

**SKILLED NURSING FACILITY
WORKFORCE & QUALITY
INCENTIVE PROGRAM:
2023 TECHNICAL PROGRAM
GUIDE**



DOCUMENT REVISION HISTORY

Status	Version	Author	Review/ Approval Date
Initial Draft	0.01	HSAG/DHCS	TBD
Final	1.0	HSAG/DHCS	03/08/2024

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

TABLE OF CONTENTS

DOCUMENT REVISION HISTORY	2
TABLE OF CONTENTS.....	3
Overview	4
Introduction.....	4
WQIP Metrics	5
Data Sources	6
Metrics Calculations.....	11
Workforce Metrics Domain	13
MDS Clinical Metrics Measurement Area	21
Claims-Based Clinical Metrics.....	25
Equity Metrics	27
WQIP Scoring.....	29
Overview	29
WQIP Scoring Methodology.....	29
Performance Targets/Benchmarking.....	31
Workforce Metrics Domain Scoring	31
Clinical Metrics Domain	40
Equity Metrics Domain.....	57
Final WQIP Scoring.....	62
Payment Calculations	63
A/AA Citations	65
Appendix A: Clinical Metrics Domain Metric Specifications.....	67
MDS Clinical Metrics Measurement Area	67
Claims-Based Clinical Metrics Measurement Area	69

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. 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 payment year (PY) 1 (i.e., January 1–December 31, 2023), 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. Any eligible provider furnishing qualifying skilled nursing services to Medi-Cal managed care enrollees may earn performance-based directed payments from the Medi-Cal MCPs they contract with. Freestanding pediatric subacute care facilities, distinct part facilities, and SNFs with 100% designated special treatment program beds are not eligible for WQIP payments. 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.ca.gov/faces/billPdf.xhtml?bill_id=202120220AB186&version=20210AB18695CHP

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 National Quality Forum (NQF) identification (ID) (if applicable), that will be evaluated as part of PY1 of the WQIP.

Table 1—WQIP Metrics

N/A indicates there is no applicable NQF ID.

Metric	NQF ID
Workforce Metrics Domain	
Acuity-Adjusted Staffing Hour Metrics Measurement Area	
<i>Acuity-Adjusted Total Nursing Hours</i>	N/A
<i>Acuity-Adjusted Weekend Total Nursing Hours</i>	N/A
<i>Acuity-Adjusted RN Hours</i>	N/A
<i>Acuity-Adjusted LVN Hours</i>	N/A
<i>Acuity-Adjusted CNA Hours</i>	N/A
Staffing Turnover Metric Measurement Area	
<i>Staffing Turnover</i>	N/A
Clinical Metrics Domain	
MDS Clinical Metrics Measurement Area	
<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	0679

Metric	NQF ID
<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	0674
<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	N/A
Claims-Based Clinical Metrics Measurement Area	
<i>Outpatient ED Visits per 1,000 Long-Stay Resident Days</i>	N/A
<i>Healthcare-Associated Infections Requiring Hospitalization</i>	N/A
<i>Potentially Preventable 30-Day Post-Discharge Readmission</i>	N/A
Equity Metrics Domain	
Medi-Cal Disproportionate Share Measurement Area	
<i>Medi-Cal Disproportionate Share</i>	N/A
MDS Racial and Ethnic Data Completeness Measurement Area	
<i>MDS Racial and Ethnic Data Completeness</i>	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

The Centers for Medicare & Medicaid Services (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

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: Mar 11, 2024.

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 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 PY1, HSAG will use the most up-to-date data from the October 2023 and January 2024 Care Compare refresh to calculate the Acuity-Adjusted Staffing Hour Metrics Measurement Area for April 1, 2023, to September 30, 2023. Additionally, HSAG will use data from the January 2024 Care Compare refresh to calculate the Staffing Turnover Metric Measurement Area for PY1.

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: Mar 11, 2024.

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/certificationandcompliance/downloads/usersguide.pdf>. Accessed on: Mar 11, 2024.

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 receive MDS 3.0 data from the California Department of Health (CDPH) as part of a data use agreement (DUA) between CDPH, HSAG, and CMS, which allows access to all MDS 3.0 data submitted by California facilities. In addition to the MDS 3.0 data, HSAG will also receive 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 MDS Clinical Metrics Measurement Area, the MDS Racial and Ethnic Data Completeness Metric Measurement Area, and MDS Data Completeness as displayed in Table 1-1. For further details about the MDS data, please see the LTC Facility Resident Assessment Instrument 3.0 User Manual.⁷

Audited Claims-Based Metrics Data

As part of the measurement year 2023 Medi-Cal Managed Care Accountability Set (MCAS), MCPs are required to submit audited claims-based metrics to DHCS in June 2024 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 AuditTM,⁹ timeline and in accordance with the methods

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: Mar 11, 2024.

⁷ CMS. LTC facility resident assessment instrument 3.0 user's manual V1.17.1. 2019. Available at: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf. Accessed on: Mar 11, 2024.

⁸ DHCS. MCAS for MCPs Measurement Year 2023. Accessed on: Mar 13, 2023. Available at: <https://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal-Accountability-Set-Reporting-Year-2024.pdf>

⁹ HEDIS Compliance AuditTM is a trademark of the National Committee for Quality Assurance (NCQA).

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 the 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. 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 Metric Calculations section and a discussion of the WQIP payment eligibility requirements and payment determinations may be found in the WQIP Scoring Methodology section.

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 Metric Calculations section.

A/AA Citation Data

HSAG will receive the CDPH A/AA citation data from DHCS, which will be used to adjust payments for those facilities that receive an A or AA citation. 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. Class AA citations are issued to facilities for actions that are the proximate cause of resident death. HSAG will review the records provided to identify A/AA citations with violation dates during

¹⁰ CMS. CMS External Quality Review (EQR) Protocols. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Mar 11, 2024.

¹¹ CDPH. Licensed and certified healthcare facility listing. Available at: <https://data.chhs.ca.gov/dataset/healthcare-facility-locations>. Accessed on: Mar 11, 2024.

PY1. A more detailed discussion of A/AA citation penalties is provided in the Payment Calculations section.

METRICS CALCULATIONS

As part of WQIP PY1, HSAG will evaluate 14 metrics across three domains (i.e., Workforce Metrics, Clinical Metrics, and Equity Metrics). Table 2 presents the PY1 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 2—WQIP Domains, Metrics, Measure Steward, and Data Source

N/A indicates there is no applicable NQF ID.

Metric	NQF ID
Workforce Metrics Domain	
Acuity-Adjusted Staffing Hour Metrics Measurement Area	
<i>Acuity-Adjusted Total Nursing Hours</i>	N/A
<i>Acuity-Adjusted Weekend Total Nursing Hours</i>	N/A
<i>Acuity-Adjusted RN Hours</i>	N/A
<i>Acuity-Adjusted LVN Hours</i>	N/A
<i>Acuity-Adjusted CNA Hours</i>	N/A
Staffing Turnover Metric Measurement Area	
<i>Staffing Turnover</i>	N/A
Clinical Metrics Domain	
MDS Clinical Metrics Measurement Area	
<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	0679
<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	0674
<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	N/A
Claims-Based Clinical Metrics Measurement Area	
<i>Outpatient ED Visits per 1,000 Long-Stay Resident Days</i>	N/A
<i>Healthcare-Associated Infections Requiring Hospitalization</i>	N/A
<i>Potentially Preventable 30-Day Post-Discharge Readmission</i>	N/A

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

Table 3 displays the PY1 measurement areas, measurement periods, and measurement populations. Please note, the Acuity-Adjusted Staffing Hour Metric measurement area will use a six-month measurement period (i.e., April 1, 2023–September 30, 2023) to give facilities time to start submitting PBJ data, if they are not already doing so.

Table 3—PY1 Measurement Areas, Measurement Periods, and Measurement Population

Measurement Area	Measurement Period	Measurement Population
Acuity-Adjusted Staffing Hour Metrics	April 1, 2023–September 30, 2023	All direct care staff
Staffing Turnover Metric	April 1, 2022–September 30, 2023	All direct care staff
MDS Clinical Metrics	July 1, 2022–June 30, 2023	All long-stay patients
Claims-Based Clinical Metrics	January 1, 2023–December 31, 2023	Patients enrolled in Medi-Cal managed care, including Medi-Cal/Medicare dual eligible members
Medi-Cal Disproportionate Share Metric	January 1, 2023–December 31, 2023	All patients
MDS Racial and Ethnic Data Completeness Metric	January 1, 2023–December 31, 2023	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 April 1, 2023, to September 30, 2023. 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’ Guide¹² 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 4 provides a crosswalk of the rates included in the Care Compare data to those that will be used for WQIP.

Table 4—CMS Care Compare Staffing Rates and Associated WQIP Metrics

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

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/certificationandcompliance/downloads/usersguide.pdf>. Accessed on: Mar 11, 2024.

HSAG will calculate a final rate for each facility by averaging each facility's quarterly rates for the measurement period. 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 measurement period 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) 21-11¹³ 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 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:

¹³ CDPH. AFL 21-11. Available at: <https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-11.aspx>. Accessed on: Mar 11, 2024.

- 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 (MDS_{census}) 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 result 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 5 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 5—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
	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

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)
	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 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:

¹⁴ CDPH. AFL 21-11. Available at: <https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-11.aspx>. Accessed on: Mar 11, 2024.

- 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 ($\text{Hrs_RN} + \text{Hrs_LPN} + \text{Hrs_CNA} + \text{Hrs_Natrtn}$) 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 (MDS census) 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 59 or less 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 (MDS_{census}) 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 PY1, HSAG will use the *Staffing Turnover Metric* rates reported in the January 2024 Care Compare refresh for nursing staff. Please refer to the CMS Five Star Users' Guide¹⁵ 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 High-Risk Residents with Pressure Ulcers, Long Stay*; *Percent of Residents Who Received an Antipsychotic Medication, 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, 2022–June 30, 2023) for each facility. Additionally, HSAG will calculate the metrics for the year prior to the measurement period (i.e., July 1, 2021–June 30, 2022) 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 15.0.¹⁶ 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.

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/certificationandcompliance/downloads/usersguide.pdf>. Accessed on: Mar 11, 2024.

¹⁶ CMS. MDS 3.0 Quality Measures User's Manual V15.0. Available at: <https://www.cms.gov/files/zip/mdsqmusersmanualv15effective01-01-2022.zip>. Accessed on: Mar 11, 2024.

Target Assessment

HSAG will use the target assessment criteria to identify the assessment that will be used to calculate the *Percent of High-Risk Residents with Pressure Ulcers, Long Stay* and the *Percent of Residents Who Received an Antipsychotic Medication, Long Stay* Metrics. The 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 PY1 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 15.0. 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 High-Risk Residents with Pressure Ulcers, Long Stay

The *Percent of High-Risk Residents with Pressure Ulcers* Metric is defined as the percentage of long-stay, high-risk residents with Stage II-IV or unstageable pressure ulcers. The denominator of the metric includes all long-stay residents with a selected target assessment who meet the definition of high risk, except for those with exclusions. Residents are considered high-risk if they meet any of the following criteria: impaired bed mobility or transfer, comatose, or malnutrition or at risk of malnutrition. The numerator includes all long stay residents with a selected target assessment on which stage II-IV or unstageable pressure ulcers are present. Residents who do not qualify for the numerator and do not report pressure ulcer information will be excluded from the metric.

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.

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.

The denominator will be the long-stay residents who are identified for each facility during the quarter. 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.

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 will be used. If a metric does not meet the minimum denominator, 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 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 or a long-term care hospital (LTCH) 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 MCBBD 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 MCBDDs during the measurement year for each facility based on the MCBDD Data. For this metric, MCBDD 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.

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 calculate 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:
 - Prior to October 1, 2023, an assessment is considered completed if it meets the following criteria:
 - Race/Ethnicity field is populated (A1000A = [1] or A1000B = [1] or A1000C = [1] or A1000D = [1] or A1000E = [1] or A1000F = [1])
 - After October 1, 2023, the MDS item set will change to separate the race and ethnicity fields, 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 = [01,02,03,04,05,06], 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 6.

Table 6—WQIP Metrics

N/A indicates there is no applicable NQF ID.

Metric	NQF ID
Workforce Metrics Domain	
Acuity-Adjusted Staffing Hour Metrics Measurement Area	
<i>Acuity-Adjusted Total Nursing Hours</i>	N/A
<i>Acuity-Adjusted Weekend Total Nursing Hours</i>	N/A
<i>Acuity-Adjusted RN Hours</i>	N/A
<i>Acuity-Adjusted LVN Hours</i>	N/A
<i>Acuity-Adjusted CNA Hours</i>	N/A
Staffing Turnover Metric Measurement Area	
<i>Staffing Turnover</i>	N/A
Clinical Metrics Domain	
MDS Clinical Metrics Measurement Area	
<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	0679
<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	0674
<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	N/A
Claims-Based Clinical Metrics Measurement Area	
<i>Outpatient ED Visits per 1,000 Long-Stay Resident Days</i>	N/A

Metric	NQF ID
<i>Healthcare-Associated Infections Requiring Hospitalization</i>	N/A
<i>Potentially Preventable 30-Day Post-Discharge Readmission</i>	N/A
Equity Metrics Domain	
Medi-Cal Disproportionate Share Measurement Area	
<i>Medi-Cal Disproportionate Share</i>	N/A
MDS Racial and Ethnic Data Completeness Measurement Area	
<i>MDS Racial and Ethnic Data Completeness</i>	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 7 (e.g., the Acuity-Adjusted Staffing Hour Metrics Measurement Area accounts for 35 percent of the total WQIP score). Table 7 displays the overall points and weights by measurement area for PY1. Additionally, the individual measurement domain sections below provide a detailed description of how scores will be calculated for each domain.

Table 7—Points and Weighting by Measurement Area for PY1

**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	5	6	30	35%
	Staffing Turnover Metric	1	6	6	15%

Domain	Measurement Area	Number of Metrics	Possible Points per Metric	Possible Points for Measurement Area	Percent of Total Score
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%
	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 Workforce Metrics Domain, 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 Claims-Based Metrics Measurement Area and Medi-Cal Disproportionate Share Metric Measurement Area will be set retrospectively for PY1 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 PY1 Annual Report.

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

Using publicly available Care Compare data for the Workforce Metrics Domain, HSAG established prospective benchmarks for the Acuity-Adjusted Staffing Hour Metrics Measurement Area and Staffing Turnover Metric Measurement Area. HSAG limited the data to those facilities that were eligible to participate in the historical QASP program for SFY 2020–21 (i.e., July 1, 2020–June 30, 2021), and calculated percentile distributions for each metric. To calculate the baseline annual rates facility for all metrics in the Acuity-Adjusted Staffing Hour Metrics Measurement Area except for the *Acuity-Adjusted Weekend Total Nursing Hours* metric, four quarters of rates (i.e., Q3 2021, Q4 2021, Q1 2022, and Q2 2022) were averaged for each facility. The *Acuity-Adjusted Weekend Total Nursing Hours* was first reported in 2022 so only two quarters of rates (i.e., Q1 2022 and Q2 2022) were averaged to calculate the baseline annual rates. The percentile distribution was then calculated for each metric to establish the Acuity-Adjusted Staffing Hour Metrics Measurement Area baseline benchmarks for PY1. For the Staffing Turnover Metric Measurement Area, the *Staffing Turnover* Metric rate from the October 2022 refresh of the Care Compare data was used for each facility. The percentile distribution was then calculated for the *Staffing Turnover* Metric to establish the baseline benchmarks for PY1.

The PY1 benchmarks based on baseline Care Compare data for the Acuity-Adjusted Staffing Hour Metrics Measurement Area and Staffing Turnover Metric Measurement Area are displayed in Table 8.

Table 8—Workforce Metric Domain Benchmarks for PY1

Metric	Baseline Period	Number of Facilities	25th Percentile	37.5th Percentile	50th Percentile	62.5th Percentile	75th Percentile	90th Percentile
Acuity-Adjusted Staffing Hour Metrics Measurement Area								
<i>Acuity-Adjusted Total Nursing Hours</i>	7/1/21–6/30/22	1,047	3.853	3.997	4.129	4.282	4.473	4.961

Metric	Baseline Period	Number of Facilities	25th Percentile	37.5th Percentile	50th Percentile	62.5th Percentile	75th Percentile	90th Percentile
<i>Acuity-Adjusted Weekend Total Nursing Hours</i>	1/1/22–6/30/22	1,037	3.409	3.575	3.716	3.856	4.019	4.445
<i>Acuity-Adjusted RN Hours</i>	7/1/21–6/30/22	1,047	0.371	0.429	0.486	0.560	0.645	0.882
<i>Acuity-Adjusted LVN Hours</i>	7/1/21–6/30/22	1,047	0.992	1.067	1.145	1.235	1.331	1.560
<i>Acuity-Adjusted CNA Hours</i>	7/1/21–6/30/22	1,047	2.266	2.385	2.479	2.569	2.698	2.985
Staffing Turnover Metric Measurement Area								
<i>Staffing Turnover</i>	4/1/21–3/31/22	927	56.900%	51.000%	47.000%	42.400%	38.000%	29.400%

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, the final rate for each facility will be the average of the facility’s quarterly rates for the measurement period. For the Staffing Turnover Metric Measurement Area, the final rate for each facility will be the rate reported in the January 2024 Care Compare data, representing data for the April 1, 2022, to September 30, 2023, measurement period. As outlined in Table 9 facilities will receive a score based on how the final rate compares to the percentiles for each metric in Table 8 Please note, the Acuity-Adjusted Staffing Hour Metrics Measurement Area and Staffing Turnover Metric Measurement Area are not eligible for improvement points.

Table 9—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. HSAG will multiply the raw score for each metric by the completeness score to calculate the final score for each metric. Further details regarding the calculation of the HPPD minimum performance benchmark for each metric may be found in the Metric Calculations section.

Table 10 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 9. 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. The percentiles used in these examples are derived from the prospective benchmarks as displayed in Table 8. To calculate the metric scores, the facility's rate for the individual metrics will be compared to the prospective benchmarks. Based on a facility's performance, the facility will be assigned a raw score ranging from 0 to 6 points.

Table 10—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	Final Score
Facility 1	<i>Acuity-Adjusted Total Nursing Hours</i>	4.550	75th Percentile	5	72.0%	3.600

Facility	Metric	Rate	Achievement Benchmark	Raw Score	Staffing Data Completeness	Final Score
	<i>Acuity-Adjusted Weekend Total Nursing Hours</i>	3.981	62.5th Percentile	4	68.0%	2.720
	<i>Acuity-Adjusted RN Hours</i>	0.654	75th Percentile	5	89.5%	4.475
	<i>Acuity-Adjusted LVN Hours</i>	2.111	90th Percentile	6	89.5%	5.370
	<i>Acuity-Adjusted CNA Hours</i>	2.654	62.5th Percentile	4	78.6%	3.144
Facility 2	<i>Acuity-Adjusted Total Nursing Hours</i>	4.331	62.5th Percentile	4	95.0%	3.800
	<i>Acuity-Adjusted Weekend Total Nursing Hours</i>	4.385	75th Percentile	5	92.5%	4.625
	<i>Acuity-Adjusted RN Hours</i>	0.555	50th Percentile	3	100%	3.000
	<i>Acuity-Adjusted LVN Hours</i>	1.312	62.5th Percentile	4	100%	4.000
	<i>Acuity-Adjusted CNA Hours</i>	2.425	37.5th Percentile	2	90.6%	1.812
Facility 3	<i>Acuity-Adjusted Total Nursing Hours</i>	4.120	37.5th Percentile	2	100%	2.000
	<i>Acuity-Adjusted Weekend Total Nursing Hours</i>	3.512	25th Percentile	1	100%	1.000
	<i>Acuity-Adjusted RN Hours</i>	0.478	37.5th Percentile	2	100%	2.000
	<i>Acuity-Adjusted LVN Hours</i>	1.212	50th Percentile	3	100%	3.000
	<i>Acuity-Adjusted CNA Hours</i>	1.850	Below the 25th Percentile	0	100%	0.000
Facility 4	<i>Acuity-Adjusted Total Nursing Hours</i>	NR	Data Are Missing	0	NR	0.000

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

As shown in Table 10, Facility 1 has a rate of 4.550 for the *Acuity-Adjusted Total Nursing Hours* metric, which is greater than the 75th percentile (4.473) but lower than the 90th percentile (4.961). Based on the achievement benchmarks, as displayed in Table 8, the facility will achieve the 75th Percentile and receive a raw score of 5 points, as outlined in Table 9. 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 final metric score. For this example, the raw score of 5 points is multiplied by 72.0 percent to get a final metric 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 NA in the example table), the facility will receive a final score of 0 points as presented in Table 10 for Facility 4 and Facility 5.

Once the five individual metric scores have been calculated, the final score 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 11 provides an example of how the final measurement area unweighted scores will be calculated.

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

Facility	<i>Acuity-Adjusted Total Nursing Hours Metric Score</i>	<i>Acuity-Adjusted Weekend Total Nursing Hours Metric Score</i>	<i>Acuity-Adjusted RN Hours Metric Score</i>	<i>Acuity-Adjusted LVN Hours Metric Score</i>	<i>Acuity-Adjusted CNA Hours Metric Score</i>	Final Points	Total Possible Points	Final Measurement Area 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 11, 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., $[19.309/30] \times 100$). 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.

Table 12 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 9.

Table 12—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	46.250%	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 8). 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 12, Facility 1 has a *Staffing Turnover* Metric rate of 46.250 percent which is less than the 50th Percentile (47.000 percent) but higher than the 62.5th Percentile (42.400 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 9. 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 NA 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 7, to derive the overall Workforce Metrics Domain score.

Table 13—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
	Unweighted Score	Measurement Area Weight	Final Weighted Score	Unweighted Score	Measurement Area Weight	Final Weighted Score	
Facility 1	64.363%	35	22.527	50.000%	15	7.500	30.027
Facility 2	57.457%	35	20.110	83.333%	15	12.500	32.610
Facility 3	26.667%	50	13.334	N/A	0	N/A	13.334
Facility 4	0.000%	50	0.000	N/A	0	N/A	0.000
Facility 5	0.000%	35	0.000	66.667%	15	10.000	10.000

As displayed in Table 13, Facility 1 receives a final Acuity-Adjusted Staffing Hour Metrics Measurement Area score of 64.363 percent, which is 35 percent of the facility's overall total score. To calculate the final measurement area score, the unweighted score of 64.363 percent for the Acuity-Adjusted Staffing Hour Metrics Measurement Area is multiplied by 35 percent to calculate a final weighted score of 22.527 and the unweighted score of 50.000 percent for the Staffing Turnover Metric Measurement Area is multiplied by 15 percent to calculate a final weighted score of 7.500. These two weighted measurement area scores are then 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 (i.e., the Acuity-Adjusted Staffing Hour Measurement Area will be worth 50 percent of the total WQIP score) and the Staffing Turnover Metric Measurement Area will not be included the final score calculation. 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. 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. 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 0 points. This is illustrated for Facility 3, Facility 4, and Facility 5 in Table 13.

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 PY1 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 2022 Care Compare data refresh. These data were limited to those facilities that were eligible to participate in the historical QASP program for SFY 2020–21 (i.e., July 1, 2020–June 30, 2021) based on the reported four quarter average score for each facility. The PY 1 benchmarks based on baseline Care Compare data for each metric is displayed in Table 14.

Table 14—MDS Clinical Metrics Measurement Area Benchmarks for PY1

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								
<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	7/1/21–6/30/22	1,030	9.554%	7.721%	6.356%	5.042%	3.676%	1.923%
<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	7/1/21–6/30/22	1,035	2.564%	1.880%	1.333%	0.926%	0.408%	0.000%

Metric	Baseline Period	Number of Facilities	25th Percentile	37.5th Percentile	50th Percentile	62.5th Percentile	75th Percentile	90th Percentile
<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	7/1/21–6/30/22	1,029	12.821%	10.000%	7.792%	5.714%	3.614%	0.709%

As discussed in the Metric Calculations section, HSAG will calculate the final rate for each facility for each metric within the MDS Clinical Metric Measurement Area. Table 15 displays the points a facility is eligible to receive based on achievement or improvement.

Table 15—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 14. Table 16 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 16—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	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	4.850%	62.5th Percentile	4
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	0.785%	62.5th Percentile	4
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	3.800%	62.5th Percentile	4
Facility 2	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	NR	Data Are Missing	N/A
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	0.300%	75th Percentile	5
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	5.740%	50th Percentile	3
Facility 3	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	NR	Data Are Missing	N/A

Facility	Metric	Current Year Rate	Achievement Benchmark	Achievement Score
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	1.500%	37.5th Percentile	2
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	NR	Data Are Missing	N/A
Facility 4	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	NR	Data Are Missing	N/A
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	NR	Data Are Missing	N/A
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	NR	Data Are Missing	N/A
Facility 5	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	NR	Data Are Missing	N/A
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	NR	Data Are Missing	N/A
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	NR	Data Are Missing	N/A

As displayed in Table 16, 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 14. 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 High-Risk Residents with Pressure Ulcers, 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 15. 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 17 provides an example of how the gap closure percentage will be calculated.

Table 17—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	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	5.645%	4.850%	1.923%	3.722	0.795	21.359%
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	0.850%	0.785%	0.000%	0.850	0.065	7.647%
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	4.250%	3.800%	3.614%	0.636	0.450	70.755%
Facility 2	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	3.990%	NR	1.923%	N/A	N/A	N/A
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	0.655%	0.300%	0.000%	0.655	0.355	54.198%
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	4.050%	5.740%	3.614%	0.436	-1.690	-387.615%
Facility 3	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	NR	NR	1.923%	N/A	N/A	N/A
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	2.230%	1.500%	0.000%	2.230	0.730	32.735%

Facility	Metric	Prior Year Rate	Current Year Rate	Gap Closure Benchmark	Gap	Improvement Value	Gap Closure Percentage
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	NR	NR	3.614%	N/A	N/A	N/A
Facility 4	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	NR	NR	1.923%	N/A	N/A	N/A
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	NR	NR	0.000%	NA	N/A	N/A
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	NR	NR	3.614%	N/A	N/A	N/A
Facility 5	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	NR	NR	1.923%	N/A	N/A	N/A
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	NR	NR	0.000%	N/A	N/A	N/A
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	NR	NR	3.614%	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 High-Risk Residents with Pressure Ulcers, 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 17, Facility 1 has a prior year rate of 5.645 percent, a current year rate of 4.850

percent, and a gap closure benchmark of 1.923 percent (i.e., the 90th percentile in Table 14) for the *Percent of High-Risk Residents with Pressure Ulcers, 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., 5.645 percent–1.923 percent = 3.722). Next the improvement value is calculated as the difference between the prior year rate and current year rate (i.e., 5.645 percent–4.850 percent = 0.795). 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., $0.795/3.722 \times 100 = 21.359$ 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.

Once the gap closure percentage is calculated, HSAG will determine the improvement score. Table 18 provides an example of how the improvement score will be calculated.

Table 18—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	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	21.359%	20% Gap Closure	2
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	7.647%	10% Gap Closure	0
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	70.755%	50% Gap Closure	5
Facility 2	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	N/A	N/A	N/A
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	54.198%	75th Percentile and 20% Gap Closure	6
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	-387.615%	No Improvement	0
Facility 3	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	N/A	N/A	N/A

Facility	Metric	Gap Closure Percentage	Improvement Threshold	Improvement Score
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	32.735%	30% Gap Closure	3
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	N/A	N/A	N/A
Facility 4	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	N/A	N/A	N/A
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	N/A	N/A	N/A
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	N/A	N/A	N/A
Facility 5	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	N/A	N/A	N/A
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	N/A	N/A	N/A
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	N/A	N/A	N/A

As shown in Table 18, Facility 1 has a 21.359 percent gap closure for the *Percent of High-Risk Residents with Pressure Ulcers, Long Stay* Metric. Based on the Improvement Thresholds in Table 15, 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 70.755 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 19 provides an example comparison of the achievement and improvement scores that will be used for WQIP.

Table 19—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	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	4	2	4
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	4	0	4
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	4	5	5
Facility 2	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	N/A	N/A	N/A
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	5	6	6
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	3	0	3
Facility 3	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	N/A	N/A	N/A
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	2	3	3
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	N/A	N/A	N/A

Facility	MDS Metrics	Achievement Score	Improvement Score	Final Raw Score
Facility 4	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	N/A	N/A	N/A
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	N/A	N/A	N/A
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	N/A	N/A	N/A
Facility 5	<i>Percent of High-Risk Residents with Pressure Ulcers, Long Stay</i>	N/A	N/A	N/A
	<i>Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay</i>	N/A	N/A	N/A
	<i>Percent of Residents Who Received an Antipsychotic Medication, Long Stay</i>	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 7, 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 20 provides examples of the final MDS clinical metrics measurement area score calculations.

Table 20—MDS Clinical Metrics Measurement Area Scoring Example

N/A indicates a value could not be determined.

Facility	Percent of High-Risk Residents with Pressure Ulcers, 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 Anti-psychotic 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 PY1. As outlined in Table 21 facilities will receive an achievement score based on how the final rate compares to the percentiles, once established, 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 Metric Calculations sections for more detail on the claims-based clinical metric calculation. The achievement score calculation mirrors the process for the MDS clinical metrics achievement score calculation. For PY1, the claims-based metrics will not be eligible for improvement points because historical data are unavailable. DHCS intends for claims-based metrics to be eligible for improvement points in future program years.

Table 21—Claims-Based Clinical Metrics Measurement Area Scoring

Points	Achievement Benchmarks
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
N/A	Data Are Missing

Please refer to Table 22 for examples of how the 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 21 includes mock data and is for illustrative purposes only. If a facility does not have a reportable rate for an claims-based clinical metric due to insufficient denominators (indicated as NA in the example table), the metric will not be assigned a score.

Table 22—Claims-Based Metrics 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	<i>Outpatient ED Visits per 1,000 Long-Stay Resident Days</i>	NR	Data Are Missing	N/A
	<i>Healthcare-Associated Infections Requiring Hospitalization</i>	NR	Data Are Missing	N/A
	<i>Potentially Preventable 30-Day Post-Discharge Readmission</i>	NR	Data Are Missing	N/A
Facility 2	<i>Outpatient ED Visits per 1,000 Long-Stay Resident Days</i>	0.750	37.5th Percentile	2
	<i>Healthcare-Associated Infections Requiring Hospitalization</i>	1.120	50th Percentile	3

Facility	Metrics	Current Year Rate	Achievement Benchmark	Achievement Points
	<i>Potentially Preventable 30-Day Post-Discharge Readmission</i>	1.150	50th Percentile	3
Facility 3	<i>Outpatient ED Visits per 1,000 Long-Stay Resident Days</i>	0.050	90th Percentile	6
	<i>Healthcare-Associated Infections Requiring Hospitalization</i>	NR	Data Are Missing	N/A
	<i>Potentially Preventable 30-Day Post-Discharge Readmission</i>	NR	Data Are Missing	N/A
Facility 4	<i>Outpatient ED Visits per 1,000 Long-Stay Resident Days</i>	1.500	Below the 25th Percentile	0
	<i>Healthcare-Associated Infections Requiring Hospitalization</i>	1.333	37.5th Percentile	2
	<i>Potentially Preventable 30-Day Post-Discharge Readmission</i>	NR	Data Are Missing	N/A
Facility 5	<i>Outpatient ED Visits per 1,000 Long-Stay Resident Days</i>	NR	Data Are Missing	N/A
	<i>Healthcare-Associated Infections Requiring Hospitalization</i>	NR	Data Are Missing	N/A
	<i>Potentially Preventable 30-Day Post-Discharge Readmission</i>	NR	Data Are Missing	N/A

Table 23 combines the previous examples to illustrate the final Claims-Based Clinical Metrics Measurement Area score calculations.

Table 23—Claims-Based Metrics Measurement Area Scoring Example

N/A indicates a value could not be determined.

Facility	<i>Outpatient ED Visits per 1,000 Long-Stay Resident Days</i> Metric Score	<i>Healthcare-Associated Infections Requiring Hospitalization</i> Metric Score	<i>Potentially Preventable 30-Day Post-Discharge Readmission</i> 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 5	N/A	N/A	N/A	0	0	N/A

As displayed in Table 23, 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 7, 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 Metric Domain Score

Once the unweighted scores 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 7, 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 24.

Table 24—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	20	N/A	N/A	20	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 24. 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 24 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 PY1.

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 Metric 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 25 for the *Medi-Cal Disproportionate Share* Metric peer group assignments.

Table 25—Medi-Cal Disproportionate Share Metric Peer Groups

Peer Group	County/Region
Group 1	LA Region 1, Pasadena
Group 2	Alameda, Berkeley, San Francisco
Group 3	Contra Costa, El Dorado, Lassen, Marin, Monterey, Napa, Nevada, San Mateo, Shasta, Siskiyou, Sonoma
Group 4	Amador, Butte, Humboldt, Placer, Santa Clara, Santa Cruz, Sutter
Group 5	Calaveras, Mendocino, Sacramento, Santa Barbara, Solano, Ventura
Group 6	Inyo, Orange, San Luis Obispo, Tuolumne, Yolo, Yuba
Group 7	San Diego, San Joaquin, Stanislaus
Group 8	Riverside, San Bernardino
Group 9	Colusa, Del Norte, Fresno, Imperial, Kern, Kings, Lake, Madera, Merced, Tehama, Tulare
Group 10	LA Region 2
Group 11	Long Beach, LA Region 3

HSAG will then use the facility-level Medi-Cal share rates for PY1 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 26 provides an example of the percentile distributions for three of the peer groups.

Table 26—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 27.

Table 27—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 28 for an example of how the Medi-Cal Disproportionate Share Metric Measurement Area will be scored for illustrative purposes only.

Table 28—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 27, 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 28 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 historical MDS data to assess the overall completeness of the race and ethnicity fields for facilities that were eligible to

participate in the historical QASP program for SFY 2020–21 (i.e., July 1, 2020–June 30, 2021). Based on the average completeness rate (i.e., benchmark statistic), DHCS determined the performance target for this measure, as noted in Table 29.

Table 29—MDS Racial and Ethnic Data Completeness Metric Measurement Area Performance Target for PY1

Metric	Baseline Period	Benchmark Statistic	Performance Target
<i>MDS Racial and Ethnic Data Completeness</i>	7/1/19–6/30/22	95.960%	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 Metric Calculations section). Facilities with a data completeness rate of 90 percent or more will be eligible to receive points as outlined in Table 30.

Table 30—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 31 provides an example of how the MDS Racial and Ethnic Data Completeness Metric Measurement Area will be scored.

Table 31—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%). 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 31.

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 7, 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 32 provides an example of the Equity Metrics Domain final scoring.

Table 32—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 33 provides an example of the final score calculations for the example facilities used throughout the WQIP Scoring section.

Table 33—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	32.610	8.889	5.400	46.899
Facility 3	13.334	25.000	6.900	45.234

Facility	Workforce Metrics Domain Score	Clinical Metrics Domain Score	Equity Metrics Domain Score	Final WQIP Score
Facility 4	0.000	6.667	0.000	6.6670
Facility 5	10.000	0.000	5.600	15.600

Payment Calculations

For PY1, \$280 million is budgeted for WQIP payments. These funds are not pooled and are at-risk based on utilization. DHCS will establish a baseline, uniform per diem rate by dividing \$280 million by the projected number of WQIP-eligible days. For WQIP, days attributed to a special treatment program will not be included for the purposes of payment calculations. DHCS will direct MCPs to make payments to the facilities on a per diem basis based on the facility’s WQIP score.

Linear Curve Application

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

- » Calculate the total number of WQIP-eligible days for each facility obtained from the reported MCBBD Data. For payment calculations, the only bed days which shall count are managed care network provider contracted bed days where Medi-Cal is the primary payor.
- » Calculate a weighted WQIP score for each facility by multiplying the facility’s overall score by the facility’s WQIP-eligible days.
- » Calculate a weighted average WQIP score using the following logic:
 - » Weighted numerator: Sum the weighted WQIP scores for each facility
 - » Weighted denominator: Sum the WQIP eligible days for each facility
 - » Divide the weighted numerator by the weighted denominator to get the weighted average WQIP score.
- » Calculate a curve factor by dividing 100 by the weighted average WQIP score. A maximum possible curve factor was set based on an expected weighted average WQIP score of 35 percent; therefore, the maximum curve factor for PY1 is approximately 2.86 (i.e., 100/35). The curve factor cannot exceed this maximum

curve factor (i.e., if the curve factor is greater than approximately 2.86 then it will be reduced to approximately 2.86). Please note that the maximum possible curve factor was rounded to 2.86 in this document for display purposes; however, the calculations will be based on unrounded numbers.

- » 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: The curved WQIP scores may exceed 100 percent.

Table 34 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 PY1.

Table 34—Curve Factor Calculation Example

Facility	Final Score	WQIP Eligible 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	5,000	320,575.0	736,227.5	22,750	32.362	3.09
Facility 2	46.899	3,500	164,146.5	736,227.5	22,750	32.362	3.09
Facility 3	45.234	4,000	180,936.0	736,227.5	22,750	32.362	3.09
Facility 4	6.6670	10,000	66,670.0	736,227.5	22,750	32.362	3.09
Facility 5	15.600	250	3,900.0	736,227.5	22,750	32.362	3.09

Table 35 displays an example of how the final raw curve factor will be applied to calculate the final curved WQIP score. 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 35—Final WQIP Curve Factor Calculation Example

Facility	Final Score	Final Curve Factor	Final Curved WQIP Score
Facility 1	64.115	2.86	183.186%
Facility 2	46.899	2.86	133.997%
Facility 3	45.234	2.86	129.240%
Facility 4	6.6670	2.86	19.049%
Facility 5	15.600	2.86	44.571%

Once the curved WQIP score is calculated, HSAG will calculate the final WQIP payments using the following equation:

$$WQIP \text{ Eligible Days} \times \text{Curved WQIP Score} \times \text{Uniform Per Diem Rate}$$

Table 36 provides an example of how the final payment will be calculated using the curved WQIP score, the number of WQIP eligible days, and the uniform per diem rate.

Table 36—Payment Calculation Example

Facility	Final Curved WQIP Score	WQIP Eligible Days (MCBDs)	Uniform Per Diem Rate	Calculated Payment
Facility 1	183.186%	5,000	1,500	\$13,738,950
Facility 2	133.997%	3,500	1,500	\$7,034,843
Facility 3	129.240%	4,000	1,500	\$7,754,400
Facility 4	19.049%	10,000	1,500	\$2,857,350
Facility 5	44.571%	250	1,500	\$167,141

A/AA Citations

Once the curved WQIP score and the WQIP payment amount have been calculated, DHCS will adjust payments for facilities that received A or AA citations that occurred during the PY. DHCS will disqualify facilities from the WQIP payment that have one or more AA citation and will apply a 40 percent penalty to facilities' WQIP payments that have one or more A citation. 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 recoup and withhold WQIP payments until all appeals are exhausted. 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 37 provides an example of how citations will affect the final WQIP payment.

Table 37—A/AA Citation Application Example

Facility	Calculated Payment	Citation	Final Adjusted Payment
Facility 1	\$13,738,950	A	\$8,243,370
Facility 2	\$7,034,843	None	\$7,034,843
Facility 3	\$7,754,400	None	\$7,754,400
Facility 4	\$2,857,350	AA	\$0
Facility 5	\$167,141	None	\$167,141

APPENDIX A: CLINICAL METRICS DOMAIN

METRIC SPECIFICATIONS

MDS Clinical Metrics Measurement Area

Percent of High-Risk Residents with Pressure Ulcers, Long Stay (NQF #0679)

The *Percent of High-Risk Residents with Pressure Ulcers* measure is defined as the percentage of long-stay, high-risk residents with Stage II-IV or unstageable pressure ulcers. 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 that meet the following criteria:

- » Stage II-IV or unstageable pressure ulcers are present, as indicated by any of the following:
 - The presence of stage II pressure ulcers (M0300B1 = [1,2,3,4,5,6,7,8, or 9])
 - The presence of stage III pressure ulcers (M0300C1 = [1,2,3,4,5,6,7,8, or 9])
 - The presence of stage IV pressure ulcers (M0300D1 = [1,2,3,4,5,6,7,8, or 9])
 - The presence of unstageable pressure ulcers (M0300E1 = [1,2,3,4,5,6,7,8, or 9] or M0300F1 = [1,2,3,4,5,6,7,8, or 9] or M0300G1 = [1,2,3,4,5,6,7,8, or 9])

The denominator criteria for this measure include long-stay residents with a target assessment defined as high risk except those with exclusions. Residents are defined as “High-risk” if they meet any of the following criteria:

- » Impaired bed mobility or transfer indicated, by either or both of the following:
 - Bed mobility, which includes moving to and from the lying position and turning side to side, requires staff assistance (G0110A1 = [3,4,7,8]).
 - Transfers, or moving from bed to chair to wheelchair, requires staff assistance (G0110B1 = [3, 4, 7, 8]).
- » The resident is in a persistent vegetative state with no discernible consciousness (B0100 = [1]).
- » The resident exhibits protein calorie malnutrition or is at risk for malnutrition (I5600 = [1]).

The following exclusions apply:

- » The target assessment is either for an admission (A0310A = [01]) or a PPS 5-Day assessment (A0310B = [01]).
- » The target assessment does not meet the numerator criteria, and a missing value is entered when indicating the number of Stage II-IV or unstageable pressure ulcers on the target assessment (M0300B1 = [-], M0300C1 = [-], M0300D1 = [-], M0300E1 = [-], M0300F1 = [-], M0300G1 = [-]).

Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay (NQF #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:

- » N0410A = [1,2,3,4,5,6,7].

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 N0410A = [-].
- » 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.¹⁷

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

¹⁷ CMS. Nursing Home Compare Claims-Based Quality Measure Technical Specifications. 2019. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/Nursing-Home-Compare-Claims-based-Measures-Technical-Specifications-April-2019.pdf>.

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:

- » The resident was not enrolled in the MCP during any portion of the stay (i.e., between admission and discharge or the end of the target period [whichever is earlier]).
- » The resident was enrolled in Medicare managed care during any portion of the stay.
- » 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.¹⁸

Data Sources

Medicare FFS Part A claims, Medicare eligibility files as well as Medi-Cal claims and eligibility files.

Denominator

The eligible population includes Medicare Part A FFS as well as Medi-Cal members and those who are dually eligible for both Medicare and Medi-Cal. Eligible SNF stays are those that overlap with the measurement period (i.e., the admission date is prior to December 28, 2023 and the discharge date is later than January 1, 2023). 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 with the MCP from 30 days prior to the acute inpatient admission date for the HAI (or through December 31st of the measurement year if the SNF stay is still active). There are no allowable gaps during the continuous enrollment period.
- » 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.

¹⁸ 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: Mar 11, 2024.

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, 2023 and before (not including) December 29, 2023. The acute inpatient hospitalization must occur during the period 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.¹⁹

Data Sources

Medicare FFS Part A claims, Medicare eligibility files as well as Medi-Cal claims and eligibility files.

Denominator

The denominator includes all eligible SNF stays with an admission date on or after January 1, 2023 and with a discharge date on or before December 1, 2023 for Medi-Cal and dually eligible residents 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.

¹⁹ 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: Mar 11, 2024.

- » 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.
- » Residents who did not have a short-term acute-care stay within 30 days prior to a SNF admission date.
- » Residents discharged against medical advice (AMA) identified by a discharge status code of "07" on the SNF discharge claim.
- » Residents from 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.