TO: Health and Human Services Commission
Executive Council

DATE: December 6, 2018

FROM: Victoria Grady, Financial Services Division

AGENDA ITEM: 2.s

SUBJECT: Quality Incentive Payment Program (QIPP) for Nursing Facilities

BACKGROUND: ☒ Federal ☐ Legislative ☒ Other: Program Initiative

The Texas Health and Human Services Commission (HHSC) proposes an amendment to §353.1303, concerning Quality Incentive Payment Program for Nursing Facilities before September 1, 2019, new §353.1302, concerning Quality Incentive Payment Program for Nursing Facilities on or after September 1, 2019, and new §353.1304, concerning Quality Metrics for the Quality Incentive Payment Program for Nursing Facilities on or after September 1, 2019.

In order to continue incentivizing Nursing Facilities (NFs) to improve quality and innovation in the provision of NF services in Year 3 of the program (i.e., September 1, 2019, through August 31, 2020) and beyond, HHSC is proposing new quality metrics, eligibility requirements, and financing components for the program.

ISSUES AND ALTERNATIVES:

HHSC must receive annual approval from CMS in order to continue the QIPP. With approval of the QIPP for Year 2, CMS encouraged HHSC to modify and enhance the quality measures in future program years. HHSC was also encouraged by stakeholders to expand the program to allow more Medicaid NF clients to benefit.

STAKEHOLDER INVOLVEMENT:

During the months of June, July, and August 2018, HHSC convened a workgroup of industry stakeholders to assist in the program redesign. At the conclusion of the workgroup meetings, the proposed rule amendments and new rules were shared with the workgroup. Comments received from the workgroup were reviewed by HHSC staff and taken into consideration. Workgroup participants included representatives of private and public nursing facility owners and operators, nursing facility industry groups,

nursing facility client advocates, and representatives from managed care organizations.

FISCAL IMPACT:

☒ None

SERVICES IMPACT STATEMENT:

The proposed rules will benefit HHSC's Medicaid clients because the QIPP incentives are paid to providers who improve the quality of care in their nursing facilities.

RULE DEVELOPMENT SCHEDULE:

October 12, 2018	Publish proposed rules in *Texas Register*
November 8, 2018	Present to the Medical Care Advisory Committee
December 6, 2018	Present to HHSC Executive Council
December 2018	Publish adopted rules in *Texas Register*
January 2019	Effective date

PROPOSED PREAMBLE

The Texas Health and Human Services Commission (HHSC) proposes an amendment to §353.1303, concerning Quality Incentive Payment Program for Nursing Facilities before September 1, 2019, new §353.1302, concerning Quality Incentive Payment Program for Nursing Facilities on or after September 1, 2019, and new §353.1304, concerning Quality Metrics for the Quality Incentive Payment Program for Nursing Facilities on or after September 1, 2019.

BACKGROUND AND PURPOSE

In order to continue incentivizing Nursing Facilities (NFs) to improve quality and innovation in the provision of NF services, HHSC is proposing new quality metrics, eligibility requirements, and financing components for the Quality Incentive Payment Program for Nursing Facilities (QIPP) to begin in program year 3 (i.e., September 1, 2019, through August 31, 2020).

The QIPP is a type of Medicaid managed care delivery system and provider payment initiative, or directed payment program. Such programs require annual approval from the Centers for Medicare & Medicaid Services (CMS). In April of 2017, CMS approved the QIPP for implementation on September 1, 2017, and HHSC adopted Texas Administrative Code §353.1301 and §353.1303 to govern the program. The QIPP is now in its second year, which began on September 1, 2018.

While still a very young program, HHSC heard stakeholder calls to expand the QIPP to allow more Medicaid NF clients to benefit. HHSC also received feedback from CMS when it approved year 2 of the program that the QIPP quality measures should be modified and enhanced in future program years.

With these goals in mind, HHSC convened a series of workgroup meetings during June, July, and August 2018. The workgroup included private and public nursing facility owners and operators, managed care organizations (MCOs), and advocacy groups representing NF providers and NF clients. The proposed rules emerged from these workgroup meetings.

Existing §353.1301 is not being amended at this time. Existing §353.1303 will be modified to make it applicable to the program's operation before September 1, 2019. Proposed new §353.1302 and §353.1304 will apply to the program's operation beginning on September 1, 2019. A description of the conceptual framework of the redesigned program is as follows:

Eligibility

QIPP is open to two classes of NFs: non-state government-owned NFs and privately-owned NFs. Eligibility for non-state government-owned NFs is being expanded beyond NFs that are located in the same Regional Healthcare Partnership (RHP) as, or within 150 miles of, the non-state governmental entity taking ownership of the facility. Eligibility can now be demonstrated by ownership of the NF by the non-state governmental entity for no less than four years prior to the first day of the eligibility period, or by certification in connection with the enrollment application that the NF can demonstrate an active partnership between the NF and the non-state governmental entity that owns the NF. Criteria that demonstrate an active partnership between the NF and the non-state governmental entity that owns the NF are Monthly meetings (in-person or virtual) with NF administrative staff to review the NF's clinical and quality operations and identify areas for improvement, quarterly joint trainings on topics and trends in nursing home care best practices or on needed areas of improvement, and annual, on-site inspections of the NF by a non-state governmental entity-sponsored Quality Assurance team.

The eligibility criteria for private NFs is also being expanded, and the percentage of Medicaid NF days of service that a private NF must meet or exceed to participate in the QIPP is being set at 65 percent of historical Medicaid NF days of service provided under fee for service (FFS) and managed care compared to the NF's total days of service. Previously, the NF needed to have a percentage of Medicaid NF days of service greater than or equal to "the private NF QIPP eligibility cut-off point," which was equal to the mean percentage of historical Medicaid NF days of service provided under FFS and managed care by all private NFs plus one standard deviation, as determined by HHSC.

Capitation Rate Structure

QIPP dollars will be limited by 1115 waiver budget-neutrality capacity and the amount of intergovernmental transfer (IGT) funds available for the program. The non-federal share of all QIPP payments is funded through IGTs from sponsoring non-state governmental entities. No general revenue is available to support QIPP. The MCOs' distribution of QIPP funds to the enrolled NFs will be based on each NF's performance on a set of defined quality metrics. QIPP IGTs for a specific capitation rate period will be due to HHSC approximately three months prior to the beginning of the rate period to allow HHSC's actuaries certainty as to the amount of funding to be incorporated into the capitation rates for QIPP. The amount of the capitation

will be determined by the amount of the non-federal share available for the program.

QIPP funds will be paid through four components of the STAR+PLUS NF managed care per member per month (PMPM) capitation rates. Each component's value will be determined as a percentage of the amount of funding available for the QIPP program.

Capitation Rate Components

- Component One will have a total value equal to 110 percent of the non-federal share of the QIPP program. The interim allocation of funds across qualifying non-state government-owned NFs will be based on historical Medicaid days of NF service. Monthly payment to non-state government-owned NFs will be triggered by the NF's submission of a form to HHSC in which it attests that it convened a Quality Assurance Performance Improvement (QAPI) meeting. Private NFs are not eligible for payments from Component One. The interim allocation of funds across qualifying non-state government-owned NFs will be reconciled to the actual distribution of Medicaid NF days of service across these NFs during the eligibility period as captured by HHSC's Medicaid contractors for fee-for-service and managed care 180 days after the last day of the eligibility period. This reconciliation will only be performed if the weighted average (weighted by Medicaid NF days of service during the eligibility period) of the absolute values of percentage changes between each NFs proportion of historical Medicaid days of NF service and actual Medicaid days of NF service is greater than 18 percent.

- Component Two will have a total value equal to 30 percent of remaining QIPP funds after accounting for the funding of Component One and Component Four. Allocation of funds across qualifying non-state government-owned and private NFs will be proportional, based on historical Medicaid days of NF service. Monthly payments to NFs will be triggered by achievement of performance requirements.

- Component Three will have a total value equal to 70 percent of remaining QIPP funds after accounting for the funding of Component One and Component Four. Allocation of funds across qualifying non-state government-owned and private NFs will be proportional, based on historical Medicaid days of NF service. Quarterly payments to NFs will be triggered by achievement of performance requirements.

- Component Four will have a total value equal to 16 percent of the funds of the QIPP. Allocation of funds across qualifying non-state government-owned

NFs will be proportional, based upon historical Medicaid days of NF service. Quarterly payments to non-state government-owned NFs will be triggered by achievement of performance requirements. Private NFs are not eligible for payments from Component Four.

- Funds that are non-disbursed due to failure of one or more NFs to meet performance requirements will be distributed across all QIPP NFs based on each NF's proportion of total earned QIPP funds from Components One, Two, Three, and Four combined.

Quality Design

For each eligibility period, HHSC will designate one or more of the following quality metrics for each QIPP capitation rate component: QAPI meetings, Minimum Data Set (MDS)-based measures, a recruitment and retention program, RN staffing metrics, and an infection control program. HHSC may develop additional metrics for inclusion in QIPP if there is a specific systemic data-supported quality concern impacting Texas Medicaid NF residents. For year 3, QAPI meetings have been designated as the quality metric for Component 1, the recruitment and retention plan and two RN staffing metrics will be used in Component Two, MDS-based measures will be used in Components Three and Four, and the infection control program will be used in Component Four.

For each eligibility period, HHSC will specify the performance requirements that will be associated with the designated quality metric. NFs must make improvements or meet performance requirements that will be established for each facility prior to the beginning of the eligibility period. A NF's baseline will remain the same throughout the eligibility period, while the amount of improvement required each quarter increases.

HHSC will publish notice of the proposed metrics and their associated performance requirements no later than December 31 of the calendar year that precedes the first month of the eligibility period. Final quality metrics and performance requirements will be provided through the QIPP webpage on HHSC’s website on or before February 1 of the calendar year that also contains the first month of the eligibility period.

SECTION-BY-SECTION SUMMARY

Proposed new §353.1302 provides the framework for the QIPP for program years beginning September 1, 2019.

Proposed new §353.1302(a) describes the purpose and goals of QIPP. QIPP is designed to incentivize NFs to improve quality and innovation in the provision of NF services to Medicaid recipients through the use of metrics that are expected to advance at least one of the goals and objectives of the state's quality strategy.

Proposed new §353.1302(b) defines key terms used in the section. Terms that are used in this and other sections of this subchapter may also be defined in §353.1301 (relating to General Provisions) or §353.1304 (relating to Quality Metrics for the Quality Incentive Payment Program for Nursing Facilities on or after September 1, 2019) of this subchapter.

Proposed new §353.1302(c) indicates the eligibility requirements for participation in the QIPP by non-state government-owned (NSGO) NFs and private NFs.

Proposed new §353.1302(d) specifies the data sources used to determine historical units of service. Historical units of service are used to determine an individual private NF's QIPP eligibility status and the distribution of QIPP funds across eligible and enrolled NFs.

Proposed new §353.1302(e) describes participation requirements for the QIPP.

Proposed new §353.1302(f) describes how the non-federal share of QIPP payments is funded through IGTs. No state general revenue is available to support QIPP.

Proposed new §353.1302(g) describes the QIPP capitation rate components and eligibility related thereto. The NF must have had at least one Medicaid client in the care of that NF for each reporting period to be eligible for payments.

Proposed new §353.1302(h) specifies the timing and distribution of QIPP payments. Prior to the beginning of each eligibility period, HHSC will calculate the portion of the PMPM associated with each QIPP-enrolled NF broken down by QIPP capitation rate component, quality metric, and payment period.

Proposed new §353.1302(i) describes the eligibility requirements of participants who undergo a change of ownership (CHOW). This includes a NF undergoing a CHOW from privately-owned to NSGO, as well as from NSGO to privately-owned.

Proposed new §353.1302(j) discusses changes in operation and indicates that participants who close voluntarily or cease to provide NF services within the facility must notify HHSC within 10 business days of closing or ceasing to provide NF services.

Proposed new §353.1302(k) indicates the circumstances under which payments may be subject to recoupment.

The proposed amendment of §353.1303 adds “before September 1, 2019” to the title of the section and to subsection (a) to clarify that this rule applies to the QIPP prior to September 1, 2019.

Proposed new §353.1304 describes the quality metrics associated with the QIPP on or after September 1, 2019.

Proposed new §353.1304(a) introduces the section.

Proposed new §353.1304(b) defines key terms used in the section. Terms that are used in this and other sections of this subchapter may also be defined in §353.1301 (relating to General Provisions) or §353.1302 (relating to Quality Incentive Payment Program for Nursing Facilities on or after September 1, 2019) of this subchapter.

Proposed new §353.1304(c) describes the quality metrics HHSC can designate for each QIPP capitation rate component. Possible metrics include QAPI meetings, MDS-based measures , a recruitment and retention program, RN staffing metrics, and an infection control program. HHSC may develop other, evidence-based metrics if there is a specific systemic data-supported quality concern impacting Texas Medicaid NF residents.

Proposed new §353.1304(d) discusses the performance requirements that will be associated with the designated quality metrics. Achievement of performance requirements will trigger payments for the QIPP capitation rate components as described in §353.1302 of this subchapter.

Proposed new §353.1304(e) provides that HHSC will publish notice of the proposed metrics and their associated performance requirements no later than December 31 of the calendar year that precedes the first month of the eligibility period. The notice must be published either by publication on HHSC’s Internet web site or in the *Texas Register*.

Proposed new §353.1304(f) provides that final quality metrics and performance requirements will be provided through the QIPP webpage on

HHSC's website on or before February 1 of the calendar year that also contains the first month of the eligibility period.

Proposed new §353.1304(g) establishes telehealth requirements that relate to the RN staffing metric.

FISCAL NOTE

Greta Rymal, Deputy Executive Commissioner for the Financial Services Division for HHSC, has determined that for each year of the first five years the proposed sections are in effect, there will be no fiscal implications to state government, but there may be fiscal implications to local governments. Capitation payments for MCOs will increase in order to provide performance-based incentives for NFs. The increase to capitation payments would be funded with federal funds and with the non-federal share provided through IGTs from non-state governmental entities. The amounts of such funds are dependent upon the actions of local units of government and cannot be estimated, but could potentially be significant.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the sections will be in effect:

(1) The proposed rules will not create or eliminate a government program;
(2) Implementation of the proposed rules will not affect the number of employee positions;
(3) Implementation of the proposed rules will not require an increase or decrease in future legislative appropriations;
(4) The proposed rules will not affect fees paid to the agency;
(5) The proposed rules will create new rules;
(6) The proposed rules will limit an existing rule;
(7) The proposed rules will increase the number of individuals subject to the rules; and
(8) The proposed rules will positively affect the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Greta Rymal has also determined there may be an adverse economic effect on small businesses, micro-businesses, or rural communities because the rules could increase the number of private NFs participating in the program, resulting in decreased payments to existing participants on a per day per bed basis. However, that is only true assuming the pool size remains

constant, and pool size is determined through a separate administrative action. As the pool size for QIPP year 3 and future program years has not yet been established, the impact cannot be determined at this time.

Additionally, participation in the program is optional and payments are not guaranteed. However, possible payments to private providers may decrease from $18.60 per day per bed to less than $10.00 per day per bed, if the pool remains constant.

HHSC considered four alternatives to minimize the possible adverse economic effect.

Alternative 1: Alternative 1 would maintain the program with no modifications.

Alternative 2: Alternative 2 would modify the eligibility criteria only.

Alternative 3: Alternative 3 would modify the quality metrics only.

Alternative 4: Alternative 4 would expand the program eligibility, modify the quality metrics, and modify the financial components of the program.

Alternative 1 was not selected. CMS, our federal partner, must approve the program design annually. In the approval notification for year 2 of QIPP (September 1, 2018 - August 31, 2019), CMS provided guidance that certain quality metrics should evolve for year 3 in order to continue to receive approval for the program. Therefore, leaving the program unchanged would jeopardize future CMS approval.

Alternative 2 was not selected. While modifying the eligibility criteria only would have allowed additional Medicaid clients to benefit from QIPP, it would not address the guidance issued by CMS for future approval of the program.

Alternative 3 was not selected. While this option would have addressed the CMS guidance described above, it would not have allowed additional Medicaid clients to benefit from this program.

HHSC selected Alternative 4. Modification of the quality metrics and financial components, while simultaneously expanding the eligibility criteria, will allow the program to continue and evolve as directed by CMS. These modifications also allow for additional Medicaid clients to benefit from the program, while maintaining a stable funding mechanism.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

HHSC has determined there are no anticipated economic costs to persons who are required to comply with the sections as proposed.

There is no anticipated negative impact on local employment.

COSTS TO REGULATED PERSONS

Texas Government Code, §2001.0045 does not apply to these rules because the rules do not impose a cost on regulated persons and they are necessary to receive a source of federal funds.

PUBLIC BENEFIT

Greta Rymal has determined that for each year of the first five years the sections are in effect, the anticipated public benefit of adopting the proposed rules is expanded opportunity for NFs to participate in the program and receive payments to incentivize quality improvements. Texas Medicaid NF clients will also experience better quality of care.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Government Code, §2007.043.

PUBLIC HEARING

HHSC will conduct a public hearing on October 19, 2018, at 9:00 a.m. to receive public comments on the proposal. The public hearing will be held in HHSC's Public Hearing Room in the Brown-Heatly Building located at 4900 N. Lamar Boulevard, Austin, Texas. Entry is through security at the main entrance of the building, which faces Lamar Boulevard. Free parking is available in front of the building and in the adjacent parking garage. Persons requiring Americans with Disability Act (ADA) accommodation or auxiliary aids or services should contact Rate Analysis by calling (512) 730-7401 at least 72 hours prior to the hearing so appropriate arrangements can be made.

HHSC will broadcast the public hearing; but it cannot accept testimony from persons watching remotely. The broadcast can be accessed at

https://hhs.texas.gov/about-hhs/communications-events/live-archived-meetings,and it will be archived for access on demand at the same website.

PUBLIC COMMENT

Written comments on the proposal may be submitted in lieu of, or in addition to, oral testimony at the hearing, within 30 days of publication of this proposal in the *Texas Register*. Written comments may be sent by U.S. mail to the Health and Human Services Commission, Rate Analysis Department, H-400, P.O. Box 149030, Austin, Texas 78714-9030; by fax to Rate Analysis at (512)730-7475; or by e-mail to RAD-LTSS@hhsc.state.tx.us.

To be considered, comments must be submitted no later than 30 days after the date of this issue of the *Texas Register*. The last day to submit comments falls on a Sunday; therefore, comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) faxed or e-mailed by midnight on the last day of the comment period. When faxing or e-mailing comments, please indicate "Comments on Proposed Rule 18R035" in the subject line.

STATUTORY AUTHORITY

The amendment and new rules are proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; Texas Government Code §531.021(b), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code, Chapter 32; and with Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

The proposed amendment and new rules implement Texas Government Code, Chapter 531; Texas Government Code, Chapter 533; and Texas Human Resources Code, Chapter 32. No other statutes, articles, or codes are affected by this proposal.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353 MEDICAID MANAGED CARE
SUBCHAPTER O DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

§353.1302. Quality Incentive Payment Program for Nursing Facilities on or after September 1, 2019.

(a) Introduction. This section establishes the Quality Incentive Payment Program (QIPP) for nursing facilities (NFs) providing services under Medicaid managed care on or after September 1, 2019. QIPP is designed to incentivize NFs to improve quality and innovation in the provision of NF services to Medicaid recipients through the use of metrics that are expected to advance at least one of the goals and objectives of the state's quality strategy.

(b) Definitions. The following definitions apply when the terms are used in this section. Terms that are used in this and other sections of this subchapter may be defined in §353.1301 (relating to General Provisions) or §353.1304 (relating to Quality Metrics for the Quality Incentive Payment Program for Nursing Facilities on or after September 1, 2019) of this subchapter.

(1) CHOW application--An application filed with HHSC for a NF change of ownership (CHOW).

(2) Eligibility period--A period of time for which an eligible and enrolled NF may receive the QIPP amounts described in this section. Each QIPP eligibility period is equal to a state fiscal year (FY) beginning September 1 and ending August 31 of the following year.

(3) Network nursing facility--A NF located in the state of Texas that has a contract with an MCO for the delivery of Medicaid covered benefits to the MCO's enrollees.

(4) Non-state government-owned NF--A network nursing facility where a non-state governmental entity located in the state of Texas holds the license and is a party to the NF's Medicaid provider enrollment agreement with the state.

(5) Private NF-- A network nursing facility not owned by a governmental entity located in the state of Texas, and holds a license.

(6) Regional Healthcare Partnership (RHP)--A collaboration of interested participants that work collectively to develop and submit to the state a regional plan for health care delivery system reform as defined and established under Chapter 354, Subchapter D, of this title (relating to Texas Healthcare Transformation and Quality Improvement Program).

(c) Eligibility for participation in QIPP. A NF is eligible to participate in QIPP if it complies with the requirements described in this subsection.

(1) The NF is a non-state government-owned NF.

(A) The non-state governmental entity that owns the NF must certify the following facts on a form prescribed by HHSC.

(i) That it is a non-state government-owned NF where a non-state governmental entity holds the license and is party to the facility's Medicaid contract; and

(ii) That all funds transferred to HHSC via an intergovernmental transfer (IGT) for use as the state share of payments are public funds.

(B) The NF must be located in the state of Texas in the same RHP as, or within 150 miles of, the non-state governmental entity taking ownership of the facility, be owned by the non-state governmental entity for no less than four years prior to the first day of the eligibility period, or must be able to certify in connection with the enrollment application that they can demonstrate an active partnership between the NF and the non-state governmental entity that owns the NF. The following criteria demonstrate an active partnership between the NF and the non-state governmental entity that owns the NF.

(i) Monthly meetings (in-person or virtual) with NF administrative staff to review the NF’s clinical and quality operations and identify areas for improvement. Meetings should include patient observations; regulatory findings; review of CASPER reports, quality measures, grievances, staffing, risk, incidents, accidents, and infection control measures; root cause analysis, if applicable; and design of performance improvement plans.

(ii) Quarterly joint trainings on topics and trends in nursing home care best practices or on needed areas of improvement.

(iii) Annual, on-site inspections of the NF by a non-state governmental entity-sponsored Quality Assurance team.

(2) The NF is a private NF. The NF must have a percentage of Medicaid NF days of service that is greater than or equal to 65 percent. For each private NF, the percentage of Medicaid NF days is calculated by summing the NF's Medicaid NF fee-for-service and managed care days of service, including dual-eligible demonstration days of service, and dividing that sum by the facility's total days of service in all licensed beds. Medicaid hospice days of service are included in the denominator but excluded from the numerator.

(A) The days of service will be annualized based on the NF's latest cost report or accountability report but from a year in which HHSC required the submission of cost reports.

(B) HHSC will exclude any calendar days that the NF was closed due to a natural or man-made disaster. In such cases, HHSC will annualize the days of service based on calendar days when the NF was open.

(d) Data sources for historical units of service. Historical units of service are used to determine an individual private NF's QIPP eligibility status and the distribution of QIPP funds across eligible and enrolled NFs.

(1) All data sources referred to in this subsection are subject to validation using HHSC auditing processes or procedures as described under §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports).

(2) Data sources for the determination of each private NF's QIPP eligibility status are listed in priority order below. For each eligibility period, the data source must be from a cost-reporting year and must align with the NF's fiscal year.

(A) The most recently available Medicaid NF cost report for the private NF. If no Medicaid NF cost report is available, the data source in subparagraph (B) of this paragraph must be used.

(B) The most recently available Medicaid Direct Care Staff Rate Staffing and Compensation Report for the private NF. If no Medicaid Direct Care Staff Rate Staffing and Compensation Report is available, the data source in subparagraph (C) of this paragraph must be used.

(C) The most recently available Medicaid NF cost report for a prior owner of the private NF. If no Medicaid NF cost report for a prior owner of the private NF is available, the data source in subparagraph (D) of this paragraph must be used.

(D) The most recently available Medicaid Direct Care Staff Rate Staffing and Compensation Report for a prior owner of the private NF. If no Medicaid Direct Care Staff Rate Staffing and Compensation Report for a prior owner of the private NF is available, the private NF is not eligible for participation in QIPP.

(3) Data sources for determination of distribution of QIPP funds across eligible and enrolled NFs are listed in priority order below. For each eligibility period, the data source must be from a cost-reporting year and must align with the NF's fiscal year.

(A) The most recently available Medicaid NF cost report for the NF. If the cost report covers less than a full year, reported values are annualized to represent a full year. If no Medicaid NF cost report is available, the data source in subparagraph (B) of this paragraph must be used.

(B) The most recently available Medicaid Direct Care Staff Rate Staffing and Compensation Report for the NF. If the Staffing and Compensation Report covers less than a full year, reported values are annualized to represent a full year. If no Staffing and Compensation Report is available, the data source in subparagraph (C) of this paragraph must be used.

(C) The most recently available Medicaid NF cost report for a prior owner of the NF. If the cost report covers less than a full year, reported values are annualized to represent a full year. If no Medicaid NF cost report for a prior owner of the NF is available, the data source in subparagraph (D) of this paragraph must be used.

(D) The most recently available Medicaid Direct Care Staff Rate Staffing and Compensation Report for a prior owner of the NF. If the Staffing and Compensation Report covers less than a full year, reported values are annualized to represent a full year.

(e) Participation requirements. As a condition of participation, all NFs participating in QIPP must allow for the following.

(1) HHSC must be able to access data for the NF from one of the data sources listed in subsection (d) of this section.

(2) The NF must submit a properly completed enrollment application by the due date determined by HHSC. The enrollment period must be no less than 30 calendar days, and the final date of the enrollment period will be at least nine days prior to the IGT notification.

(3) The entity that owns the NF must certify, on a form prescribed by HHSC, that no part of any payment made under the QIPP will be used to pay a contingent fee, consulting fee, or legal fee associated with the NF's receipt of QIPP funds and the certification must be received by HHSC with the enrollment application described in paragraph (2) of this subsection.

(4) The entity that owns the NF must submit to HHSC, upon demand, copies of contracts it has with third parties that reference the administration of, or payments from, QIPP.

(f) Non-federal share of QIPP payments. The non-federal share of all QIPP payments is funded through IGTs from sponsoring non-state governmental entities. No state general revenue is available to support QIPP.

(1) HHSC will share suggested IGT responsibilities for the eligibility period with all QIPP eligible and enrolled non-state government-owned NFs at least 15 days prior to the IGT declaration of intent deadline. Suggested IGT responsibilities will be based on the maximum dollars to be available under the QIPP program for the eligibility period as determined by HHSC, plus eight percent; forecast STAR+PLUS NF member months for the eligibility period as determined by HHSC; and the distribution of historical Medicaid days of service across non-state government-owned NFs enrolled in QIPP for the eligibility period. HHSC will also share estimated maximum revenues each eligible and enrolled NF could earn under QIPP for the eligibility period with those estimates based on HHSC's suggested IGT responsibilities and an assumption that all enrolled NFs will meet 100 percent of their quality metrics. The purpose of sharing this information is to provide non-state government-owned NFs with information they can use to determine the amount of IGT they wish to transfer.

(2) Sponsoring governmental entities will determine the amount of IGT they wish to transfer to HHSC for the entire eligibility period and provide a declaration of intent to HHSC 15 business days before the first half of the IGT amount is transferred to HHSC.

(A) The declaration of intent is a form prescribed by HHSC that includes the total amount of IGT the sponsoring governmental entity wishes to transfer to HHSC and whether the sponsoring governmental entity intends to accept Component One payments.

(B) The declaration of intent is certified to the best knowledge and belief of a person legally authorized to sign for the sponsoring governmental entity but does not bind the sponsoring governmental entity to transfer IGT.

(3) Sponsoring governmental entities will transfer the first half of the IGT amount by a date determined by HHSC. The second half of the IGT amount will be transferred by a date determined by HHSC. The IGT deadlines and all associated dates will be published on the HHSC QIPP webpage by January 15 of each year.

(4) Reconciliation. HHSC will reconcile the amount of the non-federal funds actually expended under this section during each eligibility period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period using the methodology described in §353.1301(g) of this subchapter.

(g) QIPP capitation rate components. QIPP funds will be paid to MCOs through four components of the STAR+PLUS NF managed care per member per month (PMPM) capitation rates. The MCOs' distribution of QIPP funds to the enrolled NFs will be based on each NF's performance related to the quality metrics as described in §353.1304 of this subchapter. The NF must have had at least one Medicaid client in the care of that NF for each reporting period to be eligible for payments.

(1) Component One.

(A) The total value of Component One will be equal to 110 percent of the non-federal share of the QIPP.

(B) Interim allocation of funds across qualifying non-state government-owned NFs will be proportional, based upon historical Medicaid days of NF service.

(C) Monthly payments to non-state government-owned NFs will be triggered by achievement of performance requirements as described in §353.1304 of this subchapter.

(D) Private NFs are not eligible for payments from Component One.

(E) The interim allocation of funds across qualifying non-state government-owned NFs will be reconciled to the actual distribution of Medicaid NF days of service across these NFs during the eligibility period as captured by HHSC's Medicaid contractors for fee-for-service and managed care 180 days after the last day of the eligibility period. This reconciliation will only be performed if the weighted average (weighted by Medicaid NF days of service during the eligibility period) of the absolute values of percentage changes between each NFs proportion of historical Medicaid days

of NF service and actual Medicaid days of NF service is greater than 18 percent.

(2) Component Two.

(A) The total value of Component Two will be equal to 30 percent of remaining QIPP funds after accounting for the funding of Component One and Component Four.

(B) Allocation of funds across qualifying non-state government-owned and private NFs will be proportional, based upon historical Medicaid days of NF service.

(C) Monthly payments to NFs will be triggered by achievement of performance requirements as described in §353.1304 of this subchapter.

(3) Component Three.

(A) The total value of Component Three will be equal to 70 percent of remaining QIPP funds after accounting for the funding of Component One and Component Four.

(B) Allocation of funds across qualifying non-state government-owned and private NFs will be proportional, based upon historical Medicaid days of NF service.

(C) Quarterly payments to NFs will be triggered by achievement of performance requirements as described in §353.1304 of this subchapter.

(4) Component Four.

(A) The total value of Component Four will be equal to 16 percent of the funds of the QIPP.

(B) Allocation of funds across qualifying non-state government-owned NFs will be proportional, based upon historical Medicaid days of NF service.

(C) Quarterly payments to non-state government-owned NFs will be triggered by achievement of performance requirements as described in §353.1304 of this subchapter.

(D) Private NFs are not eligible for payments from Component Four.

(5) Funds that are non-disbursed due to failure of one or more NFs to meet performance requirements will be distributed across all QIPP NFs based on each NF's proportion of total earned QIPP funds from Components One, Two, Three, and Four combined.

(h) Distribution of QIPP payments.

(1) Prior to the beginning of the eligibility period, HHSC will calculate the portion of each PMPM associated with each QIPP-enrolled NF broken down by QIPP capitation rate component, quality metric, and payment period. For example, for NF A, HHSC will calculate the portion of each PMPM associated with that NF that would be paid from the MCO to the NF as follows.

(A) Monthly payments from Component One as performance requirements are met will be equal to the total value of Component One for the NF divided by twelve.

(B) Monthly payments from Component Two associated with each quality metric will be equal to the total value of Component Two associated with the quality metric divided by twelve.

(C) Quarterly payments from Component Three associated with each quality metric will be equal to the total value of Component Three associated with the quality metric divided by four.

(D) Quarterly payments from Component Four associated with each quality metric will be equal to the total value of Component Four associated with the quality metric divided by four.

(E) For purposes of the calculations described in subparagraphs (B), (C), and (D) of this paragraph, each quality metric will be allocated an equal portion of the total dollars included in the component.

(F) In situations where a NF does not have enough data for a quality metric to be calculated, the funding associated with that metric will be evenly distributed across all remaining metrics within the component.

(2) MCOs will distribute payments to enrolled NFs as they meet their reporting and quality metric requirements. Payments will be equal to the portion of the QIPP PMPM associated with the achievement for the time period in question multiplied by the number of member months for which the MCO received the QIPP PMPM. In the event of a CHOW, the MCO will distribute the payment to the owner of the NF at the time of the payment.

(i) Changes of ownership.

(1) A NF undergoing a CHOW from privately owned to non-state government owned or from non-state government owned to privately-owned will only be eligible to enroll as the new class of facility if HHSC received a completed CHOW application no later than 30 days prior to the first day of the enrollment period. All required documents pertaining to the CHOW (i.e., HHSC must have a complete application for a change of ownership license as described under 40 TAC §19.201 (relating to Criteria for Licensing), 40 TAC §19.210 (relating to Change of Ownership and Notice of Changes), and 40 TAC §19.2308 (relating to Change of Ownership)) must be submitted in the timeframe required by HHSC.

(2) If an enrolled NF changes ownership, including to a new class of facility during the pendency of the application or during the eligibility period, the NF under the new ownership must meet the eligibility requirements described in this section for the new owner's facility class in order to continue QIPP participation during the eligibility period.

(3) An enrolled NF must notify the MCOs it has contracts with of a potential CHOW at least 30 days before the anticipated date of the CHOW. An enrolled NF must also notify the HHSC Rate Analysis Department by hand delivery, United States (U.S.) mail, or special mail delivery at least 30 days before the anticipated date of the CHOW. Notification is considered to have occurred when HHSC receives the notice.

(j) Changes in operation. If an enrolled NF closes voluntarily or ceases to provide NF services in its facility, the NF must notify the HHSC Rate Analysis Department by hand delivery, United States (U.S.) mail, or special mail delivery within 10 business days of closing or ceasing to provide NF services. Notification is considered to have occurred when HHSC receives the notice.

(k) Recoupment. Payments under this section may be subject to recoupment as described in §353.1301(j) and §353.1301(k) of this subchapter.

§353.1303. Quality Incentive Payment Program for Nursing Facilities before September 1, 2019.

(a) Introduction. This section establishes the Quality Incentive Payment Program (QIPP) for nursing facilities (NFs) providing services under Medicaid managed care (MC) before September 1, 2019. QIPP is designed to incentivize NFs to improve quality and innovation in the provision of NF services to Medicaid recipients, using the Centers for Medicare & Medicaid Services (CMS) Five-Star Quality Rating System as its measure of success.

(b) Definitions. The following definitions apply when the terms are used in this section. Terms that are used in this and other sections of this subchapter may be defined in §353.1301 of this subchapter (related to General Provisions).

(1) Baseline--A NF-specific starting measure used as a comparison against NF performance throughout the eligibility period to determine progress in the QIPP Quality Measures.

(2) Benchmark--The CMS National Average prior to the start of the eligibility period by which a NF's progress with the Quality Measures is determined.

(3) CHOW application--An application filed with the Department of Aging and Disability Services (DADS) for a NF change of ownership (CHOW).

(4) DADS--The Texas Department of Aging and Disability Services or its successor agency.

(5) Eligibility period--A period of time for which an eligible and enrolled NF may receive the QIPP amounts described in this section. Each QIPP eligibility period is equal to a state fiscal year (FY) beginning September 1 and ending August 31 of the following year. Eligibility Period One is equal to FY 2018, beginning September 1, 2017, and ending August 31, 2018.

(6) MCO--A Medicaid managed care organization contracted with HHSC to provide NF services to Medicaid recipients.

(7) Network nursing facility--A NF that has a contract with an MCO for the delivery of Medicaid covered benefits to the MCO's enrollees.

(8) Non-state government-owned NF--A network NF where a non-state governmental entity holds the license and is a party to the NF's Medicaid provider enrollment agreement with the state.

(9) Private NF--A NF that is not owned by a governmental entity.

(10) Quality Assurance Performance Improvement (QAPI) Validation Report--A monthly report submitted by a NF, that is eligible for and enrolled in QIPP, to an MCO that demonstrates that the NF has convened a meeting to review the NF's CMS-compliant plan for maintaining and improving safety and quality in the NF.

(11) Regional Healthcare Partnership (RHP)--A collaboration of interested participants that work collectively to develop and submit to the state a regional plan for health care delivery system reform as defined and established under Chapter 354, Subchapter D, of this title (relating to Texas Healthcare Transformation and Quality Improvement Program).

(c) Eligibility for participation in QIPP. A NF is eligible to participate in QIPP if it complies with the requirements described in this subsection for each eligibility period.

(1) Eligibility Period One. A NF is eligible to participate in QIPP for Eligibility Period One if it meets the following requirements:

(A) The NF is a non-state government-owned NF.

(i) The NF must be a non-state government-owned NF with a Medicaid contract effective date of April 1, 2017, or earlier. A NF undergoing a CHOW from privately owned to non-state government owned will only be eligible under this subparagraph if DADS received a completed CHOW application by March 2, 2017, and all required documents pertaining to the CHOW (i.e., DADS must have a complete application for a change of ownership license as described under 40 TAC §19.201 (relating to Criteria for Licensing), §19.210 (relating to Change of Ownership License), and §19.2308 (relating to Change of Ownership)) by March 31, 2017.

(ii) The non-state governmental entity that owns the NF must certify the following facts on a form prescribed by HHSC.

(I) that it is a non-state government-owned NF where a non-state governmental entity holds the license and is party to the facility's Medicaid contract; and

(II) that all funds transferred to HHSC via an intergovernmental transfer (IGT) for use as the state share of payments are public funds.

(iii) The NF must have been a participant in the Minimum Payment Amounts Program (MPAP) or must be located in the same RHP as, or within 150 miles of, the non-state governmental entity taking ownership of the facility. This geographic proximity criterion does not apply to NFs that can establish good cause for an exception to this criterion.

(B) Private NFs. The NF must have a percentage of Medicaid NF days of service that is greater than or equal to the private NF QIPP eligibility cut-off point. The private NF QIPP eligibility cut-off point will be equal to the

mean percentage of historical Medicaid NF days of service provided under fee-for-service (FFS) and MC by all private NFs plus one standard deviation, as determined by HHSC. For each private NF, the percentage of Medicaid NF days is calculated by summing the NF's Medicaid NF FFS and MC days of service and dividing that sum by the facility's total days of service in all licensed beds. Medicaid hospice days of service are included in the denominator but excluded from the numerator.

(2) Future eligibility periods. Eligibility requirements for eligibility periods after Eligibility Period One are the same as the requirements under paragraph (1) of this subsection except that the deadlines specified in paragraph (1)(A)(i) will be updated by HHSC. Updated deadlines will be shared with all NFs by a date to be determined by HHSC.

(d) Data sources for historical units of service. Historical units of service are used to determine the private NF QIPP eligibility cut-off point, individual private NF QIPP eligibility status, and the distribution of QIPP funds across eligible and enrolled NFs.

(1) All data sources referred to in this subsection are subject to validation using HHSC auditing processes or procedures as described under §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports).

(2) The data source for the determination of the private NF QIPP eligibility cut-off point is the most recently available, audited Texas Medicaid NF cost report database.

(3) Data sources for the determination of each private NF's QIPP eligibility status are listed in priority order below. For each eligibility period, the data source must align with the NF's fiscal year that ends no more recently than in the calendar year four years prior to the calendar year within which the eligibility period ends. For example, for the eligibility period ending on August 31, 2018, the data source must align with the NF's 2014 fiscal year or an earlier fiscal year and for the eligibility period ending on August 31, 2019, the data source must align with the NF's 2015 fiscal year or an earlier fiscal year.

(A) The most recently available Medicaid NF cost report for the private NF. If no Medicaid NF cost report is available, the data source in subparagraph (B) of this paragraph must be used.

(B) The most recently available Medicaid Direct Care Staff Rate Staffing and Compensation Report for the private NF. If no Medicaid Direct

Care Staff Rate Staffing and Compensation Report is available, the data source in subparagraph (C) of this paragraph must be used.

(C) The most recently available Medicaid NF cost report for a prior owner of the private NF. If no Medicaid NF cost report for a prior owner of the private NF is available, the data source in subparagraph (D) of this paragraph must be used.

(D) The most recently available Medicaid Direct Care Staff Rate Staffing and Compensation Report for a prior owner of the private NF. If no Medicaid Direct Care Staff Rate Staffing and Compensation Report for a prior owner of the private NF is available, the private NF is not eligible for participation in QIPP.

(4) Data sources for determination of distribution of QIPP funds across eligible and enrolled NFs. For each eligibility period, the data source must align with the NF's fiscal year that ends no more recently than in the calendar year four years prior to the calendar year within which the eligibility period ends. For example, for the eligibility period ending on August 31, 2018, the data source must align with the NF's 2014 fiscal year or an earlier fiscal year and for the eligibility period ending on August 31, 2019, the data source must align with the NF's 2015 fiscal year or an earlier fiscal year.

(A) The most recently available Medicaid NF cost report for the NF. If the cost report covers less than a full year, reported values are annualized to represent a full year. If no audited Medicaid NF cost report is available, the data source in subparagraph (B) of this paragraph must be used.

(B) The most recently available Medicaid Direct Care Staff Rate Staffing and Compensation Report for the NF. If the Staffing and Compensation Report covers less than a full year, reported values are annualized to represent a full year. If no Staffing and Compensation Report is available, the data source in subparagraph (C) of this paragraph is must be used.

(C) The most recently available Medicaid NF cost report for a prior owner of the NF. If the cost report covers less than a full year, reported values are annualized to represent a full year. If no Medicaid NF cost report for a prior owner of the NF is available, the data source in subparagraph (D) of this paragraph must be used.

(D) The most recently available Medicaid Direct Care Staff Rate Staffing and Compensation Report for a prior owner of the NF. If the Staffing

and Compensation Report covers less than a full year, reported values are annualized to represent a full year.

(e) Participation requirements. As a condition of participation, all NFs participating in QIPP must allow for the following:

(1) HHSC must be able to access data for the NF from one of the data sources listed in subsection (d) of this section.

(2) The NF must submit a properly completed enrollment application by the due date determined by HHSC.

(3) The entity that owns the NF must certify, on a form prescribed by HHSC, that no part of any payment made under the QIPP will be used to pay a contingent fee, consulting fee, or legal fee associated with the NF's receipt of QIPP funds and the certification must be received by HHSC with the enrollment application described in paragraph (2) of this subsection.

(4) The entity that owns the NF must submit to HHSC, upon demand, copies of contracts it has with third parties that reference the administration of, or payments from, QIPP.

(f) Non-federal share of QIPP payments. The non-federal share of all QIPP payments is funded through IGTs from sponsoring non-state governmental entities. No state general revenue is available to support QIPP.

(1) HHSC will share suggested IGT responsibilities for the eligibility period with all QIPP eligible and enrolled non-state government-owned NFs on or around May 15 of the calendar year that also contains the first month of the eligibility period. Suggested IGT responsibilities will be based on the maximum dollars to be available under the QIPP program for the eligibility period as determined by HHSC, plus ten percent; forecast STAR+PLUS NF member months for the eligibility period as determined by HHSC; and the distribution of historical Medicaid days of service across non-state government-owned NFs enrolled in QIPP for the eligibility period. HHSC will also share estimated maximum revenues each eligible and enrolled NF could earn under QIPP for the eligibility period with those estimates based on HHSC's suggested IGT responsibilities and an assumption that all enrolled NFs will meet 100 percent of their quality metrics. The purpose of sharing this information is to provide non-state government-owned NFs with information they can use to determine the amount of IGT they wish to transfer.

(2) Sponsoring governmental entities will determine the amount of IGT they wish to transfer to HHSC for the entire eligibility period and will transfer one-half of that amount by May 31 of the calendar year that also contains the first month of the eligibility period. The second half of the IGT amount will be transferred by November 30 of the calendar year that also contains the first month of the eligibility period.

(3) Reconciliation. HHSC will reconcile the amount of the non-federal funds actually expended under this section during each eligibility period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period using the methodology described in §353.1301(g) of this subchapter.

(g) QIPP capitation rate components. QIPP funds will be paid to MCOs through three new components of the STAR+PLUS NF MC per member per month (PMPM) capitation rates. The MCOs' distribution of QIPP funds to the enrolled NFs will be based on each NF's performance on a set of defined quality metrics.

(1) Component One.

(A) The total value of Component One will be equal to 110 percent of the non-federal share of the QIPP program.

(B) Interim allocation of funds across qualifying non-state government-owned NFs will be proportional, based upon historical Medicaid days of NF service.

(C) Monthly payments to non-state government-owned NFs will be triggered by the NF's submission to the MCOs of a monthly QAPI Validation Report.

(D) Private NFs are not eligible for payments from Component One.

(E) The interim allocation of funds across qualifying non-state government-owned NFs will be reconciled to the actual distribution of Medicaid NF days of service across these NFs during the eligibility period as captured by HHSC's Medicaid contractors for fee-for-service and managed care 180 days after the last day of the eligibility period. This reconciliation will only be performed if the weighted average (weighted by Medicaid NF days of service during the eligibility period) of the absolute values of percentage changes between each NFs proportion of historical Medicaid days of NF service and actual Medicaid days of NF service is greater than 20 percent.

(2) Component Two.

(A) The total value of Component Two will be equal to 35 percent of remaining QIPP funds after accounting for the funding of Component One.

(B) Allocation of funds across qualifying non-state government-owned and private NFs will be proportional, based upon historical Medicaid days of NF service.

(C) Quarterly payments to NFs will be triggered by achievement of performance requirements as described in subsection (h) of this section.

(3) Component Three.

(A) The total value of Component Three will be equal to 65 percent of remaining QIPP funds after accounting for the funding of Component One.

(B) Allocation of funds across qualifying non-state government-owned and private NFs will be proportional, based upon historical Medicaid days of NF service.

(C) Quarterly payments to NFs will be triggered by achievement of performance requirements as described in subsection (h) of this section. Payments made to NFs meeting the standards of Component Three will include both the 35 percent allocated for Component Two and the remaining 65 percent allocated for Component Three.

(4) Funds that would lapse due to failure of one or more NFs to meet QAPI reporting requirements or quality metrics will be distributed across all QIPP NFs based on each NF's proportion of total earned QIPP funds from Components One, Two, and Three combined.

(h) Distribution of QIPP payments.

(1) Prior to the beginning of the eligibility period, HHSC will calculate the portion of each PMPM associated with each QIPP-enrolled NF broken down by QIPP capitation rate component, quality metric, and payment period. For example, for NF A, HHSC will calculate the portion of each PMPM associated with that NF that would be paid from the MCO to the NF as follows:

(A) Monthly payments from Component One as QAPI reporting requirements are met will be equal to the total value of Component One for the NF divided by twelve.

(B) Quarterly payments from Component Two associated with each quality metric will be equal to the total value of Component Two associated with the quality metric divided by four.

(C) Quarterly payments from Component Three associated with each quality metric will be equal to the total value of Component Three associated with the quality metric divided by four.

(D) For purposes of the calculations described in subparagraphs (B) and (C) of this paragraph, each metric will be allocated an equal portion of the total dollars included in the component.

(E) In situations where a NF does not have enough data for a metric to be calculated, the funding associated with that metric will be evenly distributed across all remaining metrics.

(2) MCOs will distribute payments to enrolled NFs as they meet their reporting and quality metric requirements. Payments will be equal to the portion of the QIPP PMPM associated with the achievement for the time period in question multiplied by the number of member months for which the MCO received the QIPP PMPM.

(i) Performance requirements.

(1) Quality metrics.

(A) There will be a minimum of three quality metrics for an eligibility period. For eligibility period one, there are the following four quality metrics:

(i) high-risk long-stay residents with pressure ulcers;

(ii) percent of residents who received an antipsychotic medication (long-stay);

(iii) residents experiencing one or more falls with major injury; and

(iv) residents who were physically restrained.

(B) Quality metrics may change from eligibility period to eligibility period but will always be limited to those under the CMS Five-Star Quality Rating System. Information regarding specific quality metrics for an eligibility period will be provided annually through the QIPP webpage on the HHSC website on or before February 1 of the calendar year that also contains the first month of the eligibility period.

(C) Quality metric baselines will be based on each individual NF's average performance on the metric as reported by CMS for the federal quarter that ends prior to the first day of the eligibility period and the three prior federal quarters, or as determined by HHSC.

(D) Quality metric benchmarks will be based on the national average for the metric as reported by CMS for the federal quarter that ends prior to the first day of the eligibility period, or as determined by HHSC.

(2) Achievement requirements. In order to receive payments from Components Two and Three for a quality metric, a NF must show improvement over the baseline or exceed the benchmark for the metric.

(A) To qualify for a payment from Component Two, a NF must meet at least the initial quarterly goal of 1.7 percent improvement from the baseline, with subsequent quarterly goals increasing to a maximum of seven percent by the end of the eligibility period. For example, to qualify for a payment from Component Two for a quality metric for the second quarter of the eligibility period, the NF must meet at least the second quarter goal of 3.4 percent improvement from the baseline.

(B) To qualify for a payment from Component Three, a NF must meet at least the initial quarterly goal of 5.0 percent improvement from the baseline with subsequent quarterly goals increasing to a maximum of 20 percent by the end of the eligibility period. For example, to qualify for a payment from Component Three for a quality metric for the second quarter of the eligibility period, the NF must meet at least the second quarter goal of 10.0 percent improvement from the baseline. A NF that qualifies for a payment from Component Three for a metric automatically qualifies for a payment from Component Two for the same metric.

(C) A NF that exceeds the benchmark for a metric qualifies for a payment from both Component Two and Component Three for that metric. A NF that exceeds the benchmark may decline in performance and still qualify for a payment from both Component Two and Component Three as long as the NF continues to exceed the benchmark for the metric.

(j) Changes of ownership.

(1) If an enrolled NF changes ownership during the eligibility period to private ownership, the NF under the new ownership must meet the private NF eligibility requirements described in this section in order to continue QIPP participation during the eligibility period.

(2) If a non-state government-owned NF changes ownership during the eligibility period to another non-state governmental entity, the NF under the new ownership must meet the non-state government-owned eligibility requirements described in this section in order to continue QIPP participation during the eligibility period.

(k) Recoupment. Payments under this section may be subject to recoupment as described in §353.1301(k) of this subchapter.

§353.1304. Quality Metrics for the Quality Incentive Payment Program for Nursing Facilities on or after September 1, 2019.

(a) Introduction. This section establishes the quality metrics that may be used in the Quality Incentive Payment Program (QIPP) for nursing facilities (NFs) on or after September 1, 2019.

(b) Definitions. The following definitions apply when the terms are used in this section. Terms that are used in this and other sections of this subchapter may be defined in §353.1301 (relating to General Provisions) or §353.1302 (relating to Quality Incentive Payment Program for Nursing Facilities on or after September 1, 2019) of this subchapter.

(1) Baseline—A NF-specific initial standard used as a comparison against NF performance in each metric throughout the eligibility period to determine progress in the QIPP quality metrics. For example, for MDS-based measures, the facility's baselines will be set at the most recently available four-quarter average for each metric.

(2) Benchmark—A metric-specific initial standard set prior to the start of the eligibility period and used as a comparison against a NF's progress throughout the eligibility period. For example, for MDS-based measures, the benchmarks will be set at the most recently published CMS National Average for each metric.

(c) Quality metrics. For each eligibility period, HHSC will designate one or more of the following quality metrics for each QIPP capitation rate component.

(1) Quality assurance and performance improvement (QAPI) meetings. Monthly meetings in which the NF reviews its CMS-compliant plan for maintaining and improving safety and quality in the NF. QAPI meetings must contribute to a NF's ongoing development of improvement initiatives regarding clinical care, quality of life, and consumer choice. For the eligibility

period beginning September 1, 2019, QAPI meetings have been designated as the quality metric for Component 1.

(2) MDS-based measures. Measures listed in CMS' Five-Star Quality Rating System and based on Minimum Data Set (MDS) assessment data. Within the Five-Star Quality Rating System, HHSC can select any MDS-based measure as long as there are viable data sources available for timely calculations related to the measure. For the eligibility period beginning September 1, 2019, the following five MDS-based measures may be used in Components Three and Four:

(A) high-risk long-stay residents with pressure ulcers;

(B) percent of residents who received an antipsychotic medication (long-stay);

(C) percent of residents with decreased independent mobility;

(D) percent of residents with urinary tract infections; and

(E) percent of residents appropriately given the pneumonia vaccine.

(3) Recruitment and retention program. A program that includes a plan developed by the NF to improve recruitment and retention of staff and monitor outcomes related thereto. For the eligibility period beginning September 1, 2019, the recruitment and retention plan will be used in Component Two.

(4) RN staffing metrics. Registered nurse (RN) hours beyond and non-concurrent with the CMS-mandated eight hours of RN on-site coverage each day. Telehealth services can be used to meet some or all of the RN staffing metrics when a NF has telehealth policies and procedures developed in accordance with subsection (g) of this section. For the eligibility period beginning September 1, 2019, the following two RN staffing metrics will be used in Component Two:

(A) four hours of additional RN coverage per day; and

(B) eight hours of additional RN coverage per day. A NF that meets the eight hours of additional RN coverage per day will automatically qualify for the metric described in subparagraph A.

(5) Infection control program. A program that improves antibiotic stewardship and measures outcomes through the use of infection control

and data elements. For the eligibility period beginning September 1, 2019, the infection control program will be used in Component Four, and the program will consist of the following infection control and data elements:

(A) whether a facility:

(i) has identified leadership individuals for antibiotic stewardship;

(ii) has created written policies on antibiotic prescribing;

(iii) has an antibiotic use report generated by a pharmacy within last 6 months;

(iv) audits (monitors and documents) adherence to hand hygiene (HH);

(v) audits (monitors and documents) adherence to personal protective equipment (PPE) use;

(vi) has an infection control coordinator who has received infection control training;

(vii) has infection prevention policies that are evidence-based and reviewed at least annually;

(viii) has a current list of reportable diseases;

(ix) knows points of contact at local or state health departments for assistance;

(B) the number of:

(i) vaccines administered to residents and employees;

(ii) residents with facility acquired Clostridium difficile diagnosis;

(iii) residents on antibiotic medications;

(iv) residents with multi-drug resistant organisms; and

(C) select infection rates.

(6) Other metrics related to improving the quality of care for Texas Medicaid NF residents. HHSC may develop additional metrics for inclusion in QIPP if there is a specific systemic data-supported quality concern impacting

Texas Medicaid NF residents. Any metric developed for inclusion in QIPP will be evidence-based and will be presented to the public for comment in accordance with subsection (e) of this section.

(d) Performance requirements. For each eligibility period, HHSC will specify the performance requirement that will be associated with the designated quality metric. Achievement of performance requirements will trigger payments for the QIPP capitation rate components as described in §353.1302 of this subchapter. For some quality metrics, achievement is tested merely on a met versus unmet basis. Other metrics require a certain level of improvement, such as reaching a quarterly percentage goal. The following performance requirements are associated with the quality metrics described in subsection (c) of this section.

(1) QAPI meetings. Each month, a NF must attest on a form designated by HHSC that it convened a QAPI meeting. The NF must submit the form to HHSC by the first business day following the end of the month. Each quarter, HHSC will validate a random sample of the attestation forms. The NF that submitted the attestation form must provide the supporting documentation stated in the attestation form.

(2) MDS-based measures. A NF must show a five percent relative improvement on a quarterly basis over the baseline or exceed the benchmark for the selected measure.

(A) Baseline improvement is measured against quarterly targets determined by HHSC prior to the eligibility period.

(B) A NF that exceeds the benchmark for a measure qualifies for the payment from any related component. A NF that exceeds the benchmark may decline in performance and still qualify for a payment from the related component as long as the NF continues to exceed the benchmark for the measure.

(3) Recruitment and retention program. During the first month of the eligibility period, a NF must submit its recruitment and retention plan to HHSC. If substantive changes are made to the recruitment and retention plan, an update of the plan must be submitted to HHSC during the month in which the changes take effect.

(A) Failure to submit the recruitment and retention plan in the first month of the eligibility period will result in not meeting the metric for that month for the related component.

(B) Each subsequent month, a NF will submit to HHSC documentation produced during the development of self-direct staffing goals and in the monitoring of staffing outcomes, in accordance with the NF's recruitment and retention plan.

(C) Each quarter, HHSC will validate a random sample of recruitment and retention plans and outcome monitoring documentation. The NF that submitted the plan must provide supporting documentation, including policies and outcomes.

(4) RN staffing metrics. A NF meets the RN staffing metrics by showing that the facility was staffed at the required number of hours for at least 90 percent of the days in the reporting period.

(5) Infection control program. Each quarter, a NF must report:

(A) the presence of a number of infection control elements to exceed a quarterly benchmark. For the eligibility period beginning September 1, 2019, the NF must report the presence of seven of the nine elements in subparagraph (c)(5)(A) of this section to meet the metric; and

(B) all required data elements regarding infection control tracking in subparagraphs (c)(5)(B) and (C) of this section.

(6) Other metrics related to improving the quality of care for Texas Medicaid NF residents. If HHSC develops additional metrics for inclusion in QIPP, the associated performance requirements will be presented to the public for comment in accordance with subsection (e) of this section.

(e) Notice and hearing.

(1) HHSC will publish notice of the proposed metrics and their associated performance requirements no later than December 31 of the calendar year that precedes the first month of the eligibility period. The notice must be published either by publication on HHSC's Internet web site or in the *Texas Register*. The notice required under this section will include the following:

(A) instructions for interested parties to submit written comments to the HHSC regarding the proposed metrics and performance requirements; and

(B) the date, time, and location of a public hearing.

(2) Written comments will be accepted within 15 business days of publication. There will also be a public hearing within that 15-day period to allow interested persons to present comments on the proposed metrics and performance requirements.

(f) Final quality metrics and performance requirements will be provided through the QIPP webpage on HHSC's website on or before February 1 of the calendar year that also contains the first month of the eligibility period.

(g) Telehealth. In order for a NF to use telehealth services to meet some or all of the RN staffing metric, the following requirements must be met:

(1) the telehealth services must be both audio and visual in nature;

(2) the telehealth services must be provided by a RN, Advanced Practice Registered Nurse (APRN), or Physician's Assistant (PA); and

(3) The NF must have policies and procedures for such services. The NF's policy must include the following:

(A) how the NF arranges telehealth services;

(B) how the NF trains staff regarding the availability of services, implementation of services, and expectations for the use of these services; and

(C) how the NF documents telehealth services including initiation of services, the services provided, and the outcome of services.