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Quality Incentive Payment Program (QIPP)

Getting Ready for SFY 2025

Program Overview, Quality Measures, & Performance Requirements

Contents

- QIPP Overview & Introduction
- Component Structure & Quality Measures
- Baselines, Benchmarks & Targets
- Measurement Periods & Reporting
- Program Resources
  - ✓The SFY 2025 program proposal is still under review by CMS. The information in these slides is subject to change until CMS issues final approval.
  - ✓This webinar focuses on program quality measure and performance requirements. For more information on enrollment, eligibility, and payments, please contact the HHSC Provider Finance Department.

QIPP Overview 1 of 3

What is QIPP?

- 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.
- The SFY 2025 program (September 1, 2024, through August 31, 2025) proposal is currently under review by CMS.
- QIPP is governed by the Texas Administrative Code (TAC) Rules at 1 TAC §353.1301 to §353.1304.

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QIPP Overview 2 of 3

Who can participate?

Two classes of Texas nursing facilities are eligible to participate:

- **Non-State Government-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

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QIPP Overview 3 of 3

Change in the quality measure data source:

- No monthly reporting or PIPs
- HHSC will use data published by CMS quarterly in the **Provider Data Catalog**.
- To accommodate this new data source, HHSC has adjusted the measurement periods for all quarters. The first measurement period for all measures is **7/1/2024 – 9/30/2024**.
- Data for this measurement period will be published by CMS in January 2025, and the first scorecard will be published by HHSC in February or March 2025.

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Component Structure & Quality Measures

Redefined components and new quality measures for SFY 2025

July 23, 2024

Component Funding Structure

Annual Budget

1.7B

Component One

44%

NSGOs

Component Three

44%

NSGOs

Component Two

20%

All NFs

Component Four

20%

All NFs

Component Quality Structure

- **Component One (NSGOs only)**
  - Hospital Partner Minimum Data Set (MDS) Quality Measures
- **Component Two (All enrolled NFs)**
  - Workforce Development Hours Per Resident Day (HPRD) Quality Measures
- **Component Three (All enrolled NFs)**
  - Texas Priority MDS Quality Measures
- **Component Four (NSGOs only)**
  - Resident Focus MDS Quality Measures

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Component One

Hospital Partner MDS Measures (NSGO-only)

- **Metric 1:** (CMS N013.02) Percent of residents experiencing one or more falls with major injury
- **Metric 2:** (CMS N024.02) Percent of residents with a urinary tract infection
- **Metric 3:** (CMS N029.03) Percent of residents who lose too much weight
- **Metric 4:** (CMS N031.04) Percent of residents who received an antipsychotic medication
- **Metric 5:** (CMS N035.04) Percent of residents whose ability to walk independently worsened

✓ Achievement in 1 metric earns 90% of eligible funds; achievement in 2 metrics earns 100%

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Component Two

Workforce Development HPRD Measures (All Facilities)

- **Metric 1:** Reported Certified Nursing Assistant (CNA) HPRD
- **Metric 2:** Reported Licensed Nursing HPRD
- **Metric 3:** Reported Total Nursing Staff HPRD

✓ Achievement in 1 metric earns 70% of eligible funds; achievement in 2 metrics earns 100%

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Component Three

Texas Priority MDS Measures (All Facilities)

- **Metric 1:** (CMS N030.03) Percent of residents who have depressive symptoms
- **Metric 3:** (CMS N036.03) Percent of residents who used antianxiety or hypnotic medication
- **Metric 3:** (CMS N046.01) Percent of residents with new or worsened bowel or bladder incontinence

✓ Equally weighted measures, each worth 33.33% of available component funds

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Component Four

Resident Focus MDS Measures (NSGO-only)

- **Metric 1:** (CMS N045.01) Percent of residents with pressure ulcers
- **Metric 2:** (CMS N026.03) Percent of residents who have/had a catheter inserted and left in their bladder

✓ Equally weighted measures, each worth 50% of available component funds

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Component Reference Chart

Item	Component 1	Component 2	Component 3	Component 4
Eligibility	NSGO	All Providers	All Providers	NSGO
Type	MDS	HPRD	MDS	MDS
# of Measures	5	3	3	2
Measure Weight	1 metric = 90% 2 metrics = 100%	1 metric = 70% 2 metrics = 100%	33.33% each	50% each
Benchmark Source	Texas Mean	National Mean	National Mean	Texas Mean
Improvement Target	5%	1%	5%	5%
Allowed Margin of Decline	Absolute 2%	Relative 2%	Absolute 2%	Absolute 2%

Quality Measure Reference Chart 1 of 2

Component 1 – NSGO Only

5 clinical MDS measures impacted by state initiatives and the facility's relationship with their hospital partners:

- Antipsychotic Medications
- Residents Experiencing Falls with Major Injury
- Weight Loss
- Urinary Tract Infections
- Independent Mobility

Performance Targets: 5% relative improvement on quarterly performance, or performing equal to or better than the Texas Mean without declining in performance

Component 2 – All Facilities

3 Hours Per Resident Day staffing quality measures related to staff-to-patient ratios, as directed by HB 2658 (87th regular session)

- Reported Total Nursing
- Reported Certified Nurses Assistant
- Reported Licensed Nursing (LVN+RN)

Performance Targets: 1% relative improvement on quarterly performance, or performing equal to or better than the National Mean without declining in performance

Quality Measure Reference Chart 2 of 2

Component 3 – All Facilities

3 clinical MDS measures selected as special focus areas:

- Anti-anxiety/hypnotic Medications
- Bowel and Bladder Control
- Depressive Symptoms

Performance Targets: 5% relative improvement on quarterly performance, or performing equal to or better than the National Mean without declining in performance

Component 4 – NSGO Only

2 clinical MDS measures that reflect staff adequacy and resident quality of care:

- Pressure Ulcers
- Catheter Left in Bladder

Performance Targets: 5% relative improvement on quarterly performance, or performing equal to or better than the Texas Mean without declining in performance

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Baselines, Benchmarks, & Performance Targets

Data sources and methodologies for setting facility baselines and quarterly targets

"Frozen" MDS Data

CMS Updated the Resident Assessment Instrument, effective 10/1/2023

- This resulted in three QIPP measures being redefined or replaced with a similar measure
- Baselines for the three impacted measures will not be available until January 2025:
  - ➢ CMS N035.4: Percent of residents whose ability to walk independently worsened
  - ➢ CMS N045.01: Percent of residents with pressure ulcers
  - ➢ CMS N046.01: Percent of residents with new or worsened bowel or bladder incontinence
  - ✓ For more information, see CMS publication QSO-23-21-NH

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Baselines 1 of 4

Methodology

- Baselines will be taken from the weighted four-quarter averages of CY2023 performance published by CMS in the Provider Data Catalog
- Where the weighted four-quarter average is not available, HHSC will calculate the non-weighted average from all available quarters

  ✓ HHSC will publish available baselines, benchmarks, and targets this month. To ensure you receive notification, sign up for GovDelivery alerts.

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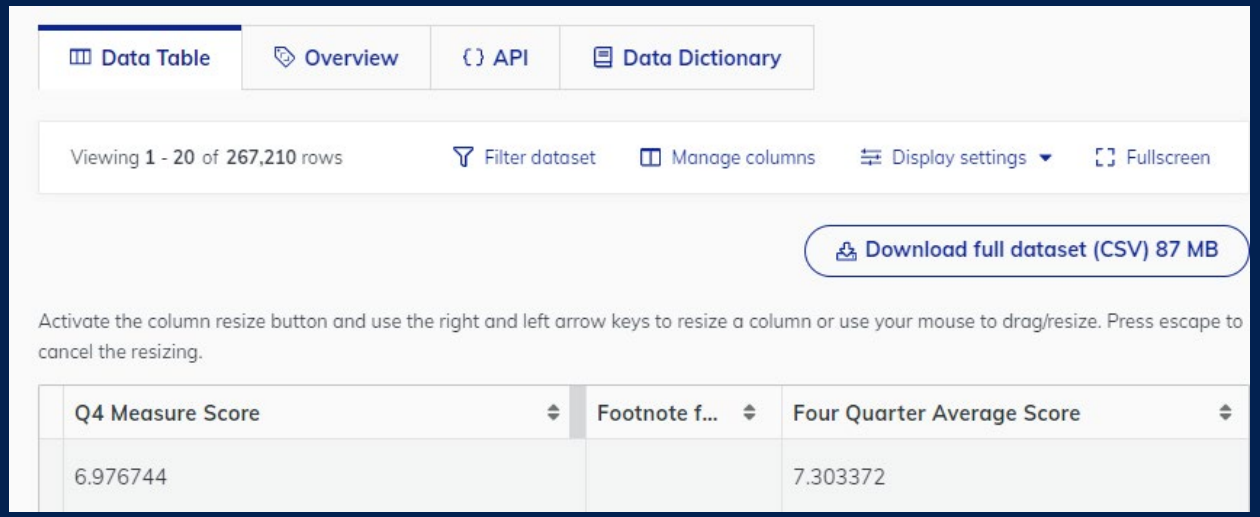
Baselines 2 of 4

Most MDS Measures

- For all non-frozen MDS measures, the weighted four-quarter average is available
- Baseline data come from the June 2024 MDS Quality Measures Public Use File (PUF)



Baselines 3 of 4

Frozen MDS Measures

- For the frozen and new MDS measures, the baseline will come from the only available CY2023 data, the Quarter 4 performance
- Baseline data will be published in the January 2025 MDS Quality Measures Public Use File (PUF)

  ✓ CMS archives monthly performance updates as "data snapshots" in the Provider Data Catalog

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Baselines 4 of 4

HPRD Staffing Measures

- For all HPRD measures, the baseline will come from the non-weighted average of available CY2023 quarters
- CMS "froze" staffing measure data in April 2024 so only three quarters of CY2023 data are available
- HHSC will average performance data from the most recently published version of each quarter's data update:
  - CY2023 Q1: September 2023 update
  - CY2023 Q2: December 2023 update
  - CY2023 Q3: June 2024 update
- HPRD performance is found in the Provider Information PUF

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Baseline Reference Chart

Measure Type	# of Measures	Source Quarters	Availability	Provider Data Catalog Dataset	Data Snapshot Files
Non-Frozen MDS Measures	7	Weighted CY2023 Q1-Q4	June 2024	MDS Quality Measures	6/25/2024
Frozen/New MDS Measures	3	Non-Weighted CY2023 Q4	January 2025	MDS Quality Measures	Forthcoming
HPRD Measures	3	Non-Weighted CY2023 Q1-Q3	June 2024	Provider Information	9/27/2023 12/20/2023 6/25/2024

Benchmarks

Methodology

- Program-wide benchmarks come from the National or Texas Mean and correspond to the same measurement period as the baseline
  - Component 1: Texas Mean
  - Component 2: National Mean
  - Component 3: National Mean
  - Component 4: Texas Mean
- Non-Frozen MDS benchmark data that come from four-quarter averages are published in the State US Averages PUF

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Performance Targets 1 of 4

Methodology

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 benchmark without declining in performance beyond an allowed margin of decline from the NF's baseline

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Performance Targets 2 of 4

Facility-Specific Targets

Facility-specific targets are calculated as relative improvement from the NF's baseline.

- **MDS Measures:** Relative 5% improvement from the NF baseline, increasing by 5% each quarter (5% in Q1, 10% in Q2, 15% in Q3, 20% in Q4)
- **HPRD Staffing Measures:** Relative 1% improvement from the NF baseline, increasing by 1% each quarter (1% in Q1, 2% in Q2, 3% in Q3, 4% in Q4)

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Performance Targets 3 of 4

Program-Wide Benchmarks

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

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Performance Targets 4 of 4

Allowed Margin of Decline

- For MDS Measures, the allowed margin of decline is an *absolute* 2%
  - i.e. [Baseline + 2.0]% (where higher percentages equal worse performance)
- For HPRD Measures, the allowed margin of decline is a *relative* 2%
  - i.e. Baseline * 0.98 (where lower values equal worse performance)

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Data Availability

Missing or "MIN DATA" Results

- In situations where a NF does not have enough data for all quality metrics to be calculated, the funding associated with any missing metric will be evenly distributed across all remaining metrics within the component.
- If a NF does not have enough data for any quality metrics in a component to be calculated, no funds will be earned.

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Measurement Periods & Reporting

New quarterly measurement periods and reminders for submitting data to CMS

Measurement Periods

Measure Type	Months Covered	Performance Data Published by CMS	Scorecard Published by HHSC
Quarter 1	July – September 2024	January 2025	February/March 2025
Quarter 2	October – December 2024	April 2025	May/June 2025
Quarter 3	January – March 2025	July 2025	August/September 2025
Quarter 4	April – June 2025	October 2025	November/December 2025

MDS Data Reporting

Minimum Data Set Reporting Requirements

- NFs must report MDS Resident Assessment data to CMS per federal requirements
- MDS assessment data must be submitted to CMS in time for the publication dates listed on the previous slide

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PBJ Data Reporting

Payroll-Based Journal (PBJ) Reporting Requirements

- NFs must report staffing data to CMS per federal requirements
- Payroll data are due 45 days after the end of the measurement period

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Program Resources

Links

- Medicaid and CHIP Services QIPP Homepage
- QIPP Resources Page
- Provider Finance Department Website
- Subscribe to QIPP GovDelivery Alerts

✓ These slides will be made available in PDF after an accessibility review

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Thank you

For Questions, email QIPP at

QIPP@hhs.texas.gov