Measure Bundle Protocol for Demonstration Years (DY) 7-8: Summary of Stakeholder Feedback and HHSC Reponses

On June 22, 2017, HHSC released the draft DSRIP Measure Bundle Protocol for Demonstration Years (DY) 7-8 for stakeholder feedback. The Measure Bundle Protocol describes reporting requirements related to Category A Core Activities; Category B System definition; Category C Measure Bundles for hospitals and physician practices and Measures for community mental health centers and local health departments; and Category D statewide reporting measures. HHSC hosted a webinar on June 21, 2017 to provide an overview of the draft Measure Bundle Protocol requirements and answer questions. Stakeholders submitted questions through an online survey that closed on July 7, 2017.

This document summarizes the stakeholder feedback HHSC received through the 167 responses to the survey. The DSRIP team reviewed stakeholder comments, drafted responses, and determined Measure Bundle Protocol changes through multiple team meetings and discussion with leadership. HHSC grouped together similar comments and responses rather than including individual feedback. Questions that were specific to Category C measure specifications are not addressed in this document. HHSC has reviewed those comments and questions and is working on updating the Category C measure specifications that will be included as Appendix A to the Measure Bundle Protocol in the fall of 2017. Changes to the Measure Bundle Protocol based on stakeholder feedback and HHSC direction are reflected in the updated Measure Bundle Protocol and noted in the responses herein.

HHSC submitted the Measure Bundle Protocol for DY7-8 to CMS on July 28, 2017 for review and feedback. All DY7-8 requirements are subject to CMS approval and HHSC will continue to work with CMS to achieve timely approval. HHSC is targeting September 2017 for CMS approval of the Measure Bundle Protocol.

Contents

Category A

Selecting Core Activities

1. Many stakeholders appreciate flexibility in Core Activity selection, which includes the option to specify their own Core Activity. Providers requested that HHSC maintain that flexibility when providers propose their own Core Activities even if it is not part of a national quality initiative. Providers also requested additional details related to the approval process for when a provider submits their own Core Activity under the 'Other' option.
    - **HHSC RESPONSE**: Selection and reporting of Core Activities is designed to offer providers the flexibility in deciding which initiatives contribute the most to the goals set by the Performing Providers. HHSC anticipates that there will be minimal feedback on Other Core Activities as long as providers meet the minimum requirement by selecting at least one Core Activity that supports the achievement of Category C measure goals. Providers should review the list of Core Activities in the MBP prior to selecting 'Other.' As long as there is a logical connection between a Core Activity and selected measure bundles or measures, HHSC does not anticipate following up with providers, and Other Core Activities will be approved as part of the RHP Plan Update.

2. Several providers expressed support for reporting of Core Activities tied to the mission of the Performing Provider's organization even if they are not tied directly to the selected measure bundles or measures.
    - **HHSC RESPONSE**: HHSC encourages providers to continue sharing information about best practices and initiatives that are core to the organization's mission. Providers have to ensure that at least one Core Activity is tied to the selected Measure Bundles or measures. HHSC will have a way for providers to indicate which Core Activity or Activities are tied to the measures.

3. Several stakeholders wanted to clarify how many Core Activities they have to select and if providers need to select one for each measure bundle or measure.
    - **HHSC RESPONSE**: A Performing Provider needs to select and report on at least one Core Activity that supports the achievement of its Category C measure goals for the selected Measure Bundle(s) or measures. There is no maximum number of Core Activities that the Performing Provider may select. Requirement of at least one Core Activity was designed to increase the flexibility for Performing Providers and to lessen the reporting commitment by the providers. It is reasonable to assume that some Performing Providers will have just one main activity and requiring them to report on many initiatives would not benefit the Performing Providers or state and federal entities. However, providers with many initiatives can benefit from sharing what activities they are implementing. If some Performing Providers are successful at achieving the goals for the measures they are working on, understanding the main drivers for this success is beneficial to the state and federal government as well as other Performing Providers who are working on similar quality initiatives. In addition, sharing information on Core Activities can lead to further collaboration among providers within and across the regions.

4. Some stakeholders asked HHSC to provide guidance regarding additional supporting documentation required.
    - **HHSC RESPONSE**: A description of a Core Activity during the RHP Plan Update and regular reporting periods is sufficient to meet HHSC requirements. HHSC will develop additional

guidance on this reporting and include it in the reporting companion. Any other documentation supporting implementation of the selected Core Activity should be available for review by the state, the independent assessor or federal entities.

5. Several stakeholders requested clarification regarding the type of Core Activity that the provider needs to select for cost-benefit analysis - whether it has to be the one that is tied to the goal of Measure Bundles or measures, or any Core Activity that the provider is reporting on. Providers also wanted to know if they can do cost-benefit analysis on a portion of a broad Core Activity.
    - **HHSC RESPONSE**: For the cost-benefit analysis, Performing Providers can select any Core Activity that provider selected for reporting to HHSC and specify why a specific activity was chosen for the cost-benefit analysis. If a selected Core Activity is broad in scope, the provider can concentrate its analysis on a component of the Core Activity and provide an explanation for such focus during the reporting. This was reflected in the revised version of the MBP.

6. Providers requested clarification regarding existing projects and whether they need to select a Core Activity for the projects that will continue in DY7-8.
    - **HHSC RESPONSE**: In the RHP Plan Update, providers will indicate, which projects are completed and which projects (or components of them) will continue. Providers are not required to select a Core Activity for each of the projects that will continue in DY7-8. However, providers may choose to include those as additional Core Activities to report on.

7. Some stakeholders were concerned that that the change in a Core Activity will not be approved fast enough for the provider to adjust its course, or the provider will get scrutinized because of changes in the initiative or face a recoupment.
    - **HHSC RESPONSE**: If adjustments are needed, Performing Providers can revise their strategies used in achieving Category C goals and update their selection of Core Activities at any time without HHSC approval. During the second reporting period of each DY, Performing Providers will provide a description of any newly selected Core Activity and the reason for selecting it along with reporting progress on previously selected Core Activities. This should satisfy HHSC requirements.

8. Some stakeholders inquired about the timing for stakeholder meetings.
    - **HHSC RESPONSE**: HHSC recommends that providers conduct their stakeholder meetings prior to the RHP Plan Update.

9. Several stakeholders suggested that HHSC consider providing payments for the reporting of Category A.
    - **HHSC RESPONSE**: HHSC provided responses to these questions in the stakeholder summary for the PFM. Please see that document for more details Summary of Stakeholder Feedback on the First Draft DY7-8 PFM (PDF) (5/17/17).

10. Some stakeholders inquired about a decision to stop current DY2-6 projects and whether there will be additional scrutiny because of that decision.
    - **HHSC RESPONSE**: There is not a requirement for providers to discontinue their current projects with the move to a provider-level reporting. Performing Providers can transition their current projects into Core Activities. If providers determine that their current DY2-6 initiatives no longer benefit the patients they serve, providers may decide to substitute these initiatives with other activities that contribute to improving the quality of care.

Reporting on Core Activities

11. Providers requested clarification on what will be reviewed during the audits.
    - **HHSC RESPONSE**: Qualitative reporting on core activities will be reviewed similar to the current review of a project summary or progress updates. HHSC does not plan to flag core activities for compliance monitoring, but anything is subject to audit.

12. Providers asked if they can add new core activities that are not related to Category C measures after the initial submission.
    - **HHSC RESPONSE**: Yes, providers can update their Core Activities during the subsequent reporting period for Category A.

Examples of Core Activities: Access to Primary Care Services

13. Stakeholders submitted their recommendations for changes within the Core Activity list.
    - **HHSC RESPONSE**: HHSC revised the Core Activity list to incorporate stakeholder feedback. HHSC added Core Activities related to Telehealth/Telemedicine services and provision of services to individuals that address social determinants of health.

Examples of Core Activities: Access to Specialty Care Services

14. Some stakeholders recommended adding a Core Activity related to the data sharing between providers and facilities.
    - **HHSC RESPONSE**: Data sharing can be included as part of any Core Activity selected by the provider, but it should not be the only or primary Core Activity that the provider reports on. This is reflected in the MBP.

Examples of Core Activities: Maternal and Infant Health Care

15. Stakeholders submitted their recommendations for changes within the Core Activity list.
    - **HHSC RESPONSE**: HHSC revised the Core Activity list to incorporate stakeholder feedback. HHSC added a Core Activity related to Telehealth/Telemedicine services.

Examples of Core Activities: Prevention and Wellness

16. Stakeholders submitted their recommendations for changes within the Core Activity list.
    - **HHSC RESPONSE**: HHSC revised the Core Activity list to incorporate stakeholder feedback. HHSC added the following Core Activities: Implementation of evidence based strategies to reduce sexually transmitted diseases; and Implementation of interventions focusing on social determinants of health that can lead to improvement in well-being of an individual. Additional recommendations did not result in new Core Activities because many of them could be reflected under existing options.

Examples of Core Activities: Chronic Care Management

17. Stakeholders submitted their recommendations for changes within the Core Activity list.
    - **HHSC RESPONSE**: HHSC revised the Core Activity list to incorporate stakeholder feedback. HHSC added a Core Activity related to Telehealth/Telemedicine services.

Examples of Core Activities: Availability of Appropriate Levels of Behavioral Health Care Services

18. Stakeholders submitted their recommendations for changes within the Core Activity list.

- **HHSC RESPONSE**: HHSC revised the Core Activity list to incorporate stakeholder feedback. HHSC added the following Core Activities: Provision of care aligned with Certified Community Behavioral Health Clinic (CCBHC) model; and Provision of services to individuals that address social determinants of health and/or family support services. In addition, HHSC added Core Activities related to Substance Use Disorder.

  HHSC also clarified in the MBP that Performing Providers can select Core Activities from various groupings as long as it reflects what the provider is carrying out. Performing Providers working on quality initiatives in the area of behavioral health are not limited to areas directly related to behavioral health Core Activities and can select items in other areas.

Examples of Core Activities: Behavioral Health Crisis Stabilization Services

19. Stakeholders submitted their recommendations for changes within the Core Activity list.
    - **HHSC RESPONSE:** HHSC revised the Core Activity list to incorporate stakeholder feedback. HHSC added a Core Activity to the list: Provision of services to individuals that address social determinants of health.

Examples of Core Activities: Palliative Care

20. Stakeholders submitted their recommendations for changes within the Core Activity list.
    - **HHSC RESPONSE**: HHSC revised the Core Activity list to incorporate stakeholder feedback. HHSC added the following Core Activities: Provision of palliative care services in outpatient setting; Provision of services to individuals that address social determinants of health; and Utilization of services assisting individuals with pain management.

Core activities not currently included that should be added

21. Stakeholders submitted their recommendations for changes within the Core Activity list.
    - **HHSC RESPONSE**: HHSC revised the Core Activity list to incorporate stakeholder feedback. HHSC added the following Core Activities: Other for each Core Activity area; Telemedicine/telehealth to many of the Core Activity areas.

      HHSC also clarified in the MBP that there are certain activities that Performing Providers can incorporate in any Core Activity as a sub-activity if it contributes to improving quality of care; such as technology improvements (e.g., Electronic Medical Records or Health Information Exchange connectivity) and continuous quality improvement (CQI), but the technological advances activities or the CQI should not be the only or primary activity that Performing Providers choose to report on.

Other Comments on Core Activities

22. Stakeholders asked for clarification regarding strategies to participate in VBP with MCOs, and whether it is a requirement to participate in APM/VBP.
    - **HHSC RESPONSE**: Providers should describe activities toward APM/VBP arrangements with MCOs (including barriers) in order to keep HHSC informed of any progress. The reporting is qualitative only.

Category B

System Definition

23. One provider requested to add in specific language from the PFM that indicates non-clinical settings (such as school-based intervention) do not need to be included in the system definition. Another provider requested clarification, however, that those settings are stilled allowed to be included.
    - **HHSC RESPONSE**: Since this language is already included in the PFM, it does not need to be repeated in the MBP. However, the principle remains; non-clinical settings are optional and vary dependent upon access to data (that can be used to support any potential audit of reported information). HHSC does hope that those projects that have benefited clients in the non-clinical settings will continue, regardless of whether or not they are specifically being measured. Please note, however, that many of the activities in a non-clinical setting will not be part of any Category C measurement unless actual, documented services are being delivered.

24. Some providers requested to limit their system definition to only certain populations that are being served.
    - **HHSC RESPONSE**: Providers may not limit the system definition by types of populations being served. The System should be as inclusive as possible to get the largest count of patients being served by the provider. Choosing a specific population (such as by zip code, diagnosis, or certain high-risk behaviors) for purposes of the system definition may give unfair advantages to providers when calculating achievement of Category C outcome measures. The Category C measures will naturally limit the denominators of measures by the setting of the measurement and by measure specifications (which may target specific populations based on diagnosis, for example).

25. The PFM indicates that providers should include in the Patient Population by Provider (PPP) count even those clients that receive services that are funded exclusively by a federal grant or program.
    - **HHSC RESPONSE:** That is correct; providers may include in their PPP and system those clients that are served through federal grant or other-funded programs. PPP is no longer measuring the impact specific to DSRIP; it is looking at who the provider's system is serving at large. Providers should check guidelines for any other federal grants to see if there are any conflicts therein.

26. One provider asked if a Core Activity that was previously provided through a contracted entity for DY 2-6 DSRIP activities is discontinuing in DY 7, should we exclude those patient counts in the Total PPP and MLIU PPP baselines.
    - **HHSC RESPONSE:** It depends on the location of the services. If the activity was occurring in one of the required components of the system, then they should not be excluded. If the activity was in an optional component of the system, then the population may be excluded from the baseline.

27. Some providers raised concerns about capturing system-wide data across different EMR systems.
    - **HHSC RESPONSE:** We understand this may take some additional work to get a unique patient count within one system but across different EMR systems. But in the efforts to

prepare providers for more data-supported quality improvement and improved patient outcomes, and to prepare providers for sustainability through HIE partnerships or potential VBP arrangements, we think this is an important step.

28. A number of providers raised questions about active patient definitions.
    - **HHSC RESPONSE:** For purposes of Cat. B System definition and the PPP, the patient must have received a service in the DY, as defined in the PFM. Category C measure specifications may have different allowances for active patient definition.

29. Some providers seem still confused about the relationship of system definition to measure bundles and measures. Some want to have different system definitions for different bundles.
    - **HHSC RESPONSE:** Each provider will only have one system. The entire system population is not necessarily (and most likely is not) the denominator for any one measure. The system definition and PPP is larger than the denominator of any one measure. The denominator will be limited by the setting of any one measure and by the measure specifications. The system is the universe of patients that may or may not be measured in the Category C measures. But all people included in a Cat C measure should be included in the Category B System PPP. So if a provider wants to partner with other clinics in order to add more measures and reach their MPT, they need to include those partner clinics in their system (and be able to access data necessary for reporting measure outcomes and patient populations). Providers may not limit their system based on their Category C measure bundle selections. They should be counting all patients who they serve for the purposes of Category B Patient Population by Provider.

30. Respondents requested the definition of Performing Provider.
    - **HHSC RESPONSE:** According to the PFM, "'Performing Providers' are providers that are responsible for: 1) implementing Core Activities to achieve the Category C measure goals in an RHP Plan Update; and 2) measuring, reporting, and improving performance on the Category C measure goals in an RHP Plan Update, among other reporting requirements outlined in this protocol. All Performing Providers must have a current Medicaid provider identification number. Performing Providers that complete milestones and measures as specified in [the] "Measure Bundle Protocol" are the only entities that are eligible to receive DSRIP incentive payments in DY7-8. Performing Providers will primarily be hospitals, but CMHCs, LHDs, and physician practices may also receive DSRIP payments."

31. Many respondents were concerned about how to avoid duplication across provider systems.
    - **HHSC RESPONSE:** There may be overlap in system definition between providers who share the same contracted entity, but Performing Providers should avoid system definitions that include required components of another DSRIP Performing Provider's system. For example, DSRIP Performing Provider hospital A should not include the specialty clinic that is operated by the DSRIP Performing Provider hospital B. Individuals may be in multiple systems, but should not be included in each system based on the same single service. If an individual is served by System A in DY7 and also served by System B in DY7, they may be counted in both systems in the providers' respective system PPP.

For example, if one hospital Performing Provider system refers an individual patient to a separate Performing Provider CMHC for services. They would both count this individual as part of their Patient Population by Provider for Category B purposes. However, they are providing different services, and most likely, will be selecting different measures for Category C. In this hypothetical scenario, the hospital may not be measuring some mental health related outcome based on the referral to the CMHC, but the CMHC might.

32. Some respondents stated there is a potential, based on outside factors, for certain grant-funded or other non-DSRIP services to be decreased in the future and impact the provider's ability to maintain their system population.
    - **HHSC RESPONSE:** There are allowances for normal fluctuation in the system makeup by the fact that (1) the baseline is set on the average of two years to account for natural fluctuations; (2) providers are granted an allowable variance from 100% achievement [the percentage variance is to be determined based on provider type and MLIU populations]; and (3) there are partial achievement levels in the Category B PPP. In addition, the PFM indicates that a provider may request to amend their baseline and goal in the event that a major change impacts the provider's system definition, such as a policy change that the provider has little control over.

33. There was concern about a system crossing two TPIs.
    - **HHSC RESPONSE:** If these are two separate TPIs that are used for DSRIP payments because they are two separate DSRIP providers, then the TPIs may not be combined (unless previously approved or it is a hospital and physician practice that work in the same space). But outside of DSRIP participation, a single provider may have many TPIs. That is not a factor for the purposes of DSRIP system definition.

34. Respondents inquired about the role of data availability in determining system definition.
    - **HHSC RESPONSE:** Data availability may be used in consideration of which optional system components to choose. But data availability (or simplicity of accessing data) is not a reason to exclude one of the required components of the system definition.

35. Respondents asked if they have to choose Measure Bundles or measures that address the entire system or if they are free to choose any bundles or measures as long as they meet the MPT.
    - **HHSC RESPONSE:** You may choose any bundles as long as you meet the MPT.

36. Respondents asked if they are partnering with a separate entity and including them in the system definition (under optional) do they need to include all services they provide or just services provided on our behalf.
    - **HHSC RESPONSE:** Providers may determine which arrangements make most sense for them, but providers must maintain consistency across all measurements periods and document their arrangement. For example, if a provider chooses to only include the services provided on their behalf with a contracted provider, they should document that in their system description and they should only include those contracted services (not all services) in each DY of the waiver.

37. Respondents asked about the overlap between hospitals and physician groups.
    - **HHSC RESPONSE:** HHSC will allow existing DSRIP Performing Provider physician practices and the hospitals where they practice to combine into one system since there is overlap between the individuals they serve and the collaboration for transformative purposes. These providers will have a combined total MPT, based on the original MPTs assigned, with the maximum MPT remaining at 75. These providers must notify HHSC, if they have not already done so, whether they would like to combine MPTs by August 31, 2017. This applies to the following providers. Please notify HHSC immediately if this applies to a DSRIP Performing Provider hospital and related physician practice that are not listed.

RHP	Hospital TPI	Hospital	PP TPI	Related Physician Practice
2	094092602	University of Texas Medical Branch - Galveston	109372601	University of Texas Medical Branch - Galveston
6	136141205	University Health System (Bexar County Hospital District)	092414401	Community Medicine Associates
9	175287501	University of Texas Southwestern St Paul University	126686802	UT Southwestern Medical Center at Dallas
10	126675104	Tarrant County Hospital District dba JPS Health Network	360106401	Acclaim Physician Group Inc
10	130606006	Decatur Community Hospital (Wise Reg Health System)	206106101	Wise Clinical Care Associates
12	137999206	Lubbock County Hospital District dba University Medical Center	079877902	UMC Physician Network Services

38. There was concern about timing of approval of RHP Plan Update and system definition for setting baselines.
    - **HHSC RESPONSE:** Please refer to the allowable reporting periods found in the PFM.

Systems and Geographic Location

General Clarification: This is not intended to mean that DY2-6 participating providers may now combine across regions or change RHPs. Stretching a system across regions is more specific to the affiliated clinics or partners that are coordinating/collaborating with the main participating Performing Provider.

39. Request for clarification: Does this require all LHDs to have coordinated wrap-around services?
    - **HHSC RESPONSE:** No. See proposed changes for LHDs under Category C. Also, measurements will continue to be limited by setting and measure specifications. You do not have to add new services not already provided.

40. Request for clarification: Can contracted clinics be limited by type of EMR they have accessible?
    - **HHSC RESPONSE:** Contracted clinics are optional.

41. Request for clarification: With respect to data availability and providers' ability to capture their system of patients, it would be helpful to understand, from an audit perspective, which specific data fields will be used to validate system definition. This will allow providers to create a patient list that comports with all required elements of an audit and will reduce the need for reconciliation and re-work.
    - **HHSC RESPONSE:** We will request some guidelines/parameters from the independent assessor, Myers & Stauffer. Most likely, you will need to be able to provide a unique patient ID, and evidence of encounter date within the DY. Then, you will need supporting evidence for this, such as screen shots that validate the encounter and patient ID.

42. Request for clarification: If a hospital system has multiple facilities but has only been focusing/reporting on one for DSRIP, are they now required to include all of their hospitals within the region? The other hospitals may have quite lower numbers of Medicaid and uninsured which will make their overall ratio low. I know they are not being penalized for ratios, but reporting on this broader population for Cat B and expanding interventions across these facilities (since patients will be reported in all-payer Cat C rates) could really dilute efforts intended to target the Medicaid and LIU populations. It seems to me that if we are really trying to transform care for the MLIU, a provider should focus their efforts only on those facilities in their system where the larger proportion of this population is served.
    - **HHSC RESPONSE:** This is a valid point. While we do want providers to maintain their MLIU focus, we also want to impact the healthcare delivery system at the system-level. The combination of Category B and the default reliance on MLIU denominators (with exceptions) in Cat C tries to balance out this approach.

43. Request for clarification: We intend to include activities of a partner organization in our Category A Core Activities reporting, but to exclude them from the Cat B System Definition. Is that allowed?
    - **HHSC RESPONSE:** This is allowable, such as school-based interventions that will not be measured as part of Category C. The provider should clarify in the Category A Core Activities description that they are collaborating with this partner, but not counting them for purposes of Categories B or C. Keep up the good work!

44. Respondents asked if it is at the provider discretion, if they have multiple participating provider hospitals and many owned clinics, to determine which clinic belongs to which hospital's system.
    - **HHSC RESPONSE:** Yes. Ideally the system relationship is based on collaboration between these clinics and hospital locations. But if there is not a clear delineation, the provider may determine based on proximity or other important factors. Please note, however, if a patient attending one clinic in System A attends the hospital in System B, both systems may count

that individual for purposes of Category B PPP. We know this type of duplication across systems may not be avoided.

Required and Optional Components of a System for Hospitals

45. Request for clarification: How were the required and optional system elements determined? What stakeholders contributed? Did the discussion of required of system components occur during the BAT process?
    - **HHSC RESPONSE:** The system elements were determined based on stakeholder feedback in the PFM survey and from discussions with the Technical Advisory Team. HHSC is open to suggestions, but did not receive many technical proposals during the MBP survey.

46. Some respondents stated that there were components they expected to see in the required list such as outpatient services (lab, x-ray, physical/occupational/speech therapy) & observation patients.
    - **HHSC RESPONSE:** These may be included as optional components.

47. Providers thought the inclusion of required versus optional was in conflict with the statement that the system definition should incorporate all aspects of its organization that serve patients.
    - **HHSC RESPONSE:** The required components were HHSC's efforts to get at a common set of services/settings/departments among provider types that should be included in the provider's system definition. The optional components (that are not contracted) should be included if the provider has them because the goal is to get the largest sense of who the provider serves, but the optional components are less common across a provider type. If providers believe there are more common components of a provider type that have been left off the required list, please provide suggestions. Flexibility is primarily afforded for system definition in the case of contracted/partner entities.

48. Respondents asked if Rural Health Clinics are included under required hospital components.
    - **HHSC RESPONSE:** If they are owned or operated by the hospital, they should be included in the system definition.

49. Providers seems confused about required components, if they do not have one.
    - **HHSC RESPONSE:** The required components are only required to be included in the provider's system definition and PPP **if the provider has that business component.** For example, if a hospital does not perform births or have a maternal unit, it does not need to be required in the system definition.

Required and Optional Components of a System for Physician Practices

50. Request for clarification: Should "Owned or Operated Urgent Care" clinics be included in required?
    - **HHSC RESPONSE:** This has been added to the Measure Bundle Protocol list of required components for physician practices.

51. One respondent stated that the social services aspect of the physician practices should be separate, and due to the sensitivity and confidentiality of each counseling session, it would be hard to get the patient's information in an electronic form since social workers don't electronically document their sessions.

- **HHSC RESPONSE:** A Performing Provider cannot be split into two systems. Providers will not be providing PHI to HHSC for reporting purposes. If the counseling session providers are billing for their services, they should have the information required for reporting purposes. Only auditors would be eligible to review that information, should the provider be subject to an audit.

Required and Optional Components of a System for Community Mental Health Centers

52. Many CMHCs wanted to exclude components of their provider's system and patient diagnosis groups that were previously not included in DSRIP.
    - **HHSC RESPONSE:** HHSC is moving to system-wide DSRIP reporting, no longer tied to specific project interventions or target populations. Certain components, clients and services of the CMHCs may not be excluded from the system definition, even if they may not be measured for purposes of Category C.

53. CMHCs stated they do not have access to data for the required components listed in the draft (state funded community hospital, community institute for mental disease, general medical hospital, hospital, state mental health facility). CMHCs generally have access only to office/clinic and home/community based services. CMHCs may have access to state funded community hospital and state mental health facility data when they facilitate the admission, but not for all clients. Perhaps these could be optional components.
    - **HHSC RESPONSE:** HHSC has adjusted the required components of system definition for Community Mental Health Centers. Please see the updated table in the Measure Bundle Protocol.

Required and Optional Components of a System for Local Health Departments

54. Request for clarification: How would an LHD characterize public health/prevention/education services, such as teen pregnancy prevention or diabetes self-management education that is delivered in community locations for purposes of defining their system? Would these be considered optional components and fall under "*Other"*?
    - **HHSC RESPONSE:** Yes.

55. There were suggestions for other required components be added to LHD system definition.
    - **HHSC RESPONSE:** All of these components may be added under "*Other*".

56. Respondents were unclear on how LHD should define system. "For example, we are a LHD that contracts for its health service delivery improvements through the local FQHC - none of the changes are in our actual health department programs. EMS is part of the health department, but our project there is limited to only those with Medicaid or no insurance. The Behavioral Health side of some of our projects deals with people in crisis, not necessarily repeat customers who can be engaged in improved programs. And so on - no real assistance or information on how to define a system in these settings has been given."
    - **HHSC RESPONSE:** You should include the FQHC in your system, if data is accessible. And you can include the other aspects of your services under "*Other*." For purposes of Category B, you do not need to have repeat customers to count the total individuals served in a DY.

Systems and Contracted Entities

57. Respondents asked if providers can pick and choose which contractors they include in their system based on data sharing arrangements.
    - **HHSC RESPONSE:** Yes. Contracted entities are optional. And a provider should have access to data to support any reported achievement in order to include contracted/partner entities.

58. Request for clarification: What is meant by "Inclusion of the population served in the optional components may be disallowed by HHSC?"
    - **HHSC RESPONSE:** We do not have an exhaustive list of all populations, so this is reserved as a limited option.

59. Request for clarification: How should the data sharing happen, to what extent, and what infrastructure will be available to support the data sharing activities?
    - **HHSC RESPONSE:** That is to be determined by the contracted/partnered entities. The participating provider is responsible for ensuring they have access to necessary data to support any achievement reporting.

60. Request for clarification: What is the process of adding contracted entities to a system's definition? Contract arrangements can take months, therefore a timeline of approval is necessary.
    - **HHSC RESPONSE:** The system definition will be required as part of the RHP Plan Update due in January 2018. For purposes of Category B only, adding contractors is fine.

61. Respondents requested definition of owned/operated versus "contracted."
    - **HHSC RESPONSE:** If the provider has any partial ownership of the clinic, entity or service, it should be considered owned. The language also includes the use of operated -- so if the provider operates a clinic but the doctors are all private contractors, it would be considered owned or operated.

Other Feedback on Category B

62. Category B MLIU PPP goals are based on the number of Medicaid, low income, and uninsured patients to which a hospital provides services. In the initial Waiver period, providers included low-income patients based on various methods, such as patient interviews regarding income or a proxy calculated by the hospital. In the comments to the PFM protocol, HHSC states that providers who do not have systems in place to evaluate income status do not need to include low-income patients in their MLIU count, and would only be authorized to count individuals with Medicaid and individuals without insurance. If providers are not allowed to include low-income individuals in the Category B PPP reporting based on a proxy or other reliable methodology, then Provider is concerned that this will negatively impact Provider's MLIU goals. Provider respectfully requests that HHSC consider allowing providers to continue to report MLIU patients based on a proxy, patient interviews, or other reliable methodologies as they did in the prior Waiver periods.
    - **HHSC RESPONSE:** HHSC has provided flexibility in setting the baseline and goal and measuring the achievement of PPP. At this point, we want providers to get the most accurate picture possible of the patients they serve. Self-attestation is acceptable, but providers must maintain paperwork documenting the self-attestation. A proxy will not be

utilized for DY7-8 as this does not comport with the structure of the achievement at 90%, 75% and 50% thresholds, much less the allowable variance.

63. Can we receive clarification on what should be included in the Medicaid part of the MLIU calculation? I.e., Medicaid, Medicaid managed care, CSHCN, CHIP, etc.
    - **HHSC RESPONSE:** Medicaid includes Medicaid Fee-for-service, Medicaid managed care, and Medicaid dual-eligibles. CHIP may be included under Low-income and/or uninsured.

64. Providers are going to need a lot of help defining their systems. As Anchor, I feel less than competent in being able to give reliable feedback on what is ok or not ok to count. Will HHSC consider a "train the trainer" session for Anchors so we have more specific guidance on how to advise our providers? Otherwise, I think HHSC will get inundated with complex emails requests for consults.
    - **HHSC RESPONSE:** This is a good suggestion. It is under consideration and HHSC is trying to figure out the best timing to do something like this.

Category C

Limitations on Hospital and Physician Practice Selections for Rural Bundles

65. Multiple providers would prefer an alternative definition for rural than the current definition, a valuation less than or equal to $2,000,000 per DY. Suggestions for alternative definitions included: based on volume rather than valuation; including critical access hospitals; using definition of a rural hospital as outlined in Texas Administrative Code Title 1, Section 355.8052(b)(29); and extend to Rider 38 hospitals.

    Some providers (2 respondents) would like a higher valuation cap to be able to choose the K1 and K2 rural bundles.

    Several requests for clarification:
    - To be able to select K1 and K2, a provider must have a valuation less than or equal to $2,000,000 per DY, regardless of the size of population served (valuation threshold has changed)
    - The $2,000,000 threshold is for total Performing Provider valuation per DY, not just Category C valuation
    - Limitation is impacted by valuation only, not volume served.

- **HHSC RESPONSE:** Changed the Measure Bundle Protocol to reflect a higher valuation of $2,500,000 instead of $2,000,000 for the requirement: under Limitations on Hospital and Physician Practice Measure Bundle Selections and Optional Measure Selections, Measure Bundles K2 Rural Preventative Care and K2 Rural Emergency Care can only be selected by hospitals with a valuation less than or equal to $2,500,000 per DY. Based on multiple definitions for "rural," HHSC determined the use of valuation was the most straightforward approach for the requirement and captured many of the smaller, rural Performing Provider hospitals.

Each hospital or physician practice with a valuation of more than $2,000,000 per DY must select at least one 3-point measure

66. Majority of providers are fine with or agree with this limitation, or did not have any comments. (149/167 respondents)
67. Some providers expressed that a 3-point measure should not be required.
68. Some providers expressed that there needs to be more 3-point measures available if they are required, particularly since some measures/bundles are limited by the DSRIP specified setting. More inpatient 3-point measures are desired, since it may limit the participation of small private providers/ providers with only inpatient services.
69. Some providers requested that the J1 Hospital Safety bundle contain a 3-point measure.
70. The 3-point measure requirement is not for providers with valuations less than $2,000,000. There was confusion regarding this, with many providers believing a 3-point measure is also required for providers with $2,000,000 valuation or lower. This requirement has been updated to hospitals and physician practices with a valuation of more than $2,500,000 per DY.

- **HHSC RESPONSE:** Changed the Measure Bundle Protocol to reflect a higher valuation of $2,500,000 instead of $2,000,000 for the requirement: Each hospital or physician practice with a valuation of

more than $2,500,000 per DY must either: 1) select at least one Measure Bundle with at least one required 3 point measure; or 2) select at least one Measure Bundle with at least one optional 3 point measure, and select an optional 3 point measure in that Measure Bundle. HHSC values the importance of selecting 3 point measures similar to the required standalone measures in DY2-6 and has maintained the requirement. The assignment of 3 point measures was based on previous DY2-6 standalone measures. In particular, measures for which improvement in the measure represents an improvement in patient health outcomes or utilization patterns, and are not otherwise included in another category valued at 1 or 2 points, are valued at 3 points.

A CMHC and LHD must select at least one 3-point measure

71. Only 3 points will be counted towards the MPT if selected more than one of the depression response measures. Is this only for the depression response measures?
    - **HHSC RESPONSE:** Yes, this is only applicable to the three depression response measures, M1-165, M1-181, and M1-286.

72. Can other entities that are not CMHC or LHD choose measures from that bundle if they apply to the service determined to be beneficial to the population?
    - **HHSC RESPONSE:** No, entities other than CMHCs or LHDs cannot choose measures from the CMHC or LHD menu, unless a request is approved due to the provider's limited scope of practice.

73. How were 3-point measures selected as such, is the measure that much more relevant to the outcome for their participants?
    - **HHSC RESPONSE:** Measures for which improvement in the measure represents an improvement in patient health outcomes or utilization patterns, and are not otherwise included in another category valued at 1 or 2 points, are valued at 3 points.

- **HHSC RESPONSE:** Changed the Measure Bundle Protocol to base minimum requirements similarly to the hospital and physician practices' requirement of 3 point measures and minimum bundle points: Each CMHC with a valuation of more than $2,500,000 per DY must select at least one 3 point measure. CMHCs and LHDs must select and report on at least two unique measures.

Hospital and Physician Practice Minimum Volume Requirements

74. Please confirm that the definition of "significant volume" means at least 30 qualifying individuals in the measurement period.
    - **HHSC RESPONSE:** Significant volume is defined, for most outcome measures, as an MLIU denominator for the measurement period that is greater than or equal to 30, unless an exception has been granted to use the all-payer denominator in which case significant volume is defined, for most measures, as an all-payer denominator for the measurement period that is greater than or equal to 30.

75. Please clarify if the information regarding optional measures means that they will be paid achievement based on performance at the all-payer level.
    - **HHSC RESPONSE:** Providers will be paid for achievement based on performance at the MLIU level, unless an exception is granted due to low volume of MLIU. If an exception is granted,

performance achievement may be based on the all-payer level, Medicaid-only payer type, or LIU-only payer type. Payer type requirements apply to both optional and required measures.

76. Will the rules differ for a pediatric provider who wants to participate in a measure bundle but doesn't meet the significant volume criteria?
    - **HHSC RESPONSE:** The rules for minimum volume requirements apply to pediatric providers.

77. Several providers expressed concern that providers can select measures based on all-payer volumes, and not MLIU volumes. There are concerns that this may cause programmatic challenges when performance reporting begins since performance reporting is based on MLIU numbers. Additionally, there were equity concerns with using the all-payer volume since the 1115 waiver program is intended to target MLIU.
    - **HHSC RESPONSE:** Changed the Measure Bundle Protocol to clarify the MLIU denominator unless an exception is granted by HHSC to use an all-payer, Medicaid-only, or LIU-only denominator: A hospital or physician practice may only select a Measure Bundle for which the hospital's or physician practice's MLIU denominator for the baseline measurement period for at least half of the required measures in the Measure Bundle has significant volume, unless an exception is granted to use all-payer volume due to low MLIU volume. A hospital or physician practice may only select an optional measure in a selected Measure Bundle for which the hospital or physician practice's MLIU denominator for the baseline measurement period has significant volume, unless an exception is granted to use all-payer volume due to low MLIU volume.

Insignificant Volume

78. Is this applicable to the rural bundles?
    - **HHSC RESPONSE:** Yes, this requirement is applicable to the rural bundles.

79. Clarify "insignificant volume"
    - **HHSC RESPONSE:** Insignificant volume is defined, for most outcome measures, as an MLIU denominator for the measurement period that is less than 30, but greater than 0, unless an exception is granted to use the all-payer denominator.

80. MLIU - Please clarify that no volume or insignificant volume for any of the measures in a chosen bundle does not impact the point value of the bundle.
    - **HHSC RESPONSE:** The point value for no volume or insignificant volume for any measure in a chosen bundle will not impact the point value of the bundle.

81. Will it be determined by HHSC that volume is insignificant when the baseline data is submitted or when we select measures will the providers need to demonstrate this for approval?
    - **HHSC RESPONSE:** If a hospital or physician practice has insignificant volume for the baseline measurement period for a required measure in a selected Measure Bundle at the time of RHP Plan Update submission, the hospital or physician practice will notify HHSC in the RHP Plan Update that it has insignificant volume for the measure.

No Volume

82. Does no baseline volume relate only to the denominator or to the numerator too? Can we report a baseline of 0?

- **HHSC RESPONSE:** In cases where a Performing Provider has significant denominator volume and no measureable numerator because required numerator inclusions and exclusions are not tracked during the baseline measurement period, a Performing Provider may request in the RHP Plan Update to use a baseline numerator of 0 for certain measures designated as process measures and QISMC. Measures that are eligible for a numerator of 0 will be indicated in Appendix A Category C Measure Specifications of the MBP. If a provider is approved by HHSC to report a baseline numerator of 0, the goal for DY7 goal achievement milestone will be equal to the 75th percentile as indicated in Attachment TBD Measure Bundle Protocol and the goal for the DY8 goal achievement milestone will be equal to a 10% gap closure between the 75th percentile and the HPL. Measures approved to report with a numerator of 0 will have standard baseline and performance year measurement periods.

83. Can a provider select a measure bundle if there is insufficient or no volume for a required measure? Confirm that it is allowable as long as the provider can report for 50% of the required measures in the bundle.
    - **HHSC RESPONSE:** Yes, a provider may select a measure bundle if there is insufficient or no volume for a required measure. A hospital or physician practice may only select a Measure Bundle for which the hospital's or physician practice's MLIU denominator for the baseline measurement period for at least half of the required measures in the Measure Bundle has significant volume.

84. Does the provider lose the points associated with a measure if there is insufficient or no volume for that measure?
    - **HHSC RESPONSE:** Measure bundle points are not impacted by insignificant or no volume for a measure.

85. Please confirm that in cases of no volume funds are reallocated among remaining selected measures or is valuation lost?
    - **HHSC RESPONSE:** In cases of no volume, valuation is redistributed, not lost. If a hospital or physician practice selects a Measure Bundle with a required measure for which the hospital or physician practice has insignificant volume, the valuations of the measure's reporting milestones will remain the same, but the valuations of the measure's achievement milestones will be redistributed proportionally among the achievement milestones for the other measures in the Measure Bundle with significant volume. Required measures with no volume because the hospital or physician practice does not serve the population measured will be removed from the Measure Bundle and the valuations of the associated reporting and achievement milestones will be redistributed proportionally among the remaining measures in the Measure Bundle.

86. Please clarify that even required measures within a bundle can be excluded if the denominator population for that measure does not exist within the system definition.
    - **HHSC RESPONSE:** Yes, required measures within a bundle may be excluded if the denominator population for that measure does not exist within a provider's system.

87. Please clarify what the resolution would be if a provider has zero volume on a required measure in a bundle (but has all of the other required elements in that bundle) - what would HHSC do to the points assigned to that zero volume measure?
    - **HHSC RESPONSE:** Measure bundle points are not impacted by insignificant or no volume for a measure.

88. Do the maximum valuation limits apply to bundles with inclusion of possible additional points which are 3 point measures?
    - **HHSC RESPONSE:** There is no maximum valuation for Measure Bundles with at least one 3-point measure, including a selected 3-point optional measures.

A CMHC or LHD may only select measures for which it has significant volume

89. Some providers indicated that there may be some difficulties meeting significant volume for every measure selected.
    - **HHSC RESPONSE**: A CMHC or LHD must have significant volume for a measure to select that measure.

90. What is the definition of "significant volume"
    - **HHSC RESPONSE:** Significant volume is defined, for most outcome measures, as an MLIU denominator for the measurement period that is greater than or equal to 30, unless an exception is granted to use the all-payer denominator.

91. How are CMHCs and LHDs supposed to address this if the only way they reach significant volume is to utilize all payers; is HHSC precluding CMHCs and LHDs from choosing low-Medicaid volume metrics or will they still have the option of requesting to use all payers?
    - **HHSC RESPONSE:** The target population of DSRIP is individuals with Medicaid coverage and individuals that are low income with no payer source. CMHCs and LHDs are encouraged to first select measures that align with the target population of the waiver. Section 21.c - 21.c of the draft Program Funding and Mechanics Protocol outlines possible exceptions to the MLIU reporting and achievement requirements.

92. For a 6-month baseline, is a volume of 15 acceptable? What if a provider is able to get a 6-month baseline of 15, but not 30 for a one-year period? Would their measurement period extend until they hit the N of 30?
    - **HHSC RESPONSE:** A provider must have a denominator for the measurement period that is greater than or equal to 30 for most measures. A denominator of 15 for a 6-month baseline is not considered significant volume for baseline reporting under the proposed DY7 - DY8 program rules.

Eligible Denominator Population

93. Providers were confused about the applicable definition of “assigned to a primary care physician” as part of the active patient definition for measures with a primary care setting.
    - **HHSC RESPONSE**: HHHSC has removed “assigned to a primary care physician” as a part of the active patient definition for a primary care setting in the MBP.

94. Providers requested clarification on the required two visits for measures with a primary care setting.

- **HHSC RESPONSE**: The active patient definition for primary care is two visits within the primary care setting. In the MBP, HHSC has clarified the active patient definition for primary care to specify to visits to the primary care setting.

95. Many providers requested the allowance of sampling for reporting Category 3 measures.
    - **HHSC RESPONSE**: Similar to DY2 - DY6, providers will be allowed to use a random sampling methodology. Sampling requirements will be included in the Measure Specifications Document.

Exceptions to MPT for Hospitals and Physician Practices with a Limited Scope of Practice

96. Several providers requested a similar provision for LHDs and/or CMHCs with a limited scope of practice,
    - **HHSC RESPONSE:** CMHCs and LHDs naturally have a similar scope of practice to all other Performing Providers within their provider type. Further, CMHCs and LHDs are granted additional flexibility in selecting measures, have no required measures, and have lower MPT caps. No changes regarding extension of limited scope of practice exceptions for CMHCs and LHDs were made in response to these comments.

97. What criteria will HHSC use to approve or disapprove these requests?
    - **HHSC RESPONSE:** HHSC will review the exception requests on a case-by-case basis. Providers must demonstrate that they have a limited scope and that they are unable to report on enough measure bundles to meet their MPT. Providers will be given an opportunity to submit the request for exception prior to the RHP Plan Update submission. HHSC will develop additional guidelines.

98. Is there a similar path for a non-hospital provider, e.g. LHD, who are unable to report enough measures to MPT?
    - **HHSC RESPONSE:** Exceptions to MPT are only applicable to hospitals and physician practices with a limited scope of practice.

99. How much of a reduction would occur?
    - **HHSC RESPONSE:** Exceptions to MPT are on a case-by-case basis. A Performing Provider will be expected to report on all measures that they are reasonably able to report on.

100. Does the limited scope of practice definition include rural hospitals with a high MPT?
    - **HHSC RESPONSE**: Rural providers are not necessarily providers with limited scope of practice. HHSC will review requests on a case-by-case basis. HHSC is changing the formula that determines the MPT for certain providers with a State Ratio greater than 10 and a valuation less than $15 million so that the MPT does not exceed 40. These changes will be made to the Program Funding and Mechanics Protocol.

Potential Standardization of Risk-Adjustment Methodology for Hospital Readmissions

101. Several providers are open to standardizing the risk adjustment methodology, with some noted concerns:
- We are open to various methodologies if they include age adjusted, sociodemographic factors and disease severity/comorbidity adjustments

- If the hospital has the right program and can afford the purchase, then it is feasible
- Standardization must be relevant to pediatrics or pediatrics must be excluded in some way
- If we were to develop a regional risk-adjustment hospital readmission program that captures who and where patients are readmitted the more sophisticated method would be more feasible and beneficial for looking at the penalty side or cost avoidance parameters?
- Several providers noted feasibility concerns, with several noting costs as a significant concern.
- Several providers made recommendations for standardizing risk adjustment:
  - Several providers recommended that the raw data be reported to HHSC, and HHSC or another entity performs the risk-adjusting
  - One provider recommended that HHSC should provide a list of approved risk-adjusting methodology

➢ **HHSC RESPONSE:** HHSC is considering these comments and potential options.

Hospital and Physician Practice Measure Bundles

102. Several providers requested that various measures that are required become optional or measures that are optional become required.
    - **HHSC RESPONSE:** HHSC presented this feedback to members of the corresponding Bundle Advisory Team clinicians for their input. HHSC did not receive consensus to make changes to the measures.

Local Health Department Measures

103. Several respondents were concerned about measure settings and access.
    - **HHSC RESPONSE:** Local Health Departments will be able to use the measures from the DY2-6 menu. HHSC is allowing for grandfathering of P4P measures for LHDs to be able to meet MPT. Grandfathered measures would use DY 6 as their baseline measurement period. HHSC has also reduced the MPT cap to 20 points from 40. LHDs may grandfather in measures, or choose measures from the LHD menu or have a combination of both.

104. Respondents identified 5 measures from the prior menu that were not included in the most recent LHD menu.
    - **HHSC RESPONSE:** Local Health Departments will be able to use the measures from the DY2-6 menu so these measures were not added to the MBP.

Community Mental Health Center Measures

105. Many respondents requested that some CMHC measures receive a state priority, particularly those measures that align with the CCBHC model.
    - **HHSC RESPONSE:** Several measures, including those that align with the CCBHC model, were allotted extra points. Measures that were allotted an extra point include some measures reported as part of the CCBHC model, measures related to substance use disorders, and some measures related to physical health for individuals with serious mental illness, and measures that align with the measures in the 2018 MCO P4Q Program. In total, 22 measures were allotted an additional point.

106. Many respondents requested that the Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA-CH) be added to the measure menu.
    - **HHSC RESPONSE:** This measure has been added to the menu.

107. Many respondents requested that measures that require a follow-up receive extra points.
    - **HHSC RESPONSE:** In most cases, these measures do not require a follow-up, but instead, they require that a follow-up plan be documented so no additional points were added.

Category D

Hospitals - PPA, PPR, PPC and PPV Reporting

108. Providers asked if Performing Providers will still receive these PPR, PPC, PPA reports from the state, including the additional PPV reports. If not and 3M modeling will be used to generate these reports, will HHSC provide technical assistance to providers who do not have an in-depth knowledge and understanding of this statistical software system?
    - **HHSC RESPONSE:** This information will be provided by the EQRO and will be e-mailed to the providers annually.

109. Providers asked that HHSC clarify that facilities with low volume will still receive payment for PPA, PPR, PPC, and PPV measures.
    - **HHSC RESPONSE:** Hospital providers will still be eligible to report if they have low volume. For PPAs, PPRs, PPCs and PPVs, hospitals with low volume are still required to respond to qualitative questions similar to qualitative questions responded to by hospitals with significant volume.

110. Providers asked if prior exemptions on particular reporting domains carry-over to DY7-8 (i.e., specialty care hospitals were previously exempt from reporting on potentially preventable 30-day readmissions). If there are no exemptions, providers asked HHSC to advise on how to report on PPRs.
    - **HHSC RESPONSE:** All Performing Providers must report on the Category D Statewide Hospitals Reporting Measure Bundle, including hospitals that were previously exempt from the reporting on population health measures during DY2-6. Each hospital Performing Provider subject to required Category D reporting must report on all measures, unless for certain measures the provider does not have statistically valid data. Providers will confirm that they received the relevant reports or that they did not have sufficient eligible admissions/readmissions to receive a given report, and respond to qualitative questions for each reporting domain. Providers who do not receive a report because of low volume are still required to respond to qualitative questions.

111. Providers asked if health systems defined as 2 separate hospitals (one acute care and one psych with separate TPIs), will be required to report Cat D measures for both?
    - **HHSC RESPONSE:** This process will remain the same as it has been in DYs 2-6. Reporting is by Performing Provider.

Hospitals - Patient Satisfaction

112. One provider requested that alternative methods inclusive of pediatric/family, such as Press Ganey, be allowed, in addition to HCAHPS.
    - **HHSC RESPONSE:** Hospitals that do not report HCAHPS as part of Medicare Inpatient Prospective Payment System due to low volume or other exempt status may use an alternative hospital patient satisfaction survey and must include information in their RHP Plan Update that describes the method they will use for reporting.

113. What about rural hospitals with less than 30 survey responses or do not participate?
    - **HHSC RESPONSE:** Hospitals that do not report HCAHPS as part of Medicare Inpatient Prospective Payment System due to low volume or other exempt status may use an

alternative hospital patient satisfaction survey and must include information in their RHP Plan Update that describes the method they will use for reporting.

114. Providers asked why HHSC is limiting HCAHPS to these domains and asked HHSC to clarify which HCAHPS questions will be reported.
    - **HHSC RESPONSE:** The HCAHPS Reporting Measures will be as follows and align with the previous Category 4 reporting:
        - Percent of patients who reported that their doctors "Always" communicated well Percent of patients who reported that their nurses "Always" communicated well
        - Percent of patients who reported that their pain was "Always" well controlled
        - Percent of patients who reported that staff "Always" explained about medicines before giving it to them
        - Percent of patients who reported that YES, they were given information about what to do during their recovery at home.
        - Percent of patients who reported that their room and bathroom were "Always" clean
        - Percent of patients who reported that the area around their room was "Always" quiet at night
        - Percent of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).
        - Percent of patients who reported YES, they would definitely recommend the hospital.

115. Will this be publicly reported results that are mode adjusted and published 1 year behind?
    - **HHSC RESPONSE:** Yes, the results will be publicly reported and will follow the measurement periods for DYs 4-6.

116. For providers who contract with an outside vendor to conduct and analyze their patient satisfaction survey, will these patient satisfaction reports be accepted to report on the themes listed in the future reporting cycles? Or will only the HHSC recommended HCAHPS data source be accepted?
    - **HHSC RESPONSE:** Providers will be able to utilize outside vendors as long as they are HCAHPS approved vendors.

Physician Practices

Physician Practices will report on their activities being carried out to impact rates measured by Prevention Quality Indicators (PQIs). Based on the regional summary of the PQIs that HHSC will make available to the Performing Providers, each physician practice will provide qualitative information on their efforts to impact these rates. (Question 83)

117. Providers asked if Category D considered a pay-for-reporting measure and if there is a requirement to report on all 13 rates listed?
    - **HHSC RESPONSE:** Category D is pay-for-reporting and providers will be required to provide qualitative responses for all thirteen rates. If any of the rates are not applicable (NA), the provider should state this in their report and provide an explanation as to why it is not applicable.

118. Providers asked if Physician Practice measures are separate from hospital and how should reporting be handled if they have both.
    - **HHSC RESPONSE:** Information will be provided based on the Performing Provider TPI. If the physician practice and hospital have separate TPIs, providers will need to report on both.

Local Health Departments

119. Some LHD representatives stated that these particular services [*Time Since Routine Checkup; High Blood Pressure Status; Diabetes Status; Overweight or Obese; Smoker Status; and Flu Shot Past Year*] are not provided by their organizations and the reporting will be minimal. Providers suggested that the reporting should be more responsive to the actual work that LHDs are doing and select other measures, such as prevention of Sexually Transmitted Diseases (STDs), immunizations, TB, and epidemiology rather than chronic disease.
    - **HHSC RESPONSE:** HHSC appreciates stakeholders' feedback on Category D measures for LHDs. Reporting areas have been adjusted to incorporate stakeholders' feedback. According to the National Association of County and City Health Officials website, Local Health Departments promote and protect the health of people and the communities where they live and work.[1] LHDs impact lives of the communities and individuals in many areas including immunization, infectious disease, chronic disease, tobacco control, maternal and child health, environmental health, emergency preparedness, food safety, injury and violence prevention. Based on this, areas for reporting selected by HHSC appear to be in line with major focus areas of the LHDs efforts. Reporting areas for LHDs have been expanded to include other types of immunization (Ever Had Pneumonia short; Ever Had MMR Vaccine, Had All HPV Shots) and prevention of STDs (Ever Had HIV Test).

      Revised list included in the Measure Bundle Protocol:
        - Time Since Routine Checkup
        - High Blood Pressure Status
        - Diabetes Status
        - Overweight or Obese
        - Smoker Status
        - Immunizations
            - Flu Shot Past Year
            - Even had Pneumonia Shot
            - Received Tetanus Shot since 2005
            - Had All HPV Shots
            - Ever Had MMR Vaccine
            - Prevention of STDs
            - Ever Had HIV Testing

120. Several LHDs suggested that the state helps the departments to get access to the primary care data in order for LHDs to assist these individuals in connecting to services.
    - **HHSC RESPONSE:** HHSC does not have access to that level of information since this data is collected via survey administered by the Department of State Health Services. For additional details about this survey, see the following website https://www.dshs.texas.gov/chs/brfss/

[1] http://www.naccho.org/about

121. At least one stakeholder indicated that their LHD does not collect information related to these areas and rates and will need to adjust their systems to be able to collect it.
    - **HHSC RESPONSE:** Providers do not need to start collecting information related to the areas included in the reporting. HHSC will share the RHP level data with the providers. LHDs will report on their activities that can impact or are already impacting these areas.

122. Stakeholders requested clarification if any part of Category D reporting is selected for the compliance monitoring similar to previous review of Category 4.
    - **HHSC RESPONSE:** All of the reported information is subject to review by the compliance monitor. In the past, a portion of the hospital reported information *Medication Management* was automatically flagged for review in cases when the provider indicated that the provider deviated from the measure specifications. Currently, no specific section of the Category D reporting has been flagged for an automatic review by the compliance monitor.

Community Mental Health Centers (CMHCs)

123. Providers indicated that they are in agreement with the measures but wanted to confirm that the DSRIP team will use the data that is already being reported based on the performance contracts.
    - **HHSC RESPONSE:** CMHCs do not have to report data for these measures to the DSRIP team, since this information is already available at the Health and Human Services Commission. However, CMHCs will have to provide qualitative information on their activities that are impacting the trends/measures during DSRIP reporting.

124. Providers indicated that the measures are under HHSC review and the specifications of some measures may be changed in the future. Providers asked if HHSC can qualify how the changes impact DSRIP reporting.
    - **HHSC RESPONSE:** Since HHSC will be using the data that is reported for the performance contracts, CMHCs will be using the same specifications as included in the performance contracts. HHSC is deleting measure specifications from the MBP. If certain measures will be changed to the extent that the MBP would not reflect the measures' intent, HHSC will request an amendment to the protocol to update the measures.

125. The Texas Council of Community Centers recommended excluding *"CMHCs must report on Juvenile Justice Avoidance and provide qualitative reporting as required by HHSC"* due to lack of alignment with CMS focus. Additionally, the current measure is under review, compromising continuity over the DSRIP extension period.
    - **HHSC RESPONSE:** HHSC believes that this measure has a strong alignment with DSRIP, since CMHCs proposed projects related to this issue, which were approved by HHSC and CMS. As previously stated, changes to the performance contract measures will be reflected in the MBP.

126. The Texas Council of Community Centers recommended the exclusion of *"Community Mental Health Centers (CMHCs) must report on Adult Jail Diversion and provide qualitative reporting as required by HHSC"* due to lack of alignment with CMS focus. Additionally, the current measure is under review, compromising continuity over the DSRIP extension period.

- **HHSC RESPONSE:** HHSC believes that this measure has a strong alignment with DSRIP, since CMHCs proposed projects related to this issue, which were approved by HHSC and CMS. As previously stated, changes to the performance contract measures will be reflected in the MBP. HHSC updated the title of the measures in MBP to Adult Jail Diversion/Reduction of Criminal Behavior.

Other Comments on Category D

127. Some providers asked when they would know what their Category D allocation is.
    - **HHSC RESPONSE:** Providers should know about their Category D percent allocation during the RHP Plan Update submission based on the region's private hospital participation.

Feedback on VBP Roadmap from MBP Survey

128. Providers' feedback included an assortment of suggestions for moving to Value-based Purchasing. Feedback ranged from requests for additional behavioral health metrics in MCO quality programs and risk adjustments at the provider level for VBP arrangements to spelling corrections.
    - **HHSC RESPONSE:** HHSC appreciates the thoughtful feedback. HHSC will consider all of this input as we move forward toward VBP goals. The VBP Roadmap is a living document and will continue to be updated and changed as HHSC develops additional policies and clarifications in consultation with state leadership and stakeholders.

129. DSRIP providers wanted additional clarification on what role the VBP Roadmap plays for DSRIP providers in reporting requirements.
    - **HHSC RESPONSE:** The Roadmap serves as a reference document for providers and may inform their Category A qualitative reporting.