Quality Incentive Payment Program (QIPP) Non-Disbursed Funds Measure State Fiscal Year (SFY) 2025

Designated Measure for Eligibility to Receive Non-Disbursed Funds

Pursuant to 1 Tex. Admin. Code § 353.1302(g)(5)(B), funds that are non-disbursed due to a failure of one or more nursing facilities (NFs) to meet performance requirements ("non-disbursed funds") will be distributed across QIPP NFs who have demonstrated achievement of a quality measure designated by HHSC.

For the program period that begins on September 1, 2024, and ends on-August 31, 2025, HHSC designates the following quality measure for a NF to become eligible to receive a share of non-disbursed funds:

- The NF maintains eight additional hours of RN staffing coverage per day, for 90% of days in each month of the program period, beyond the CMS mandate of onsite RN coverage 8 hours a day, 7 days a week.

RN Coverage Performance Requirements

The NF has only achieved the performance measure if a NF maintains eight *additional* hours of coverage each day beyond the federal requirements in place at the time of program application. HHSC may utilize staffing data submitted by each facility to the CMS developed Payroll-Based Journal (PBJ) system for verification that a NF met federal staffing requirements.

Facilities must monitor 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 track 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 eight 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 achievement of the non-disbursed funds RN coverage measure.

HHSC outlines the following requirements for how a NF is considered to have achieved this measure:

- 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 eight additional hours.

- NFs must provide in total 16 hours of RN coverage on at least 90% of the days each month of the program 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-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.

A NF's failure to properly document staffing hours above the federal staffing requirements will result in the facility being deemed ineligible to receive a share of non-disbursed funds in a program period.

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 for achievement of the non-disbursed funds measure. 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.

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 achievement requirements for the non-disbursed funds measure:

- 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.

RN Coverage Reporting Requirements

A NF must attest on their application for enrollment in QIPP for SFY 2025 that they will ensure compliance with the measure described above. The NF must maintain documentation, in accordance with any document retention requirements in 1 Tex.

Admin. Code §353.1302, to verify all attested coverage, and the NF must produce the documentation to HHSC (or its appointed agent) upon request.

A NF's failure to properly document staffing hours above the federal staffing requirements will result in the facility being deemed ineligible to receive a share of non-disbursed funds in a program period.