On Aug. 17, 2017, HHS hosted a nursing facility (NF) provider webinar training on the Quality Incentive Payment Program (QIPP). During the webinar, providers asked questions and HHS staff answered many of them. As discussed during the training, HHS staff are providing a list of all questions posed with responses in the table below. The questions and answers were consolidated to remove duplicates and sorted by topic. If you have any additional questions related to QIPP, please send them to QIPP@hhsc.state.tx.us.

Table A: Scorecards*

Questions:	Responses:
It was stated that the scorecards were sent out on the 15th. Where did Andrew get the email to send them to? How were they sent? What do we do if we have not received the scorecard? What if I received the wrong card or my card has 0.00 in the fields? When we choose our facility number into the Scorecard the amounts do not change from zero? However, the NPI number listed on our Scorecard does not match what we have on record, could this be why all of our values are still zero? Will providers be emailed an updated scorecard each quarter?	• The scorecards were emailed on 8/15. • Email addresses came from the enrollment form for the program. • If you didn't receive a scorecard, please email **QIPP@hhsc.state.tx.us**. • You would have received the same file all of the facilities received. • You will need to click on the dropdown arrow on the facility name to get your facility specific information. • The providers will receive a quarterly scorecard from the MCOs.
Can the report being sent to the facilities also be sent to corporate level emails?	The scorecard can be sent to any email address the NF/Corporation desires.
When will the quarterly targets be published?	The targets have been sent to the facilities and managed care organizations (MCOs) by Andrew Wolfe.
Are the scorecards available on the QIPP website?	Not at this time. However, the benchmarks are on the QIPP webpage.

* **If you would like to walk through any specific parts of the scorecard, please send an email to QIPP@hhsc.state.tx.us to schedule a conference call with HHS Rate Analysis staff.**

Table B: Quality Metrics: Benchmarks, Baselines, and Quarterly Numbers

Questions:	Responses:
I saw that as the quarters went on the metric increased in percent Q1 (5%) Q2 (10%) etc. What does this mean?	The percentages cited here reflect the proportional improvement required over time to meet Component 3. For example, a facility with 30% Baseline in the antipsychotic medication Quality Metric (QM), would need to score 28.5% or better (lower is better) in the first quarter (Q1) to receive the Component 3 payout. In Q2, the facility would need to score 27% or better to receive that quarter's Component 3 payout. The complete chart of improvement targets for all quarters of Components 2 and 3 is available on slide 20 of the NF QIPP Training Webinar Power Point presentation.
How is the Baseline calculated?	The Baseline was calculated as a non-weighted average of the four latest quarters of Centers for Medicare & Medicaid Services (CMS) data (Q1n + Q2n + Q3n + Q4n) / (Q1d + Q2d + Q3d + Q4d).
Where do we look for the benchmarks we should have received? Are facility benchmarks available online?	The benchmark data is on the scorecard file emailed 8/15. Benchmark data is available on the QIPP webpage.

Questions:	Responses:
Why is the algorithm used in the presentation different than the one on 5 Star? ((QM1*D1)+ (QM2*D2) + (QM3*3D)+ (QM4*D4)/ (D1+D2+D3+D4))	For non-risk-adjusted QMs, this formula is equivalent to the formula HHS used. Because none of the QIPP year-one QMs are risk-adjusted, the more complicated formula is not needed to represent the same calculation. The more basic version of the calculation is explained in Appendix A (Technical Details), Section 2 (QM Calculations) of the Minimum Data Set (MDS) QM Users' Manual.
If my Baseline is established from the last 4 quarters and we just had a CHOW earlier this month, am I held to the standard of previous company's documentation? I have some concerns about accuracy of previous company's documentation.	Facilities must have the full four quarters of QM data to receive a Baseline and to be eligible for QIPP. The performance of the facility over the last four quarters will set the Baseline regardless of ownership.
If the quarter is Sept 1-Nov 30 for reporting performance, how will data be extracted from CMS/MDS? Will it be a separate state calculated QM?	HHS has access to the same MDS data Nursing Home Compare and CASPER do, and we can pull the data any time. The state will calculate the QMs according to the specifications in the MDS Manual and then verify them against data in CASPER to ensure accuracy.
When calculating antipsychotic rates, are there any diagnoses that are excluded from this total?	The diagnoses excluded from the antipsychotic medication QM calculation include: **Schizophrenia, Huntington's Disease, and Tourette's**.
Will the QM's be measured over the entire quarter or are they the average of each monthly QM within the quarter?	They will be measured over the entire quarter as a single reporting period.

Questions:	Responses:
For components 2 and 3, if the facility begins above the benchmark, but then falls below, will they then be measured based on improvement from Baseline? The example showed that they had to continue to meet the benchmark every quarter.	The facility is measured against its unique Baseline each quarter. To receive payment, the facility must be better (lower number) than the Baseline OR better (lower number) than the Benchmark. If a facility earns Component 2 or 3 payments in one quarter, it will have no effect on whether or not they meet the target for the next quarter. The targets are set quarter by quarter regardless of whether improvement occurs or not. For example, if a facility fails to reach the 1.7% improvement from the Baseline for Component 2 in Q1, they are still held to a 3.4% improvement from the Baseline for Q2.
Why QMs measured are they reported Sept - Nov? The CMS data is reported by a quarter...July-Sept...Oct-December.	As noted in Title 1 TAC, Section 353.1303, QIPP follows **state fiscal quarters**.
Is there written guidance and instructions for calculating payment for Components 2 and 3?	Please see Title 1 Texas Administrative Code (TAC), Section 353.1303.

Table C: Quality Assurance Performance Improvement (QAPI) Validation Report Forms

Questions:	Responses:
Is the Facility ID required in the QAPI form the Medicaid Contract Number, Medicare Number, or Vendor/Facility License Number on the DADS license?	The facility ID required on the form is the Facility ID listed on the QIPP scorecard. It is the same Facility ID used to find a provider in CASPER.
Is there a window for submission? What if IT/computer failure or other unforeseen problems?	Facilities participating in QIPP will have the whole month to submit their QAPI Validation report and should consider submitting it once the meeting has been conducted. Additional time will not be allotted for receipt of the form past the required deadline: **the 1st business day after the end of the month.**

Questions:	Responses:
When you have your meeting can you go ahead and send your Validation Report before the September date?	Yes, please submit the form as soon as you complete the meeting.
Are there any requirements or an outline for the facility to complete for the QAPI that we are sending the validation report on? Do we have to review any required things or can we just do our usual QA program we have in place? QAPI looks at metrics from previous month's results. September metrics will not be available on October 2nd, the validation deadline. Is the October 2nd validation date for September QAPI to review August metrics?	The facility's QAPI meeting should discuss the needs of the facility at that moment in time. HHS **will not** be providing an outline or any specific requirements for what must be discussed at these meetings.
Are PVT facilities still responsible for submitting the monthly QAPI form even though there is no reimbursement associated with it for them?	No. Private facilities **are not eligible** for Component 1. The submission of the QAPI form is only required under Component 1.
Should Providers utilize some sort of read receipt verification when submitting the QAPI Validation report via email or will THHS provide some sort of positive confirmation when reports are successfully received each month? Will HHS send a notification stating whether or not all requirements of the form were met?	• When the report is emailed to MCS_QIPP_QAPI@hhsc.state.tx.us, you will receive an **automatic reply.** • **HHS will not send confirmation reports, nor will HHS send any notification stating whether or not the form requirements are met.** Meeting the requirements of the form is the responsibility of the facility.
The validation report file on the QIPP website is PDF format. How do we edit the first sentence to reflect the center specific data that needs to be included? Is there a word.doc format available? Who can sign the QAPI Validation report form? Does it have to be the person on the 2031?	A new form with clean lines to input data will be placed on the **QIPP webpage, Resources section. Whoever has been designated by the facility to sign the form should sign it.**

Table D: Lapse Funds

Questions:	Responses:

Will the lapse funds be allocated for Private NF's using Component 1, 2 and 3 even though they don't participate in Component 1?	Yes. The lapse funds pool is for all lapse funds and is paid based on the total amount earned by each provider compared to the total earned among all providers.
Will forfeited Component 1 funds be treated as lapse and redistributed? What is the treatment of funds not earned in a given quarter? How is the lapse portion of a payment factor measured? Please provide more details on lapse funds.	Yes, missed component 1 funds are lapsed funds. The spreadsheet "QIPP Lapse Funds Example" on the QIPP webpage details that calculation.

Table E: Member Months, Runout, and Adjustment Periods

Questions:	Responses:
What is the definition of member month?	A Member Month means one Member enrolled with the MCO during any given month. The total Member Months for each month of a year comprise the annual Member Months.
If member months decrease during the runout period, are NFs required to pay the MCOs back? If so, are there protections to prevent large, unexpected repayments?	Yes, an NF would be required to have funds recouped if there were negative adjustments to the member month count for a time period. However, they will be netted out against all other payments and adjustments during the payment period. Also to minimize the chance of this happening, the adjustment periods, where most small adjustments happen, are covering a longer time period to allow for the adjustments to be netted out.
I don't understand why the number of Medicaid member months and the facility's Medicaid resident days wouldn't be the same number. This was discussed, but I didn't follow.	Member months are the total number of Medicaid clients enrolled in an MCO and in an NF risk group at a particular point in time in the month in the entire service delivery area (SDA). Those clients don't have to be receiving services to be included in the member-month count. Your facility's Medicaid resident days are the number of days Medicaid clients in your facility received services.
Will member month data be communicated to providers?	The member month data will be placed on the scorecard sent to the facility.

Questions:	Responses:
What is runout and why is it important?	• Run out is the adjustment to the prospective number of member months paid for a month. • The runout ensures a facility is paid the full amount of funds they are due based on the amount of money the MCO receives for those member months.
What are the Adjustment Periods?	Adjustment period describes the time period after the first 12 months of the program where no new quality metric data is coming into the program. During that time, only adjustments to the member months can affect payments.

Table F: Questions related to MCOs, Letters Of Agreement (LOAs) and Contracting

Questions:	Responses:
So we have to contract with all MCOs for the service area to participate in QIPP?	Yes. You must be contracted with **all MCOs** in your service area.
If we are already contracted with the MCOs, do we need to update the contracts to include QIPP?	Any questions related to MCO contracts should be directed to the MCOs, as HHS does not have that information.
Talk about being contracted with all MCOs in your SDA. Is it a nursing facility requirement only? Does the requirement apply to the government owner at the EIN level or is the requirement at the individual nursing facility NPI level?	The NF owner must be contracted with all MCOs in the service area where the NF (NPI level) is located.
One of the MCOs has not released their LOA yet, is that a requirement of the program?	Under Title 1 TAC, Section 353.1303, an LOA is **not a requirement** for participation in QIPP.

Can you briefly describe how MCOs are paid by the state and then how MCOs go on to pay NFs?	MCOs are paid on a per-member per-month basis. There are set monthly amounts they receive per member based on the member's risk group. HHS calculated an amount to increase the payment for the NF-specific risk group based on the total funds needed to be added to a specific service delivery area (SDA). HHS calculates the total funds needed for an SDA by adding the estimated values of each facility's components together. Based on the member months paid to an MCO for a specific SDA, HHS can calculate the payment amount owed to a facility based on QM achieved.

Table G: Change of Ownership (CHOW), Change in Administrator, NF Closure

Questions:	Responses:
If a NF was closed in the first month of the IGT period, will the Public entity who put up the IGT still receive Component one payments through the six month IGT period? Issue, no QAPI report in months 2-6.	No. To receive Component 1 payment for a month, a QAPI report must be submitted for that month. If a provider closes, it will not be able to submit the report and will not receive the funds.
There was a change in administrator in July. Who do I need to notify of this change and provide new contact information?	Any time there is a change in the QIPP contact person, the facility should notify HHS by email at QIPP@hhsc.state.tx.us.

If a QIPP participant undergoes a CHOW midway through the QIPP year, does it remain in the QIPP program?	Per Title 1 TAC Section 353.1303(j), Changes of ownership: (1) If an enrolled NF changes ownership during the eligibility period to private ownership, the NF under the new ownership must meet the private NF eligibility requirements described in this section in order to continue QIPP participation during the eligibility period; (2) If a non-state government-owned NF changes ownership during the eligibility period to another non-state governmental entity, the NF under the new ownership must meet the non-state government-owned eligibility requirements described in this section in order to continue QIPP participation during the eligibility period.

Table H: Miscellaneous

Questions:	Responses:
Can annual estimated revenue be calculated now or will it have to be calculated on a periodic (monthly, quarterly) basis?	HHS cannot accurately estimate annual revenue until we have at least a quarter's worth of data. The variables are: your individual NF's ability to meet metrics, the actual number of member months for each SDA, and the total amount of lapse funds due to other facilities not meeting their metrics. A prospective or proxy payment for this program would not be possible.

Questions:	Responses:
Please explain the 5% risk margin. Will the MCOs always retain this 5% or is it possible that the 5% will be distributed to providers?	The MCOs will retain the 5% risk margin. There are two main risks to the MCOs. The first is the possible redistribution of component 1 during the reconciliation. The second is if they pay out more in lapse funds than a specific SDA received in "bump" payments.
Is QIPP for one year only or will we be doing this in future years? What is the chance for a 2nd year?	QIPP is required to be approved by CMS **on a yearly basis.** At this time, we only have CMS approval for year 1 (9/1/17-8/31/18). Approval will be sought yearly as required.
Is the QIPP program for Skilled Nursing Facilities?	Facilities are eligible for QIPP if they **comply with the requirements described in** Title 1 **TAC, Section** 353.1303(c).