TEXAS Health and Human Services

Draft Quality Metrics for Quality Incentive Payment Program (QIPP) SFY2022 for Nursing Facilities

Quality Metric Summary

HHSC has designated the following quality metrics for QIPP Year Five capitation rate components, covering the program eligibility period that begins on September 1, 2021.

Component One – Quality Assurance and Performance Improvement (QAPI) Meetings

HHSC designates one quality metric for Component One. Component One is open only to non-state government-owned (NSGO) providers. Funds in this Component are distributed monthly on a "Met" or Not Met" basis, contingent upon proper submission of the QAPI Validation Report form and data related to a NF-specific performance improvement project (PIP). The metric is:

- **Metric 1:** Facility holds a QAPI meeting each month that accords with quarterly federal requirements and pursues specifics outcomes developed by the NF as part of a focused PIP.

This metric entails an attestation by the facility administrator or authorized staff of a monthly meeting that incorporates all goals set forth for QAPI development by CMS. These goals are designed around existing federal rule 42 C.F.R. § 483.75 and arranged as follows:

- **F865:** §483.75(a), (b), (f), & (h) Each LTC facility, including a facility that is part of a multi-unit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life.
- **F866:** §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring.
- **F867:** §483.75(d) & (e) Program systematic analysis and systemic action and Program activities.
- **F868:** §483.75(g) Quality assessment and assurance.

This metric also entails monthly reporting of ongoing data collection and analysis that inform the development and implementation of their PIP, which must focus on a CMS long-stay MDS data with data published on the Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare website.

As part of their QAPI process, the nursing facility (NF) will be required to discuss the workforce development metric (see "Component Two" below) to review progress that is being made to improve the workforce in areas such as recruitment and retention, turnover, and vacancy rates.

HHSC will perform quarterly QAPI reviews on a representative sample of providers. If selected, the NF will have 14 days to submit the following records at the request of HHSC:

- Minutes from QAPI meetings;
- Sign-in or attendance sheets;
- Policies and outcomes developed in/as a result of meetings;
- Records related to results of actions taken in/as a result of meetings; and
- Records demonstrating owner/operator involvement in meetings.
- Summary of activities undertaken for the PIP planning and monthly reports (For example: topic selection, problem or question, target population, indicator measures of change with goal, baseline and measurement timeframes, sampling methods and interventions used, data collection and analysis plan listing sources of verifiable data, use of systemic analyses such as Root Cause Analyses (RCA), review and interpretation of results, assessment of impact and real improvement, and strategy for sustaining improvement).

Failure to participate in the review or to provide supporting documentation could result in adjustments pursuant to 1 T.A.C. §353.1301(k).

Component Two – Workforce Development

HHSC designates three equally weighted quality metrics for Component Two.

Component Two is open to all provider types, and funds are distributed monthly. The three metrics are:

- **Metric 1:** NF maintains four additional hours of registered nurse (RN) staffing coverage per day, beyond the CMS mandate.
- **Metric 2:** NF maintains eight additional hours of RN staffing coverage per day, beyond the CMS mandate.
- **Metric 3:** NF has a workforce development program in the form of a PIP that includes a self-directed plan and monitoring outcomes.

For quality metrics one and two, HHSC has outlined the following requirements for how a NF meets these metrics:

- Facilities must submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data e.g. staffing metrics reported to the Payroll Based Journal.
- Hours above the federally mandated eight hours of in-person RN coverage must be scheduled non-concurrently with mandated hours.
- Additional hours must be dedicated to direct-care services; Director of Nursing (DON) or managerial hours cannot be counted towards the 4 or 8 additional hours.
- NFs must provide in total 12 or 16 hours of RN coverage, respectively, on at least 90 percent of the days within the reporting period.
- Only hours actually worked count toward additional coverage; meal breaks must be deducted from scheduled hours.
- NFs may use telehealth technologies for scheduling hours beyond the eight hour in-person mandate.

For quality metric three, each NF will submit a self-directed PIP on the topic of resident-centered culture change, workforce development, or staff retention during the first reporting period and subsequently report outcomes related to that plan throughout the eligibility period.

Consideration of workforce development activities specific to Certified Nursing Assistants is encouraged as part of the PIP process. HHSC will not determine specific outcomes required for meeting the metric; rather, each NF must monitor and regularly report ongoing development of its self-directed goals and outcomes. HHSC has outlined the following requirements for how a NF meets this metric:

- NFs must submit their performance improvement project to HHSC during the first reporting period of the eligibility year.
- In subsequent reporting periods, the NF must report all documentation and data elements related to activities undertaken for the PIP as listed on the QIPP Component Two portal. Elements may include infection control training and protocols as applicable to workforce development and resident-centered culture change.

HHSC will conduct quarterly reviews of RN hours and performance improvement projects on a representative sample of providers. If selected, the NF will have 14 days to submit to HHSC:

- Direct-care staffing information (including agency and contract staff) based on payroll and other auditable data. The data, when combined with census information available through PBJ and MDS, may be used by HHSC to validate

the level of staff in each nursing home, as well as employee turnover and tenure, which can impact the quality of care delivered and
- Ongoing outcome-monitoring activities undertaken in a PIP. (For example: topic selection, problem or question, target population, indicator measures of change with goal, baseline and measurement timeframes, sampling methods and interventions used, data collection and analysis plan listing sources of verifiable data, use of systemic analyses such as Root Cause Analyses (RCA), review and interpretation of results, assessment of impact and real improvement, and strategy for sustaining improvement).

Failure to participate in the review or to provide supporting documentation could result in adjustments pursuant to 1 T.A.C. §353.1301(k).

Component Three – Minimum Data Set CMS Five-Star Quality Measures

HHSC designates four equally weighted quality metrics for Component Three.

Component Three is open to all provider types, and funds are distributed quarterly. All four metrics relate to Long-Stay Minimum Data Set (MDS) quality metrics and are measured against program-wide as well as facility-specific targets. The four metrics are:

- **Metric 1:** (CMS N015.03) Percent of high-risk residents with pressure ulcers, including unstageable pressure ulcers.
- **Metric 2:** (CMS N031.03) Percent of residents who received an antipsychotic medication.
- **Metric 3:** (CMS N035.03) Percent of residents whose ability to move independently has worsened.
- **Metric 4:** (CMS N024.02) Percent of residents with a urinary tract infection.

Facility-specific targets are calculated as improvements upon a NF's initial baseline, beginning with a five percent relative improvement in quarter one and increasing by five percent each subsequent quarter, up to 20% relative improvement by Quarter 4. Program-wide targets are set at the most recently published national average for each quality metric in quarter one and increase by five percent each subsequent quarter, up to 15% relative improvement by Quarter 4. NF initial baselines and quality metric benchmarks will be posted to the QIPP website in August 2021.

For a quality metric to be considered "Met" in a quarter, the NF must perform equal to or better than its facility-specific target or equal to or better than the program-wide target. A metric will be considered "Not Met" in any quarter in which the NF performs 10% worse than its previous result.

HHSC may conduct quarterly reviews of all the metrics. If selected, the NF will have 14 days to submit to HHSC explanation of discrepancy between data reported on the LTSS portal and MDS data. Failure to participate in the review or to provide supporting documentation could result in adjustments pursuant to 1 T.A.C. §353.1301(k).

Component Four – Infection Control Program

HHSC designates one quality metric for Component Four that entails alternating performance targets over the four quarters of the program year. Component Four is open only to NSGO providers, and funds are distributed quarterly. This metric is:

- **Metric 1:** Facility has active infection control program that includes pursuing improved outcomes in vaccination rates and antibiotic stewardship.
- **Quarter 1 Performance Target:** The NF must submit evidence-based infection control policies and supporting documentation that include at least the following antibiotic stewardship elements:
  - Designated leadership individuals for antibiotic stewardship
  - Written policies on antibiotic prescribing
  - Pharmacy-generated antibiotic use report from within the last six months
  - Antibiogram report from within the last six months (or from regional hospital)
  - Audits (monitors and documents) of adherence to hand hygiene
  - Audits (monitors and documents) of adherence to personal protective equipment use
  - Current list of reportable diseases
- **Quarter 2 Performance Target:** The NF must submit supporting documentation for the following training elements:
  - Nursing Facility Administrator (NFA) and Director of Nursing (DON) completing annual training in Infection Control and passing the CDC Infection and Control Program certification program for Infection Preventionist.
  - Infection control policies demonstrating data-driven analysis of NF performance and evidence-based methodologies for intervention. (Updated within 6 months of reporting period)
- **Quarter 3 Performance Target:** These mirror requirements from Quarter 1. The NF must submit evidence-based infection control policies and supporting documentation that include at least the following:

  - Designated leadership individuals for antibiotic stewardship
  - Written policies on antibiotic prescribing
  - Pharmacy-generated antibiotic use report from within the last six months
  - Lab-generated antibiogram report from within the last six months (or from regional hospital)
  - Audits (monitors and documents) of adherence to hand hygiene
  - Audits (monitors and documents) of adherence to personal protective equipment use
  - Current list of reportable diseases
- **Quarter 4 Performance Targets:** The following MDS measures related to vaccination rates will be measured against program-wide benchmarks derived from the most recently published national average at the beginning of the eligibility period. To meet the metric, both percentages must reach the target:
  - Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (CMS N020.02)
  - Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (CMS N016.03)

Facilities will report additional data elements (e.g. COVID-19 vaccinations, Number of Hospitalizations Due to COVID-19) each quarter for tracking purposes. Reporting these elements is mandatory, but the specific values reported will not factor into a facility meeting or not meeting the quality metric.

HHSC will conduct quarterly reviews of infection prevention and control data and PIP documentation on a representative sample of providers. If selected, the NF will have 14 days to submit to HHSC auditable data and documents related to the PIP data elements listed for metrics two and three. Failure to participate in the review or to provide supporting records could result in a determination that Component Four payments should be recouped or adjusted pursuant to 1 TAC §353.1301(k).

SFY2022 Reporting Requirements & Instructions

Component One – QAPI Portal Instructions

Data will be collected monthly through the LTSS Quality Component Data Web Portal. Facilities will have one business day into the following month to complete their submission for the reporting period (the previous calendar month).

Beyond a signed attestation form, this metric entails monthly reporting of ongoing data collection and analysis that inform the development and implementation of their PIP, which must focus on a CMS long-stay MDS data with data published on the Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare website.

Sample data elements for the Web Portal include:

- The MDS-based measure selected for improvement
- Most recently published performance percentage as of the beginning of the eligibility period
- Performance percentage reviewed during the reporting period
- Updates to methodologies, analyses, and proposed interventions delineated in the PIP
- Evaluations of outcomes and completed interventions

Sample QAPI Validation Report Text

I, _____ [responsible party], on behalf of _____ [facility name] hereby attest that this facility conducted its monthly QAPI meeting on _____ [calendar date] at _____ [time of day].

I further attest that this meeting provided for meaningful contribution to a program of quality assurance and performance improvement per the Code of Federal Regulations requirements and definitions contained in 42 C.F.R. §483.75(a) thru (h), as noted in the State Operations Manual (SOM) Appendix PP under the following FTags:

- **F865:** Quality Assurance Performance Improvement (QAPI) program;
- **F866:** Program feedback, data systems and monitoring;
- **F867:** Program systematic analysis and systemic action; and
- **F868:** Quality assessment and assurance. I understand that both holding the monthly meeting and correctly submitting this document are required to receive payments under Component One of the Quality Incentive Payment

Program (QIPP), as set out in the UMCM contract, and in compliance with the rules set forth in 1 T.A.C. §§353.1302 and 353.1304.

I further understand that this report will be considered submitted correctly only if the report is:

- Received by HHSC by close of business on the first business day of the following month;
- Submitted through the portal found at the following link: http://registration.hhsc.state.tx.us/qipp_app/qipp_app/Default.aspx; and
- Titled clearly with the following information:
  - Provider Name
  - Facility ID
  - Month and Year of Meeting
  - e.g. "Stony Creek – 49679 – October 2019"

I further understand that HHSC will audit quarterly a sample of reports submitted by participating facilities. The facility that filed the report must provide the following documents for any and all months under review:

- Meeting minutes;
- Attendance and/or sign-in sheets;
- Demonstration of owner and/or operator involvement, as delineated in §483.75(f), such as proof of oversight, monitoring, or attendance;
- All documents related to program feedback and monitoring, as delineated in §483.75(c), such as records of the development and evaluation of performance indicators, adverse event monitoring, and collecting input from staff, residents, and resident representatives; and
- All documents related to program analysis and action, as delineated in §483.75(d), such as root cause analyses, corrective action plans, program interventions, and impact of projects on clinical care, quality of life, and consumer choice.

HHSC may recoup Component One payments when a facility's documentation does not support the information reported. Failure of a facility to provide supporting documentation to HHSC within 14 days may result in recoupment of Component One payments.

[Signature and Date]

If you have any questions or concerns about monthly QAPI attestations, please email MCS_QIPP_QAPI@hhsc.state.tx.us with a clearly titled Subject line.

Component Two – Workforce Development Portal Instructions

Data will be collected monthly through the LTSS Quality Component Data Web Portal. Facilities will have three business days into the following month to complete their submission for the reporting period (the previous calendar month).

Performance Improvement Project (PIP)

Metric 3 entails monthly reporting of ongoing data collection and analysis that inform the development and implementation of their workforce development PIP, including data in areas such as recruitment and retention, turnover, and vacancy rates. Monthly submissions may require appropriate supporting documentation.

RN Coverage Metrics

Facilities must attest to the number of days the additional RN staffing hours were met and how services were rendered (in-person or via telehealth). For telehealth services, facilities must report total hours covered, summary encounter data, and any encounters that do not meet an in-person level of care.

Only direct-care services count toward the additional 4 or 8 hours of RN coverage each day. As per the Payroll-Based Journal Manual, RN hours are counted according to the RN's primary role for the hours logged; only non-administrative, direct-care hours count toward the Component Two RN coverage metrics.

Telehealth Services

Telehealth technologies can be used to provide a flexible modality of additional RN coverage, not to provide an alternative to additional RN coverage. This section will outline requirements regarding the appropriate use of telehealth technologies in meeting the first two quality metrics for Component Two.

For purposes of the QIPP, when health care services are delivered by a provider to a resident at a different physical location than the provider using telecommunications or information technology, such services are considered to be telehealth services. In accordance with 1 T.A.C. §353.1304(g)(2), telehealth services may be provided only by an RN, APRN, NP, PA, or physician.

To be considered appropriate and sufficient, telehealth services must be provided in compliance with all standards established by the respective licensing or certifying board of the provider. The requirements for telehealth services in acute care settings do not apply to the use of telehealth services in the QIPP context.

The provider must obtain informed consent to treat from the resident, resident's parent, or the resident's legal guardian prior to rendering services via telehealth. Healthcare providers at the resident's physical location cannot give consent on behalf of the resident.

HHSC will review telehealth performance during quarterly quality assurance reviews and will not approve policy. Many private telehealth services do not provide direct access to RNs or an in-person level of care, and so would not count toward coverage for the purposes of QIPP. For example, dispatchers do not count as RNs. Each facility is responsible for meeting all requirements, including those related to patient privacy and consent, if telehealth services are used as a modality of RN coverage.

Service Delivery Modalities

In accordance with 1 T.A.C. §353.1304(g)(1), telehealth services must engage the following modalities to meet the first two quality metrics for Component Two:

- Synchronous audio-video interaction established and maintained between the provider and the resident; or
- Asynchronous forwarding technology that supplements or works in conjunction with a synchronous audio or video interaction between the provider and the resident.

To provide appropriate and sufficient service that would meet the in-person standard of care, the provider may need access to:

- Clinically relevant photographic or video images, including diagnostic images; or
- The resident's relevant medical records, such as medical history, laboratory and pathology results, and prescriptive histories; or
- Other forms of audiovisual telecommunication technologies that allow the provider to meet the in-person visit standard of care.

Availability

Telehealth services are considered available only when the telehealth technologies are working properly and the RN is available to provide an in-person level of care. If either element is lacking, the hours do not count toward additional coverage metrics.

Further considerations relating to availability include:

- Hours wherein telehealth services are unavailable for any reason will not count toward RN metric hours, whether an encounter was requested during that time or not.

- Hours wherein telehealth services are available may count toward RN metric hours, whether an encounter was requested during that time or not.
- If an RN is engaged by one facility, the RN is considered unavailable for any other facility, whether another encounter is requested during that time or not.
- Telehealth services will be considered unavailable during any encounter that does not meet the in-person level of care.

Timeliness

If the time that elapses between facility staff recognizing a need for RN-level care and initiating a telehealth service request exceeds 15 minutes, the encounter does not meet the in-person standard of care. Furthermore, if the time that elapses between a completed request for telehealth services and the engagement of the telehealth professional in a resident consultation exceeds 15 minutes, the encounter does not meet the in-person standard of care.

If the timeliness requirement is not met, then the RN is considered unavailable for at least the 30-minute window represented by the missed encounter duration. Hours cannot be counted for any time the RN is unavailable.

Portal Data Elements

The LTSS Quality Component Data Web Portal is the form through which all Component data are submitted. The Component Two tab of the portal includes the following required questions:

1. How many days during the reporting period (the previous calendar month) did the facility meet 4 hours of additional RN coverage?
2. How many days during the reporting period (the previous calendar month) did the facility meet 8 hours of additional RN coverage?
3. By checking this box, I attest that additional RN hours used to meet these metrics were not concurrent with otherwise mandated RN hours.

The first two items are tied directly to meeting the first two quality metrics for Component Two. The following questions are only to help track telehealth use and to inform HHSC staff prior to quality assurance reviews.

4. Did the facility use telehealth services for any of these shifts?

If the facility answers 'Yes' to item 4, then the Web portal will load the following questions:

5. How many days during the reporting period did the facility use telehealth services to meet the additional RN coverage hours?
6. How many hours during the reporting period did the facility use telehealth services to meet the additional RN coverage hours?

NOTE: The days reported in question 5 specify how many of the previously reported total days from questions 1 and 2 were met with telehealth services. Only the answers to questions 1 and 2 will be measured against the monthly target.

The Web portal also includes a "Submit Documentation" button that allows NFs to upload or update recruitment and retention plans (mandatory for the first reporting period of the eligibility year) and documentation regarding goals and outcomes related to the current PIP (mandatory for every subsequent reporting period of the eligibility year). Facilities must submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data e.g. staffing metrics reported to the Payroll Based Journal.

Component Four – Infection Control Program Portal Instructions

Data for the infection control program metrics of Component Four will be collected quarterly through the LTSS Quality Component Data Web Portal. In alignment with the process of MDS data submissions, facilities will have a one-month reconciliation window at the end of the quarter to submit and update data related to the MDS-based metrics.

NOTE: Because data collection follows the CMS publishing scheduled, the reconciliation period ends on the final Sunday of the month. This may not be the final day of the calendar month. Please see the QIPP website for specific deadlines each eligibility period.

All data will be considered final when HHSC begins calculations at the end of the reconciliation period.

Portal Data Elements

Each quarter will provide a separate tab for reporting Component Four data through the LTSS Quality Component Data form. Definitions of terms and acceptable sources for reporting data will be included in the portal instructions and covered in provider training webinars.

Facilities will report additional data elements (e.g. COVID-19 vaccinations, Number of Hospitalizations Due to COVID-19) each quarter for tracking purposes. HHSC may add elements to the portal as needed to include additional infection rates or to track trends. In all cases, reporting the items remains mandatory, but values will not be used to count against the facility for meeting any Component Four metrics.

Quarter 1

NF must attest to and submit documents supporting each of the key metric elements below before the end of the reconciliation period:

- Designated leadership individuals for antibiotic stewardship
- Written policies on antibiotic prescribing
- Pharmacy-generated antibiotic use report from within the last six months
- Antibiogram report from within the last six months (or from regional hospital)
- Audits (monitors and documents) of adherence to hand hygiene
- Audits (monitors and documents) of adherence to personal protective equipment use
- Current list of reportable diseases

NOTE: Documentation is required from all NFs for HHSC to consider the submission complete.

Quarter 2

NF must attest to and submit documents supporting each of the key metric elements below before the end of the reconciliation period:

- Nursing Facility Administrator (NFA) and Director of Nursing (DON) completing annual training in Infection Control and passing the CDC Infection and Control Program certification program for Infection Preventionist.
- Infection control policies demonstrating data-driven analysis of NF performance and evidence-based methodologies for intervention. (Updated within 6 months of reporting period)

Quarter 3

The Quarter 3 tab will be identical to that of Quarter 1, and identical data elements are required for submission. See quarterly deadlines on the QIPP website.

Quarter 4

No reporting is required for the Quarter 4 metrics. NF performance on the following MDS measures will be derived from the most recently published CMS data:

- Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (CMS N020.02)
- Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (CMS N016.03)

Proposed Quality Metrics – Table View

Component	Type	Tag(s)	Metric
One	State Benchmark	N/A	Facility holds a QAPI meeting each month in accordance with quarterly federal requirements and pursuant of a facility-developed PIP
Two	State Benchmark	N/A	NF maintains 4 additional hours of RN coverage per day, beyond the CMS mandate
Two	State Benchmark	N/A	NF maintains 8 additional hours of RN coverage per day, beyond the CMS mandate
Two	State Benchmark	N/A	Facility has a workforce development PIP that includes a self-directed plan and monitoring outcomes
Three	Minimum Data Set	CMS N015.03	Percent of high-risk residents with pressure ulcers
Three	Minimum Data Set	CMS N031.03	Percent of residents who received an antipsychotic medication
Three	Minimum Data Set	CMS N035.03	Percent of residents whose ability to move independently has worsened
Three	Minimum Data Set	CMS N024.02	Percent of residents with a urinary tract infection
Four	State Benchmark	NA	Facility has active infection control program that includes pursuing improved outcomes in vaccination rates and antibiotic stewardship.
Four	Minimum Data Set	CMS N020.02	Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine
Four	Minimum Data Set	CMS N016.03	Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine