# QIPP Quality Metric Technical Requirements & Portal Instructions for State Fiscal Year (SFY) 2024

The Texas Health and Human Services Commission (HHSC) is providing these specifications for the Quality Incentive Payment Program (QIPP) measures. HHSC may make technical updates to quality measure specifications as needed and appropriate to reflect recommended clinical practice, current coding standards, and/or changes in Centers for Medicare and Medicaid (CMS) measure specifications. QIPP is governed Texas Administrative Code (TAC) Rules 1 TAC §353.1301, 1 TAC §353.1302, and 1 TAC §353.1304.

The instructions given below are published in accordance with the approved QIPP SFY 2024 (Year 7) preprint. Visit the QIPP Website for a general overview of the program. The QIPP Resources Webpage includes the overview webinar, QIPP Year 7 performance requirements, required reporting templates, and self-paced training on how to use the *QIPP Data Submission Portal* to meet reporting requirements.

**NOTE:** The QIPP Data Submission Portal will temporarily be taken offline for scheduled maintenance to close out QIPP Year 6 and will re-open before the first QIPP Year 7 reporting deadline. Data reported in the QIPP Data Submission Portal must come from a documented, auditable source. This source must entail a consistent methodology for producing these data, standardized across every reporting period.

**January 2024 Update:** Due to changes made to the Resident Assessment Instrument (RAI) and related long-stay Minimum Data Set (MDS) quality measures that went into effect 10/01/2023, the independent mobility (N035.03) and pressure ulcer (N015.03) MDS measures have been removed from Component 3 for the duration of SFY 2024.

This change is reflected on pages 19 and 26 below. Each remaining measure is now worth 50% of available funds in the component.

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# Who Can Participate in QIPP?

Two classes of Texas nursing facilities (NF) serving residents enrolled in STAR+PLUS Medicaid are eligible to participate:

- Non-state government-owned nursing facilities (NSGO)
- Privately-owned nursing facilities that have a percentage of Medicaid NF days of service that is greater than or equal to 65%

Providers earn payments for meeting participation and performance requirements for up to four components:

- Component One: Quality Assurance and Performance Improvement (QAPI)
- Component Two: Workforce Development
- Component Three: Minimum Data Set (MDS) CMS Quality Measures
- Component Four: Infection Prevention and Control Program

As seen in Figure 1, below, if you are an NSGO facility, you are eligible to participate in all four components. If you are an eligible privately-owned facility, you are eligible to participate only in Components Two and Three.

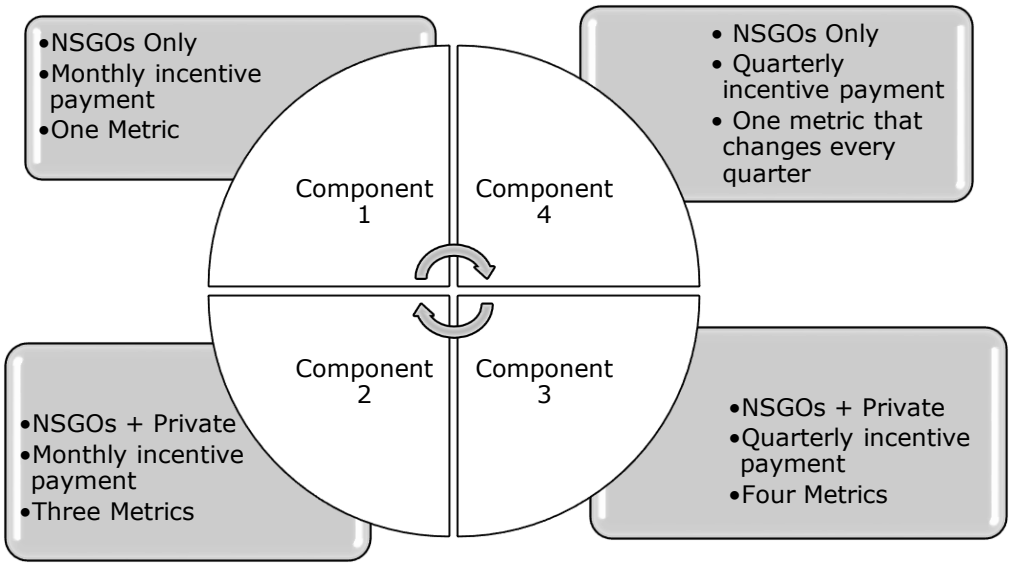


**Figure 1: QIPP Component Structure**

Component One has one quality metric, while Components Two through Four include up to four quality metrics each. The quality metrics are equally weighted

(within a component) for payment each month or quarter, as appropriate. QIPP funds are paid through these four components of the STAR+PLUS nursing facility managed care per member per month capitation rates. Each component's value is determined as a percentage of the total amount of funding available for the QIPP program.

# Changes of Ownership

NFs changing ownership to a new class of facility are a member of the new class retroactive to the effective date of the change in ownership (CHOW), following HHSC approval of the CHOW application. NFs must meet eligibility requirements for the new facility class beginning with the effective date of the CHOW.

**NOTE:** If a NF changes ownership to become a non-state government owned NF, the conditions of participation reporting requirements under Component 1 will become effective on the final HHSC approval of the CHOW application.

# Conditions of Participation

As a condition of participation, all NFs participating in QIPP must report all quality data denoted as required for each component as outlined below. Facilities must use Quality Assurance and Performance Improvement (QAPI) processes to develop a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes in the form of two Performance Improvement Projects (PIP).

A sample of the PIPs submitted at the beginning and end of the program year may be reviewed as part of program evaluation activities by an External Quality Review Organization. Enrolled NFs must submit all requested information necessary for HHSC to evaluate to what degree the program is advancing one or more state quality goals.

If the NF does not submit completed PIP templates and attest to whether the NF held the monthly QAPI meetings, HHSC (or its appointed agent) will follow up to provide an opportunity for the provider to meet the reporting requirements. If the NF does not submit the required information within timelines communicated by HHSC, the NF will be removed from the program and all payments will be recouped.

Conditions of participation apply to the following components:

- **Component 1:** Facility holds a QAPI meeting each month that accords with any applicable quarterly federal and state requirements and pursues specific outcomes developed by the NF as part of a focused PIP. This metric entails an attestation by the facility administrator or authorized staff that a monthly meeting was held that incorporates all goals set forth by CMS for QAPI development.

- **Component 2, Metric 3:** NF has a workforce development program in the form of a PIP that includes a self-directed plan and monitoring outcomes. NF completes the PIP reporting template with appropriate information on PIP implementation.

**NOTE:** A NF that fails to meet all required conditions of participation will be removed from the program retroactive to the first day of the program period. HHSC will redistribute revenue paid to facilities removed from the program to the remaining facilities participating in the program period. Facilities that meet the conditions of participation will remain enrolled in the program period. For a full list of the required conditions of participation, including conditions not discussed here, please refer to 1 TAC 353.1302(e).

# Option to Decline Payment

A facility may notify HHSC that it wishes to decline revenue from a component of QIPP at any time. If a facility notifies HHSC that it wishes to decline payment for a component or components, HHSC will remove the facility from consideration of the component when allocating revenues associated with that component.

For example, if a NSGO facility determines that it does not wish to receive funds from Component 1, HHSC will not include the days of that facility when calculating the interim distribution of QIPP payments in the scorecard, nor will HHSC consider the days of that facility when conducting post-program period reconciliations. **Declining payment impacts only the receipt of funds and does not impact any other program requirement, including meeting eligibility standards or conditions of participation.**

A provider's ability to decline a payment and the exclusion of that provider from certain calculations is a distinct process from how HHSC will consider revenues that are associated with components for which payments are based on measure achievement. In circumstances in which payment is tied to measure achievement, revenue that would have been designated for the facility in the component but was

not earned by the facility will be entered into non-dispersed funds and distributed across qualifying QIPP participants based on each NF's proportion of total earned QIPP funds by component.

For more information, please visit the Provider Finance QIPP Website.

If your facility wishes to decline revenue for a QIPP component(s), please email QIPP@hhs.texas.gov.

# Quality Assurance

All data and documentation supplied to HHSC (or its appointed agent) by the NF to demonstrate achievement of performance requirements is subject to validation and audit. HHSC (or its appointed agent) will select a random, representative sample of participating NFs for quality assurance review each program period and will conduct reviews on one-fourth of the total sample each program quarter.

- If selected, the NF will have 14 business days from the date of the request from HHSC (or its appointed agent) to submit to HHSC (or its appointed agent) the required data and documentation.

- If the selected NF fails to participate in the review or to provide the required data or documentation, any payments to the provider for the quality metric or component under review may be considered an Overpayment and subject to recoupment or adjustment as described in §353.1301(k) of this subchapter.

# Component One – Quality Assurance and Performance Improvement

Component One is open only to NSGO providers, and funds are distributed monthly. As a condition of participation, NSGO facilities must:

- Conduct a monthly quality assurance and performance improvement (QAPI) meeting (in accordance with 42 C.F.R. § 483.75 requirements for quarterly meetings);
- Conduct and report progress updates on their Performance Improvement Project (PIP) based on a CMS long-stay MDS quality measure at the beginning and end of the program year; and
- Serve at least one Medicaid member per payment period.

**Reporting Frequency:** Semi-annually

**Deadline:** Elements constituting the PIP Charter are due December 6, 2023; final elements covering PIP implementation and outcomes are due September 6, 2024.

# Component One: Performance & Reporting Requirements

As a condition of participation, all NSGO NFs participating in QIPP must report all quality data denoted as required. A facility must submit the information necessary for HHSC to evaluate if the program is advancing the quality goal or strategy.

> Each NF must complete all the reporting requirements through the QIPP Data Submission Portal. Reporting frequency for SFY2024 is **twice a year**. Performance requirements remain the same as in SFY2022 and SFY2023, and monthly QAPI meetings should be utilized for the development and implementation of a PIP.

## Monthly QAPI Meetings

This component entails an attestation by the facility administrator or authorized staff of a monthly meeting that incorporates all goals set forth for QAPI development by the state and CMS (in accordance with 42 C.F.R. § 483.75).

## Component One PIP Data Elements

Each NF must select one MDS-based long-stay quality measure to act as the primary quality measure for the performance improvement project. Initial data elements recorded in the *Component One PIP Reporting Template* include:

- Topic of the PIP: one MDS-based long-stay quality measure;
- Primary quality measure used to track progress;
- NF's data source for tracking the measure, which must remain consistent across reporting periods;
- Most recently published performance data, including numerator, denominator, and resulting percentage;
- Reporting period for data; and
- Reasonable performance goal for the program year.

The performance data entered for the first reporting period will function as the baseline for the rest of the program year. These data must reflect the most recently published data from the designated data source for the measure.

Data reported in the final reporting period will be measured against this baseline; however, HHSC does not determine specific outcomes for meeting the PIP goals as measures of success or failure. Facilities determine their own criteria. If the goal is met at some point in the program year, the facility should strive for further improvement and set a higher goal or implement additional interventions.

## Component One PIP Reporting

The NF is required to upload the *Component One PIP Reporting Template* document **twice a year**. The first reporting period requires completion of Tabs 1-3; the second reporting period requires completion of Tabs 4-6.

Data and documentation will be submitted in the following manner:

- **December 6, 2023:** The NF is required to submit documentation that constitutes the PIP Charter as delineated in the *Component One PIP Reporting Template* Tabs 1 through 3. The PIP Charter includes information about the PIP leadership team, definitions of the primary quality measure,

baseline data, improvement goals, a summary of the root cause analysis undertaken, and at least one planned intervention.

- **September 6, 2024:** The NF must submit documentation that records the implementation and outcomes of the PIP as delineated in Tabs 4 through 6 of the template. The final tabs include records of project interventions and outcomes, the tracking of secondary quality measures or performance indicators, and overall outcomes.

This template is to be used to fulfill reporting requirements only. It does not provide prescriptive guidance on how to conduct QAPI activities. Submission of the *Component One PIP Reporting Template* and relevant supporting documentation on both dates described above is required to meet conditions of participation.

# Component One: Quality Assurance Review

HHSC will conduct quarterly reviews of CMS long-stay MDS quality measure performance improvement projects on a sample of providers. If selected, the NF will have 14 business days to submit the following records at the request of HHSC (or its appointed agent):

- Minutes from monthly QAPI meetings;
- Sign-in or attendance sheets showing names, titles, and roles of attendees;
- Policies and outcomes developed in or as a result of meetings;
- Records related to results of actions taken in or as a result of meetings;
- Records demonstrating owner/operator involvement in meetings; and
- Current QAPI plan and summary of activities undertaken for the PIP planning and implementation. For example: measure and 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 may result in adjustments pursuant to 1 T.A.C. §353.1301(k).

# Component Two – Workforce Development

Component Two is open to all provider types, and funds are distributed monthly. HHSC designates three equally weighted metrics for Component Two. Metric 1 and Metric 2 have monthly reporting and performance requirements. As previously stated, the third metric is a condition of participation. The three metrics are:

**Metric 1:** NF maintains four additional hours of registered nurse (RN) staffing coverage per day, for 90% of days in the month, beyond the CMS mandate of onsite RN coverage 8 hours a day, 7 days a week.

**Metric 2:** NF maintains eight additional hours of RN staffing coverage per day, for 90% of days in the month, beyond the CMS mandate of onsite RN coverage 8 hours a day, 7 days a week.

**Metric 3:** NF has a workforce development program in the form of a PIP that includes a self-directed plan and monitoring outcomes. NF must complete the PIP reporting template and submit appropriate information on PIP implementation.

> For Component Two, NFs must complete all reporting requirements through QIPP Data Submission Portal.
>
> **For Metric 1 & 2, reporting frequency is monthly**, due on the 4th business day following the end of each reporting period.
>
> **For Metric 3, reporting frequency is twice a year.** As a condition of participation, all data and documentation are due in December 2023 and September 2024.

# Metrics 1 & 2: RN Coverage Performance Requirements

Performance target for Metrics 1 and 2 are "met" only if a NF maintains four or eight *additional* hours for 90% of days in the month beyond the federal requirement to have an RN onsite 8 hours a day, 7 days a week. HHSC may utilize

staffing data submitted by each facility to the CMS developed Payroll-Based Journal (PBJ) system[a] for verification of federal staffing requirements.

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 staff services count toward the additional 4 or 8 hours of RN coverage each day. Direct Care Staff will be defined as per the Payroll-Based Journal Long-Term Care Facility Policy Manual (Version 2.6, June 2022). 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.

For Metrics 1 and 2, HHSC has outlined the following requirements for how a NF is considered to have met these metrics:

- Facilities must submit direct care staffing information (including information for agency and contract staff) based on payroll or other auditable data. Attestations to hours must be made with evidence.
- 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% of the days within the reporting period.
- HHSC defers to the Electronic Staffing Data Submission Payroll-Based Journal Long-Term Care Facility Policy Manual (Version 2.6, June 2022) for definitions of staffing hours such as time, workday and date, hours and mealtimes, shifts, labor classification and job titles, and co-located (hospital-

[a] Staffing Data Submission Payroll Based Journal (PBJ), Nursing Home Quality Initiative, Centers for Medicare and Medicaid Services. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ

based) facilities. 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.

# 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 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. **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 applicable 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 may not give consent on behalf of the resident.

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

## Service Delivery Modalities

Telehealth services must employ at least one of the following methods 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;
- 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 in which 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 in which telehealth services are available may count toward RN metric hours, whether an encounter was requested during that time or not.
- If an RN is providing a telehealth service to one resident in one facility, the RN is considered unavailable at that same time 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 requirements described above are not met, then the RN is considered unavailable for at least the 30-minute window represented by the missed encounter duration. Hours may not be counted for any time the RN is unavailable.

# Metrics 1 & 2: RN Coverage Reporting Requirements

These metrics entail an attestation by the facility administrator or authorized staff to the accuracy of the data provided. Data are collected monthly through the QIPP Data Submission Portal. Facilities have four business days into the following month to complete their submission for Registered Nurse (RN) coverage and workforce development data.

When selecting the reporting period from the Portal dropdown menu, select the month for which you are reporting data. **Do not select the month of the deadline.**

## RN Coverage Data Elements

The monthly Component Two module in the QIPP Data Submission Portal includes the following required questions:

- How many days during the reporting period (the previous calendar month) did the facility meet 4 hours of additional RN coverage?
- How many days during the reporting period (the previous calendar month) did the facility meet 8 hours of additional RN coverage?
- 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 used only to help track telehealth use and to inform HHSC staff prior to quality assurance reviews.

- 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:

- How many days during the reporting period did the facility use telehealth services to meet the additional RN coverage hours?
- How many hours during the reporting period did the facility use telehealth services to meet the additional RN coverage hours?
- How many telehealth encounters did the NF experience over the reporting period?

**NOTE:** The days reported in the telehealth section specify how many of the previously entered total days from Questions 1 and 2 were met with telehealth services. **Only the number of days entered into Section One will be measured against the monthly target.**

## RN Coverage Required Documentation

***RN Coverage Tracking Sheet:*** Facilities must submit direct care staffing information (including agency and contract staff) based on payroll or other auditable data, e.g., staffing metrics reported to the PBJ. No specific template is required for NFs to track their RN coverage; however, the source of all data entered into the Portal must be labeled and identifiable in support documentation.

***Summary Telehealth Encounter Data:*** Facilities that use telehealth hours to meet Metric 1 or 2 requirements must submit summary data for all telehealth encounters that demonstrate that the level of care, availability, and timeliness requirements were met.

# Metric 3: Workforce Development PIP Requirements

Metric 3 requirements include the development of a PIP in a topic of workforce development and bi-annual reporting of ongoing implementation through the *Component Two PIP Reporting Template* found on the QIPP Resources Webpage.

> The PIP topics for Component Two, Metric 3 differ from those for Component One.
>
> *Examples of Component Two topics include recruitment or vacancy rates; turnover, tenure, or retention rates; infection control training or protocols; workforce development activities specific to Certified Nursing Assistants; resident satisfaction; staff satisfaction; resident-centered culture change; staff-to-patient ratios (e.g., RN, CNAs); hospital readmissions; and preventable emergency department visits.*

## Workforce Development PIP Data Elements

After choosing a topic for the PIP, each NF must select or create a primary quality measure to track progress in the area of focus. Initial data elements recorded in the *Component Two PIP Reporting Template* include:

- Topic of the workforce development PIP;
- Primary quality measure used to track progress;
- NF's data source for tracking the measure, which must remain consistent across reporting periods;
- Most recently published performance data, including numerator, denominator, and resulting percentage;
- Reporting period for data; and
- Reasonable performance goal for the program year.

The data entered for the first reporting period will function as the baseline for the rest of the program year. These data must reflect the most recently published data from the designated data source for the measure.

Data reported in the final reporting period will be measured against this baseline; however, HHSC does not determine specific outcomes for meeting the PIP goals as measures of success or failure. Facilities determine their own criteria. If the goal is met at some point in the program year, the facility should strive for further improvement and set a higher goal or implement additional interventions.

## Workforce Development PIP Reporting

The NF is required to upload the *Component Two PIP Reporting Template* document **twice a year**. The first reporting period requires completion of Tabs 1-3; the second reporting period requires completion of Tabs 4-6.

Data and documentation will be submitted in the following manner:

- **December 6, 2023:** The NF is required to submit documentation that constitutes the PIP Charter as delineated in the *Component Two PIP Reporting Template* Tabs 1 through 3. The PIP Charter includes information about the PIP leadership team, definitions of the primary quality measure, baseline data, improvement goals, a summary of the root cause analysis undertaken, and at least one planned intervention.
- **September 6, 2024:** The NF must submit documentation that records the implementation and outcomes of the PIP as delineated in Tabs 4 through 6 of the template. The final tabs include records of project interventions and outcomes, the tracking of secondary quality measures or performance indicators, and overall outcomes of the project.

The NF may use its own documents or CMS templates during the PIP process; however, submitting the *Component Two PIP Reporting Template* and relevant supporting documentation on both dates described above is required to meet conditions of participation.

# Component Two: Quality Assurance Review

HHSC will conduct quarterly reviews of RN hours and workforce development performance improvement projects on a sample of providers. If selected, the NF will have 14 business days to submit to HHSC (or its appointed agent):

- Direct-care staffing information (including agency and contract staff), based on payroll or other auditable data. The data 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, e.g., copies of applicable shift schedules & corresponding timesheets from the NF's payroll system verifying that the shift schedule was covered by a qualifying RN and/or other direct care staff.

- Telehealth: Outcome data for all telehealth encounters; telehealth usage policy; and documentation of ongoing monitoring for appropriate use, service delivery modality, availability, and timeliness.

- Ongoing outcome-monitoring activities undertaken in a PIP to improve the workforce, e.g. topic selection, problem or question development, 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.

**NOTE:** Performance target for Metrics 1 and 2 are "met" only if NF maintains four or eight additional hours for 90% of days in the month beyond the federal requirement to have an RN onsite 8 hours a day, 7 days a week. HHSC may utilize data submitted by each facility through the PBJ and published through Nursing Home Care Compare for verification of federal staffing requirements.

If the NF is selected for a Quality Assurance Review (QAR), documentation from across the program year will be reviewed. Failure to participate in the review or to provide supporting documentation may result in adjustments pursuant to 1 T.A.C. §353.1301(k).

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

Component Three is open to all provider types, and funds are distributed quarterly. HHSC designates two equally weighted quality metrics for Component Three. Both metrics relate to Long-Stay Minimum Data Set (MDS) quality metrics and are measured against program-wide as well as facility-specific targets.

> Facility-specific performance targets and quarterly results showing "Met/Not Met" status for each measure are published on the HHSC Provider Finance Website through a scorecard Excel document.

The two metrics are:

**Metric 1:** (CMS N031.03) Percent of residents who received an antipsychotic medication.

**Metric 2:** (CMS N024.02) Percent of residents with a urinary tract infection.

# Component Three: Performance Requirements

Facility-specific targets are calculated as improvements upon a NF's initial baseline, beginning with a 5% relative improvement in quarter one and increasing by 5% each subsequent quarter, up to a 20% relative improvement by Quarter 4. Program-wide targets are set at the most recently published national average for each quality metric. NF initial baselines and quality metric benchmarks will be posted to the QIPP website at the beginning of the SFY 2024 program year.

For a quality metric to be considered "Met" in a quarter, the NF must perform either:

- Equal to or better than its facility-specific target; **or**
- Equal to or better than the program-wide target, without declining in performance beyond an allowed margin from the NF's initial baseline.

Each metric-specific margin will be defined as the absolute +/- change in the national average for that metric from the previous program year to the current program year. Any metric will be considered "Not Met" for the quarter or year if a NF performs worse than its initial baseline by more than this margin.

Table 1 illustrates the escalating 5% performance targets for improvement.

**Table 1: Performance Targets**

| Requirement | Q1 Target | Q2 Target | Q3 Target | Q4 Target |
|---|---|---|---|---|
| Improve on NF-specific baseline | 5% relative improvement on baseline | 10% relative improvement on baseline | 15% relative improvement on baseline | 20% relative improvement on baseline |
| | **OR** | **OR** | **OR** | **OR** |
| Meet or Exceed program-wide benchmark | Most recently published national average at the beginning of the program period (Benchmark) | Benchmark | Benchmark | Benchmark |

# Component Three: Reporting Requirements

> **NFs do not have to report MDS data or results to HHSC for QIPP.** NFs Report MDS Assessment Data to CMS, per federal requirements.

# Component Four – Infection Prevention and Control Program

HHSC designates one quality metric for Component Four. However, there are different performance requirements staged differently for each quarter 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[b].

**Frequency**: Quarterly

**Deadlines**: End of the "one-month reconciliation" period, which is set as the last business day of the month following the reporting period. For the SFY 2024 program year, the deadlines are 12/29/2023 (Q1), 3/29/2024 (Q2), 6/28/2024 (Q3), and 9/30/2024 (Q4 MDS assessment data).

**Required Document Submission**: Antibiotic prescription policies, HH audit documentation, PPE audit documentation (Q1, Q3); infection control training certificates (Q2). No documentation is required for Q4.

# Component Four: Performance & Reporting Requirements

While QIPP has only one quality metric in Component Four, there are different performance requirements staged for each quarter. All performance targets within the given quarter must be met to earn an incentive payment for the component in that reporting period. The performance requirements for each quarter are as follows:

[b] Recommended evidence-based resource: **Implement, Monitor, and Sustain an Antimicrobial Stewardship Program**. Content last reviewed October 2016. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/nhguide/toolkits/implement-monitor-sustain-program/index.html

## Quarters 1 & 3: Requirements

For a quality metric to be considered "Met" in Q1 or Q3, NFs must attest to and submit documents supporting all key antibiotic stewardship and infection control elements listed below before the end of the reconciliation period:

- Evidence demonstrating implementation of antibiotic stewardship program (ASP) activities for seven core elements outlined in the *Checklist for Core Elements of Antibiotic Stewardship in Nursing Homes*[c]
    - Designated leadership individuals for antibiotic stewardship named in the policy document (performance requirement)
    - Pharmacy-generated antibiotic use report from within the last six months (performance requirement)
    - Antibiogram report from within the last six months (lab-generated or from regional hospital) (performance requirement)
    - Current list of reportable diseases (performance requirement)
    - Antibiotic use and resistance data is reviewed in quality assurance meetings
    - Requires prescribers to document a dose, duration, and indication for all antibiotic prescriptions
    - Facility-specific algorithm for assessing residents
    - Facility-specific algorithms for appropriate diagnostic testing (e.g., obtaining cultures) for specific infections
    - Facility-specific treatment recommendations for infections
    - Personalized feedback on antibiotic prescribing practices (to clinical providers)

[c] **Seven Core Elements of Antibiotic Stewardship in Nursing Homes**. Content last reviewed August 20, 2021. Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Division of Healthcare Quality Promotion (DHQP). https://www.cdc.gov/antibiotic-use/core-elements/nursing-homes.html

- Audits (monitors and documents) of adherence to hand hygiene[d]
- Audits (monitors and documents) of adherence to personal protective equipment use[e]

## Antibiograms

Due to the wide variation in the format of the antibiogram data provided by laboratories, NFs may modify their antibiogram to serve their changing needs. Per AHRQ, for an antibiogram to represent effectively a community's antimicrobial resistance patterns, it is important that it contain timely data. Antibiogram data should be collated and updated at least once in Q1 and once in Q3. In nursing facilities with small sample sizes, it is reasonable to include more than 6 months of data, but the data still should be updated.

## Observational Audits

AHRQ's observational audit guidelines suggest that facilities should tailor the frequency and timing of audits to obtain accurate compliance rates and identify process failures, such as a step in the handwashing process that some staff miss. These are the data points that are necessary for effective Quality Assurance and Performance Improvement (QAPI) projects. Facilities will need to balance their ability to deliver care with the need to collect data sufficient to guide improvement. A realistic commitment to a weekly sample size that is achievable, yet adequate to provide useful information, is recommended.

The following data elements for both categories of audits must be entered into the QIPP Data Submission Portal for each reporting period:

- Number of Employees Audited
- Number of Perfect Audits

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[d] **Hand Hygiene Observational Audits Data Tracking Tool and User Guide,** Auditing Strategies to Improve Infection Prevention Processes in Nursing Homes. Content last reviewed July 2021. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/nursing-home/materials/prevention/observational-audits.html

[e] **Personal Protective Equipment COVID-19 Observational Audit Data Tracking Tool and User Guide,** Auditing Strategies to Improve Infection Prevention Processes in Nursing Homes. Content last reviewed July 2021. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/nursing-home/materials/prevention/observational-audits.html

- Compliance Rate
- Average Number of Failures per Audit

## Quarter 2: Requirements

NFs must attest to and submit overall certificates of completion for the following staff on or before the reporting deadline:

- Nursing Facility Administrator (NFA) **and** Director of Nursing (DON) have completed the *Nursing Home Infection Preventionist Training Course* produced by CDC in collaboration with the Centers for Medicare & Medicaid Services (CMS) (CDC Train Course ID#3814, CE#WB4448).

The *Nursing Home Infection Preventionist Training Course* is located on CDC's TRAIN website (https://www.train.org/cdctrain/training_plan/3814) as a free and flexible online course. The total time to complete the course is estimated at 20 hours and consists of modules that can be completed in any order and over multiple sessions. The course is made up of 24 modules and submodules addressing a variety of topics including an overview of the IPC program and the role of the infection preventionist, infection surveillance and outbreak management, infection prevention practices such as hand hygiene, and antibiotic stewardship.

> To obtain the overall certificate of completion, each individual must first register for the course on the 'Nursing Home Infection Preventionist Training Course' is located on CDC's TRAIN website:
> https://www.train.org/cdctrain/training_plan/3814

**NOTE:** If a NF does not have a DON or NFA on staff when Component 4 Quarter 2 training certificates are due, the NF should list the individual who most recently held the position and copies of their certificates of training completion. If either position was left vacant for the entire program year, the NF cannot meet Component 4 performance requirements.

## Quarter 4: Requirements

NFs must meet performance targets in **both** the vaccination measures listed below for the metric to be considered "Met" for the reporting period. NF performance will

be measured against NF-specific baselines and the most recently published national average as of the beginning of the program year:

- 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)

Facility-specific targets are calculated as a 5% relative improvement upon a NF's initial baseline. Program-wide targets are set at the most recently published national average for each quality metric as of the beginning of the program year.

For a vaccination quality metric to be considered "Met" in Quarter 4, the NF must perform **either**:

- Equal to or better than its facility-specific target; **or**
- Equal to or better than the program-wide target, without declining in performance beyond an allowed margin from the NF's initial baseline.

Each metric-specific margin will be defined as the absolute +/- change in the national average for that metric from the previous program year to the current program year. Any metric will be considered "Not Met" for the quarter or year if a NF performs worse than its initial baseline by more than this margin.

> **NFs do not have to report MDS data or results to HHSC for QIPP.** NFs Report MDS assessment data to CMS per federal requirements.

# Quality Measure Summaries

**Table 2: Final Quality Metrics**

| Component & Metric | Type | Tag(s) | Metric |
|---|---|---|---|
| One | State Benchmark<br>Required as a condition of participation | N/A | Facility holds a QAPI meeting each month in accordance with quarterly federal requirements and pursuant of a facility-specific PIP submitted at the beginning and end of the program year. |
| Two: Metric 1 | State Benchmark | N/A | NF maintains 4 additional hours of RN coverage per day, beyond the CMS mandate |
| Two: Metric 2 | State Benchmark | N/A | NF maintains 8 additional hours of RN coverage per day, beyond the CMS mandate |
| Two: Metric 3 | State Benchmark<br>Required as a condition of participation | N/A | Facility has a workforce development PIP that includes a self-directed plan and monitoring outcomes submitted at the beginning and end of the program year. |
| Three: Metric 1 | Minimum Data Set | CMS N031.03 | Percent of residents who received an antipsychotic medication |
| Three: Metric 2 | Minimum Data Set | CMS N024.02 | Percent of residents with a urinary tract infection |

| Component & Metric | Type | Tag(s) | Metric |
|---|---|---|---|
| Four: Quarters 1 & 3 | State Benchmark (One metric with staged quarterly performance targets) | Quarters 1 & 3 Performance Targets:<br>The NF must submit evidence-based infection control policies and supporting documentation that include stipulated antibiotic stewardship elements, observational audits of hand hygiene and PPE adherence, and antibiogram report. | |
| Four: Quarter 2 | State Benchmark (One metric with staged quarterly performance targets) | Quarter 2 Performance Target: The NF must submit supporting documentation for staff training:<br>• Certificates of completion for Nursing Facility Administrator (NFA) and Director of Nursing (DON) for "Nursing Home Infection Preventionist Training Course" ID#3814, CE#WB4448. | |
| Four: Quarter 4 | Minimum Data Set (One metric with staged quarterly performance targets) | Quarter 4 Performance Targets: To meet the metric, both vaccination percentages must meet or exceed the performance targets:<br>• Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine<br>• Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine | |