Quality Scoring Metrics and Special Population Determination
Effective October 1, 2024

Summary of Updates:

- None. System is new at 10/1/2024.

Quality Scoring Metrics:

(1) Quality outcome measures shall reflect those aspects of the delivery of NF services determined in consultation with industry stakeholders, to most impact the day-to-day experience of care for NF residents, as follows:

a. Each quality measure shall be valued at twenty (25) of the one hundred (100) possiblequality performance points.

i. Percentage of long-stay residents with a catheter inserted and left in their bladder among patients consistent with the methodology described in the CMS Five Star Nursing Home Quality Rating System.
ii. Percentage of long-stay residents with a urinary tract infection among patients consistent with the methodology described in the CMS Five Star Nursing Home Quality Rating System.
iii. Percentage of long-stay residents who received an antipsychotic medication among patients consistent with the methodology described in the CMS Five Star Nursing Home Quality Rating System.
iv. Percentage of long-stay residents who have depressive symptoms among patients consistent with the methodology described in the CMS Five Star Nursing Home Quality Rating System.

b. Note: Adjusted total Nurse Staffing Hours Per Resident and Percentage of high risk long-stay residents with pressure ulcers are measures included in the scorecard for informational purposes beginning October 1, 2024, and may be considered for future scoring metrics.

c. Performance benchmarks for each of the Clinical Performance measures were established based on statewide average performance measures in Q1 and Q2 2023. Individual facility scores shall be compared to the cut scores below as follows:

Percentage of long-stay residents with a catheter inserted and left in their bladder		
Tier	***Cut Score*** *(provider must score equal to or less than)*	***Points***
5	0.33%	25.00
4	0.88%	20.00
3	2.00%	15.00
2	4.51%	10.00
1	>4.51%	5.00

Percentage of long-stay residents with a urinary tract infection		
Tier	***Cut Score*** *(provider must score equal to or less than)*	***Points***
5	1.64%	25.00
4	2.77%	20.00
3	5.00%	15.00
2	7.00%	10.00
1	>7.00%	5.00

Percentage of long-stay residents who received an antipsychotic medication		
Tier	***Cut Score*** *(provider must score equal to or less than)*	***Points***
5	7.97%	25.00
4	11.98%	20.00
3	19.00%	15.00
2	27.00%	10.00
1	>27.00%	5.00

Percentage of long-stay residents who have depressive symptoms		
Tier	***Cut Score*** *(provider must score equal to or less than)*	***Points***
5	0.00%	25.00
4	1.50%	20.00
3	5.00%	15.00
2	13.50%	10.00
1	>13.50%	5.00

(2) A NFs quality incentive program score is based on the point structure previously described in this rule. Should there be any blanks in data, or should a provider not be found in the Care Compare datasets, the facility will be assigned to Tier 3 for the applicable measure(s).

Special Population Determination:

(1) Nursing facilities are eligible for an add-on for each unique resident residing in the facility in the semi-annual period of MDS data most recently available at the time of rate setting for whom West Virginia Department of Human Services, Bureau for Medical Services is the primary payer and who was coded as 1, 2 or 3 on one or more of the following Minimum

Data Set 3.0 (MDS 3.0) indicators:

a. Behavioral Health (E0200A, E0200B, or E0200C);
b. Rejection of Care (E0800) or;
c. Wandering (E0900).

Data Sources Used:

(1) 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.
b. 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
    i. 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.
    ii. For the October 1, 2024 rates, this should be the July 2024 Care Compare Dataset.

(2) Special Population:

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.
    i. 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 year immediately prior.
    ii. For the October 1, 2024 rates, this should be the Q1/Q2 2024 MDS data.

Quality Per Diem Calculation:

1. Quality: Facilities are eligible for quality based reimbursement via a per diem in the reimbursement rate. The total combined projected pool of dollars for quality shall start at a total pool of $60,000,000. On an annual basis this pool shall be inflated using the most recently published Skilled Nursing Facility without Capital Market Basket Index published by IHS Markit or a comparable index, if this index ceases to be produced. The inflation factor, once set for a given rate period, is not adjusted as it represents what is a reasonable expectation for cost increases. The inflation factor will be applied from the mid-point of the prior state fiscal year rate period, to the mid-point of the state fiscal year rate period. This annual pool of dollars will then be split between the Quality Scoring Metrics and the Special Populations as shown below, with scores and related per-diems updated semi-annually:

Component	Percent of Quality/Special Populations Budget
Quality Scoring Metrics	90.00%
Special Populations	10.00%

    a. Quality Measure Reimbursement: Quality outcome measures and associated measure cut points shall be established and contained in the policy document, "Quality Scoring Metrics and Special Population Determination". These measures shall be weighted out of 100 total available points per facility per semi-annual rate period. Changes to the "Quality Scoring Metrics and Special Population Determination" document shall be determined by the State. These changes shall be published to the State website.
    Quality scores shall be calculated each semi-annual rate period using the most recently available source data information available for the quality measures calculated in accordance with the published policy document "Quality Scoring Metrics and Special

Population Determination".

b. Special Populations Reimbursement: The rate component is meant to offset additional costs associated with certain members with behavioral conditions as established and contained in the policy document, "Quality Scoring Metrics and Special Population Determination". Changes to the "Quality Scoring Metrics and Special Population Determination" document shall be determined by the State. These changes shall be published to the State's website.
c. The rate component will based on the most recently available semiannual MDS assessment data prior to each semi-annual rate calculation and paid claims from the same time period.
d. These payments will be calculated as follows:
    i. Quality Measure Reimbursement:
        1. The facility's percentage of the projected annual payment pool
            a. Quality score adjusted Medicaid days / Total statewide quality adjusted Medicaid days
                i. Quality adjusted Medicaid days
                    1. Facility's semi-annual quality score / 100 points possible multiplied by Medicaid days
                    2. 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.
                    3. 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.
        2. Multiplied by the total projected annual quality measures payment pool
    ii. Special Populations Reimbursement
        1. The facility's allocation of the projected annual payment pool
            a. Semi-Annual Special Population adjusted Medicaid days / Total statewide Semi-Annual Special Population adjusted Medicaid days
                i. Special Population Adjusted Medicaid Days
                    1. Number of Qualifying Medicaid Assessments / Total Statewide Number of Qualifying Medicaid Assessments from the same period multiplied by Medicaid days
                    2. 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.
                    3. 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.
        2. Multiplied by the total projected annual special populations payment pool
    iii. Per Diem Determination: The total semi-annual quality per diem is calculated by summing the quality measure allocation, and the allocation of the special population's reimbursement. This amount will then be divided by total annualized Medicaid days from the most recently reviewed cost report available at the time of rate determination to set the semi-annual quality per diem.