Quality Incentive Payment Program (QIPP) Requirements State Fiscal Year (SFY) 2025

Program Overview

The Quality Incentive Payment Program (QIPP) is a state-directed payment program (DPP) designed to help nursing facilities achieve transformation in care quality through innovation. QIPP was first implemented on September 1, 2017.

HHSC first proposed quality metrics for SFY 2025 on November 30, 2023; held a public hearing on December 13, 2023; and collected public comments until December 15, 2023. After reviewing public comments, HHSC proposes the following quality metrics for the program period that begins September 1, 2024, and ends on August 31, 2025. These quality metrics and requirements will be submitted to CMS for program review and approval. The final quality metrics and requirements will be posted on the QIPP webpage following CMS' approval.

Quality Goals

QIPP aims to advance the goals of the Texas Managed Care Quality Strategy. Nursing facilities will be measured on quality metrics that tie to the following strategy goals.

1. Keep patients free from harm by building a safer healthcare system that limits human error.
2. Promote effective practices for people with chronic, complex and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of healthcare costs.
3. Attract and retain high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers to participate in team-based, collaborative, and coordinated care.

Program Structure

Two classes of Texas nursing facilities (NFs) serving residents enrolled in STAR+PLUS Medicaid are eligible to participate in QIPP:

- Non-state government-owned (NSGO) NFs
- Privately-owned NFs that have a percentage of Medicaid NF days of service that is greater than or equal to 65%

Providers earn payments by meeting performance requirements in four components:

- Component One: Hospital Partner Minimum Data Set (MDS) Measures
- Component Two: Workforce Development
- Component Three: Texas Priority MDS Measures
- Component Four: Resident Focus MDS Measures

All components are structured as pay-for-performance and include nationally recognized quality measures. For SFY 2025, the program does not require NFs to report data or documentation to HHSC.

Component One

HHSC designates five metrics for Component One. Component One is open only to NSGO NFs. Funds in this Component are distributed **quarterly**.

Facility achievement will be based on performance across a pool of five long-stay MDS quality measures[a]. NFs are required to meet performance targets (defined below) in **at least two of the five metrics** to earn all component funds. The quality metrics are:

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

Achievement in one of the available measures will earn 90% of eligible component funds; achievement in two or more of the available measures will earn 100% of eligible component funds.

Performance Requirements

Quarterly performance will be based on a NF's most recently published quarterly performance according to the Public Use Files (PUFs) published by CMS at data.cms.gov.

Facility-specific targets are calculated as relative improvements from the NF's initial baseline published at the beginning of the program year.

Program-wide targets are set at the most recently published **Texas mean** for each quality metric according to the PUFs published by CMS at data.cms.gov for the baseline reporting period (calendar year 2023).

[a] Definitions and technical specifications for MDS quality measures can be found at: https://www.cms.gov/medicare/quality/nursing-home-improvement/quality-measures

Table 1. Component 1 Measurement Periods and Relative Improvement Targets

Reporting Period	Measurement Period	NF-Specific Relative Improvement[b] Target
Baseline	January 1, 2023 – December 31, 2023	-
QIPP Quarter 1	July 1, 2024 – September 30, 2024	5%
QIPP Quarter 2	October 1, 2024 – December 31, 2024	10%
QIPP Quarter 3	January 1, 2025 – March 31, 2025	15%
QIPP Quarter 4	April 1, 2025 - June 30, 2025	20%

Achievement

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 target without declining in performance beyond an absolute 2% allowed margin of decline[c] from the NF's baseline.

> NFs report MDS assessment data to CMS, per federal requirements. NFs do not have to report MDS data or results to HHSC for QIPP.

[b] Improvement-over-self is measured as relative improvement from the NF's baseline: Baseline – (Baseline * Improvement Target) = Quarterly Performance Target.
[c] The allowed margin of decline is defined as an absolute 2% addition to the NF's baseline. If a NF has a baseline already better than the program-wide target, quarterly targets will be set at the NF's baseline + 2.0, up to the program-wide target itself.

Component Two – Workforce Development

HHSC designates three quality metrics for Component Two. Component Two is open to all NF types. Funds are distributed **quarterly**. The weight of each quality measure will vary over the course of three upcoming program years:

- For program periods beginning on September 1, 2024, achievement in one metric earns 70 percent, and achievement in two metrics earns 100 percent of total dollars included in the component;
- For program periods beginning on September 1, 2025, achievement in one metric earns 60 percent, achievement in two metrics earns 85 percent, and achievement in 3 metrics earns 100 percent of total dollars included in the component; and
- For program periods beginning on or after September 1, 2026, each quality metric will be allocated an equal portion of the total dollars included in the component (equally weighted).

All three measures relate to staff-to-patient ratios and are measured in Hours Per Resident Day (HPRD) based on data NFs provide quarterly to CMS through the Payroll Based Journal (PBJ)[d]. The three metrics are:

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

Performance Requirements

Quarterly performance will be based on a NF's most recently published quarterly performance according to the PUFs published by CMS at data.cms.gov.

Facility-specific targets are calculated as improvements upon a NF's initial baseline, beginning with a one percent relative improvement in quarter one and increasing by one percent each subsequent quarter, up to four percent relative improvement by quarter four.

[d] Definitions and technical specifications for the PBJ-based quality measures can be found in the Five-Star Technical Users Guide available at: https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf

Program-wide targets are set at the most recently published **national mean** for each quality metric according to the PUFs published by CMS at data.cms.gov at the beginning of the program year.

Table 2. Component 2 Measurement Periods and Relative Improvement Targets

Reporting Period	Measurement Period	NF-Specific Relative Improvement Target
Baseline	January 1, 2023 – December 31, 2023	-
QIPP Quarter 1	July 1, 2024 – September 30, 2024	1%
QIPP Quarter 2	October 1, 2024 – December 31, 2024	2%
QIPP Quarter 3	January 1, 2025 – March 31, 2025	3%
QIPP Quarter 4	April 1, 2025 - June 30, 2025	4%

Achievement

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 target without declining in performance beyond an absolute 2% allowed margin of decline from the NF's baseline.

> NFs report PBJ staffing data to CMS, per federal requirements. NFs do not have to report PBJ data or coverage hours to HHSC for QIPP.

Component Three – Texas Priority MDS Quality Measures

HHSC designates three equally weighted quality metrics for Component Three. Component Three is open to all NF types. Funds are distributed **quarterly**.

All three metrics relate to Long-Stay Minimum Data Set (MDS) quality metrics and are measured against program-wide as well as facility-specific targets. The three metrics are:

- **Metric 1:** (CMS N030.03) Percent of residents who have depressive symptoms
- **Metric 2:** (CMS N046.01) Percent of residents with new or worsened bowel or bladder incontinence
- **Metric 3:** (CMS N036.03) Percent of residents who used antianxiety or hypnotic medication

Performance Requirements

Quarterly performance will be based on a NF's most recently published quarterly performance according to the PUFs published by CMS at data.cms.gov.

Facility-specific targets are calculated as relative improvements from the NF's initial baseline published at the beginning of the program year.

Program-wide targets are set at the most recently published **national mean** for each quality metric according to the PUFs published by CMS at data.cms.gov for the baseline reporting period.

Table 3. Component 3 Measurement Periods and Relative Improvement Targets

Reporting Period	Measurement Period	NF-Specific Relative Improvement Target
Baseline	January 1, 2023 – December 31, 2023	-
QIPP Quarter 1	July 1, 2024 – September 30, 2024	5%

Reporting Period	Measurement Period	NF-Specific Relative Improvement Target
QIPP Quarter 2	October 1, 2024 – December 31, 2024	10%
QIPP Quarter 3	January 1, 2025 – March 31, 2025	15%
QIPP Quarter 4	April 1, 2025 - June 30, 2025	20%

Achievement

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 target without declining in performance beyond a 2% allowed margin of decline from the NF's baseline.

> NFs report MDS assessment data to CMS, per federal requirements. NFs do not have to report MDS data or results to HHSC for QIPP.

Component Four – Resident Focus

HHSC designates two equally weighted quality metrics for Component Four. Component Four is open only to NSGO NFs. Funds are distributed **quarterly**.

Both metrics relate to Long-Stay Minimum Data Set (MDS) quality metrics and are measured against program-wide as well as facility-specific targets. The two metrics are:

- **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

Performance Requirements

Quarterly performance will be based on a NF's most recently published quarterly performance according to the PUFs published by CMS at data.cms.gov.

Facility-specific targets are calculated as relative improvements from the NF's initial baseline published at the beginning of the program year.

Program-wide targets are set at the most recently published **Texas mean** for each quality metric according to the PUFs published by CMS at data.cms.gov for the baseline reporting period.

Table 4. Component 4 Measurement Periods and Relative Improvement Targets

Reporting Period	Measurement Period	NF-Specific Relative Improvement Target
Baseline	January 1, 2023 – December 31, 2023	-
QIPP Quarter 1	July 1, 2024 – September 30, 2024	5%
QIPP Quarter 2	October 1, 2024 – December 31, 2024	10%
QIPP Quarter 3	January 1, 2025 – March 31, 2025	15%

Reporting Period	Measurement Period	NF-Specific Relative Improvement Target
QIPP Quarter 4	April 1, 2025 - June 30, 2025	20%

Achievement

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 target without declining in performance beyond an absolute 2% allowed margin of decline from the NF's baseline.

> NFs report MDS assessment data to CMS, per federal requirements. NFs do not have to report MDS data or results to HHSC for QIPP.

Appendix A: Quality Measure Summary

Table 5: Final Quality Metrics

Comp.	Measure Type	Program-Wide Benchmark	Relative Improvement Targets	Components Funds per Measure	Metrics
One (NSGOs only)	Minimum Data Set (MDS) Long-Stay Quality Measure	Texas Mean	Quarter 1: 5% Quarter 2: 10% Quarter 3: 15% Quarter 4: 20%	Achievement in 1 metric earns 90% of eligible funds; achievement in 2 metrics earns 100% of eligible funds	• **Metric 1:** (CMS N031.04) Percent of residents who received an antipsychotic medication • **Metric 2:** (CMS N013.02) Percent of residents experiencing one or more falls with major injury • **Metric 3:** (CMS N029.03) Percent of residents who lose too much weight • **Metric 4:** (CMS N024.02) Percent of residents with a urinary tract infection • **Metric 5:** (CMS N035.04) Percent of residents whose ability to walk independently worsened

Comp.	Measure Type	Program-Wide Benchmark	Relative Improvement Targets	Components Funds per Measure	Metrics
Two	Payroll Based Journal (PBJ) Staffing Measure in Hours Per Resident Day (HPRD)	National Mean	Quarter 1: 1% Quarter 2: 2% Quarter 3: 3% Quarter 4: 4%	For the program year beginning on 09/01/2024: Achievement in 1 metric earns 70% of eligible funds; achievement in 2 metrics earns 100%[e]	• **Metric 1:** Reported Total Nursing Staff HPRD • **Metric 2:** Reported Certified Nursing Assistant (CNA) HPRD • **Metric 3:** Reported Licensed Nursing HPRD
Three	Minimum Data Set (MDS) Long-Stay Quality Measure	National Mean	Quarter 1: 5% Quarter 2: 10% Quarter 3: 15% Quarter 4: 20%	Equally weighted	• **Metric 1:** (CMS N030.03) Percent of residents who have depressive symptoms • **Metric 2:** (CMS N046.01) Percent of residents with new or worsened bowel or bladder incontinence • **Metric 3:** (CMS N036.03) Percent of residents who used antianxiety or hypnotic medication
Four (NSGOs only)	Minimum Data Set (MDS) Long-Stay Quality Measure	Texas Mean	Quarter 1: 5% Quarter 2: 10% Quarter 3: 15% Quarter 4: 20%	Equally weighted	• **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

[e] For the program year beginning on 09/01/2025: Achievement in 1 metric earns 60% of eligible funds; achievement in 2 metrics earns 85%; achievement in all 3 metrics earns 100%. For the program year beginning on 09/01/2026: Equally weighted

Appendix B: Highlights of Program Changes in SFY 2025

1) Component 1

    a) Quarterly MDS measures; three measures were in Component 3 in SFY 2024; two measures are new to QIPP in SFY 2025.

    b) Component funds will be measured and distributed quarterly in SFY 2025. Prior to SFY 2025 they were distributed monthly.

2) Component 2

    a) New quarterly HPRD measures.

    b) Component funds will be measured and distributed quarterly in SFY 2025. Prior to SFY 2025, achievement was measured and payments were distributed monthly.

3) Component 3

    a) Three new quarterly MDS measures.

    b) The performance measurement period will align with calendar year quarters (Q1 is July – September) in SFY 2025. Prior to SFY 2025, the performance measurement period aligned with state fiscal year quarters (Q1 was September – November).

4) Component 4

    a) Quarterly MDS measures; one measure was in Component 3 in SFY 2024; one measure is new to QIPP in SFY 2025.

    b) The performance measurement period will align with calendar year quarters (Q1 is July – September) in SFY 2025. Prior to SFY 2025, the performance measurement period aligned with state fiscal year quarters (Q1 was September – November).

For all components, the allowable margin of decline is set as a two percent absolute decline for metrics where baselines are better than the program-wide benchmark.