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QIPP Year 5: Overview

Quality Incentive Payment Program: SFY2022

Introduction

QIPP is a statewide program that provides incentive payments to qualifying nursing facilities.

STAR+PLUS MCOs are directed to make payments once the facilities demonstrate meeting the required goals.

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Introduction

- Directed Payment Program under 42 C.F.R. §438.6(c)
- Annual review cycle with CMS
- Governed by 1 TAC §353.1301 to §353.1304
- Program Year Five: Sept. 1, 2021, to Aug. 31, 2022 State Fiscal Year (SFY) 2022

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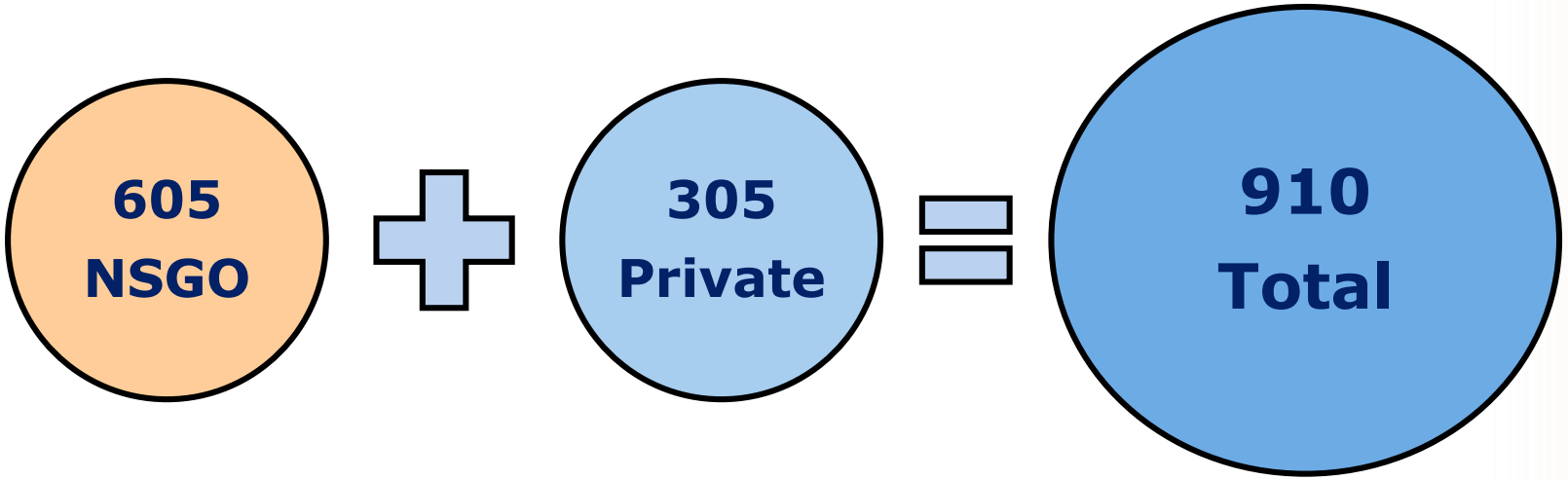
Enrollment



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Capitated Component Structure

Component One
110% of Non-Federal Share
Monthly
NSGOs only

Component Three
60% after C1 & C4
Quarterly
All NFs

Annual Budget
$1.1 B

Component Two
40% after C1 &C4
Monthly
All NFs

Component Four
16% of Total Funds
Quarterly
NSGOs only

Reference: QIPP Year 5 Component Values, Published June 2021 by Department of Provider Finance at HHSC

Reporting Deadlines

Component	Cycle	Location	Date
One and Two	Monthly	QIPP Data Portal	4th business day after end of reporting month
Three	Quarterly	CMS	MDS data must be submitted to CMS by last Sunday in the month following the reporting period
Four	Quarterly	QIPP Data Portal	The final Monday (or next business day) of the month following the reporting period

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Component 1: QAPI

Performance Requirements

- The NF must hold a monthly QAPI meeting
- The NF maintains a facility-specific PIP based around improvement on an MDS Long-stay Measure

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Component 1: QAPI

Reporting Requirements

- As a condition of participation in QIPP, NFs must submit ongoing data and documentation regarding their PIP
  - Monthly updates on measure and intervention data through QIPP portal
  - Uploading Component 1 PIP Reporting Template each month with supporting documentation as needed
- Improvement in the primary quality measure is not required to meet the metric

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Component 2: Workforce Development

Three Quality Metrics

- **Metric 1:** NF maintains 4 additional hours of registered nurse (RN) staffing coverage per day, beyond the CMS mandate
- **Metric 2:** NF maintains 8 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

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Component 2: Metrics 1 & 2

RN Coverage Definitions

- Only direct-care hours are counted
- Coverage is defined as hours of the day with at least one RN on duty and available

Telehealth Technologies

- NFs may use telehealth technologies to meet RN coverage metrics
- Please refer to the SFY 2022 Technical Specifications document for details and requirements

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Component 2: Metrics 1 & 2

Reporting Requirements

- Monthly attestation of staffing-hours beyond the CMS mandate through QIPP portal
- Monthly upload of direct-care staffing and telehealth encounter data

HHSC may validate whether facility met CMS-mandated RN hours using Payroll Based Journal

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Component 2: Metric 3

Reporting Requirements

- As a condition of participation in QIPP, NFs must submit ongoing data and documentation regarding their PIP
  - Monthly updates on measure and intervention data through QIPP portal
  - Uploading Component 2 PIP Reporting Template each month with supporting documentation as needed

Improvement in the primary quality measure is not required to meet the metric

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PIP Reporting Templates

Visit QIPP Resources Page

Performance Requirements

- QIPP SFY 2022 Quality Metric Packet (PDF): This document lists the final quality metrics and performance requirements. (Updated 11/17/2021)
- QIPP SFY 2022 Technical Specifications (PDF): This document includes a list of new and updated QIPP performance measures with instructions on data collection and guidelines for use of templates and submission using the QIPP Data Portal. (Updated 11/17/2021)

Reporting Templates

Component One PIP Reporting Template (MS Word): Performance Improvement Plan (PIP): This document will be used to fulfill the condition of participation requirements wherein facilities must report monthly progress updates on monitoring their outcomes in the PIP. (Updated 11/17/2021)

Component Two: Staffing hours: HHSC does not prescribe specific template. Facilities must submit direct-care staffing information based on payroll or other auditable data through the QIPP Data Submission Portal as described in the Quality Metric Packet (PDF) and the Technical Specifications (PDF).

Component Two PIP Reporting Template (MS Word): Performance Improvement Plan (PIP): This document will be used to fulfill the condition of participation requirements wherein facilities must report monthly progress updates on monitoring their outcomes in the PIP. (Updated 11/17/2021)

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Component 3: Core MDS Measures

Four Quality Metrics

- **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

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Component 3: Core MDS Measures

Performance Measure Data

- The quality metrics of Component 3 are weighted evenly and earned independently
- If no NF performance data are available for some metrics, Component funds can be earned based on performance in remaining metrics
- If no data are available for any quality metrics, the NF cannot receive Component 3 funds
- NF-specific baselines, program-wide benchmarks, and quarterly targets will be published in the upcoming scorecard

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Component 3: Core MDS Measures

Performance Targets

- For a metric to be considered "Met" the NF must:
  - Meet improvement-over-self targets measured against their baseline each quarter

OR

- Perform better than the program-wide benchmark

WITHOUT

- Declining in performance beyond an allowed margin set for each metric

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Component 3: Core MDS Measures

Improvement Over Self

- Defined as improvement against the NF's baseline over the course of the program year
  - Quarter 1: 5%
  - Quarter 2: 10%
  - Quarter 3: 15%
  - Quarter 4: 20%

Each quarter is measured against the NF's baseline, not against the prior quarter's performance

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Component 3: Benchmarks & Allowed Margins of Decline

Pressure Ulcers

- YR4 National Average: 7.315%
- YR5 National Average: 8.263%
- Allowed Margin of Decline: **0.948**

Antipsychotic Medications

- YR4 National Average: 14.225%
- YR5 National Average: 14.316%
- Allowed Margin of Decline: **0.091**

Note: The margin is an absolute value, not a relative %

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Component 3: Benchmarks & Allowed Margins of Decline

Independent Mobility

- YR4 National Average: 17.094%
- YR5 National Average: 25.372%
- Allowed Margin of Decline: **8.278**

Urinary Tract Infections

- YR4 National Average: 2.651%
- YR5 National Average: 2.524%
- Allowed Margin of Decline: **0.127**

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Component 3: Maintaining High Performance

Defining "Maintenance"

- In prior program years, a NF whose baseline was better than the national average did not need to meet improvement-over-self targets
- Beginning in SFY2022, performing better than the national average no longer constitutes maintaining high performance
- If the NF cannot meet improvement-over-self targets, it must peform better than the benchmark **without** declining on its baseline beyond the allowed margin

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Component 3: Maintaining High Performance

For Example:

- NF Baseline: 2%
- Program-Wide Benchmark: 5%
- Allowed Margin of Decline: 1%

NOTE: The allowed margin of decline relates to the NF's baseline and does not refer to quarter-over-quarter decline

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Component 3: Maintaining High Performance

For Example (cont.):

- The sample NF must perform better than the program-wide benchmark (5%)

WITHOUT

- Declining in performance more than the margin (1%) from its baseline (2%)

MEANING

- The target that defines maintaining high performance for the NF is 3%
  - The 2% baseline plus the 1% allowed margin

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Component 3: Core MDS Measures

Reporting Requirements

- NFs Report MDS Assessment Data to CMS per Federal Requirements
- NFs do not have to report MDS data or results to HHSC
- HHSC will pull data from a CASPER to calculate NF performance each quarter

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Component 4: Infection Control

One Quality Metric

Component 4 consists of a single quality metric that has different performance and reporting requirements each quarter.

- **Q1:** Infection control program that includes antibiotic stewardship and auditing staff performance on HH & PPE
- **Q2:** Leadership training and circulation of updated policies
- **Q3:** (Same as Q1)
- **Q4:** MDS-based vaccination measures

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Component 4: Quarters 1 & 3

Antibiotic Stewardship Performance Requirements

The NF must maintain antibiotic prescribing policies that contain at least the following elements:

- Designated leadership individuals
- Pharmacy-generated antibiotic use report (within the last six months)
- Lab- or hospital-generated antibiogram report (from within the last six months)
- Current list of reportable diseases (required)

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Component 4: Quarters 1 & 3

Antibiotic Stewardship Reporting Requirements

- **Data:** The NF must submit data through the QIPP Data Submission portal by the deadline attesting to all the elements listed as requirements
- **Documentation:** The NF must also upload its antibiotic prescribing policies as a single document that includes all attested to elements

HHSC does not require use of specific templates for these documents

Component 4: Quarters 1 & 3

Performance Requirements for Monitoring & Auditing

The NF must audit (including monitoring and providing feedback) staff on:

- Use of personal protective equipment (PPE)
- Hand Hygiene (HH)

There are no required tracking or reporting templates for these audits, but HHSC recommends the use of AHRQ templates

Component 4: Quarters 1 & 3

Recommended Auditing Templates

Component Four: Nursing Facilities must collect audit data for each month within the program year and report summaries to HHSC in Quarters 1 and 3. For Quarter 1, NFs should report monthly data for September, October and November 2021, as available. The Quarter 3 reporting period will then include audit data from December 2021 through May 2022.

- **Hand Hygiene Observational Audit Tracking Tool** (Excel): This pre-programmed Excel workbook has been published by the Agency for Healthcare Research and Quality (AHRQ). It compiles hand hygiene observational data by individual, shift, position, location, and department to help staff regularly review opportunities for hand hygiene performance improvement. This tracking tool is used in conjunction with the Hand Hygiene Observational Audit Tracking Tool User Guide (PDF), available here.
- **Personal Protective Equipment (PPE) COVID-19 Observational Audit Tracking Tool** (Excel): This pre-programmed Excel workbook has been published by the AHRQ. It compiles PPE audit data by individual, shift, position, location, and department, to help staff regularly review opportunities for improvement in donning and removing PPE. This tracking tool is best used in conjunction with Personal Protective Equipment (PPE) COVID-19 Observational Audit Tracking Tool User Guide (PDF), available here.
- **Antibiogram:** Nursing Facilities are not required to use a specific template for reporting their antibiogram. AHRQ has offered a template here:
  - *Toolkit 3. The Nursing Home Antibiogram Program Toolkit: How To Develop and Implement an Antibiogram Program. Content last reviewed November 2016. Agency for Healthcare Research and Quality, Rockville, MD.*
- **Infection Control and Antibiotic Stewardship policies**: Nursing Facilities are not required to use a specific template. Nursing facilities can utilize resources published by AHRQ, CDC and other agencies to tailor development and implementation of evidence-based policies and practices.

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Component 4: Quarters 1 & 3

PPE & HH Audit Reporting Requirements

- **Data:** NF must report summary audit results for the quarter through the QIPP portal, which include:
  - Number of audits given
  - Number of perfect audits
  - Rate of compliance (percentage of perfect audits)
  - Average number of fails per audit
- **Documentation:** The NF must upload two audit reports (one for HH, one for PPE) that each include individual audit results by month

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Component 4: Quarter 2

Leadership Training & Updated Infection Control Policies

The Nursing Facility Administrator (NFA) and Director of Nursing (DON) must both complete the *"Nursing Home Infection Preventionist Training Course"* offered by CDC Train.

- Course certification must be current as of reporting date
- See the *SFY 2022 Technical Specifications* document for course numbers

Also, the NF must update and circulate infection control policies

Component 4: Quarter 2

Reporting Requirements

- **Data:** Through the QIPP Data Submission portal, the NF must report the names and training completion dates for both the NFA and DON
- **Documentation:** The NF must upload a single training completion certificate for each staff member. If an individual has multiple certificates, combine them into a single document for submission.
- **Infection Control Policies:** The NF must also submit its updated policy document

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Component 4: Quarter 4

MDS-Based Vaccination Quality Measures

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

Both measures must be "Met" for the NF to receive Component 4 funds.

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Component 4: Quarter 4

Pneumococcal Vaccines

- YR4 National Average: 93.866%
- YR5 National Average: 93.845%
- Allowed Margin of Decline: **0.021**

Seasonal Influenza Vaccines

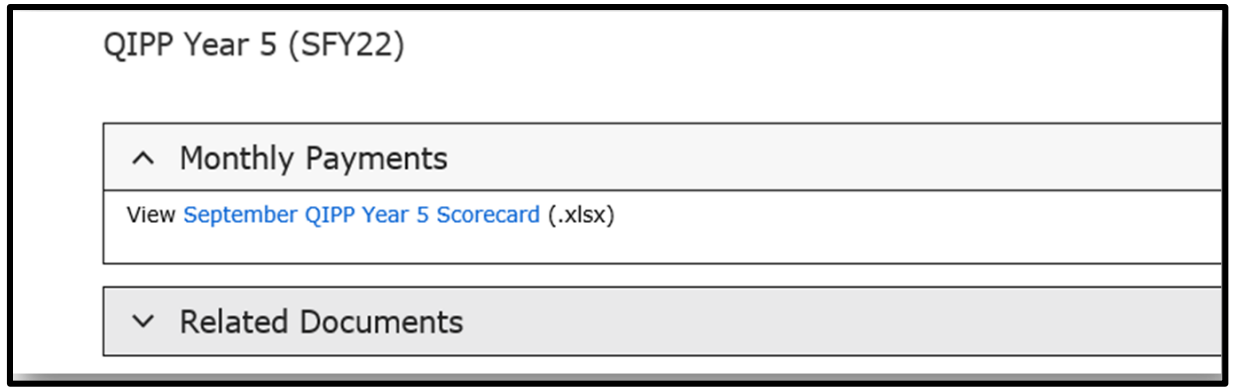
- YR4 National Average: 95.968%
- YR5 National Average: 96.073%
- Allowed Margin of Decline: **0.105**

Note: The margin is an absolute value, not a relative %

PFD QIPP Website

Finding the Scorecard

- Do a search for "Provider Finance QIPP"
- Click on the first result.
- Then click on "Visit the QIPP Provider Finance website"
- Scroll down to the QIPP Year 5 drop-down menus



PFD QIPP Website

Finding the Scorecard Training

- Located under QIPP Year 5 (SFY22) Related Documents
- Provides broad program overview
- How eligibility and funding is determined
- How funds are calculated for pay periods

View QIPP Year 5 Scorecard Training Video (.wmv): The QIPP Year 5 Scorecard Training video focuses on the "Scorecard" tab and is most useful for stakeholders who are new to the program.

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PFD QIPP Website

Other Useful Tools

- Program Overview
- Texas Administrative Code Rules
- Dates to Remember
- Monthly and Quarterly Scorecards for QIPP Years 1 – 5
- Be sure to check out the "Related Documents" section for further useful information!

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Primary & Secondary Contacts

Primary Owner

- Can Assign & Approve Users
- Can Submit Data

Owner Representative

- Can Assign & Approve Users
- Can Submit Data

Facility Submitter

- Can Submit Data
- Create an account in the QIPP Portal
- Notify QIPP via email you are the new owner
- Do not email QIPP to assign other user

Important Changes to Year 5

Interim Allocations

- Interim allocations for QIPP Year 5 and future years have been removed
- The State has committed to reconciling historical data to actual data after the program period
- Funds recouped will be redistributed via non-dispersed funds.
- Only applies to Component 1 for NSGOs.

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Conditions of Participation

Failure to meet any conditions of participation described in this presentation will result in removal of the provider from the program and recoupment of all funds previously paid during the program period.

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Resources

- **Training/Webinar**
  - Overview
  - Data Portal
  - Scorecard
- **Templates**
  - PIP- Comp 1
  - PIP- Comp 2
- **FAQs**

- **Resources**
  - CMS- QAPI- PIP
  - Payroll-based journal
  - Antibiotic Stewardship
  - Infection Control Training and Policies
  - AHRQ- Audits for HH and PPE

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Communications

- Subscribe to GovDelivery Alerts
- Email QIPP Program Staff
  - QIPP@hhs.texas.gov
- Visit QIPP Websites
  - Provider Finance
  - Quality Monitoring Program

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Thank You!

QIPP@hhs.texas.gov