Comprehensive Hospital Increased Reimbursement Program Stakeholder Feedback on Measures and Performance Requirements

As Required by

Texas Administrative Code

§353.1307

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Contents

1. Overview

On January 12, 2021, HHSC released the draft measures and performance requirements for Comprehensive Hospital Increased Reimbursement Program (CHIRP) for stakeholder feedback. The documents included measure specifications, attribution methodology, reporting requirements, and achievement goals. HHSC hosted a webinar on January 20, 2021 to provide an overview of the proposed measures and performance requirements and answer questions. Stakeholders submitted feedback through an online survey that closed on February 2, 2021.

This document summarizes the stakeholder feedback HHSC received through the 57 respondents to the survey, as well as additional comment letters received outside of the survey. The Healthcare Transformation Waiver team reviewed stakeholder comments, grouped similar comments together, drafted responses, and determined changes through internal discussion and guidance from leadership. Changes made are reflected in the updated *CHIRP Measure Specifications*, *CHIRP Requirements,* and are noted in the responses herein.

HHSC will include the measures and performance requirements in the CHIRP state directed payment preprint submitted to the Centers for Medicare & Medicaid Services (CMS) in March 2021. All CHIRP requirements are subject to CMS approval. HHSC will post any changes requested by CMS as required in TAC §353.1307.

Summary of Changes

- HHSC decreased the reporting frequency for structure measures from quarterly, to twice-yearly to align with reporting of data-based measures.
- HHSC changed the requirement to report certain measures stratified by STAR, STAR+PLUS, Other Medicaid, Uninsured, and Other Payer, to require reporting by Medicaid, Uninsured, and Other Payers.
- HHSC removed the following measures from the draft CHIRP proposal:
    - C1 – UHRIP
        - Data Quality Review
    - C2 - ACIA Maternal Care
        - PC-03 Antenatal Steroids
    - C2 - ACIA Psychiatric Care Transitions
        - Post-discharge appointment for behavioral health
        - Rate of 30-day readmissions for BH Conditions
        - Follow-Up After Hospitalization for Mental Illness
    - C2 - ACIA Care Transitions
        - Post-discharge appointment for heart failure
        - Transition Record with Specified Elements Received by Discharged Patients (Discharges from Inpatient Facility)
    - C2 - ACIA ED Best Practices

        - Use of validated screening tool for food insecurity
        - Food Insecurity Screening
        - Adult Major Depressive Disorder: Suicide Risk Assessment
        - Follow-Up After ED Visits for Mental Illness
    - C2 - ACIA Rural Hospital Best Practices
        - Use of validated screening tool for food insecurity and suicide risk
        - Food Insecurity Screening
    - C2 - ACIA Rural Hospital Best Practices
        - Inpatient Influenza Immunization IMM-2
- HHSC removed Children's Hospitals from eligibility for the Non-Psychiatric Care Transitions module.
- HHSC added one measure to the ACIA Pediatric module:
    - C2-116 Engagement in Integrated Behavioral Health

2. Component 1 Measures

C1-101: HIE Participation

1. Multiple stakeholders asked for clarification on what constitutes HIE participation and which HIEs qualify for CHIRP purposes.

   HHSC Response: HHSC does not have a prescribed HIE for hospital participation. There are currently multiple HIEs that engage with the Texas Health Services Authority that operates HIE Texas. Reporting will be structured primarily around multiple choice/drop down questions that will track statewide progress towards implementation of the strategies included in the Health IT Strategic Plan including:

   - Local HIEs connecting hospitals to their information technology systems and exchanging Admission, Discharge, Transfer (ADT) messages through the EDEN system – Texas' statewide Health Information Exchange Plan, which provides the ADT processing infrastructure used by hospital systems to exchange ADT data between HIEs or hospitals via THSA when a hospital does not connect directly to a HIE.

   - Electronic exchange of clinical health information via Consolidated Clinical Document Architecture (C-CDA) when multiple providers provide coordinated care to a client.

   HHSC will share the details of reporting questions for structure measures prior to twice-yearly reporting periods.

2. Several stakeholders described difficulties for providers, especially rural providers, in connecting to HIEs. Stakeholders suggested allowing providers to receive funding if they show progress toward adopting EHRs and connecting to HIEs.

   HHSC Response: For a structure measure, a provider must submit responses to qualitative reporting questions that summarize a hospital's progress towards implementing a structure measure. Hospitals are not required to implement structure measures as a condition of reporting or program participation.

C1-XX: Data Quality Review

3. Multiple stakeholders expressed difficulties and discrepancies with data quality review methodologies and requested the measure be revised or removed.

HHSC Response: HHSC has removed Data Quality Review as a structure measure.

C1-102: SDA Learning Collaborative Participation

4. Several stakeholders requested that the definition of the type of learning collaborative required for this measure be broadened to include learning collaboratives hosted by a variety of entities, not just SDAs.

   HHSC Response: This structure measure is intended to align with the DSRIP transition. As part of the DSRIP Transition Plan, HHSC is evaluating the potential for an entity to assist with regional collaboration and/or technical assistance in the proposed DPPs. In June 2021, HHSC must submit to CMS options to maintain regional stakeholder collaboration consistent with approaches for sustaining delivery system reform. Additional detail on SDA Learning Collaborative participation will be shared as it becomes available. HHSC will share reporting questions for structure measures prior to twice-yearly reporting periods.

5. Multiple stakeholders requested virtual participation be permitted.

   HHSC Response: HHSC is not prescribing the method of participation in a SDA learning collaborative at this time. The requirements for SDA Learning Collaboratives are still being developed as part of the DSRIP Transition Plan. Hospitals are not required to implement structure measures as a condition of reporting or program participation.

General Component 1 feedback

6. Stakeholders requested that the number of Component 1 structure measures be reduced.

   HHSC Response: HHSC has removed one measure from Component 1: *Data Quality Review.*

3. Component 2 Measures

C2-103: ACIA Maternal Care: AIM Collaborative Participation

7. Several stakeholders requested additional information on the requirements for collaboration needed, including how many meetings and data submissions are required to be considered participating, and which version of AIM providers will be required to participate in as there are multiple versions. Several stakeholders requested HHSC consider limiting the number of AIM topics that providers are required to participate in to a maximum of one topic of the provider's choice.

   HHSC Response: Reporting for this measure will be primarily based on multiple choice/dropdown questions that will reflect a Hospital's current participation level on all available Texas AIM topics. For a structure measure, a provider must submit responses to qualitative reporting questions that summarize a hospital's progress towards implementing a structure measure. Hospitals are not required to implement structure measures as a condition of reporting or program participation.

C2-104: ACIA Maternal Care: Severe Maternal Morbidity

8. Some stakeholders requested the measure adhere to the measure steward definition including limited period to capture data and sample size requirements. One stakeholder noted that The Joint Commission (TJC) is currently developing an electronic Clinical Quality Measure (eCQM) to capture, calculate and report on maternal morbidity and encouraged HHSC to reach out to TJC to determine if their version will be available to use instead of the proposed AIM measures to avoid reporting of duplicate measures and increased burden on hospital reporting.

   HHSC Response: CHIRP will utilize the Severe Maternal Morbidity specifications that align with the AIM program.

9. One stakeholder asked that as the state already receives this information from claims-based data whether HHSC believes it is necessary for hospitals to re-submit for CHIRP participation.

   HHSC Response: Hospitals have more timely access to their own SMM data. More timely data is important for the annual evaluation of the DPP program as required by CMS. Additionally, there is value in hospitals monitoring their performance on this key measure in as near to real-time as possible.

C2-105: ACIA Maternal Care: PC-02 Cesarean Section

10. One stakeholder recommended that the ePC-02 version be adopted to align with the TJC ORYXX reporting requirements and that Texas HHS allow hospitals to use the results reported to TJC under the ORYX reporting program to fulfill the requirements.

    HHSC Response: HHSC intends to allow providers to use either the chart abstracted measure (PC-02) or the eCQI (ePC-02) recently developed by TJC for ACIA reporting. Reporting to HHSC for ACIA should align with the data hospitals use for reporting to TJC. Providers will indicate the source data used (chart abstraction or E.H.R.) at the time of reporting.

C2-X: ACIA Maternal Care: PC-03 Antenatal Steroids

11. Multiple stakeholders recommended eliminating this measure as the Joint Commission retired the measure in 2020 and providers have consistently met and exceeded the performance standards.

    HHSC Response: Based on stakeholder feedback, HHSC has removed PC-03 Antenatal Steroids as a measure.

C2-106: ACIA Hospital Safety: Hospital Safety Collaborative Participation

12. Multiple stakeholders requested additional details on the requirements, including the definition of collaborative, whether specific organizations need to host the collaborative, and the number of meetings providers need to attend annually.

    HHSC Response: HHSC is not prescribing a collaborative for participation. Reporting will be structured primarily around multiple choice/drop down questions that will track statewide progress towards implementation of the structure measure. Hospitals are not required to implement structure measures as a condition of reporting or program participation.

13. One stakeholder suggested the SDA and Hospital Safety Collaborative should be combined into one requirement.

    HHSC Response: The SDA Learning Collaborative and Hospital Safety Collaborative are separate requirements, as the SDA Collaborative is a structure measure for Component 1 that all participating Hospitals are required toreport, while the Hospital Safety Collaborative is specifically for providers in the Component 2 ACIA module. Additionally, the SDA Learning Collaborative can address a variety of topics, while the Hospital Safety Learning Collaborative must focus on hospital safety topics.

C2-107: ACIA Hospital Safety: Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

14. One stakeholder asked how HHSC and providers will handle the risk adjusted requirement of this measure. One stakeholder requested it be specified that this is an adult-only measure, as there is also a pediatric CAUTI measure.

    HHSC Response: Reporting for this measure should align with the CDC specifications and Standardized Infection Ratio (SIR) as provided by National Healthcare Safety Network (NHSN). Hospitals that are eligible to report the pediatric hospital safety measures are not eligible to report this measure.

15. One stakeholder recommended HHSC consider whether it could access the necessary data via DSHS.

    HHSC Response: Hospitals have more timely access to measure data than DSHS, and timely data are essential for monitoring and evaluation of both provider performance and statewide performance.

16. One stakeholder noted that because this measure requires chart abstractions and review before submitting to NHSN to get the Standardized Infection Ratio (SIR) and Adjusted Ranking Metric (ARM) and because there is a waiting period in getting SIR calculated, these metrics have a 90-day lag time. Stakeholder asked how providers should report these measures if SIR is not calculated in time for a quarter and asked what the minimum number of cases needed to report this measure. Stakeholder recommended at least 180 days after a performance period before reporting to allow completion of the full SIR review and calculation process and recommended reporting by cases because the SIR does not populate when the predicted number of infections is less than 1.

    HHSC Response: HHCS will allow a three-month lag in data reporting. This data lag is consistent with what has been used successfully for the DSRIP program. Currently, HHSC expects that hospitals will submit data for a January-June measurement period in October and data for a January-December measurement period in April.

C2-108: ACIA Hospital Safety: Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure

17. One stakeholder requested it be specified that this is an adult-only measure, as there is also a pediatric CLABSI measure.

    HHSC Response: Reporting for this measure should align with the CDC specifications and Standardized Infection Ration (SIR) as provided by NHSN. Hospitals that are eligible to report the pediatric hospital safety measures are not eligible to report this measure.

18. One stakeholder recommended HHSC consider whether it could access the necessary data via DSHS. One stakeholder recommended HHSC use the results from the CMS Inpatient Quality Reporting Program (IQR) to avoid duplicate reporting and decrease reporting burden on hospitals.

    HHSC Response: Hospitals have more timely access to measure data than DSHS, and timely data are essential for monitoring and evaluation of both provider performance and statewide performance.

19. One stakeholder noted that because this measure requires chart abstractions and review before submitting to NHSN to get the Standardized Infection Ratio (SIR) and Adjusted Ranking Metric (ARM) and because there is a waiting period in getting SIR calculated, these metrics have a 90-day lag time. Stakeholder asked how providers should report these measures if SIR is not calculated in time for a quarter and asked what the minimum number of cases needed to report this measure. Stakeholder recommended at least 180 days after a performance period before reporting to allow completion of the full SIR review and calculation process and recommended reporting by cases because the SIR does not populate when the predicted number of infections is less than 1.

    HHSC Response: HHCS will allow a three-month lag in data reporting. This data lag is consistent with what has been used successfully for the DSRIP program. Currently, HHSC expects that hospitals will submit data for Jan – June in October, and data for Jan – December in April.

C2-109: ACIA Hospital Safety: Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

20. One stakeholder recommended HHSC consider whether it could access the necessary data via DSHS.

    HHSC Response: Hospitals have more timely access to measure data than DSHS, and timely data are essential for monitoring and evaluation of both provider performance and statewide performance.

21. One stakeholder noted that because this measure requires chart abstractions and review before submitting to NHSN to get the Standardized Infection Ratio (SIR) and Adjusted Ranking Metric (ARM) and because there is a waiting period in getting SIR calculated, these metrics have a 90-day lag time. Stakeholder asked how providers should report these measures if SIR is not calculated in time for a quarter and asked what the minimum number of cases needed to report this measure. Stakeholder recommended at least 180 days after a performance period before reporting to allow completion of the full SIR review and calculation process and recommended reporting by

cases because the SIR does not populate when the predicted number of infections is less than 1.

HHSC Response: HHCS will allow a three-month lag in data reporting. This data lag is consistent with what has been used successfully for the DSRIP program. Currently, HHSC expects that hospitals will submit data for Jan – June in October, and data for Jan – December in April.

C2-110: ACIA Hospital Safety: Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure

22. One stakeholder requested it be specified that this is an adult-only measure, as there is also a pediatric SSI measure. One stakeholder recommended HHSC use the results from the CMS Inpatient Quality Reporting Program (IQR) to avoid duplicate reporting and decrease reporting burden on hospitals.

    HHSC Response: Reporting for this measure should align with the CDC specifications and Standardized Infection Ration (SIR) as provided by NHSN. Hospitals that are eligible to report the pediatric hospital safety measures are not eligible to report this measure.

23. One stakeholder recommended HHSC consider whether it could access the necessary data via DSHS.

    HHSC Response: Hospitals have more timely access to measure data than DSHS, and timely data are essential for monitoring and evaluation of both provider performance and statewide performance.

24. One stakeholder noted that because this measure requires chart abstractions and review before submitting to NHSN to get the Standardized Infection Ratio (SIR) and Adjusted Ranking Metric (ARM) and because there is a waiting period in getting SIR calculated, these metrics have a 90-day lag time. Stakeholder asked how providers should report these measures if SIR is not calculated in time for a quarter and asked what the minimum number of cases needed to report this measure. Stakeholder recommended at least 180 days after a performance period before reporting to allow completion of the full SIR review and calculation process and recommended reporting by cases because the SIR does not populate when the predicted number of infections is less than 1.

    HHSC Response: HHCS will allow a three-month lag in data reporting. This data lag is consistent with what has been used successfully for the DSRIP program. Currently, HHSC expects that hospitals will submit data for Jan – June in October, and data for Jan – December in April.

C2-111: ACIA Pediatric Hospital Safety: Hospital Safety Collaborative Participation

25. Multiple stakeholders requested additional details on the requirements, including the definition of collaborative, whether specific organizations need to host the collaborative, and the number of meetings providers need to attend annually. One stakeholder asked if participation in a CMS approved Patient Safety Organization as required under the Affordable Care Act (ACA) meets the requirement for this measure.

    HHSC Response: HHSC is not prescribing a collaborative for participation. Reporting will be structured primarily around multiple choice/drop down questions that will track statewide progress towards implementation of the structure measure. The patient safety measures include in the Pediatric module are taken from the Children's Hospitals' Solutions for Patient Safety (CHSPS). Hospitals are not required to implement structure measures as a condition of reporting or program participation.

C2-112: ACIA Pediatric Hospital Safety: Pediatric Adverse Drug Events

26. Multiple stakeholders expressed that as children's hospitals are high performing providers with very low rates of these events it makes improvement over self or over a benchmark very difficult.

    HHSC Response: There is no proposed Hospital-specific performance target associated with ACIA or CHIRP reporting at this time. This reporting will be used to evaluate the extent to which Hospitals are improving on the identified goals of the Medicaid Managed Care Quality Strategy. CHIRP is a one-year application and will require a new application for future program years.

27. One stakeholder requested the option to follow alternative validated specifications to SPS.

    HHSC Response: Participating Hospitals reporting the ACIA pediatric module will be required to use the most recent version of specifications as available by the measure steward CHSPS. These measure have been used successfully by Children's hospitals participating in the DSRIP program beginning in 2017.

C2-113: ACIA Pediatric Hospital Safety: Pediatric CLABSI

28. Multiple stakeholders expressed that as children's hospitals are high performing providers with very low rates of these events it makes improvement over self or over a benchmark very difficult.

    HHSC Response: There is no proposed Hospital-specific performance target associated with ACIA or CHIRP reporting at this time. This reporting will be

used to evaluate the extent to which Hospitals are improving on the identified goals of the Medicaid Managed Care Quality Strategy. CHIRP is a one-year application and will require a new application for future program years.

29. One stakeholder requested the option to follow alternative validated specifications to SPS.

    HHSC Response: Participating Hospitals reporting the ACIA pediatric module will be required to use the most recent version of specifications as available by the measure steward CHSPS. These measures have been used successfully by Children's hospitals participating in the DSRIP program beginning in 2017.

30. One stakeholder recommended HHSC use the results from the CMS Inpatient Quality Reporting Program (IQR) to avoid duplicate reporting and decrease reporting burden on hospitals.

    HHSC Response: Solutions for Patient Safety and pediatric specific patient safety measures are not reported to CMS Inpatient Quality Reporting Program. Hospitals reporting the ACIA adult hospital safety measures will not be eligible to report the pediatric hospital safety measures.

C2-114: ACIA Pediatric Hospital Safety: Pediatric CAUTI

31. Multiple stakeholders expressed that as children's hospitals are high performing providers with very low rates of these events it makes improvement over self or over a benchmark very difficult.

    HHSC Response: There is no proposed Hospital-specific performance target associated with ACIA or CHIRP reporting at this time. This reporting will be used to evaluate the extent to which Hospitals are improving on the identified goals of the Medicaid Managed Care Quality Strategy. CHIRP is a one-year application and will require a new application for future program years.

32. One stakeholder requested the option to follow alternative validated specifications to SPS.

    HHSC Response: Participating Hospitals reporting the ACIA pediatric module will be required to use the most recent version of specifications as available by the measure steward CHSPS. These measures have been used successfully by Children's hospitals participating in the DSRIP program beginning in 2017.

C2-115: ACIA Pediatric Hospital Safety: Pediatric SSI

33. Multiple stakeholders expressed that for children select surgeries are more appropriate to measure for preventability according to literature and expert organizations, such as NHSN. Stakeholders suggested aligning the definition to match national best practices.

    HHSC Response: Participating Hospitals reporting the ACIA pediatric module will be required to use the most recent version of specifications as available by the measure steward CHSPS. These measures have been used successfully by Children's hospitals participating in the DSRIP program beginning in 2017.

34. One stakeholder recommended HHSC use the results from the CMS Inpatient Quality Reporting Program (IQR) to avoid duplicate reporting and decrease reporting burden on hospitals.

    HHSC Response: Solutions for Patient Safety and pediatric specific patient safety measures are not reported to CMS inpatient Quality Reporting Program. Hospitals reporting the ACIA adult hospital safety measures will not be eligible to report the pediatric hospital safety measures.

C2-117: ACIA Psychiatric Care Transitions: Written transition procedures for psychiatric patient that include formal MCO relationship or EDEN notification/ADT Feed

35. Multiple stakeholders requested a definition for timely notification. One stakeholder asked what consists a formal MCO relationship.

    HHSC Response: Timely notification consists of notification prior to or upon discharge. HHSC will share the details of reporting questions on structure measures prior to twice-yearly reporting periods.

36. One stakeholder asked if an organization does not currently have EDEN notification or ADT feed with MCOs will HHSC require that organizations implement this under the CHIRP program.

    HHSC Response: Hospitals are not required to implement structure measures as a condition of reporting or program participation.

C2-X: ACIA Psychiatric Care Transitions: Post-discharge appointment for behavioral health

37. Multiple stakeholders recommended not including this measure due to the factors outside of providers' control, the difficulty in coordinating with MCO networks, and the need for additional resources to schedule and ensure patients attend appointments.

HHSC Response: HHSC has removed Post-discharge appointment for behavioral health as a measure.

38. Multiple stakeholders recommended that the measure harmonize with the existing CMS IPFQR Measure "(TTR-PT) - Transition Record With Specified Elements Received By Patients" that captures scheduling of timely outpatient appointments.

    HHSC Response: HHSC has removed Post-discharge appointment for behavioral health as a measure.

39. One stakeholder recommended this measure reflect a progression that allows for providers to develop and then implement a program over a period of years.

    HHSC Response: HHSC has removed Post-discharge appointment for behavioral health as a measure.

C2-X: ACIA Psychiatric Care Transitions: Rate of 30-day readmissions for BH Conditions

40. Several stakeholders recommended that the measure harmonize with the existing IPFQR Measure "30 Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility" but should improve upon the CMS measure by focusing on 30-day readmissions for BH Conditions.

    HHSC Response: HHSC has removed Rate of 30-day readmissions for BH Conditions.

C2-X: ACIA Psychiatric Care Transitions: Follow-Up After Hospitalization for Mental Illness

41. Several stakeholders recommended that the measure harmonize with the existing IPFQR Measure "(FUH) Follow-Up After Hospitalization for Mental Illness". Additionally, the stakeholders recommended the measure be a claim-based measure.

    HHSC Response: HHSC has removed Follow-Up After Hospitalization for Mental Illness as a provider reported measure. Follow-up After Hospitalization will remain a measure in the annual evaluation of the CHIRP program as improvements in care coordination for psychiatric hospitalizations may result in improvements in the follow-up after hospitalization rates in the Medicaid program.

C2-118: ACIA Care Transitions: Written transition procedures for non-psychiatric patients that include formal MCO relationship or EDEN notification/ADT Feed

42. Multiple stakeholders requested a definition of timely notification. One stakeholder asked what constitutes a formal MCO relationship.

    HHSC Response: Timely notification consists of notification prior to or upon discharge. HHSC will share the details of reporting questions for structure measures prior to twice-yearly reporting periods.

43. One stakeholder asked if an organization does not currently have EDEN notification or ADT feed will HHSC require that organizations implement this under the CHIRP program?

    HHSC Response: Hospitals are not required to implement structure measures as a condition of reporting or program participation.

44. One stakeholder noted that under the CMS Promoting Interoperability requirements, an electronic Clinical Document Architecture (CDA) summary of care document is required to be sent to a patient's primary provider. Stakeholder recommended HHSC adopt this already required measure to align federal and state programs and decrease reporting burden.

    HHSC Response: HHSC appreciates the support for sharing of Consolidated-Clinical Document Architecture (C-CDA) data with a patient's primary care provider. HHSC declines to add this additional measure at this time.

C2-X: ACIA Care Transitions: Post-discharge appointment for heart failure

45. Multiple stakeholders requested modifications to the measure including excluding children, excluding patients who refuse to schedule follow-up appointments, and including telehealth appointments as eligible appointments.

    HHSC Response: HHSC has removed Post-discharge appointment for heart failure as a measure.

C2-X: ACIA Care Transitions: Transition Record with Specified Elements Received by Discharged Patients (Discharges from Inpatient Facility)

46. Multiple stakeholders recommended not including this measure because many organizations would need to undertake changes in policy and EHR modifications, the elements of the transition plan that fall under the managed care plan's scope, and the difficulties for children's hospitals to implement.

Several stakeholders recommended aligning measure with the existing CMS IPFQR Measure "(TTR-PT) - Transition Record With Specified Elements Received By Patients".

HHSC Response: HHSC has removed Transition Record with Specified Elements Received by Discharged Patients (Discharges from Inpatient Facility) as a measure.

C2-X: ACIA ED Best Practices: Use of validated screening tool for food insecurity & C2-X: ACIA ED Best Practices: Food Insecurity Screening

47. Multiple stakeholders supported the inclusion of SDOH measures. Multiple stakeholders recommended not including this measure because the measure is a better fit for the outpatient clinic or physician setting rather than the ED, providers in the ED will not have time to screen patients and provide the type of follow-up that is required, the EMR for many hospitals is not set up to capture this screening and the IT build would require significant time and resources to achieve, and because unless there are programs to address food insecurity to which screened patients can be directed the program is ethically and practically problematic. Several stakeholders asked whether HHSC will provide guidance on a validated or preferred screening tool for food insecurity. Several stakeholders suggested revising the measure to report if any Social Determinants of Health are screened and listing which are included. Several stakeholders asked what solutions the state recommends for patients identified as living in food-insecure households when there are few resources. One stakeholder suggested Z-codes for food insecurity (e.g. Z59.4) be added as a requirement for positive Food Insecurity screening. One stakeholder recommended this metric reflect a progression that allows for providers to develop and standardize a Food Insecurity Screening tool over a period of years.

    HHSC Response: HHSC has removed Use of validated screening tool for food insecurity as a measure and Food Insecurity Screening as a measure.

C2-X: ACIA ED Best Practices: Adult Major Depressive Disorder: Suicide Risk Assessment

48. Multiple providers requested modifications to the measure, including a modified denominator definition as determining the measure denominator as described will require much IT support and new builds with complex algorithms to calculate, guidance on a valid suicide risk assessment and the components that should be included, and for children's hospitals either be excluded from the measure or a new pediatric specific measure be added. Several stakeholders requested clarification that the specifications allow providers to continue using any evidence-based, regulation-standard suicide risk assessment tools that providers have already put into place. One

stakeholder recommended that this metric reflect a progression that allows for providers to develop and standardize a suicide risk assessment tool over a period of years, as many providers across the state do not have a discrete Suicide Risk Assessment in their EMR.

HHSC Response: HHSC has removed Adult Major Depressive Disorder: Suicide Risk Assessment as a measure.

C2-X: ACIA ED Best Practices: Follow-Up After ED Visits for Mental Illness

49. Multiple stakeholders recommended not including this measure because it will be a new measure for hospitals and implementation will require significant resources, and because of factors outside of providers' control such as a lack of outpatient services and patient willingness to attend a 7-day post-hospitalization follow-up. Several stakeholders asked what constitutes as a follow-up for this measure. One stakeholder noted that under the CMS Promoting Interoperability requirements, an electronic Clinical Document Architecture (CDA) summary of care document is required to be sent to a patient's primary provider. Stakeholder recommended HHSC adopt this already required measure to align federal and state programs and decrease reporting burden. One stakeholder asked for the clarity on the definition of "Mental Illness." One stakeholder suggested including telehealth appointments as an option in the inclusion criteria for numerator performance for this measure and the exclusion of patients who refuse post-discharge appointment in the numerator and denominator.

    HHSC Response: HHSC has removed Follow-Up After ED Visits for Mental Illness as a measure. Follow-up After ED Visits will remain a measure in the annual evaluation of the CHIRP program.

C2-X: ACIA Rural Hospital Best Practices: Use of validated screening tool for food insecurity and suicide risk & C2-X: ACIA Rural Hospital Best Practices: Food Insecurity Screening

50. Multiple stakeholders recommended not including this measure because the measure is a better fit for the outpatient clinic or physician setting rather than the ED, providers in the ED will not have time to screen patients and provide the type of follow-up that is required, the EMR for many hospitals is not set up to capture this screening and the IT build would require significant time and resources to achieve, and because rural Texas communities do not even have a local food bank or meals on wheels program, so the only gain would be documentation. Several stakeholders asked whether HHSC will provide guidance on a validated or preferred screening tool for food insecurity. One stakeholder requested HHSC allow for a zero baseline for this measure and that exclusions be allowed for patients unable to respond due to emergent situations. Multiple stakeholders recommended not including this

measure because the measure is a better fit for the outpatient clinic or physician setting rather than the ED, providers in the ED will not have time to screen patients and provide the type of follow-up that is required, the EMR for many hospitals is not set up to capture this screening and the IT build would require significant time and resources to achieve, and because rural Texas communities do not even have a local food bank or meals on wheels program, so the only gain would be documentation. One stakeholder requested HHSC allow for a zero baseline for this measure and that exclusions be allowed for patients unable to respond due to emergent situations.

HHSC Response: HHSC has removed Use of validated screening tool for food insecurity and suicide risk as a measure.

C2-119: ACIA Rural Hospital Best Practices: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention

51. One stakeholder asked if patients can be referred to their PCP and that count toward the screening. One stakeholder requested clarification on who can perform the cessation intervention and recommended allowing not only MDs, DOs, NPs, and PAs to perform this task but also nurses (RNs and LVNs), dieticians, social workers, and community health workers.

    HHSC Response: The measure steward defines cessation intervention as including brief counseling (3 minutes or less), and/or pharmacotherapy. Concepts aligned with brief counseling (e.g., minimal and intensive advice/counseling interventions conducted both in person and over the phone) are included in the value set for the numerator. Other concepts such as written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies are not included in the value set and do not qualify for the numerator. Brief counseling also may be of longer duration or be performed more frequently, as evidence shows there is a dose-response relationship between the intensity of counseling provided (either length or frequency) and tobacco cessation rates (U.S. Preventive Services Task Force, 2015). In order to promote a team-based approach to patient care, the tobacco cessation intervention can be performed by another healthcare provider; therefore, the tobacco use screening and tobacco cessation intervention do not need to be performed by the same provider or clinician.

C2-X: ACIA Rural Hospital Best Practices: Inpatient Influenza Immunization IMM-2

52. Stakeholders were generally supportive of the inclusion of an influenza immunization measure for rural hospitals.

HHSC Response: HHSC has removed Inpatient Influenza Immunization IMM-2 as a measure in favor of keeping Preventive Care and Screening: Influenza Immunization currently in use by rural hospitals in DSRIP.

C2-120: ACIA Rural Hospital Best Practices: Preventive Care and Screening: Influenza Immunization

53. Several stakeholders asked whether the measure will align with the CMS measure, which only requires reporting for October-March, or if it will require reporting on the full year. Stakeholders expressed concerns if the measure requires a different period for capturing measures from the CMS requirement as this could require significant time, IT, and processes changes.

    HHSC Response: The measure specifications identify the calendar year as the measurement period to establish the initial population. The denominator is then determined by using the initial population AND if the individual had a specified encounter during the flu season. For CHIRP reporting purposes, Hospitals will include encounters that occur January 2021 through March 2021 and October 2021 through December 2021 of the first measurement year.

General Component 2 Feedback

54. Multiple stakeholders suggested adding a measure to the pediatric bundle focusing on behavioral health.

    HHSC Response: In response to stakeholder feedback, HHSC has added a Component 2 measure to the ACIA Pediatric Hospital Safety module, Engagement in Integrated Behavioral Health.

55. Several stakeholders expressed concerns that if the Component 2 measures transition to Pay-For-Performance, the measures will be difficult to demonstrate significant improvement over self, as most providers are already high-performing on the measures. Stakeholders suggested HHSC consider pay-for-maintenance of high performance or utilize a performance "cap" for providers who are at a high-level performance where minimal achievement above that "cap" is possible.

    HHSC Response: There is no proposed Hospital-specific performance target associated with ACIA or CHIRP reporting at this time. This reporting will be used to evaluate the extent to which Hospitals are improving on the defined goals of the Medicaid Managed Care Quality Strategy. CHIRP is a one-year application and will require a new application for future program years.

4. Quality Requirements

Attribution Methodology

56. One stakeholder requested for the ACIA Maternal Care module that the attribution methodology be limited to deliveries and not prenatal or postnatal encounters as these are hospital-based measures only. One stakeholder asked for the ACIA Maternal Care module whether the child or the pregnant mother must be enrolled in STAR or STAR+PLUS.

    HHSC Response: HHSC has updated the ACIA Maternal Care module attribution methodology to be limited to deliveries. To be included in the Medicaid rate for a measure, the delivery should be covered by Medicaid.

57. One stakeholder requested that the ACIA Hospital Safety module attribution methodology be revised to one admission and not one encounter.

    HHSC Response: The reported rates for ACIA Hospital Safety data-based measures will be determined by the measures specifications only, which is why the attributed population is broad. The attributed population should not narrow the reported population beyond what is intended by the measure specifications.

58. Several stakeholders requested the attributed population for the ACIA Psychiatric Care Transitions module be expanded to "Individuals who had one admission for inpatient or observation status with a primary BH/SA diagnosis during the measurement period" and requested a minimum of three visits or a combination of one ED visit or one admission encounter and observation. One stakeholder requested for the ACIA Psychiatric Care Transitions module the attribution methodology be narrowed to two or more admissions within one calendar year.

    HHSC Response: HHSC has removed all data-based measures from the Psychiatric Care Transitions module, and the attribution no longer applies.

59. One stakeholder requested clarification for the ACIA Psychiatric Care Transitions module as the Component Eligibility includes revenue codes for inpatient services while the attribution population states "a) One admission for inpatient or observation status during the measurement period". Stakeholder asked if observation patients are included in this component.

    HHSC Response: HHSC has removed all data-based measures from the Psychiatric Care Transitions module, and the attribution no longer applies.

Component 1 Structure Measure Requirements

60. Several stakeholders expressed concerns regarding the administrative burden of narrative responses and requested HHSC consider providing examples of the level of detail required and consider drop-down menus instead of narratives.

    HHSC Response: Reporting for structure measures will be structured primarily around multiple choice/drop down questions that will track statewide progress towards implementation of the structure measure. HHSC will share the details of reporting questions for structure measures prior to twice-yearly reporting periods.

61. Several stakeholders requested that the number of Component 1 structure measures be reduced.

    HHSC Response: HHSC has removed one measure from Component 1: *Data Quality Review.*

62. One stakeholder asked whether providers need to achieve the structure measures or if submitting responses to qualitative questions is sufficient.

    HHSC Response: Hospitals are not required to implement structure measures as a condition of reporting or program participation.

63. One stakeholder expressed that quarterly reporting may not show much trend change. Stakeholder suggested twice annual reporting for HIE Participation.

    HHSC Response: Based on stakeholder feedback, HHSC has modified the program requirements to semi-annual reporting for structure measures.

Component 2 Outcome and Process Measure Requirements

64. Multiple stakeholders requested that stratified reporting by payer type be streamlined or removed. Suggestions included reporting on Medicaid managed care, Other Medicaid, LIU; Medicaid managed care, Medicaid fee-for-service, Other payers; Medicaid managed care, Medicaid, Uninsured, Other; all Medicaid only.

    HHSC Response: Based on stakeholder feedback regarding the challenges of stratifying payer type by Medicaid managed care versus Medicaid, HHSC has updated the requirements for reporting and performance achievement to be based on Medicaid patients. Providers will also be required to report measures stratified by Uninsured and Other payer types.

Minimum Denominator Volume

65. Multiple stakeholders expressed concern about determining eligibility based on historical services in CY2019 or CY2020.

    HHSC Response: CHIRP program eligibility is not determined by volume. However, provider class and historic volume will be used to determine eligibility to report measure modules. For example, a hospital with three Medicaid births in 2019 and 2020 would not be eligible to report the ACIA Maternal Care Module. Since HHSC needs to know module eligibility prior to reporting, using current reporting year data to determine volume for eligibility is not feasible. Hospitals that are not eligible for any ACIA measures based on volume are still eligible to participate in ACIA and no reporting will be required.

66. Several stakeholders recommended the minimum threshold be set to total Medicaid or Medicaid managed care populations regardless of plan.

    HHSC Response: Based on stakeholder feedback regarding the challenges of stratifying by Medicaid managed care vs. Medicaid, HHSC has updated the requirements for reporting and performance achievement to be based on Medicaid patients. Providers will also be required to report measures stratified by uninsured and other payer types.

67. Several stakeholders asked if there is any penalty for providers that do not have the minimum volume to report. One stakeholder asked if an organization meets the class eligibility requirements for participation in a program component but does not meet minimum volume requirements for reporting, whether this impacts a hospitals eligibility for rate increase payments to that organization.

    HHSC Response: Hospitals that are not eligible for any ACIA measures based on volume are still eligible to participate in ACIA and no reporting will be required.

68. Several stakeholders recommended five or more encounters for the ACIA Hospital Safety, ACIA Pediatric Hospital Safety, and ACIA Rural Hospital Best Practices bundles.

    HHSC Response: As there is no proposed Hospital-specific performance target associated with ACIA or CHIRP reporting at this time, HHSC declines to increase the minimum volume. Additionally, increasing the minimum volume would further limit program eligibility for Hospitals to report certain measures, particularly hospitals with a low volume of Medicaid that may participate in ACIA.

Measure Class for Module Participation

69. Several stakeholders recommend removing children's hospitals from the ACIA Care Transitions and ACIA ED Best Practices modules unless modifications are made.

    HHSC Response: HHSC has removed children's hospitals from the ACIA Care Transitions module. HHSC has removed the ED Best Practices module.

70. One stakeholder asked what defines a children's hospital, stand alone or hospital within a hospital or children encounters? One stakeholder asked if a hospital is subsequently declared a children's hospital will they have to report on these measures.

    HHSC Response: A children's hospital is defined in the CHIRP program rules as a Medicaid hospital designated by Medicare as a children's hospital. Module eligibility will be determined by hospital class at the time of CHIRP enrollment.

71. One stakeholder requested rural hospitals be added to all modules where urban hospitals are listed. Another stakeholder asked why rural hospitals are excluded from the ACIA Care Transitions module.

    HHSC Response: HHSC declines to add rural hospitals to additional modules as this would disproportionately increase the administrative burden on rural hospitals.

72. One stakeholder recommended HHSC simplify the number of measures required per module to reduce barriers to participation, given the requirement that all hospitals must report on all measures in a module for which they are eligible.

    HHSC Response: HHSC has removed many measures. For hospitals participating in ACIA, the maximum number of ACIA structure measures a provider will be required to report based on hospital class and volume is four, and the minimum number is zero. The maximum number of ACIA data-based measures a hospital will be required to report based on hospital class and volume is seven and the minimum number is zero. Hospitals that are not eligible for any ACIA measures based on volume are still eligible to participate in ACIA, and no reporting will be required.

Reporting Requirements

73. Multiple stakeholders requested that stratified reporting by payer type be streamlined or removed. Suggestions included reporting on Medicaid managed care, Other Medicaid, LIU; Medicaid managed care, Medicaid fee-for-service, Other payers; Medicaid managed care, Medicaid, Uninsured, Other; all Medicaid only.

HHSC Response: Based on stakeholder feedback regarding the challenges of stratifying by Medicaid managed care vs. Medicaid, HHSC has updated the requirements for reporting and performance achievement to be based on Medicaid patients. Providers will also be required to report measures stratified by uninsured and other payer types.

74. Several stakeholders requested that reporting be once a year to reduce administrative burden.

    HHSC Response: Annual reporting would limit HHSC's ability to monitor statewide performance and provider progress and to deliver a timely evaluation of the program. HHSC has reduced the reporting to twice a year instead of the proposed four times a year.

75. Several stakeholders requested that reporting be twice a year to reduce administrative burden.

    HHSC Response: Based on stakeholder feedback, HHSC has modified the program requirements to semi-annual reporting for structure measures.

76. One stakeholder requested that reporting for TIPPS, CHIRP, and DSRIP occur at different times.

    HHSC Response: HHSC is aligning reporting to allow at least three months of data lag and ensure consistency in reporting.

77. One stakeholder requested an additional explanation of HHSC's intent to ask hospitals to report non-Medicaid performance in a Medicaid context as CHIRP payments are based on services delivered to patients enrolled in Medicaid only.

    HHSC Response: Hospitals are asked to report data for non-Medicaid populations for evaluation purposes and for alignment with the DSRIP transition. Many hospitals have expressed they do not segregate delivery of care interventions by payer type and reporting on data for all clients regardless of payer type reflects the quality of care received by a whole population. Hospital safety measures are specified at an all-payer level and are not stratified by payer type.

5. General Comments

78. Multiple stakeholders asked how the COVID-19 pandemic will be taken into account.

    HHSC Response: HHSC will continue to work with CMS to align COVID-19 impacts on quality measurement and will inform stakeholders of any changes.

79. Several stakeholders suggested new measures for consideration. Some commenters suggested general principles for measurement, or suggested concepts for new measures. Specific measure suggestions included Potentially Preventable Readmissions, Potentially Preventable Complications, Potentially Preventable ED Visits, treatment for upper respiratory infection, Proportion of opioid discharges prescriptions exceeding 7 days, avoidance of antibiotic treatment in adults with acute bronchitis, post-discharge appointment for pediatric asthma, and the advanced care plan measure utilized in DSRIP, and Engagement in Integrated Behavioral Health utilized in DSRIP

    HHSC Response: HHSC has added "Engagement in Integrated Behavioral Health" to the ACIA pediatric module.

    The measures that remain in the ACIA module are related to improving outcomes for Potentially Preventable Readmissions (PPR) and Potentially Preventable Complications (PPC). For example, efforts to improve care coordination for discharged clients may improve PPR rates, and efforts to improve hospital safety measures may improve PPC rates.

80. Many commenters expressed concern with the implementation timeline, indicating that starting a new program while still operating a DSRIP program will be challenging while resources are already diverted due to COVID.

    HHSC Response: Participation in CHIRP is optional. HHSC has simplified the reporting requirements for CHIRP, removing many measures and requiring reporting twice-a-year instead of four-times a year. Additionally, where possible, HHSC has proposed measures that align with reporting a hospital may already be undertaking as part of other federal or state reporting requirements.

81. Many comments on measures were related to their implementation in the future as a pay-for-performance program. For example, Multiple commenters requested a goal setting methodology that rewards high performance on a measure. One stakeholder commented that MCOs would prefer HHSC rank providers based on reported data and make payment determinations (a form

of pay-for-performance in which providers with better outcomes receive a higher payment).

HHSC Response: There is no proposed Hospital-specific performance target associated with ACIA or CHIRP reporting at this time nor is the program a value-based payment arrangement. Provider reporting will be used to evaluate the extent to which Hospitals are improving on the defined goals of the Medicaid Managed Care Quality Strategy. CHIRP is a one-year application and will require a new application for future program years.