West Virginia Case Mix Reimbursement System

Frequently Asked Questions

Note: This FAQ may not answer every question possible about the WV Case Mix Reimbursement system after 10/1/24. Please contact WVNF@mslc.com for any rate related questions, or wvproviderenrollment@gainwelltechnologies.com for any billing questions.

This document will continue be updated over time for any additional questions that are frequently asked.

Contents

General Questions

1. **Q: When will the new rate methodology be implemented?**

   A: PDPM Reimbursement methodology will be effective for rates October 1, 2024.

2. **Q: How often will rates be issued?**

   A: The rates will be issued semi-annually, at July 1 and January 1.

3. **Q: How will the reimbursement rates be sent to the providers?**

   A: The reimbursement rates will be sent to providers via physical mail. As the system transitions to the new rate methodology, providers can opt to go paperless. Additional information will be mailed to the providers regarding this option in the future.

4. **Q: Are there training materials available to assist with the new rate methodology?**

   A: Yes, there are pre-recorded narrated webinars that offer information on a variety of topics related to the new reimbursement methodology on the WV LTC site, including example calculations: https://dhhr.wv.gov/bms/Provider/LTC/Pages/default.aspx

   This information is available for you to review at your convenience.

Cost Reports

1. **Q: Will we be required to submit 6-month cost reports moving forward?**

   A: No, starting with calendar year 2024 (1/1/2024 – 12/31/2024) cost report filings will be for 12 month periods ending December 31.

2. **Q: Will the state use a cost report more recent than 2022 to set the initial 10/1/24 rate?**

   A: No, 12/31/2022 cost report period information will be utilized for the 10/1/2024 PDPM reimbursement rates. These cost reports will continue to be the base period information used for reimbursement purposes until the next reimbursement system rebase period (no more than 2 years after the 10/1/2024 implementation period). The base RUG rate utilized for the phase-in will utilize rates set on 6/30/2023 cost reporting data (10/1/2023 rates).

Rate Components

Note: Example rate calculations can be found in pre-recorded trainings here: https://dhhr.wv.gov/bms/Provider/LTC/Pages/default.aspx

Direct Care Component

1. **Q: What happens if the actual spending for direct care is less than the spending floor requirement?**

   A: The West Virginia reimbursement system has a built in mechanism to reduce a provider's reimbursement rate if the provider's base year direct care spending does not exceed the calculated spending floor threshold. Should this scenario occur, the direct care peer group price utilized for the provider's rate will be reduced by the difference between the spending floor requirement per diem and the individual facility's direct care spending per day.

2. **Q: What are the direct care cost component expenses?**

   A: The direct care departmental cost centers include:

   - Registered Nurses
   - Licensed Practical Nurses
   - Nurse Aides
   - Restorative
   - Contracted Nurses

3. **Q: Is the direct care per diem case-mix adjusted prior to billing?**

   A: No, case-mix adjustments for the Medicaid claim acuity will continue to occur at the claim level, and is resident specific. See "Payment and Billing Procedures" on the State's website for further details around billing: https://dhhr.wv.gov/bms/Provider/LTC/Pages/default.aspx

Care Related Component

1. **Q: What are the care related cost component expenses?**

   A: The care related cost centers include:

   - Director of Nursing
   - Supplies
   - Non-prescription drugs
   - Oxygen
   - Other nursing
   - Therapy
   - Medical Records
   - Activities

2. **Q: What happens if the actual spending for care related is less than the spending floor requirement?**

   A: The West Virginia reimbursement system has a built in mechanism to reduce a provider's reimbursement rate if the provider's base year care related spending does not exceed the calculated spending floor threshold. Should this scenario occur, the providers total care related reimbursement

rate will be reduced by the difference between the spending floor requirement per diem and the individual facility's care related spending per day.

Operational Component

1. **Q: What are the operational cost component expenses?**

   A: The care related cost centers include:

   - Dietary
   - Laundry and housekeeping
   - Administration
   - Maintenance

2. **Q: What happens if the actual spending for operations is less than the spending floor requirement?**

   A: The West Virginia reimbursement system has a built in mechanism to reduce a provider's reimbursement rate if the provider's base year operational spending does not exceed the calculated spending floor threshold. Should this scenario occur, the providers total operational reimbursement rate will be reduced by the difference between the spending floor requirement per diem and the individual facility's operational spending per day.

Capital Component (SAV)

1. **Q: When is my next appraisal?**

   A: Appraisals are not currently taking place. In lieu of ongoing appraisals, capital component data will be inflated annually each July 1, until such time as modifications to the capital component have been discussed and agreed-upon.

Pass-Through Component

1. **Q: What are the pass-through component expenses?**

   A: The pass-through cost centers include:

   - Utilities
   - Taxes and insurance

Liability Insurance Component

1. **Q: What are the liability insurance component expenses?**

   A: The liability insurance cost centers include:

   - Liability Insurance

Quality Incentive Payment Per Diem

1. **Q: Where can I find details about the Quality rate component calculation?**

   A: The "Quality Scoring Metrics and Special Population Determination" document on the State's website contains all details surrounding the Quality per diem calculation, including the quality score, time period utilized, and what data points are considered for the special population component.

   https://dhhr.wv.gov/bms/Provider/LTC/Pages/default.aspx

2. **Q: What time period of data is utilized for the Quality Metrics?**

   A: Semi-annual rate updates for the quality metrics will use care compare data released by CMS (https://data.cms.gov/provider-data/) at the time of rate calculation. This will generally be the four quarters ending one period in arrears from the date of the data refresh by CMS.

   - The data used in the semi-annual rate updates will always be the most recent update from CMS' Care Compare Datasets at the time the rate calculation is performed, however, should CMS change measurement periods or methodologies due to unforeseen complications, they will be addressed in the Technical Users' Guide: https://data.cms.gov/provider-data/topics/nursing-homes/technical-details
     - Generally, for the July rates this should be the April CMS Care Compare Dataset, and for January rates, this should be the October Care Compare Dataset.
     - For the October 1, 2024 rates, this should be the July 2024 Care Compare Dataset.

3. **Q: How are scores established for the Quality Metrics?**

   A: Providers will receive a score for each of the identified quality measures by comparing data from the applicable care compare dataset refresh against the benchmarks established in the "Quality Scoring Metrics and Special Population Determination" file on the State's website: https://dhhr.wv.gov/bms/Provider/LTC/Pages/default.aspx

   These benchmarks were established based on statewide averages and performance measures from Q1 and Q2 calendar year 2023.

4. **Q: How is the Quality Metric per diem calculated?**

   A: The Quality Metric (Measure) per diem is calculated as follows:

   - The facility's percentage of the projected annual payment pool
     - Quality score adjusted Medicaid days / Total statewide quality adjusted Medicaid days
       - Quality adjusted Medicaid days
         - Facility's semi-annual quality score / 100 points possible multiplied by Medicaid days
         - Medicaid days from the most recently reviewed cost report at the time of payment calculation or Medicaid days from the state MMIS data at the discretion of the State.

- For new providers, should no days be available at the time of calculation, the Medicaid days shall be set at the statewide average occupancy percentage, as of the date of the calculation, of the available bed days for one calendar year.
- Multiplied by the total projected annual quality measures payment pool

5. Q: What time period of data is utilized for the Special Population determination?

A: Semi-annual rate updates for special populations will utilize the most recent two quarters of MDS data available at the time of rate calculation. This should generally be the two quarters ending one period in arrears from the rate calculation.

- Generally, for the July rates this should be Q4 of the year prior and Q1 of the current year, and for January rates, this should be Q2/Q3 of the calendar year immediately prior.
- For the October 1, 2024 rates, this should be the Q1/Q2 calendar year 2024 MDS data.

6. Q: How is the Special Populations per diem calculated?

A: The Special Populations per diem is calculated as follows:

- The facility's allocation of the projected annual payment pool
    - Semi-Annual Special Population adjusted Medicaid days / Total statewide Semi-Annual Special Population adjusted Medicaid days
        - Special Population Adjusted Medicaid Days
            - Number of Qualifying Medicaid Assessments / Total Statewide Number of Qualifying Medicaid Assessments from the same period multiplied by Medicaid days
            - Medicaid days shall come from the most recently reviewed cost report at the time of payment calculation or Medicaid days from the state MMIS data at the discretion of the State.
            - For new providers, should no days be available at the time of calculation, the Medicaid days shall be set at the statewide average occupancy percentage, as of the date of the calculation, of the available bed days for one calendar year.
- Multiplied by the total projected annual special populations payment pool

Phase-In Adjustment

Note: Example rate calculations can be found in pre-recorded trainings here: https://dhhr.wv.gov/bms/Provider/LTC/Pages/default.aspx

1. Q: What does the phase-in adjustment do?

A: For rate setting periods from October 1, 2024 to June 30, 2027, a phase-in of provider reimbursement rates will occur. The phase-in adjustment will be established in an effort to ease the transition for providers to the new PDPM reimbursement methodology. The phase-in adjustment

will utilize a blended approach that will take a certain percentage of the imputed previous reimbursement rate and the remainder will be the imputed PDPM reimbursement rate, in order to ease providers into the new reimbursement methodology.

2. **Q: How is the prior system rate calculated on the new Case-Mix Reimbursement rate sheets?**

   A: Based on reimbursement rates in effect on October 1, 2023.

   - October 1, 2024 Rate
   - MULTIPLY: Index factor (12/31/2022 – 6/30/2024, and interim from midpoint of the base year to the midpoint of the rate year)
   - MULTIPLY: The inflated Nursing per diem by the Medicaid billed CMI information from 1/1/2023 – 6/30/2023.
   - ADD: Imputed Inflated Nursing per diem and Inflated Fixed per diem
   - MULTIPLY: By 100.940% for the phase-in adjustment factor
   - EQUALS: Total rate year base reimbursement rate

3. **Q: What time period is utilized for the imputed PDPM rate utilized in the phase-in adjustment calculation?**

   A: The most recent semi-annual period, as of the date of the rate calculation, of Medicaid billed CMI information will be utilized. If Medicaid billed CMI information is not available, the most recent semi-annual MDS assessment information will be utilized in its place.

Change of Ownership (CHOW)

1. **Q: If I go through a change of ownership after October 1, 2024, will I still have the option for a provisional rate?**

   A: No, effective October 1, 2024, all providers going through a change of ownership will step into the shoes of the prior owner.

Minimum Data Set (MDS)/Case Mix Index (CMI)

1. **Q: What component(s) of PDPM will be utilized for the total facility CMI (used in normalizing the direct care per diem) and the Medicaid CMI billed at the claim level?**

   A: Only the nursing component of PDPM will be utilized for any CMI value considered in rate setting.

2. **Q: What is the nursing component of PDPM?**

   A: The nursing component of PDPM is the third character of the Health Insurance Prospective Payment System (HIPPS) code and aims to capture the acuity of the resident based on their nursing needs.

3. **Q: What CMI values will be utilized for rate setting, and will the change when CMS changes values?**

   A: The system will utilize the CMI values published by CMS effective October 1, 2023. No changes to these weights will be made unless otherwise notified, and all changes will be made at the same time as a system rebase to ensure consistency through the system. The CMI values can be found in the "Patient-Driven Payment Model (PDPM) Case Mix" file on the State's website: https://dhhr.wv.gov/bms/Provider/LTC/Pages/default.aspx

4. **Q: Do we need to continue completing the Optional State Assessment (OSA) after October 1, 2024?**

   A: No. The OSA does not need to be completed for any assessment after October 1, 2024.

5. **Q: Do we need to complete new assessments to bill for PDPM after October 1, 2024?**

   A: No, a new assessment is not required. You will follow normal RAI requirements for assessment completion. PDPM data exists for assessments prior to 10/1 and will be utilized for billing where appropriate.

Billing

6. **Q: Will case mix adjustments continue to occur when I bill each claim, or will they already be in the reimbursement rate?**

   A: Case Mix adjustments will continue to be applied when you bill a claim.

7. **Q: Is there billing guidance available that can be reviewed?**

   A: Yes, it is available for download and review here: https://dhhr.wv.gov/bms/Provider/LTC/Pages/default.aspx

8. **Q: Who can I contact for additional billing questions?**

   A: You can contact Gainwell at 888-483-0793 or 304-348-3360 Monday through Friday from 8 AM – 7 PM ET. You may also reach out via email to Gainwell at wvproviderenrollment@gainwelltechnologies.com.