000
	Acuity-Adjusted LVN Hours	NR	Data Are Missing	0	NR	0.000
	Acuity-Adjusted CNA Hours	NR	Data Are Missing	0	NR	0.000

Facility	Metric	Rate	Achievement Benchmark	Raw Score	Staffing Data Completeness	Score
Facility 5	*Acuity-Adjusted Total Nursing Hours*	NR	Data Are Missing	0	NR	0.000
	Acuity-Adjusted Weekend Total Nursing Hours	NR	Data Are Missing	0	NR	0.000
	Acuity-Adjusted RN Hours	NR	Data Are Missing	0	NR	0.000
	Acuity-Adjusted LVN Hours	NR	Data Are Missing	0	NR	0.000
	Acuity-Adjusted CNA Hours	NR	Data Are Missing	0	NR	0.000

As shown in Table 11 Facility 1's rate for the *Acuity-Adjusted Total Nursing Hours* metric is considered greater than the 75th percentile but lower than the 90th percentile for the purposes of this example and receives a raw score of 5 points as outlined in Table 10. Next, the staffing data completeness for the *Acuity-Adjusted Total Nursing Hours* metric is applied to the raw score. Facility 1 has a staffing data completeness rate of 72.0 percent (i.e., 72.0 percent of the days in the measurement period met the minimum performance benchmarks). The raw score is then multiplied by the data completeness rate to obtain the metric score. For this example, the raw score of 5 points is multiplied by 72.0 percent to get a score of 3.6. The process is repeated for all five metrics included in the Acuity-Adjusted Staffing Metrics Measurement Area. If a facility does not have reported rate in the Care Compare Data for any of the metrics within the Acuity-Adjusted Staffing Metrics Measurement Area (indicated as NR in the example table), the facility will receive a score of 0 points as presented in Table 11 for Facility 4 and Facility 5.

Once the five individual metric scores have been calculated, the total score for each measurement period will be calculated by summing the individual metric scores and dividing by the total possible points for the measurement area to calculate the final unweighted measurement area score as a percentage, which will be used as part of the final Workforce Metrics Domain score. For the Acuity-Adjusted Staffing Metrics Measurement Area, the total possible points are set to 30 based on each metric having a possible maximum score of 6 points (i.e., 6 x 5 = 30). Table 12 provides an example of how the unweighted scores will be calculated.

Table 12—Acuity-Adjusted Staffing Hour Metrics Measurement Area Scoring Example

Facility	*Acuity-Adjusted Total Nursing Hours* Metric Score	*Acuity-Adjusted Weekend Total Nursing Hours* Metric Score	*Acuity-Adjusted RN Hours* Metric Score	*Acuity-Adjusted LVN Hours* Metric Score	*Acuity-Adjusted CNA Hours* Metric Score	Final Points	Total Possible Points	Unweighted Score
Facility 1	3.600	2.720	4.475	5.370	3.144	19.309	30	64.363%
Facility 2	3.800	4.625	3.000	4.000	1.812	17.237	30	57.457%
Facility 3	2.000	1.000	2.000	3.000	0.000	8	30	26.667%
Facility 4	0.000	0.000	0.000	0.000	0.000	0	30	0.000%
Facility 5	0.000	0.000	0.000	0.000	0.000	0	30	0.000%

As seen in Table 12, Facility 1 has a final total point sum of 19.309 for the Acuity-Adjusted Staffing Metrics Measurement Area. This final score will be divided by the total possible points and multiplied by 100 to obtain a final unweighted score of 64.363 percent (i.e., [19.309/30] x 100). As previously discussed, if a facility does not have data for the Acuity-Adjusted Staffing Metrics Measurement Area, the final score will be set to 0 as facilities are required to report PBJ data from which these rates are derived. This unweighted score calculation will be done for both measurement periods for the Acuity-Adjusted Staffing Metrics Measurement Area in PY 2.

Table 13 provides an example of how the score for the Staffing Turnover Metric Measurement Area will be calculated based on the achievement benchmarks displayed in Table 10.

Table 13—Staffing Turnover Metric Measurement Area Scoring Example

NR indicates the facility does not have a reported rate.

N/A indicates a value could not be determined.

Facility	Rate	Achievement Benchmark	Final Score	Total Possible Points	Final Measurement Area Unweighted Score
Facility 1	45.250%	50th Percentile	3	6	50.000%
Facility 2	32.400%	75th Percentile	5	6	83.333%
Facility 3	NR	Data Are Missing	0	0	N/A
Facility 4	NR	Data Are Missing	0	0	N/A
Facility 5	39.550%	62.5th Percentile	4	6	66.667%

To calculate the metric score, the facility's *Staffing Turnover* Metric rate is compared to the prospective benchmarks (Table 9). Based on the facility's performance, the facility will be given a raw score ranging from 0 to 6 points. Please note that for the *Staffing Turnover* Metric, a lower score indicates better performance. As displayed in Table 13, Facility 1 has a *Staffing Turnover* Metric rate of 45.250 percent which is less than the 50th Percentile (46.200 percent) but higher than the 62.5th Percentile (41.500 percent). Thus, the facility achieves the 50th Percentile and receives a raw score of 3 points for the metric, based on the achievement benchmarks displayed in Table 10. Because the Staffing Turnover Metric Measurement Area only has one metric, to calculate the final measurement area unweighted score, the facility's score is divided by the maximum possible points for the metric (i.e., 6 points). Facility 1 earns a score of 3 points which is divided by 6 possible points and multiplied by 100 to get a final measurement area score of 50 percent. Please note that due to the metric requiring six consecutive quarters of data to calculate, a facility may not have a reportable rate for the metric. If a facility does not have a reported rate in the Care Compare data (indicated as NR in the example table), the total possible points for the measurement area are set to 0 and measurement area is not assigned a final unweighted score.

Final Workforce Metrics Domain Score

Once the unweighted scores percentages for the Acuity-Adjusted Staffing Hour Metrics Measurement Area and the Staffing Turnover Metric Measurement Area are calculated, the unweighted score percentages will be multiplied by the assigned measurement area

weights, as outlined in Table 8, to derive the overall Workforce Metrics Domain score. Table 14 and Table 15 show how the weighted scores will be calculated for the Acuity-Adjusted Staffing Hour Metrics Measurement Area and the Staffing Turnover Metric Measurement Area, respectively. Table 16 then shows how the measurement area weighted scores will be combined to calculate the overall Workforce Metrics Domain score.

Table 14—Acuity-Adjusted Staffing Hour Metrics Measurement Area Weighted Scoring Example

Facility	January 1, 2024–September 30, 2024 Measurement Period			October 1, 2024–December 31, 2024 Measurement Period			Final Weighted Score
	Unweighted Score	Measurement Period Weight	Weighted Score	Unweighted Score	Measurement Period Weight	Weighted Score	
Facility 1	68.171%	26.25	17.895	52.937%	8.75	4.632	22.527
Facility 2	53.646%	26.25	14.082	68.880%	8.75	6.027	20.109
Facility 3	29.333%	37.5	11.000	18.664%	12.5	2.333	13.333
Facility 4	0.000%	37.5	0.000	0.000%	12.5	0.000	0.000
Facility 5	0.000%	26.25	0.000	0.000%	8.75	0.000	0.000

As displayed in Table 14 for the purposes of this example, Facility 1 received an unweighted Acuity-Adjusted Staffing Hour Metrics Measurement Area score of 68.171 percent for the January 1, 2024–September 30, 2024, measurement period and an unweighted score of 52.937 percent for the October 1, 2024–December 31, 2024, measurement period. The first measurement period (January 1, 2024–September 30, 2024) is worth 26.25 percent of the facility's overall total score. To calculate the measurement period's score, the unweighted score of 68.171 percent is multiplied by 26.25 percent to calculate a weighted score of 17.895. Similarly, the second measurement period (October 1, 2024–December 31, 2024) is worth 8.75 percent of the facility's overall total score. To calculate this measurement period's score, the unweighted score of 52.937 percent is multiplied by 8.75 percent to calculate a weighted score of 4.632. Finally, both measurement area weighted scores are summed to calculate a final weighted score for the Acuity-Adjusted Staffing Hour Metrics Measurement Area of 22.527. Please note, if a facility has 0 total possible points for the Staffing Turnover Metric Measurement Area, then the Staffing Turnover Measurement Area Weight is added to the Acuity-Adjusted Staffing Hour Metrics Measurement Area Weight (i.e., the measurement periods for the Acuity-Adjusted Staffing Hour

Measurement Area will be worth 37.5 percent and 12.5 percent of the total WQIP score respectively). This is illustrated in Facilities 3 and 4.

Table 15—Staffing Turnover Measurement Area Weighted Scoring Example

N/A indicates a value could not be determined.

Facility	Unweighted Score	Measurement Area Weight	Final Weighted Score
Facility 1	50.000%	15	7.500
Facility 2	83.333%	15	12.500
Facility 3	N/A	0	N/A
Facility 4	N/A	0	N/A
Facility 5	66.667%	15	10.000

As displayed in Table 15, Facility 1 received a final unweighted Staffing Turnover score of 50.000 percent for the Staffing Turnover Metric Measurement Area, which is multiplied by 15 percent to calculate a final weighted score of 7.500.

Table 16—Workforce Metrics Domain Scoring Example

N/A indicates a value could not be determined.

Facility	Acuity-Adjusted Staffing Hour Metrics Measurement Area		Staffing Turnover Measurement Area		Domain Total Score
	Measurement Area Weight	Final Weighted Score	Measurement Area Weight	Final Weighted Score	
Facility 1	35	22.527	15	7.500	30.027
Facility 2	35	20.109	15	12.500	32.609
Facility 3	50	13.333	0	N/A	13.333
Facility 4	50	0.000	0	N/A	0.000
Facility 5	35	0.000	15	10.000	10.000

As displayed in Table 16, Facility 1 received a final weighted score of 22.527 and 7.500 for the Acuity-Adjusted Staffing Hour Metrics Measurement Area and the Staffing Turnover Measurement Area respectively. These scores are summed to calculate the final Workforce Metrics Domain score of 30.027.

If a facility has 0 total possible points for the Staffing Turnover Metric Measurement Area, then the Staffing Turnover Measurement Area Weight is added to the Acuity-Adjusted Staffing Hour Metrics Measurement Area Weight, and the Staffing Turnover Metric Measurement Area will not be included the final score calculation. This is illustrated for Facility 3 and Facility 4 in Table 16. Please note that it is not possible for a facility to receive 0 total possible points for the Acuity-Adjusted Staffing Hour Metrics Measurement Area, so the Acuity-Adjusted Staffing Hour Metrics Measurement Area weight will never be redistributed to the Staffing Turnover Metric Measurement Area. This is illustrated for Facility 5 in Table 16. Finally, if a facility does not have sufficient data to calculate scores for both measurement areas, the facility will receive a final domain score of zero points. This is illustrated for Facility 4 in Table 16.

Clinical Metrics Domain

This section describes the scoring for the MDS Clinical Metrics Measurement Area and the Claims-Based Clinical Metrics Measurement Area that will be used for the PY 2 Annual Report.

MDS Clinical Metrics Measurement Area

HSAG established prospective benchmarks for the MDS Clinical Metrics Measurement Area using publicly available data from the October 2023 Care Compare data refresh. These data were limited to those facilities that were eligible to participate in the WQIP program for PY 1 based on the reported four quarter average score for each facility. The PY 2 benchmarks for each metric are displayed in Table 17.

Table 17—MDS Clinical Metrics Measurement Area Benchmarks for PY 2

Metric	Baseline Period	Number of Facilities	25th Percentile	37.5th Percentile	50th Percentile	62.5th Percentile	75th Percentile	90th Percentile
MDS Clinical Metrics Measurement Area								
Percent of Residents Who Lose Too Much Weight, Long Stay	7/1/22–6/30/23	1,031	7.229%	5.882%	4.819%	3.846%	2.811%	1.176%
Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	7/1/22–6/30/23	1,039	2.424%	1.875%	1.393%	0.973%	0.508%	0.000%
Percent of Residents Who Received an Antipsychotic Medication, Long Stay	7/1/22–6/30/23	998	13.043%	10.366%	8.201%	6.329%	4.348%	1.544%

As discussed in the Metrics Calculations section, HSAG will calculate the final rate for each facility for each metric within the MDS Clinical Metrics Measurement Area. Table 18 displays the points a facility is eligible to receive based on achievement or improvement.

Table 18—MDS Clinical Metrics Scoring

**Within the MDS Clinical Metrics Measurement Area, the maximum number of unweighted points possible points for the Percent of Residents Who Received an Antipsychotic Medication, Long Stay Metric is 5 points and the maximum number of possible points for all other metrics in the MDS Clinical Metrics Measurement Area is 6 points.*

Points	Achievement Benchmark	Improvement Threshold
6	90th Percentile	75th Percentile Achievement and 20% Gap Closure
5	75th Percentile	50% Gap Closure
4	62.5th Percentile	40% Gap Closure
3	50th Percentile	30% Gap Closure
2	37.5th Percentile	20% Gap Closure
1	25th Percentile	10% Gap Closure
0	Below the 25th Percentile	Less than 10% Gap Closure
N/A	Data Are Missing	Data Are Missing

Achievement Score

Facilities will receive an achievement score for each metric based on how the rate compares to the percentiles in Table 16.

Table 19 provides examples of how achievement scores will be calculated for the MDS Clinical Metrics Measurement Area for five mock facilities. Please note that for all metrics within the MDS Clinical Metrics Measurement Area, a lower score indicates better performance.

Table 19—MDS Clinical Metrics Achievement Scoring Example

NR indicates the facility does not have a reported rate.

N/A indicates a value could not be determined.

Facility	Metric	Current Year Rate	Achievement Benchmark	Achievement Score
Facility 1	*Percent of Residents Who Lose Too Much Weight, Long Stay*	2.850%	62.5th Percentile	4
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	0.785%	62.5th Percentile	4
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	4.800%	62.5th Percentile	4
Facility 2	*Percent of Residents Who Lose Too Much Weight, Long Stay*	NR	Data Are Missing	N/A
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	0.300%	75th Percentile	5
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	6.700%	50th Percentile	3

Facility	Metric	Current Year Rate	Achievement Benchmark	Achievement Score
Facility 3	*Percent of Residents Who Lose Too Much Weight, Long Stay*	NR	Data Are Missing	N/A
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	1.500%	37.5th Percentile	2
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	NR	Data Are Missing	N/A
Facility 4	*Percent of Residents Who Lose Too Much Weight, Long Stay*	NR	Data Are Missing	N/A
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	NR	Data Are Missing	N/A
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	NR	Data Are Missing	N/A
Facility 5	*Percent of Residents Who Lose Too Much Weight, Long Stay*	NR	Data Are Missing	N/A
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	NR	Data Are Missing	N/A
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	NR	Data Are Missing	N/A

As displayed in Table 19, Facility 1's rates are all less than the 62.5th Percentile but greater than the 75th Percentile based on the prospective benchmarks displayed in Table 17. Based on this, the metric rates meet the 62.5th Percentile achievement benchmark and are assigned 4 achievement points for each metric within the MDS Clinical Metrics Measurement Area. Please note that if a facility does not have a reportable rate for a metric within the MDS Clinical Metrics Measurement Area due to insufficient denominators (indicated as NR in the example table), the metric will not be assigned an achievement score. If a facility did not have MDS data to calculate the MDS metrics, then all three metrics will be considered unreportable.

Improvement Score

The metrics within the MDS Clinical Metrics Measurement Area are eligible for an improvement score. For the *Percent of Residents Who Lose Too Much Weight, Long Stay* Metric and the *Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay* Metric, improvement scores will be awarded based on a gap closure between the facility's prior year rate and the 90th percentile benchmark. To calculate the facility's improvement points, HSAG will first calculate the difference between the facility's prior year rate and 90th percentile benchmark to derive the facility's prior-year gap. HSAG will then calculate the difference between the facility's current rate and its prior rate to derive the facility's improvement value. HSAG will then divide the facility's improvement value by the facility's prior-year gap to determine the percentage of gap closure achieved by the facility. Improvement points will then be awarded to the facility based on the percentage of gap closure as described in Table 18. No improvement points can be earned for rates above the 90th percentile. Facilities will receive the greater of their achievement or improvement points.

DHCS recognizes that some use of antipsychotics is clinically indicated and that it is not possible or warranted to approach zero percent use. Because of this, the maximum number of points available for the *Percent of Residents Who Received an Antipsychotic Medication, Long Stay* Metric will be five points based on performance at or above the 75th percentile, and additional points will not be awarded for achievement above the 75th percentile benchmark (i.e., a facility scoring above the 90th Percentile will only receive 5 achievement points). Improvement scoring for this metric will be based on gap closure to the 75th percentile benchmark (i.e., a facility will earn one improvement point for every 10 percent of the gap closed between the prior year rate and the 75th percentile benchmark) and no improvement points can be earned for rates above the 75th Percentile. Facilities will receive the greater of their achievement or improvement points.

Table 20 provides an example of how the gap closure percentage will be calculated.

Table 20—MDS Clinical Metrics Gap Closure Calculations Example

NR indicates the facility does not have a reported rate.

N/A indicates a value could not be determined.

Facility	Metric	Prior Year Rate	Current Year Rate	Gap Closure Benchmark	Gap	Improvement Value	Gap Closure Percentage
Facility 1	*Percent of Residents Who Lose Too Much Weight, Long Stay*	3.400%	2.850%	1.176%	2.224	0.550	24.730%
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	0.850%	0.785%	0.000%	0.850	0.065	7.647%
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	5.750%	4.800%	4.348%	1.402	0.950	67.760%
Facility 2	*Percent of Residents Who Lose Too Much Weight, Long Stay*	3.990%	NR	1.176%	N/A	N/A	N/A
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	0.655%	0.300%	0.000%	0.655	0.355	54.198%
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	5.550%	6.700%	4.348%	1.202	-1.150	-95.674%

Facility	Metric	Prior Year Rate	Current Year Rate	Gap Closure Benchmark	Gap	Improvement Value	Gap Closure Percentage
Facility 3	*Percent of Residents Who Lose Too Much Weight, Long Stay*	NR	NR	1.176%	N/A	N/A	N/A
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	2.230%	1.500%	0.000%	2.230	0.730	32.735%
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	NR	NR	4.348%	N/A	N/A	N/A
Facility 4	*Percent of Residents Who Lose Too Much Weight, Long Stay*	NR	NR	1.176%	N/A	N/A	N/A
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	NR	NR	0.000%	NA	N/A	N/A
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	NR	NR	4.348%	N/A	N/A	N/A
Facility 5	*Percent of Residents Who Lose Too Much Weight, Long Stay*	NR	NR	1.176%	N/A	N/A	N/A
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	NR	NR	0.000%	N/A	N/A	N/A
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	NR	NR	4.348%	N/A	N/A	N/A

To calculate the gap closure percentage, three values are used for each metric: the prior year's rate, the current year's rate, and the gap closure benchmark based on the prospective benchmarks (i.e., the 90th Percentile for the *Percent of Residents Who Lose Too Much Weight, Long Stay* Metric and the *Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay* Metric, and the 75th percentile for the *Percent of Residents Who Received an Antipsychotic Medication, Long Stay* Metric). As shown in Table 20, Facility 1 has a prior year rate of 3.400 percent, a current year rate of 2.850 percent, and a gap closure benchmark of 1.176 percent (i.e., the 90th percentile in Table 17) for the *Percent of Residents Who Lose Too Much Weight, Long Stay* Metric. To calculate the gap closure, the difference between the facility's prior year rate and gap closure benchmark is calculated to derive the facility's prior-year gap (i.e., 3.400 percent–1.176 percent = 2.224). Next the improvement value is calculated as the difference between the prior year rate and current year rate (i.e., 3.400 percent–2.850 percent = 0.550). The improvement value is divided by the prior-year gap and then multiplied by 100 to get the gap closure percentage for the metric (i.e., 0.550/2.224 x 100 = 24.730 percent). However, if either year's rates are missing then the gap closure percentage will not be calculated. Finally, a negative gap closure percentage indicates the metric rate worsened between the prior year and the current year and the facility will receive an improvement score of zero and a gap closure percentage will not be reported.

Once the gap closure percentage is calculated, HSAG will determine the improvement score. Table 21 provides an example of how the improvement score will be calculated.

Table 21—MDS Clinical Metrics Improvement Scoring Example

N/A indicates a value could not be determined.

Facility	Metric	Gap Closure Percentage	Improvement Threshold	Improvement Score
Facility 1	*Percent of Residents Who Lose Too Much Weight, Long Stay*	24.730%	20% Gap Closure	2
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	7.647%	10% Gap Closure	0
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	67.760%	50% Gap Closure	5

Facility	Metric	Gap Closure Percentage	Improvement Threshold	Improvement Score
Facility 2	*Percent of Residents Who Lose Too Much Weight, Long Stay*	N/A	N/A	N/A
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	54.198%	75th Percentile and 20% Gap Closure	6
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	-95.674%	No Improvement	0
Facility 3	*Percent of Residents Who Lose Too Much Weight, Long Stay*	N/A	N/A	N/A
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	32.735%	30% Gap Closure	3
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	N/A	N/A	N/A
Facility 4	*Percent of Residents Who Lose Too Much Weight, Long Stay*	N/A	N/A	N/A
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	N/A	N/A	N/A
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	N/A	N/A	N/A
Facility 5	*Percent of Residents Who Lose Too Much Weight, Long Stay*	N/A	N/A	N/A
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	N/A	N/A	N/A
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	N/A	N/A	N/A

As shown in Table 21, Facility 1 has a 24.730 percent gap closure for the *Percent of Residents Who Lose Too Much Weight, Long Stay* Metric. Based on the Improvement Thresholds in Table 18, the facility earns 2 points for the improvement score (i.e., the facility had a gap closure greater than or equal to 20 percent but less than 30 percent). Similarly, the gap closure for the *Percent of Residents Experiencing One or More Falls with*

Major Injury, Long Stay Metric is less than 10 percent, which is assigned 0 points. Finally, the *Percent of Residents Who Received an Antipsychotic Medication, Long Stay* Metric has a 67.760 percent gap closure and is assigned 5 points. If a facility does not improve between years for a metric, then the metric will not receive any improvement points.

Once the achievement and improvement scores are calculated for each facility, the two values are compared, and the greater of the two is used as the points earned for the MDS Clinical Metrics Measurement Area. Table 22 provides an example comparison of the achievement and improvement scores that will be used for WQIP.

Table 22—MDS Clinical Metrics Measurement Area Achievement and Improvement Score Example

N/A indicates a value could not be determined.

Facility	MDS Metrics	Achievement Score	Improvement Score	Final Raw Score
Facility 1	*Percent of Residents Who Lose Too Much Weight, Long Stay*	4	2	4
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	4	0	4
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	4	5	5
Facility 2	*Percent of Residents Who Lose Too Much Weight, Long Stay*	N/A	N/A	N/A
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	5	6	6
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	3	0	3

Facility	MDS Metrics	Achievement Score	Improvement Score	Final Raw Score
Facility 3	*Percent of Residents Who Lose Too Much Weight, Long Stay*	N/A	N/A	N/A
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	2	3	3
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	N/A	N/A	N/A
Facility 4	*Percent of Residents Who Lose Too Much Weight, Long Stay*	N/A	N/A	N/A
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	N/A	N/A	N/A
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	N/A	N/A	N/A
Facility 5	*Percent of Residents Who Lose Too Much Weight, Long Stay*	N/A	N/A	N/A
	Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay	N/A	N/A	N/A
	Percent of Residents Who Received an Antipsychotic Medication, Long Stay	N/A	N/A	N/A

MDS Data Completeness

To ensure facilities submit the appropriate MDS assessments, DHCS will require facilities to meet a 90 percent MDS data completeness threshold to receive points for the MDS Clinical Metrics Measurement Area for the quarters included in the measurement period. Details into how the data completeness will affect a facility's score for the MDS Clinical Metrics Measurement Area is included below:

- Less than 90 percent data completeness: Facilities will earn 0 points for the MDS Clinical Metrics Measurement Area
- At or above 90 percent but below 95 percent data completeness: Facilities will be penalized 50 percent of its total points earned for the MDS Clinical Metrics Measurement Area
- At or above 95 percent data completeness: Facilities will not be penalized (i.e., the facility will earn 100 percent of its total points) for the MDS Clinical Metrics Measurement Area

The final MDS Clinical Metrics Measurement Area score will be calculated by summing the points for each metric. The sum of the metric points is then adjusted based on the facility's MDS data completeness. For example, if the facility has a data completeness of less than 90 percent, then the raw summed score is set to 0 for the remaining calculations. This score is divided by the total possible points for the measurement area as shown in Table 8, and then multiplied by 100 to obtain the final unweighted score percentage for the measurement area. If a facility does not meet denominator requirements (i.e., a minimum denominator of 30), then the maximum total points for that measurement area will be reduced based on the number of metrics the facility is able to report. For example, if a facility only has a reportable rate for the *Percent of Residents Who Received an Antipsychotic Medication, Long Stay* (maximum score of 5 points) and the *Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay* (maximum score of 6 points) MDS clinical metrics, the total points eligible for the measurement area will be reduced to 11. If all three measures are not reportable, then the total possible points for the MDS clinical metrics measurement area will be set to zero and the measurement area will not be assigned a score.

Table 23 provides examples of the final MDS clinical metrics measurement area score calculations.

Table 23—MDS Clinical Metrics Measurement Area Scoring Example

N/A indicates a value could not be determined.

Facility	*Percent of Residents Who Lose Too Much Weight, Long Stay* Metric Score	*Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay* Metric Score	*Percent of Residents Who Received an Antipsychotic Medication, Long Stay* Metric Score	Raw Score	MDS Data Complete-ness	Final Adjusted Points	Total Possible Points	Final Measurement Area Unweighted Score
Facility 1	4	4	5	13	97.000%	13.0	17	76.471%
Facility 2	N/A	6	3	9	89.500%	0.0	11	0.000%
Facility 3	N/A	3	N/A	3	92.750%	1.5	6	25.000%
Facility 4	N/A	N/A	N/A	0	50.000%	0.0	0	N/A
Facility 5	N/A	N/A	N/A	0	0.000%	0.0	0	N/A

Claims-Based Clinical Metrics Measurement Area

Because the necessary data for the metrics within the Claims-Based Clinical Metrics Measurement Area are not yet available, HSAG will determine the benchmarks retrospectively once the MCP reported data for the metrics are available. The benchmarks will be based on the calculated percentile distributions for each metric and limited to facilities included in WQIP for PY 2. As outlined in Table 24, facilities will receive an achievement score based on how the final rate compares to the percentiles, once established, and an improvement score based on a gap closure between the facility's prior year rate and the 90th percentile benchmark for each metric. A final rate will be calculated for each facility for the claims-based metrics using the MCP-reported data; please refer to the Metrics Calculations sections for more detail on the claims-based clinical metrics calculation. The achievement score and improvement score calculation mirrors the process for the MDS clinical metrics achievement and improvement score calculation. Please refer to the MDS Clinical Metrics Measurement Area section for more detail on the achievement and improvement score calculations.

Table 24—Claims-Based Clinical Metrics Measurement Area Scoring

Points	Achievement Benchmark	Improvement Threshold
6	90th Percentile	75th Percentile Achievement and 20% Gap Closure
5	75th Percentile	50% Gap Closure
4	62.5th Percentile	40% Gap Closure
3	50th Percentile	30% Gap Closure
2	37.5th Percentile	20% Gap Closure
1	25th Percentile	10% Gap Closure
0	Below the 25th Percentile	Less than 10% Gap Closure
N/A	Data Are Missing	Data Are Missing

Please refer to Table 25 for examples of how the achievement score will be calculated for the Claims-Based Clinical Metrics measurement area. Please note that for all claims-based clinical metrics, a lower score indicates better performance. Additionally, due to the retrospective benchmarks used for the claims-based metrics measurement area, Table 25 includes mock data and is for illustrative purposes only. If a facility does not have a reportable rate for an claims-based clinical metrics due to insufficient denominators (indicated as NR in the example table), the metric will not be assigned an achievement score.

Table 25—Claims-Based Metrics Achievement Scoring Example

NR indicates the facility does not have a reported rate.

N/A indicates a value could not be determined.

Facility	Metrics	Current Year Rate	Achievement Benchmark	Achievement Points
Facility 1	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	NR	Data Are Missing	N/A
	Healthcare-Associated Infections Requiring Hospitalization	NR	Data Are Missing	N/A
	Potentially Preventable 30-Day Post-Discharge Readmission	NR	Data Are Missing	N/A
Facility 2	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	0.750	37.5th Percentile	2
	Healthcare-Associated Infections Requiring Hospitalization	5.120%	50th Percentile	3
	Potentially Preventable 30-Day Post-Discharge Readmission	5.150%	37.5th Percentile	2
Facility 3	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	0.050	90th Percentile	6
	Healthcare-Associated Infections Requiring Hospitalization	NR	Data Are Missing	N/A
	Potentially Preventable 30-Day Post-Discharge Readmission	NR	Data Are Missing	N/A
Facility 4	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	1.500	Below the 25th Percentile	0
	Healthcare-Associated Infections Requiring Hospitalization	6.333%	37.5th Percentile	2
	Potentially Preventable 30-Day Post-Discharge Readmission	NR	Data Are Missing	N/A
Facility 5	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	NR	Data Are Missing	N/A
	Healthcare-Associated Infections Requiring Hospitalization	NR	Data Are Missing	N/A
	Potentially Preventable 30-Day Post-Discharge Readmission	NR	Data Are Missing	N/A

In addition to the achievement score, HSAG will calculate an improvement score for the claims-based clinical metrics. Please refer to Table 26 for examples of how the gap closure percentage will be calculated for the Claims-Based Clinical Metrics measurement area for the purposes of improvement scoring. Due to the retrospective benchmarks used for the claims-based metrics measurement area, Table 26 includes mock data for the gap closure benchmarks and is for illustrative purposes only.

Table 26—Claims-Based Metrics Gap Closure Calculations Example

NR indicates the facility does not have a reported rate.
N/A indicates a value could not be determined.

Facility	Metric	Prior Year Rate	Current Year Rate	Gap Closure Benchmark	Gap	Improvement Value	Gap Closure Percentage
Facility 1	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	NR	NR	0.250	N/A	N/A	N/A
	Healthcare-Associated Infections Requiring Hospitalization	NR	NR	1.000%	N/A	N/A	N/A
	Potentially Preventable 30-Day Post-Discharge Readmission	NR	NR	2.000%	N/A	N/A	N/A
Facility 2	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	0.800	0.750	0.250	0.550	0.050	9.091%
	Healthcare-Associated Infections Requiring Hospitalization	6.200%	5.120%	1.000%	5.200	1.080	20.769%
	Potentially Preventable 30-Day Post-Discharge Readmission	6.550%	5.150%	2.000%	4.550	1.400	30.769%

Facility	Metric	Prior Year Rate	Current Year Rate	Gap Closure Benchmark	Gap	Improvement Value	Gap Closure Percentage
Facility 3	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	NR	0.050	0.250	N/A	N/A	N/A
	Healthcare-Associated Infections Requiring Hospitalization	2.230%	NR	1.000%	N/A	N/A	N/A
	Potentially Preventable 30-Day Post-Discharge Readmission	NR	NR	2.000%	N/A	N/A	N/A
Facility 4	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	1.600	1.500	0.250	1.350	0.100	7.407%
	Healthcare-Associated Infections Requiring Hospitalization	4.900%	6.333%	1.000%	3.900	-1.433	-36.744%
	Potentially Preventable 30-Day Post-Discharge Readmission	10.000%	NR	2.000%	N/A	N/A	N/A
Facility 5	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	NR	NR	0.250	N/A	N/A	N/A
	Healthcare-Associated Infections Requiring Hospitalization	NR	NR	1.000%	N/A	N/A	N/A
	Potentially Preventable 30-Day Post-Discharge Readmission	NR	NR	2.000%	N/A	N/A	N/A

Once the gap closure percentage is calculated, HSAG will determine the improvement score.

Table 27 provides an example of how the improvement score will be calculated based on the improvement thresholds outlined in Table 24.

Table 27—Claims-Based Clinical Metrics Improvement Scoring Example

N/A indicates a value could not be determined.

Facility	Metric	Gap Closure Percentage	Improvement Threshold	Improvement Score
Facility 1	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	N/A	N/A	N/A
	Healthcare-Associated Infections Requiring Hospitalization	N/A	N/A	N/A
	Potentially Preventable 30-Day Post-Discharge Readmission	N/A	N/A	N/A
Facility 2	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	9.091%	Less Than 10% Gap Closure	0
	Healthcare-Associated Infections Requiring Hospitalization	20.769%	20% Gap Closure	2
	Potentially Preventable 30-Day Post-Discharge Readmission	30.769%	30% Gap Closure	3
Facility 3	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	N/A	N/A	N/A
	Healthcare-Associated Infections Requiring Hospitalization	N/A	N/A	N/A
	Potentially Preventable 30-Day Post-Discharge Readmission	N/A	N/A	N/A
Facility 4	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	7.407%	Less Than 10% Gap Closure	0
	Healthcare-Associated Infections Requiring Hospitalization	-36.744%	No Improvement	0
	Potentially Preventable 30-Day Post-Discharge Readmission	N/A	N/A	N/A
Facility 5	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	N/A	N/A	N/A
	Healthcare-Associated Infections Requiring Hospitalization	N/A	N/A	N/A
	Potentially Preventable 30-Day Post-Discharge Readmission	N/A	N/A	N/A

Once the achievement and improvement scores are calculated for each facility, the two values are compared, and the greater of the two is used as the points earned for the Claims-Based Clinical Metrics Measurement Area. Table 28 provides an example comparison of the achievement and improvement scores that will be used for WQIP.

Table 28—Claims-Based Clinical Metrics Measurement Area Achievement and Improvement Score Example

N/A indicates a value could not be determined.

Facility	MDS Metrics	Achievement Score	Improvement Score	Final Raw Score
Facility 1	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	N/A	N/A	N/A
	Healthcare-Associated Infections Requiring Hospitalization	N/A	N/A	N/A
	Potentially Preventable 30-Day Post-Discharge Readmission	N/A	N/A	N/A
Facility 2	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	2	0	2
	Healthcare-Associated Infections Requiring Hospitalization	3	2	3
	Potentially Preventable 30-Day Post-Discharge Readmission	2	3	3
Facility 3	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	6	N/A	6
	Healthcare-Associated Infections Requiring Hospitalization	N/A	N/A	N/A
	Potentially Preventable 30-Day Post-Discharge Readmission	N/A	N/A	N/A

Facility	MDS Metrics	Achievement Score	Improvement Score	Final Raw Score
Facility 4	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	0	0	0
	Healthcare-Associated Infections Requiring Hospitalization	2	0	2
	Potentially Preventable 30-Day Post-Discharge Readmission	N/A	N/A	N/A
Facility 5	*Outpatient ED Visits per 1,000 Long-Stay Resident Days*	N/A	N/A	N/A
	Healthcare-Associated Infections Requiring Hospitalization	N/A	N/A	N/A
	Potentially Preventable 30-Day Post-Discharge Readmission	N/A	N/A	N/A

Table 29 combines the previous examples to illustrate the final Claims-Based Clinical Metrics Measurement Area score calculations.

Table 29—Claims-Based Metrics Measurement Area Scoring Example

N/A indicates a value could not be determined.

Facility	***Outpatient ED Visits per 1,000 Long-Stay Resident Days* Metric Score**	***Healthcare-Associated Infections Requiring Hospitalization* Metric Score**	***Potentially Preventable 30-Day Post-Discharge Readmission* Metric Score**	Raw Score	Total Possible Points	Final Measurement Area Unweighted Score
Facility 1	N/A	N/A	N/A	0	0	N/A
Facility 2	2	3	3	8	18	44.444%
Facility 3	6	N/A	N/A	6	6	100.000%
Facility 4	0	2	N/A	2	12	16.667%

Facility	*Outpatient ED Visits per 1,000 Long-Stay Resident Days* Metric Score	*Healthcare-Associated Infections Requiring Hospitalization* Metric Score	*Potentially Preventable 30-Day Post-Discharge Readmission* Metric Score	Raw Score	Total Possible Points	Final Measurement Area Unweighted Score
Facility 5	N/A	N/A	N/A	0	0	N/A

As displayed in Table 29, the final Claims-Based Clinical Metrics Measurement Area score will be calculated by summing the points for each metric. The score will be divided by the total possible points for the measurement area as shown in Table 8, and will then be multiplied by 100 to get the final unweighted score percentage for the measurement area. If a facility does not meet minimum denominator requirements for one or more metrics, then the maximum total points for that measurement area will be reduced based on the number of metrics the facility is able to report. For example, if a facility only has a reportable rate for the *Healthcare-Associated Infections Requiring Hospitalization* metric, the total points eligible for the measurement area will be reduced to 6. If all claims-based measures are not reportable, then the total possible points for the claims-based clinical metrics measurement area will be set to zero and the measurement area will not be assigned a score.

Final Clinical Metrics Domain Score

Once the unweighted score percentages for the MDS Clinical Metrics Measurement Area and the Claims-Based Clinical Metrics Measurement Area are calculated, the unweighted score percentages will be multiplied by the assigned measurement area weights, as outlined in Table 8, to derive the overall clinical metrics domain score. Each measurement area makes up 20 percent of the overall WQIP score (for a total of 40 percent); thus, each clinical measurement area is assigned a weight of 20. The sum of the two measurement area scores (i.e., the MDS clinical metrics score and the claims-based clinical metrics score) will be summed to obtain the final clinical metrics domain score as shown in Table 30.

Table 30—Example Clinical Metrics Domain Scoring

N/A indicates a value could not be determined.

Facility	MDS Clinical Metrics Measurement Area			Claims-Based Clinical Metrics Measurement Area			Domain Total Score
	Unweighted Score	Measurement Area Weight	Final Weighted score	Unweighted Score	Measurement Area Weight	Final Weighted score	
Facility 1	76.471%	40	30.588	N/A	0	N/A	30.588
Facility 2	0.000%	20	0.000	44.444%	20	8.889	8.889
Facility 3	25.000%	20	5.000	100.000%	20	20.000	25.000
Facility 4	N/A	0	N/A	16.667%	40	6.667	6.667
Facility 5	N/A	0	N/A	N/A	0	N/A	0.000

If HSAG is unable to calculate a score for all three metrics within the MDS Clinical Metrics Measurement Area due to insufficient data, then the percent of the total score for the MDS Clinical Metrics Measurement Area will be added to the Claims-Based Clinical Metrics Measurement Area, and the MDS Clinical Metrics Measurement Area will not be included in the domain score calculation (i.e., the Claims-Based Clinical Metrics Measurement Area will have a weight of 40 percent instead of 20 percent) as displayed for Facility 4 in Table 30. Additionally, if HSAG is unable to calculate a score for all three metrics within the Claims-Based Clinical Metrics Measurement Area due to insufficient data, then the percent of the total score for the Claims-Based Clinical Metrics Measurement Area will be added to the MDS Clinical Metrics Measurement Area and the Claims-Based Clinical Metrics Measurement Area will not be included in the domain score calculation (i.e., the MDS Clinical Metrics Measurement Area will have a weight of 40 percent instead of 20 percent). Please see Facility 1 in Table 30 as an example. Finally, if a facility does not have sufficient data for both measurement areas to calculate scores, the facility will receive a final score of zero points for the Clinical Metrics Domain.

Equity Metrics Domain

This section describes the Medi-Cal Disproportionate Share Metric Measurement Area and the MDS Racial and Ethnic Data Completeness Metric Measurement Area scoring for PY 2.

Medi-Cal Disproportionate Share Metric Measurement Area

For the Medi-Cal Disproportionate Share Metric Measurement Area, HSAG will calculate a Medi-Cal share rate for each facility using the previously defined specifications (please see the Metrics Calculations section). For the *Medi-Cal Disproportionate Share* Metric, HSAG will assign facilities to a peer group as established by DHCS based on the county and region. Please see Table 31 for the *Medi-Cal Disproportionate Share* Metric peer group assignments.

Table 31—*Medi-Cal Disproportionate Share* Metric Peer Groups

Peer Group	County/Region
North State - Sierras	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, Trinity, Tuolumne
Greater Sacramento	El Dorado, Placer, Sacramento, Sutter, Yolo, Yuba
Bay Area	Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma
Central Coast	Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Ventura
San Joaquin Valley	Fresno, Kern, Kings, Madera, Merced, Tulare
Stockton - Modesto	San Joaquin, Stanislaus
Orange - San Diego	Orange, San Diego
Southern Inland	Imperial, Riverside, San Bernardino
LA Region 1	Los Angeles (LA Region 1)
LA Region 2	Los Angeles (LA Region 2)
LA Region 3	Los Angeles (LA Region 3)

HSAG will then use the facility-level Medi-Cal share rates for PY 2 to calculate retrospective percentile distributions for each peer group. Each peer group will have their own individual set of benchmarks which will be based on the percentile distributions of the WQIP facilities' Medi-Cal share rates in each group. Table 32 provides an example of the percentile distributions for three of the peer groups.

Table 32—Medi-Cal Share Rate Mock Percentiles

Peer Group	50th Percentile	60th Percentile	70th Percentile	80th Percentile	90th Percentile
Peer Group 1	50.000%	60.000%	70.000%	80.000%	90.000%
Peer Group 2	45.000%	55.000%	65.000%	75.000%	85.000%
Peer Group 3	30.000%	40.000%	50.000%	60.000%	70.000%

HSAG will then compare each facility's Medi-Cal share rate against its assigned peer group's percentiles and will award points based on if the facility's share of Medi-Cal patients is above its peer group's 50th percentile. The achievement benchmarks a facility must reach within its peer group to earn points is outlined in Table 33.

Table 33—*Medi-Cal Disproportionate Share* Metric

Points	Achievement Benchmark
5	90th Percentile
4	80th Percentile
3	70th Percentile
2	60th Percentile
1	50th Percentile
0	<50th Percentile

The final Medi-Cal Disproportionate Share Metric Measurement Area score will be calculated by taking the points awarded for the metric, dividing by the total maximum possible points for the metric (i.e., 5 points), and then multiplying by 100 to obtain the final score percentage for the measurement area.

Please see Table 34 for an example of how the Medi-Cal Disproportionate Share Metric Measurement Area will be scored for illustrative purposes only.

Table 34—Medi-Cal Disproportionate Share Metric Measurement Area Scoring Example

NR indicates the facility does not have a reported rate.
N/A indicates a value could not be determined.

Facility	Peer Group	Rate	Achievement Benchmark	Final Score	Total Possible Points	Final Measurement Area Unweighted Score
Facility 1	Group 1	55.000%	50th Percentile	1	5	20.000%
Facility 2	Group 1	78.000%	70th Percentile	3	5	60.000%
Facility 3	Group 2	65.500%	70th Percentile	3	5	60.000%
Facility 4	Group 3	NR	N/A	0	0	0.000%
Facility 5	Group 3	65.500%	80th Percentile	4	5	80.000%

In this example, Facility 1, which is part of Peer Group 1, has a 55.0 percent Medi-Cal share. The Medi-Cal share rate for Facility 1 will then be compared to the Peer Group 1 percentiles. In the example, Facility 1 has a rate that falls between the 50th and 60th percentiles. Based on the achievement benchmarks in Table 33, the facility would earn one point for the *Medi-Cal Disproportionate Share* Metric. Please note that while facilities may share the same Medi-Cal share rate, they may score differently based on their peer group. An example may be seen in Table 34 for Facility 3 and Facility 5. The score is then divided by the total possible points for the measurement area (i.e., 5 points) and multiplied by 100 to calculate the unweighted measurement area score. If a facility is missing PBJ data, the rate cannot be calculated due to missing data and the total possible points will be set to zero and the measurement area will receive zero points.

MDS Racial and Ethnic Data Completeness Metric Measurement Area

For the MDS Racial and Ethnic Data Completeness Metric Measurement Area, HSAG established a benchmark using the MDS data to assess the overall completeness of the race and ethnicity fields for facilities that were eligible to participate in the WQIP

program for PY 1. Based on the average completeness rate (i.e., benchmark statistic), DHCS determined the performance target for this measure, as noted in Table 35.

Table 35—MDS Racial and Ethnic Data Completeness Metric Measurement Area Performance Target for PY 2

Metric	Baseline Period	Benchmark Statistic	Performance Target
MDS Racial and Ethnic Data Completeness	7/1/22–6/30/23	95.624%	90.000%

For the *MDS Racial and Ethnic Data Completeness* Metric, HSAG will calculate a rate for each facility using the previously defined specifications (please see the Metrics Calculations section). Facilities with a data completeness rate of 90 percent or more will be eligible to receive points as outlined in Table 36.

Table 36—*MDS Racial and Ethnic Data Completeness* Metric

Points	Achievement Benchmark
10	≥99%
9	98%
8	97%
7	96%
6	95%
5	94%
4	93%
3	92%
2	91%
1	90%
0	<90%
N/A	Data Are Missing

If a facility has no reported MDS data during the measurement period, then the facility will receive zero points for the *MDS Racial and Ethnic Data Completeness* Metric. The final MDS Racial and Ethnic Data Completeness Metric Measurement Area score will be calculated by taking the points awarded for the metric, dividing by the total maximum

points for the metric, and then multiplying by 100 to obtain the final score for the measurement area.

Table 37 provides an example of how the MDS Racial and Ethnic Data Completeness Metric Measurement Area will be scored.

Table 37—MDS Racial and Ethnic Data Completeness Metric Measurement Area Scoring Example

Facility	Rate	Achievement Benchmark	Final Score	Total Possible Points	Final Measurement Area Unweighted Score
Facility 1	96.000%	96%	7	10	70.000%
Facility 2	93.250%	93%	4	10	40.000%
Facility 3	98.000%	98%	9	10	90.000%
Facility 4	78.500%	<90%	0	10	0.000%
Facility 5	N/A	Data Are Missing	0	0	0.000%

Starting with a data completeness rate of 90 percent, facilities will be awarded a point for each percentage of MDS data completeness achieved. For example, Facility 1 has an *MDS Racial and Ethnic Data Completeness* Metric rate of 96.0 percent; thus, the facility earns 7 points for this metric. The facility's score is then divided by the total possible points for the measurement area (i.e., 10 points), which is then multiplied by 100 to calculate the unweighted measurement area score (i.e., 70.0000 percent). If a facility is missing MDS data, the total possible points is set to 0 and the measurement area will receive 0 points, as shown for Facility 5 in Table 37.

Final Equity Metrics Domain Score

Once the unweighted scores percentages for the Medi-Cal Disproportionate Share Metric Measurement Area and the MDS Racial and Ethnic Data Completeness Metric Measurement Area are calculated, the unweighted score percentages will be multiplied by the assigned measurement area weights, as outlined in Table 8, to derive the overall equity metrics domain score. The Medi-Cal Disproportionate Share Metric Measurement Area accounts for 7 percent of the overall score and the MDS Racial and Ethnic Data Completeness Metric Measurement Area accounts for 3 percent; therefore, the metrics are assigned a weight of seven and three, respectively. The two measurement area scores are then summed to obtain the final Equity Metrics Domain score. If a facility is

missing data for one measurement area, the measurement area is assigned a final score of zero. Finally, if a facility does not have sufficient data for both measurement areas to calculate a score, the facility will receive a final domain score of 0 points. Table 38 provides an example of the Equity Metrics Domain final scoring.

Table 38—Equity Metrics Domain Scoring Example

Facility	Medi-Cal Disproportionate Share Metric Measurement Area			MDS Racial and Ethnic Data Completeness Metric Measurement Area			Domain Total Score
	Unweighted Score	Measurement Area Weight	Final Weighted Score	Unweighted Score	Measurement Area Weight	Final Weighted Score	
Facility 1	20.000%	7	1.400	70.000%	3	2.100	3.500
Facility 2	60.000%	7	4.200	40.000%	3	1.200	5.400
Facility 3	60.000%	7	4.200	90.000%	3	2.700	6.900
Facility 4	0.000%	7	0.000	0.000%	3	0.000	0.000
Facility 5	80.000%	7	5.600	0.000%	3	0.000	5.600

Final WQIP Scoring

To calculate the final WQIP score, HSAG will sum the final calculated scores for each domain with a maximum final score of 100 points. If a domain did not have data for all the measurement areas within it, the domain will be assigned zero points for the final score calculation. Table 39 provides an example of the final score calculations for the example facilities used throughout the WQIP Scoring section.

Table 39—Overall WQIP Scoring Example

Facility	Workforce Metrics Domain Score	Clinical Metrics Domain Score	Equity Metrics Domain Score	Final WQIP Score
Facility 1	30.027	30.588	3.500	64.115
Facility 2	32.609	8.889	5.400	46.898
Facility 3	13.333	25.000	6.900	45.233
Facility 4	0.000	6.667	0.000	6.667
Facility 5	10.000	0.000	5.600	15.600

Per Diem Calculations

For PY 2, $295,393,244 is targeted for WQIP payments. These funds are not pooled and are at-risk based on utilization. DHCS established a baseline, uniform per diem rate of $16.34 by dividing $ 295,393,244 by the 18,075,028 projected WQIP-qualifying days for CY 2024. DHCS will direct MCPs to make payments to the facilities on a per diem basis based on the facility's WQIP score.

Curve Factor

To calculate the per diem payments, DHCS will apply a linear curve factor to each facility's overall score. The curve factor will be calculated using the following steps:

- Calculate the total number of WQIP-qualifying days for each facility reported to DHCS by MCPs by June 30, 2025.
- Calculate a weighted average WQIP score using the following logic:
- Numerator: Sum of the product of every facility's WQIP score multiplied by its WQIP-qualifying days.
- Denominator: Sum of all facilities' WQIP-qualifying days.
- Divide the numerator by the denominator to get the weighted average WQIP score.
- Calculate a curve factor equal to the lesser of:
  - Dividing 100 by the weighted average WQIP score
  - Dividing 100 by 35 (approximately 2.86)
- Multiply each facility's overall score by the curve factor and then divide by 100 to derive the facility's curved WQIP score. The curved WQIP score will be formatted as a percentage. Please note that the curved WQIP scores may exceed 100 percent.

The maximum possible curve factor of 100 divided by 35 was set based on a minimum maintenance level expected weighted average WQIP score of 35 percent.

Table 40 provides an example of how the curve factor will be calculated using the five sample facilities referenced above. Please note that this example is using mock data and may not reflect the final WQIP facility population results for PY 2.

Table 40—Curve Factor Calculation Example

Facility	Final Score	WQIP Qualifying Days (MCBDs)	Weighted WQIP Score	Sum of Weighted WQIP Score	Sum of WQIP Days	Weighted Average WQIP Score	Raw Curve Factor
Facility 1	64.115	3,000	192,345	421,422	10,500	40.14	2.49
Facility 2	46.898	1,500	70,347	421,442	10,500	40.14	2.49
Facility 3	45.233	2,500	113,083	421,422	10,500	40.14	2.49
Facility 4	6.667	1,000	6,667	421,442	10,500	40.14	2.49
Facility 5	15.600	2,500	39,000	441,442	10,500	40.14	2.49

Table 41 displays an example of how the final raw curve factor will be applied to calculate the final curved WQIP score. All curved WQIP scores are calculated using unrounded curve factors. Please note that if the raw curve factor is above the approximately 2.86 maximum, the final curve factor will be reduced to approximately 2.86 before the final curved WQIP score is calculated.

Table 41—Final WQIP Curve Factor Calculation Example

Facility	Final Score	Final Curve Factor	Final Curved WQIP Score
Facility 1	64.115	2.49	159.739%
Facility 2	46.898	2.49	116.844%
Facility 3	45.233	2.49	112.696%
Facility 4	6.667	2.49	16.610%
Facility 5	15.600	2.49	38.867%

Once the curved WQIP score is calculated, DHCS will calculate the final WQIP per diem using the following equation:

Curved WQIP Score × Uniform Per Diem Rate

Table 42 provides an example of how the per diem payment will be calculated using the curved WQIP score and the uniform per diem rate. A uniform per diem rate of $16.34 is used.

Table 42—Per Diem Calculation Example

Facility	Final Curved WQIP Score	Uniform Per Diem Rate	Calculated Per Diem
Facility 1	159.739%	$16.34	$26.10
Facility 2	116.844%	$16.34	$19.09
Facility 3	112.696%	$16.34	$18.41
Facility 4	16.610%	$16.34	$2.71
Facility 5	38.867%	$16.34	$6.35

Interim Per Diem Calculation

The interim per diem will be calculated using the formula as described above for the final per diem payments but with two differences:

1. The interim WQIP score is the sum of interim calculated scores for each measurement area available in the interim payment report divided by the maximum total possible points covered by the domains that have been scored in the interim report for that facility. For example, if a facility scores 44 points on measurement areas with a maximum total possible 50 points the interim WQIP score will equal 88 percent.
2. Measurement areas which were not scored due to data not being available as of the time of the interim payment will receive a score of 0 for the purposes of scoring calculations.
3. For the Acuity-Adjusted Staffing Metric, the measurement area will be worth a maximum of 26.25 points because only the first measurement period (January 1, 2024–September 30, 2024) will be available for the interim payment calculation.
4. The calculation of the interim curve factor will utilize WQIP-qualifying days reported to DHCS by MCPs by December 31, 2024.
5. An interim payment proration factor will be applied to each facility's calculated per diem to reflect the percentage of total possible points covered by the

domains that have been scored in the interim report for that facility. For example, if only three domains accounting for 61.25 possible points have been scored for a facility in the interim report, then the interim payment proration factor applied to yield that facility's interim per diem will be 0.6125.

Payments by MCPs

DHCS will direct MCPs to make initial and final payments to facilities on a per diem basis based on performance in WQIP as described in other parts of this document. MCPs will calculate a lump sum interim and final payment for each facility by multiplying the interim and final directed per diem amounts by the WQIP-qualifying days rendered under the MCP's contract with the facility during the program year. The MCP will apply any penalties related to class AA or A citations (described below) to the interim and final payment calculation. MCPs are responsible for reconciling net payment amounts between the interim and final payments. DHCS will require MCPs to complete payments to providers no later than 45 calendar days of receiving calculated per diems for each eligible SNF. DHCS plans to release per diem exhibits to MCPs on the following schedule (which may be subject to change): Quarter 1 2025 for interim payment per diem exhibits and Quarter 4 2025 for final payment per diem exhibits.

A/AA Citations

WQIP payments to facilities that have one or more class AA or A citations that were issued by CDPH for violations that occurred wholly or in part during the PY will be reduced as follows:

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

This policy provides a stepped approach recognizing the difference in severity between AA and A citations. Additionally, for A citations, the penalty of 40 percent recognizes that 60 percent of the WQIP score is based on workforce and equity metrics.

DHCS will contractually require the MCPs to withhold WQIP payments for facilities that have applicable citations during the program year at the time of any interim and final payments. If an MCP becomes aware of an applicable citation for a program year after

the time of an interim or final payment, DHCS will contractually require the MCP to recoup and withhold the funding retroactively. If a facility appeals a citation in accordance with applicable laws and regulations, the MCP shall recoup and withhold the WQIP payments for the applicable program year until all appeals are exhausted. If a citation is overturned or reduced on appeal and all appeals are exhausted, the MCP shall release the appropriate amount of funding based on the final disposition of the citation (e.g., if an AA citation is reduced to an A citation, then release of funds should be based on an A citation). Please note that citations may be finalized after the payment determinations have been made; however, once the citation is finalized, the penalty will apply to payments associated with the PY in which the violation occurred. Table 43 provides an example of how citations will affect the final WQIP facility-specific per diem.

Table 43—A/AA Citation Application Example

Facility	*Calculated Per Diem*	*Citation*	*Final Adjusted Per Diem*
Facility 1	$26.10	A	$15.66
Facility 2	$19.09	None	$19.09
Facility 3	$18.41	None	$18.41
Facility 4	$2.71	AA	$0
Facility 5	$6.35	None	$6.35

APPENDIX A: CLINICAL METRICS DOMAIN METRIC SPECIFICATIONS

MDS Clinical Metrics Measurement Area

Percent of Residents Who Lose Too Much Weight, Long Stay (CBE #0689)

The *Percent of Residents Who Lose Too Much Weight, Long Stay* measure is defined as the percentage of long-stay residents, who had a weight loss of 5 percent or more in the last month or 10 percent or more in the last six months. The methodology used to calculate these rates aligns with the MDS 3.0 measure specifications.

The numerator criteria for this measure includes long-stay residents with a weight loss of 5 percent or more in the last month or 10 percent or more in the last six months who were not on a physician prescribed weight-less regiment (K0300 = [2]).

The denominator criteria for this measure include long-stay residents with a selected target assessment except those with exclusions.

The following exclusions apply:

- The target assessment is either for an admission (A0310A = [01]) or a PPS 5-Day assessment (A0310B = [01]).
- The resident's prognosis of life expectancy is less than six months (J1400 = [1]) or prognosis item is missing (J1400 = [-]).
- The resident is receiving Hospice care or the Hospice care item is missing. This is indicated by either of the following:
  - For target assessments with a target date prior to October 1, 2023: the resident is receiving Hospice care (O0100K2 = [1]) or the Hospice care item is missing (O0100K2 = [-]).
  - For target assessments with a target date on or after October 1, 2023: The resident is receiving Hospice care (O0110K1b = [1]) or the Hospice care item is missing (O0110K1b = [-]).
- The weight loss item is missing (K0300 = [-]) on the target assessment.

Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay (CBE #0674)

The *Percent of Residents Experiencing One or More Falls with Major Injury* measure is defined as the percentage of long-stay residents who have experienced one or more falls with major injury reported in the target period or the look-back period. The methodology used to calculate these rates aligns with the MDS 3.0 measure specifications.

The numerator criteria for this measure include long-stay residents with one or more look-back scan assessments that indicate one or more falls that resulted in major injury (J1900C = [1,2]).

The denominator criteria for this measure include long-stay residents with one or more look-back scan assessments except for those with the following exclusion:

- The number of falls with major injury was not coded for all look-back scan assessments (J1900C = [-]).

Percent of Residents Who Received an Antipsychotic Medication, Long Stay

The *Percent of Residents Who Received an Antipsychotic Medication* measure is defined as the percentage of long-stay residents who are receiving antipsychotic medication in the target period. The methodology used to calculate these rates aligns with the MDS 3.0 measure specifications.

The numerator criteria for this measure include long-stay residents with a selected target assessment who received antipsychotic medications for one or more days during the last seven days as defined by:

- For assessments with target dates prior to 10/01/2023: N0410A = [1,2,3,4,5,6,7].
- For assessments with target dates on or after 10/01/2023: N0415A1 = [1].

The denominator criteria for this measure include long-stay residents with a target assessment except with the following exclusions:

- The resident did not qualify for the numerator and any of the following is true
  - For assessments with target dates prior to 10/01/2023: N0410A = [-].
  - For assessments with target dates on or after 10/01/2023: N0415A1 = [-].
- Any of the following related conditions are present on the target assessment (unless otherwise indicated):

- Schizophrenia (I6000 = [1]).
- Tourette's syndrome (I5350 = [1]).
- Tourette's syndrome (I5350 = [1]) on the prior assessment if this item is not active on the target assessment and if a prior assessment is available.
- Huntington's disease (I5250 = [1]).

Claims-Based Clinical Metrics Measurement Area

Please note, the MCPs are responsible for calculating the claims-based clinical metrics.

Outpatient ED Visits per 1,000 Long-Stay Resident Days

Description

The *Number of Outpatient ED Visits per 1,000 Long-Stay Resident Days* measure is defined as the number of all-cause outpatient ED visits occurring in the measurement period while the individual is a long-term nursing home resident. The specifications for this measure were modified from the CMS Care Compare Claims-Based Quality Measure Technical Specifications.[18]

Data Sources

Medicare claims and eligibility files as well as Medi-Cal claims and eligibility files.

Denominator

The measure includes Medi-Cal or dually eligible members with a single stay or sequence of stays (episode) during which the member resides in a SNF for a total of 101 days or more without a gap of 30 continuous days living in the community or another institution. The denominator is the sum of all long-stay days in the measurement period. A long-stay day is any day after a resident's one-hundredth cumulative day in the SNF or the beginning of the 12-month measurement period, whichever is later. The stay ends at the day of discharge or the end of the 12-month measurement period, whichever is the earliest.

Long-stay residents meeting any of the following criteria are excluded:

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[18] CMS. Nursing Home Compare Claims-Based Quality Measure Technical Specifications. 2019. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/Nursing-Home-Compare-Claims-based-Measures-Technical-Specifications-April-2019.pdf.

- The resident was not enrolled in the MCP during any portion of the episode (i.e., between the episode start date and episode end date or the end of the target period [whichever is earlier]).
- The resident was dually-eligible for Medicare and Medicaid during any portion of the stay (i.e., between admission and discharge or the end of the measurement year [whichever is earlier]) where both of the following conditions are met: (1) the resident was not enrolled in Original Medicare (i.e., Medicare FFS) and (2) the organization is not responsible for both the Medicare and Medicaid components.
- The resident received hospice care at any point during the measurement year.
- The resident died during the measurement year.
- Long-stay days meeting any of the following criteria are excluded:
  - The resident was not in the nursing home for any reason during the episode.

Numerator

The numerator includes all ED visits for Medi-Cal and dually eligible residents who meet all the following criteria:

- Met the criteria for the denominator.
- Have an Medi-Cal outpatient claim with revenue codes (0450, 0451, 0452, 0456, 0459, 0981) for an ED visit while they were residing in the nursing home and are after the member's 100th day in the nursing home.
- Only count one ED visit per member per day.

Measure Calculation

The rate for a SNF is calculated as the observed numerator times 1,000 divided by the total number of all long-stay days that met the denominator criteria in the measurement period. For this measure, a lower rate indicates better performance. The measure will only be reported for facilities with a minimum denominator of at least 360 long-stay days during the measurement period.

Healthcare-Associated Infections Requiring Hospitalization

Description

The SNF *Healthcare-Associated Infections Requiring Hospitalization* measure estimates the rate of HAIs that are acquired during SNF care and result in hospitalization. The specifications for this measure were modified from the Skilled Nursing Facility

Healthcare-Associated Infections Requiring Hospitalization for the Skilled Nursing Facility Quality Reporting Program Technical Report.[19]

Data Sources

Medicare claims and eligibility files as well as Medi-Cal claims and eligibility files.

Denominator

The eligible population includes Medi-Cal or dually eligible members with eligible SNF stays that overlap with the measurement period (i.e., the admission date is prior to December 28, 2024 and the discharge date is later than January 1, 2024). The denominator for this measure is stay-based, not member-based. If a member has more than one stay meeting the eligibility criteria, then all eligible stays should be included in the denominator. The eligible stays for the measure are all eligible SNF stays that do not meet one or more of the following exclusion criteria during the measurement period:

- Resident is less than 18 years old at the time of SNF admission.
- The SNF length of stay was shorter than four days.
- Residents who were not continuously enrolled from the SNF admission date (or from January 1st of the measurement year if the SNF stay started prior to the measurement year) through the SNF discharge date (or through December 31st of the measurement year if they SNF stay is still active). There are no allowable gaps during the continuous enrollment period. During the continuous enrollment period, only include dual-eligible member enrollment if (1) the member was enrolled in Original Medicare (i.e., Medicare FFS) or (2) the organization is responsible for both the Medicare and Medicaid components for the member.
- Residents who were transferred to a federal hospital from the SNF as determined by the discharge status code of "43" or "88" on the SNF claim.

Numerator

The numerator is the number of stays with an HAI acquired during SNF care and result in an acute inpatient hospitalization. The acute inpatient hospitalization must occur during the measurement period, after January 1, 2024 and before (not including) December 29, 2024. The acute inpatient hospitalization must occur during the period

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[19] Acumen. Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization for the Skilled Nursing Facility Quality Reporting Program. 2021. Available at: https://www.cms.gov/files/document/snf-hai-technical-report.pdf. Accessed on: Sep 12, 2024.

beginning on the fourth day after the SNF admission and within three days of the SNF discharge.

HAIs are identified using the principal diagnosis and the Present of Admission (POA) fields on the acute inpatient hospital admission claim. The HAI definition applies a repeat infection timeline of 14 days to exclude pre-existing infections from the numerator count. Pre-existing infections are determined using all of the diagnosis codes on the prior acute inpatient hospitalization claim. The pre-existing infection recorded in the prior hospitalization must be a diagnosis related to the HAI recorded in the rehospitalization. If the number of days between the rehospitalization and the prior proximal hospitalization is less than 14 days and a pre-existing infection is recording in any diagnosis code in the prior stay then the HAI is excluded. To identify HAIs, the following steps are used:

- Step 1: Identify acute inpatient hospital stays beginning between the fourth day of a SNF stay and three days after a SNF discharge.
- Step 2: Check the principal diagnosis field of the acute inpatient hospital admission claim for an HAI diagnosis. If an HAI diagnosis is found and marked as POA then proceed with step 3. If no HAI diagnosis is found or if the diagnosis is not marked as POA then the readmission is not counted toward the numerator.
- Step 3: For each HAI acute inpatient hospital stay, check for prior acute inpatient hospital stays with a discharge date within 14 days of the HAI acute inpatient hospital stay admission date.
- Step 4: If the number of days between the prior acute inpatient hospital stay and the HAI acute inpatient hospital stay is less than 14 days, search for a HAI-related condition on all diagnosis codes of the prior acute inpatient hospital stay. If a pre-existing condition is found, exclude the HAI admission from the numerator. If no pre-existing conditions are found, include the HAI admission in the numerator.

Measure Calculation

The rate for a SNF is calculated as the observed numerator divided by the denominator. For this measure, a lower rate indicates better performance. The measure will only be reported for facilities with a minimum denominator of at least 25 eligible stays during the measurement period.

Potentially Preventable 30-Day Post-Discharge Readmission

Description

The *Potentially Preventable 30-Day Post-Discharge Readmission* measure for SNF QRP calculates the rate of potentially preventable readmissions (PPR) within a 30-day window following discharge from a SNF. The specifications for this measure were modified from the Measure Specifications for Measures Adopted in the FY 2017 SNF QRP Final Rule.[20]

Data Sources

Medicare claims and eligibility files as well as Medi-Cal claims and eligibility files.

Denominator

The denominator includes Medi-Cal or dually eligible members who have eligible SNF stays with an admission date on or after January 1, 2024 and with a discharge date on or before December 1, 2024 and who do not meet the exclusion criteria. For residents with multiple eligible SNF stays during the measurement period, each stay is eligible for inclusion. The eligible stays for the measure are all eligible SNF stays that do not meet one or more of the following exclusion criteria:

- Residents who died during the SNF stay.
- Residents less than 18 years old as of the SNF admission date.
- Residents who were transferred at the end of a stay to another SNF or short-term acute care hospital.
- Residents who were not continuously enrolled in the MCP for the 30 days prior to the SNF admission date, during the SNF stays, and a least 30 days after the SNF discharge date. No gaps in enrollment are allowed. During the continuous enrollment period, only include dual-eligible member enrollment if (1) the member was enrolled in Original Medicare (i.e., Medicare FFS) or (2) the organization is responsible for both the Medicare and Medicaid components for the member.
- Residents who did not have a short-term acute-care stay within 30 days prior to a SNF admission date.

[20] CMS. Measure Specifications for Measures Adopted in the FY 2017 SNF QRP Final Rule. 2016. Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Measure-Specifications-for-FY17-SNF-QRP-Final-Rule.pdf. Accessed on: Sep 12, 2024.

- Residents discharged against medical advice (AMA) identified by a discharge status code of "07" on the SNF discharge claim.
- Residents form whom the prior short-term acute-care stay was for nonsurgical treatment of cancer.
- Residents who were transferred to a federal hospital from the post-acute care (PAC) facility as determined by the discharge status code of "43" or "88" on the discharge claim.

Numerator

The numerator is the number of stays that had a potentially preventable, unplanned readmission between 2 and 30 days post discharge. In order for a readmission to be considered potentially preventable, the principal diagnosis on the readmission claim must have a potentially preventable diagnosis code. If the admission meets the definition of a potentially preventable readmission, confirm that it is unplanned. Planned readmissions are defined largely by the definition for the CMS Hospital Wide Readmission measure and were revised to include additional procedures determined suitable for post-SNF care. Please note that admissions to an Inpatient Psychiatric Facility are considered planned and should be excluded from the numerator. Any acute inpatient admission that occurs on or between 2 and 30 days post discharge that meets the definition of a potentially preventable readmission and does not meet the definition of a planned readmission is considered numerator positive.

Measure Calculation

The rate for a SNF is calculated as the observed numerator divided by the denominator. For this measure, a lower rate indicates better performance. The measure will only be reported for facilities with a minimum denominator of at least 25 eligible stays during the measurement period.