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Quality Incentive Payment Program (QIPP)

SFY 2024 (Year 7) Overview & Requirements

Contents

- QIPP Overview
- Component Structure
- Performance & Reporting Requirements
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- Program Resources

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QIPP Overview

What is QIPP?

Directed Payment Program	1 TAC §353.1301 to §353.1304	September 1, 2023, through August 31, 2024

The Quality Incentive Payment Program (QIPP) is a state-directed payment program designed to help nursing facilities achieve transformation in care quality through innovation.

QIPP was first implemented on September 1, 2017. In July 2023, the Centers for Medicare & Medicaid Services (CMS) approved QIPP for state fiscal year (SFY) 2024—its seventh program year.

QIPP is governed by the Texas Administrative Code (TAC) Rules in Chapter 353. The program must be approved annually by the CMS for each program year.

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QIPP Overview

Who can Participate?

Texas NFs serving residents in STAR+PLUS Medicaid	65% Medicaid Utilization for Private NFs	763 NSGOs 216 Private NFs

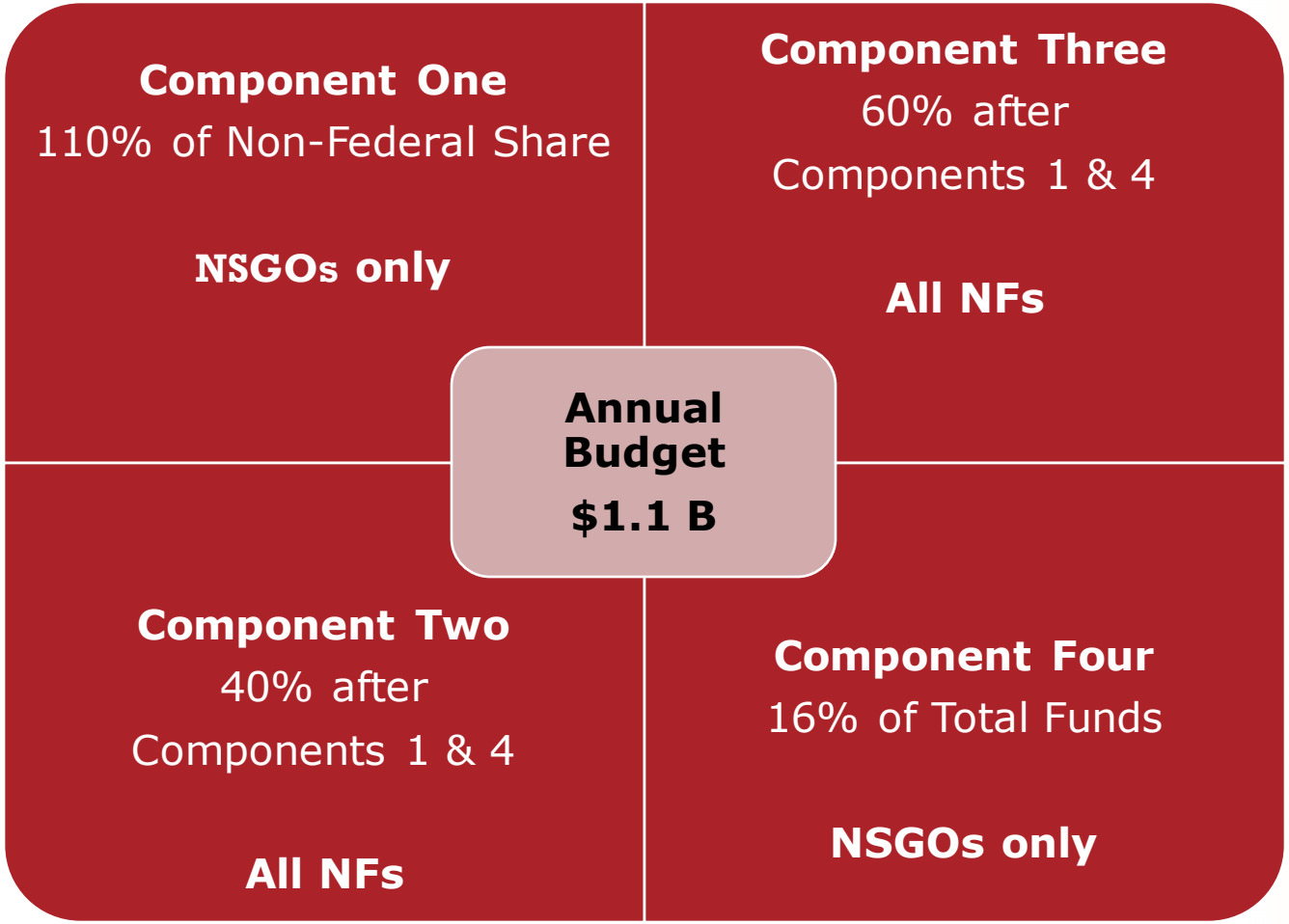
Two classes of Texas nursing facilities are eligible to participate:

- **Non-State Governmental-Owned (NSGO) Facilities**
- **Privately-Owned Facilities**

To participate, privately-owned facilities are required to meet a 65% Medicaid utilization threshold.

✓ **Full eligibility requirements can be found in 1 TAC §353.1302**

Component Fund Structure



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Component Quality Structure

Component One (NSGOs only)

- Quality Assurance & Performance Improvement (QAPI)

Component Two (All enrolled NFs)

- RN Coverage & Workforce Development

Component Three (All enrolled NFs)

- Core Minimum Data Set (MDS) Long-Stay Quality Measures

Component Four (NSGOs only)

- Infection Control & Antibiotic Stewardship, MDS Vaccination Quality Measures

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What must NFs do to earn payment incentives?

Performance & Reporting Requirements

QIPP Data Submission

- NFs must use the **QIPP Data Submission Portal** for all reporting:
  - Enter relevant fields of data
  - Email supporting documentation
  - Submit HHSC-approved templates
- The QIPP Data Submission Portal will be offline between September 8 – 18, 2023, for transition to the new program year
- A self-paced training updated for SFY 2024 has been posted on the QIPP Resources Webpage

What is a reporting period?

Quarterly: Comp 3 & 4

- Quarter 1 = September – November 2023
- Quarter 2 = December 2023 – February 2024,
- Quarter 3 = March 2024 – May 2024
- Quarter 4 = June 2024 – August 2024

Monthly: Comp 2 (i) and (ii)

- Month 1 = September 2023
- …
- Month 12 = August 2024

Conditions of Participation (PIP)

- End of Q1 (December 6, 2023) = Tabs 1-3, Report Months 1-3
- End of Q4 (September 6, 2024) = Tabs 4-6, Report Months 4-12

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Conditions of Participation

As a condition of participation, all NFs participating in QIPP must report certain quality data relating to Quality Assurance and Performance Improvement (QAPI) meetings and Performance Improvement Projects (PIPs) twice a year to provide data necessary for program evaluation.

- **If NF complies, it remains enrolled in the program**
- **If NF fails to comply, it is subject to removal from the program and recoupment of all funds previously paid during the program year**

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Component One: QAPI

As a Condition of Participation, the NF must:

- Attest to conducting a monthly quality assurance and performance improvement (QAPI) meeting
- Submit Performance Improvement Project (PIP) data template and documentation twice a year
  - Topic: Long-Stay MDS Measure
- Serve at least one Medicaid member per payment period

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Component One: MDS PIP

DUE ONLY TWICE A YEAR

December 6, 2023

- First Submission
- PIP Charter (Tabs 1-3)
- Sep. – Nov. 2023 Data
- Attest to Meetings:
  - Sep. – Nov. 2023

September 6, 2024

- Final Submission
- PIP Success Story (Tabs 1-6)
- Cumulative Data through Aug. 2024
- Attest to Meetings:
  - Dec. 2023 – Aug. 2024

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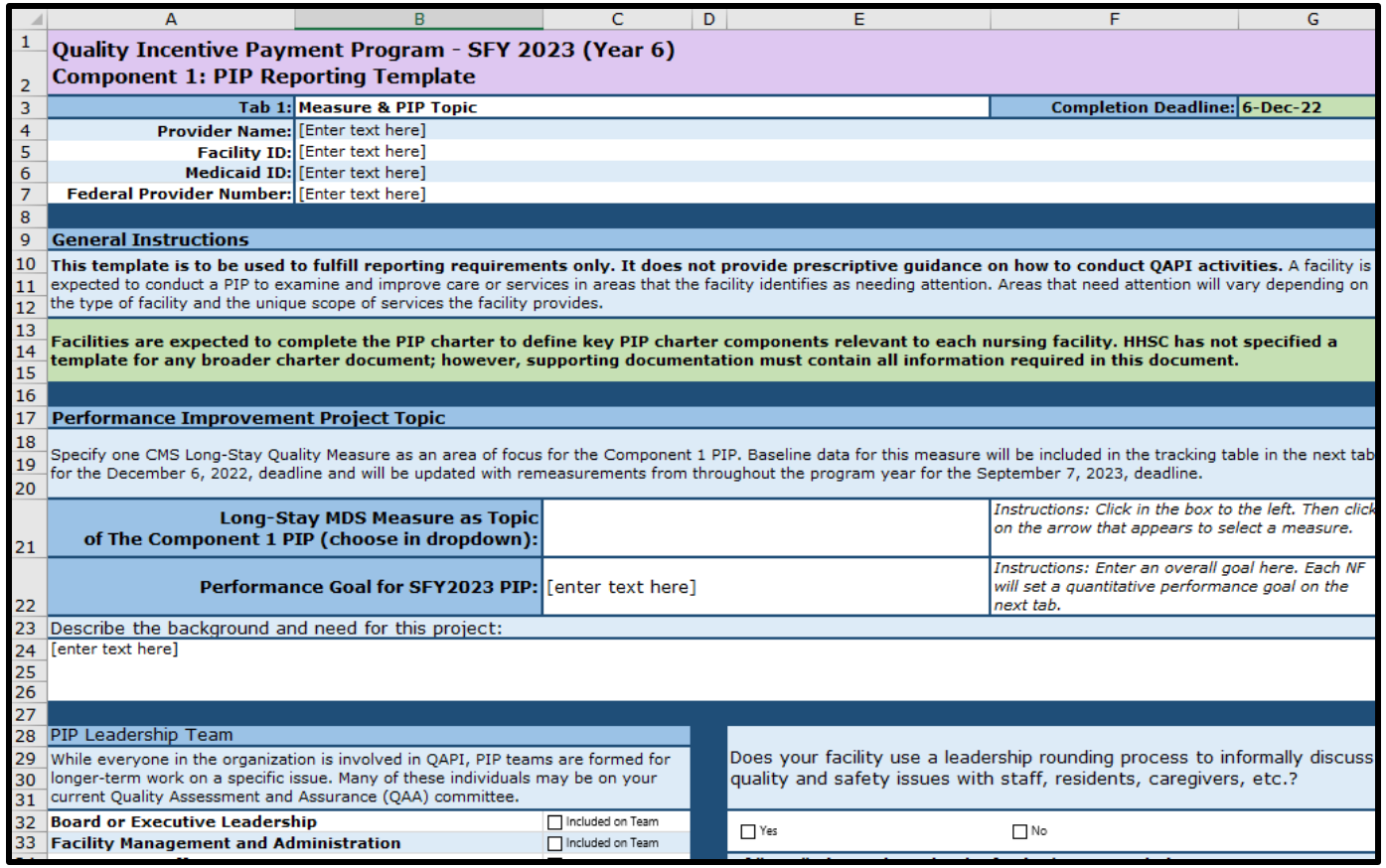
PIP Reporting Templates

SFY 2024 Templates are in Excel Format Again



	A	B	C	D	E	F	G
1	**Quality Incentive Payment Program - SFY 2023 (Year 6)**						
2	**Component 1: PIP Reporting Template**						
3		**Tab 1:**	**Measure & PIP Topic**			**Completion Deadline:**	**6-Dec-22**
4		**Provider Name:**	[Enter text here]				
5		**Facility ID:**	[Enter text here]				
6		**Medicaid ID:**	[Enter text here]				
7		**Federal Provider Number:**	[Enter text here]				
8							
9	**General Instructions**						
10	**This template is to be used to fulfill reporting requirements only. It does not provide prescriptive guidance on how to conduct QAPI activities.** A facility is						
11	expected to conduct a PIP to examine and improve care or services in areas that the facility identifies as needing attention. Areas that need attention will vary depending on						
12	the type of facility and the unique scope of services the facility provides.						
13							
14	**Facilities are expected to complete the PIP charter to define key PIP charter components relevant to each nursing facility. HHSC has not specified a**						
15	**template for any broader charter document; however, supporting documentation must contain all information required in this document.**						
16							
17	**Performance Improvement Project Topic**						
18							
19	Specify one CMS Long-Stay Quality Measure as an area of focus for the Component 1 PIP. Baseline data for this measure will be included in the tracking table in the next tab						
20	for the December 6, 2022, deadline and will be updated with remeasurements from throughout the program year for the September 7, 2023, deadline.						
21		**Long-Stay MDS Measure as Topic of The Component 1 PIP (choose in dropdown):**				*Instructions: Click in the box to the left. Then click on the arrow that appears to select a measure.*	
22		**Performance Goal for SFY2023 PIP:**	[enter text here]			*Instructions: Enter an overall goal here. Each NF will set a quantitative performance goal on the next tab.*	
23	Describe the background and need for this project:						
24	[enter text here]						
25							
26							
27							
28	PIP Leadership Team						
29	While everyone in the organization is involved in QAPI, PIP teams are formed for						
30	longer-term work on a specific issue. Many of these individuals may be on your						
31	current Quality Assessment and Assurance (QAA) committee.						
32	**Board or Executive Leadership**	☐ Included on Team					
33	**Facility Management and Administration**	☐ Included on Team					

Does your facility use a leadership rounding process to informally discuss quality and safety issues with staff, residents, caregivers, etc.?
☐ Yes ☐ No

Component Two: Workforce Development

Three Metrics

- **Metric 1**: +4 hours of registered nurse (RN) coverage per day, for 90% of the days in the month, beyond the CMS mandate
- **Metric 2**: +8 hours of registered nurse (RN) coverage per day, for 90% of the days in the month, beyond the CMS mandate
- **Metric 3**: As a condition of participation, has a workforce development program in the form of a PIP.

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Component Two: Metrics 1 & 2 (1 of 3)

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 2024 Quality Measures & Associated Performance Requirements* document on the QIPP Resources Webpage for details and requirements

Component Two: Metrics 1 & 2 (2 of 3)

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 Two: Metrics 1 & 2 (3 of 3)

Portal Questions

- How many days during the reporting period (the previous calendar month) did the facility meet 4 hours and 8 hours of additional RN coverage?
- Did the facility use telehealth services for any of these shifts?
  - For how many days?
  - For how many total hours?
  - How many telehealth encounters occurred?

✓ For telehealth, the NF must submit encounter data in support of all encounters reported

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Component Two: Metric 3

As a Condition of Participation, NF must:

- Submit Performance Improvement Project (PIP) data template and supporting documentation twice a year
  - Topic: Five-Star Staffing Measures, Retention, Recruitment, Turnover, etc.
- Serve at least one Medicaid member per payment period

✓ Similar to Component One

Component Two: Metric 3 PIP

DUE ONLY TWICE A YEAR

December 6, 2023

- First Submission
- PIP Charter (Tabs 1-3)
- Sep. – Nov. 2023 Data

September 6, 2024

- Final Submission
- PIP Success Story (Tabs 1-6)
- Cumulative Data through Aug. 2024

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Conditions of Participation

SFY 2024 Workforce Development Topics

- Total nurse staffing hours
- RN staffing
- Total weekend nurse staffing
- Total nurse turnover
- RN turnover
- Administrator turnover
- Infection control training or protocols
- Workforce development activities specific to Certified Nursing Assistants
- Resident satisfaction
- Staff satisfaction
- Resident-centered culture change
- Hospital readmissions
- Preventable emergency department visits

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Component Three: Core MDS Measures (1 of 4)

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 Three: Core MDS Measures (2 of 4)

Performance Targets

- The quality metrics of Component 3 are equally weighted 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 metrics**, the NF cannot receive Component 3 funds

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Component Three: Core MDS Measures (3 of 4)

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 Three: Core MDS Measures (4 of 4)

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 Three: Maintaining High Performance

Defining "Maintenance"

- Performing better than the national average alone does not constitute maintaining high performance
- If the NF cannot meet improvement-over-self targets, it must perform better than the program-wide benchmark without performing worse than its baseline beyond the allowed margin of decline for the measure

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SFY 2024 Benchmarks & Allowed Margins of Decline

Pressure Ulcers

- YR6 National Average: 8.138%
- YR7 National Average: 8.049%
- Allowed Margin of Decline: **0.089**

Antipsychotic Medications

- YR6 National Average: 14.490%
- YR7 National Average: 14.583%
- Allowed Margin of Decline: **0.093**

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

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SFY 2024 Benchmarks & Allowed Margins of Decline

Independent Mobility

- YR6 National Average: 18.041%
- YR7 National Average: 15.201%
- Allowed Margin of Decline: **2.840**

Urinary Tract Infections

- YR6 National Average: 2.361%
- YR7 National Average: 2.284%
- Allowed Margin of Decline: **0.077**

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

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Component Three: Maintaining High Performance

For Example:

- NF Baseline: 2%
- Program-Wide Benchmark: 5%
- Allowed Margin of Decline: 1%
- Target each Program Quarter: 3%

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

Component Three: 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 Three

Reporting Requirements

- NFs report MDS Assessment Data to CMS per federal requirements
- All MDS data must be submitted by the final business day of the month following the reporting period

No Reporting Required

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Component Four: Infection Control

One Quality Metric: Different Quarterly Performance requirements

- **Quarter 1**: Infection control program and antibiotic stewardship
- **Quarter 2**: Leadership training
- **Quarter 3**: (Same as Q1)
- **Quarter 4**: MDS-based vaccination measures

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Component Four: Quarters 1 & 3 (1 of 4)

Performance Requirements

The NF must:

- Attest to the implementation of core elements of antibiotic stewardship for nursing homes
- Submit antibiogram report (from within the last six months)
- Submit audits of adherence to Hand Hygiene (HH) and Personal Protective Equipment (PPE) use in a format consistent with AHRQ templates

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Component Four: Quarters 1 & 3 (2 of 4)

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 audits, policy documents, antibiogram reports, and any elements attested to from the core elements checklist

✓ HHSC recommends use of AHRQ templates for audit documents

Component Four: Quarters 1 & 3 (3 of 4)

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 Four: Quarters 1 & 3 (cont.)

Links to required documentation templates are available on QIPP Resources Webpage

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.

Component Four: Quarter 2 (1 of 2)

Leadership Training

- NFs must attest to and submit an overall certificate of completion for the CDC's **Nursing Home Infection Prevention Training course** (Course ID#WB4448) for both:
  - Nursing Facility Administrator (NFA)
  - Director of Nursing (DON)

✓ Course certification must be dated within two years of the end of the quarter: 3/1/2022 through 2/28/2024

Component Four: Quarter 2 (2 of 2)

Reporting Requirements

- **Data:** Report names and training completion dates for both staff members through the QIPP Data Submission portal

- **Documentation:** Upload a dated training completion certificate for both staff members

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Component Four: Quarter 4 (1 of 2)

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 meet targets for the metric to be "Met" and the NF to receive incentive funds in Quarter 4

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Component Four: Quarter 4 (2 of 2)

Pneumococcal Vaccines

- YR6 National Average: 92.700%
- YR7 National Average: 91.786%
- Allowed Margin of Decline: **0.914**

Seasonal Influenza Vaccines

- YR6 National Average: 95.425%
- YR7 National Average: 94.701%
- Allowed Margin of Decline: **0.724**

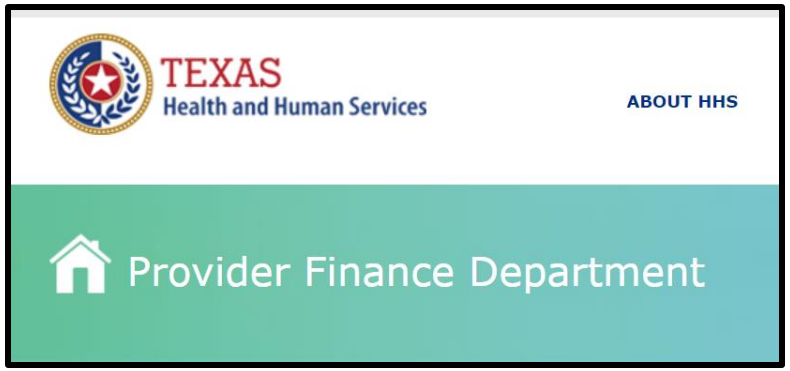
Note: The margin is an absolute value, not a relative %

Incentive Payments and Scorecard

Provider Finance Department

PFD QIPP Website

- Finding the Website
  - Do a Google search for "**Provider Finance QIPP**"
  - Click on the first result
  - Scroll down to the QIPP Year 7 drop-down menus



PFD QIPP Website

Other Useful Tools

- Dates to Remember timeline information
- Monthly and Quarterly Scorecards for all QIPP payments
- IGT information
- Be sure to check out the "Related Documents" section for further useful information!

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QIPP Data Portal Contacts

Primary Owner

- Can Assign & Approve Users
- Can Submit Data

Owner Representative

- Can Assign & Approve Users
- Can Submit Data

Facility Submitter

- Can Submit Data

- For Change in Ownership (CHOW) email QIPP requesting new owner account
- Other users must be assigned by owner
- **Initial Owner information will be used from enrollment data**

Component 1 Reconciliation

Interim Allocations

- Interim allocation triggers for QIPP Year 5 and future years have been removed
- The State has committed to reconciling 100% 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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Option to Decline Payment

- A facility may notify HHSC that it wishes to decline revenue from a component of QIPP at any time
- Upon receipt of notification, HHSC will remove the facility from consideration of the component when allocating revenues associated with that component
- **Declining payment only applies to the receipt of funds. The facility must still meet the conditions of participation and any other requirements applicable to the ownership type.**

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Condition of Participation (CoP)

Failure to Meet CoPs

- HHSC (or its appointed agent) will provide an opportunity to remediate the reporting requirements
  - If NF complies it remains enrolled in the program
  - If NF fails to comply, it will be removed from the program retroactive to the first day of the program period, and all funds previously paid during the program year will be recouped
- HHSC will redistribute revenue paid to facilities removed from the program to the remaining facilities participating in the program period

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Program Resources

Links

- QIPP Homepage
- QIPP Resources Page
  - SFY 2024 Quality Measures and Associated Performance Requirements (PDF)
  - Self-Paced Data Portal Submission Training (PDF)
- Provider Finance Division Website
- Subscribe to QIPP GovDelivery Alerts

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Thank you

For Questions, email QIPP at
QIPP@hhs.texas.gov