Comprehensive Hospital Increase Reimbursement Program (CHIRP)

Stakeholder Feedback on Proposed State Fiscal Year 2025 Quality Measures and Requirements

As Required by

Texas Administrative Code

§353.1307

Texas Health and Human

Services Commission (HHSC)

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TEXAS
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Contents

Overview

On November 16, 2023, HHSC released the proposed measures and requirements for the Comprehensive Hospital Increase Reimbursement Program (CHIRP) for state fiscal year (SFY) 2025 and requested stakeholder feedback. The CHIRP SFY 2025 proposal documents included:

1. Requirements (e.g., overview, quality goals, program structure, reporting requirements and Component 3 program elements such as achievement calculations, scoring methodology, etc.)
2. Measure specifications (e.g., detailed information on measure specifications, attribution methodology, etc.)

The CHIRP proposal documents are located on HHSC's CHIRP website.

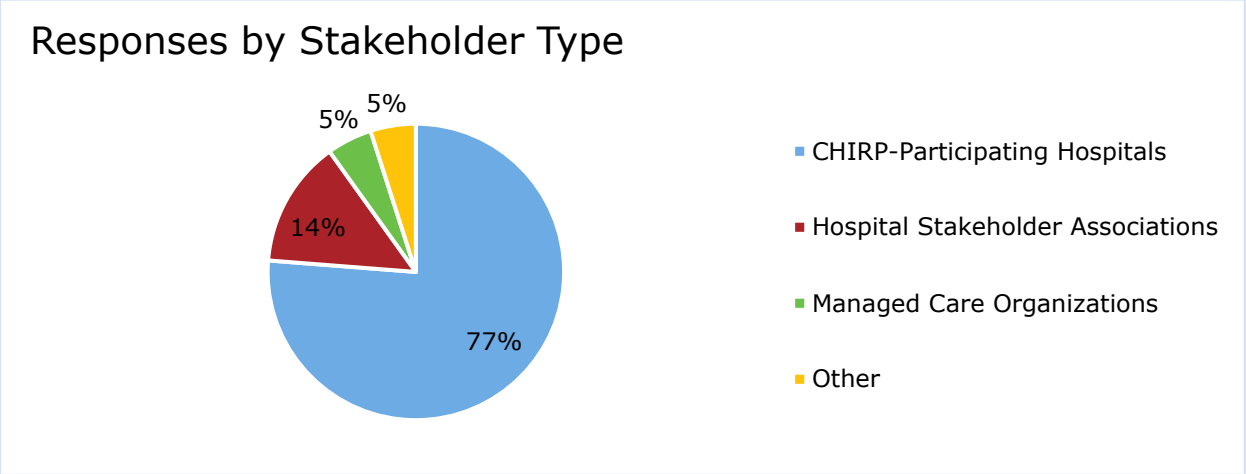
On November 30, 2023, HHSC hosted a webinar to provide an overview of the CHIRP SFY 2025 proposed measures and requirements and answer questions. Stakeholders submitted feedback through an online survey that closed on December 8, 2023. HHSC received 22 responses to the online survey.

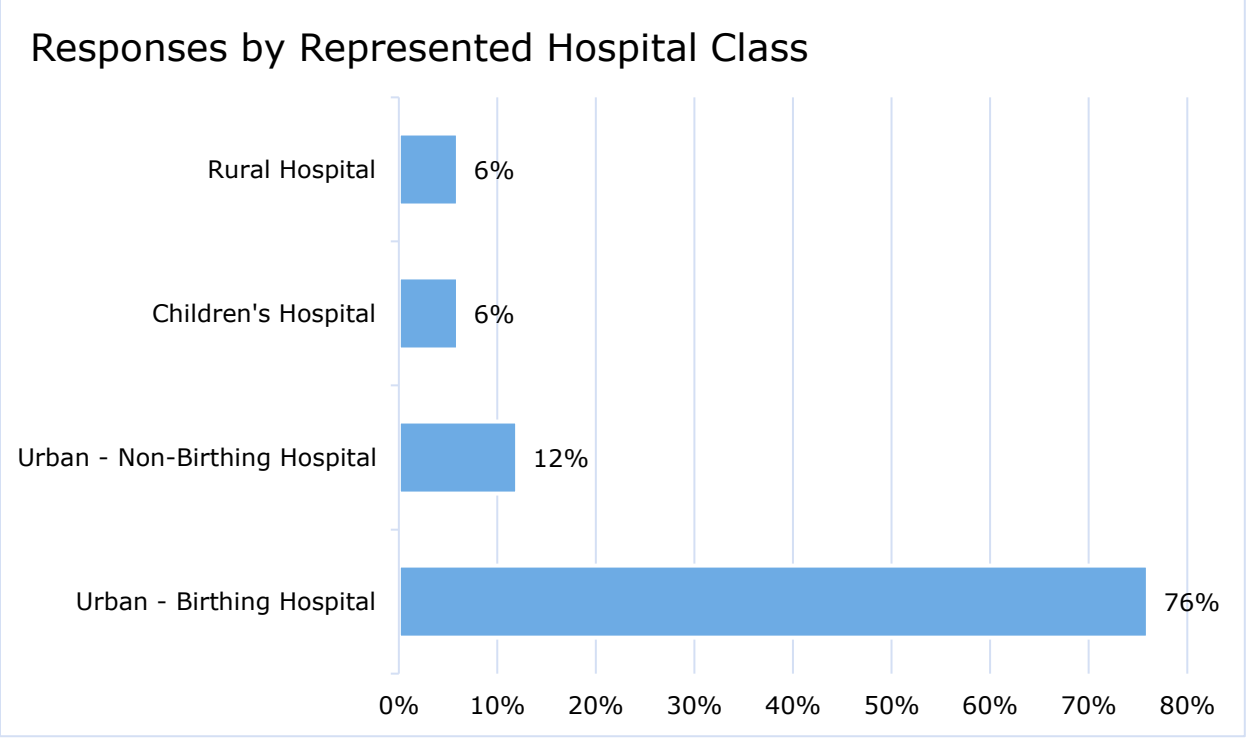
This document summarizes stakeholder feedback HHSC received through the public hearing webinar and the online survey. HHSC reviewed and considered stakeholder comments and noted any changes to requirements or measures specifications in the responses.

HHSC will include the quality measures and requirements in the CHIRP state directed payment preprint submission to the Centers for Medicare & Medicaid Services (CMS) for CHIRP in SFY 2025. HHSC expects to make this submission in March 2024. All CHIRP SFY 2025 requirements are subject to CMS approval and may change if required by CMS. HHSC will post any changes required by CMS as described in 1 TAC §353.1307.

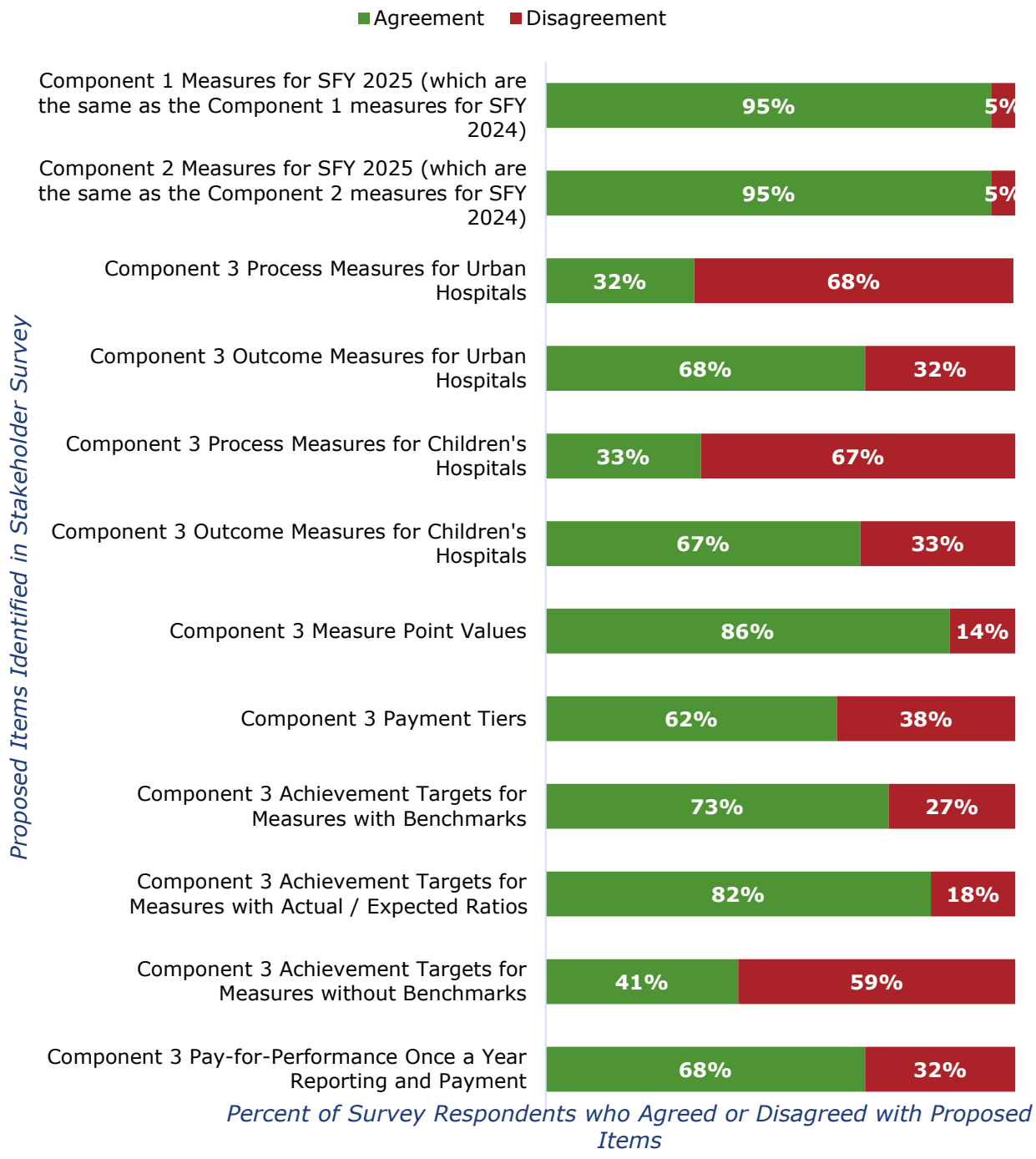
Survey Responses Summary

Stakeholders submitted feedback through an online survey that closed on December 8, 2023. HHSC received **22** responses to the online survey, further summarized in the illustrations below.





Summary of Survey Respondent Agreement with Proposed Items



Component 1: Uniform Hospital Rate Increase Program (UHRIP) - Stakeholder Comments

1. One stakeholder supports the continued use of certain measures (C1-105 Health Information Exchange (HIE) Participation; C1-163 Non-Medical Drivers of Health (NMDOH) Screening and Follow-up Plan Best Practices; C1-127 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Medication per Patient).

   However, the stakeholder noted concern with the HHSC requirement to sample all admitted patients (instead of adults-only per Leapfrog specifications). The stakeholder noted it is difficult for non-children's hospitals to include pediatric patients in this measure due to low pediatric patient volume. The stakeholder recommends HHSC allow non-pediatric providers to report on adults only, or allow all hospitals to report their Leapfrog numbers, similar to the way HHSC allows providers to use The Joint Commission data for the Cesarean Birth Measure (C2-130).

   HHSC Response: HHSC declines to make changes in response to this comment. The methodology will continue to require sampling of all admitted patients, consistent with the current specifications. Component 1 of the CHIRP program provides rate enhancements for the STAR and STAR+ PLUS populations, and the STAR population includes children. Including children in this measure is essential to ensuring the program is advancing the goals and objectives of the state's quality strategy as required by 42 CFR 438.6(c)(2)(ii)(C).

Component 2: Average Commercial Incentive Award (ACIA) - Stakeholder Comments

2. One stakeholder noted support for continued use of several measures and made recommendations on measure specifications. Specifically, the stakeholder made the following suggestions:

   C2-104 Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention: The stakeholder noted that the existing inclusion of emergency room (ER) volume distorts data because ER patients are typically not screened for tobacco use and ER volume for most hospitals exceeds inpatient volume. The stakeholder recommended changing the eligible denominator patient population to admitted patients only.

   C2-115 Preventive Care and Screening: Screening for Depression and Follow-Up Plan: The stakeholder noted that current requirements of including ER patients in the total eligible patient population can greatly distort performance data, making it difficult for providers to identify and improve on areas of concern. The stakeholder recommends changing the eligible denominator patient population to admitted patients only or eliminate the measure and replace it with a measure that can be readily identified, reported on, and improved. The stakeholder proposed alternate measures including maternal depression screening and suicide screening.

   C2-104 Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention and C2-164 PSI 13 Postoperative Sepsis Rate: The stakeholder requested HHSC remove the requirement that this data be stratified by payer type since these screenings are typically performed on admission or intake, when nursing staff does not have any knowledge about a patient's payer.

   HHSC Response: HHSC declines to make changes to C2-104 in response to this comment. Methodology for reporting on this measure has not changed from the program inception, and having the same reporting methodology across years allows providers and HHSC to consistently evaluate performance on this measure.

   HHSC declines to make changes to C2-115 in response to this comment. HHSC has identified behavioral health as a priority area for additional quality improvement in Medicaid. Major depressive disorders and other/unspecified psychoses are among the top reasons for potentially preventable admissions and potentially preventable readmissions. Therefore, screening and treatment are important, and not all patients have an established relationship with or timely access to a PCP. Untreated

depression can cause health problems directly and may also indirectly worsen patient adherence to treatment for other conditions, such as hypertension and diabetes. During planning meetings for Year 3 (SFY 2024) changes, most stakeholders supported replacing the measure that was previously in CHIRP (the influenza immunization measure) with this depression screening measure.

HHSC declines to make changes to the C2-104 and C2-164 payer type stratification requirements in response to this comment. CMS requires that the evaluation of the program is specific to the populations served by the providers under the payment arrangement. Hospitals that participate in CHIRP provide services to people in the STAR and STAR+PLUS programs, so measures in the program, and reporting concerning those measures, must be tied to the STAR and STAR+PLUS populations.

Component 3: Alternate Participating Hospital Reimbursement for Improving Quality Award – Stakeholder Comments

Urban Hospitals & Children's Hospitals – Process Measures

C3-NEW2/170 Food Insecurity Screening and Follow-up Plan

3. One stakeholder expressed concerns that the CMS Social Drivers of Health (SDOH) measures were not required until 2024 in the Hospital Inpatient Quality Reporting Program, so many facilities would not have the 2023 baseline data for CHIRP to measure improvement for SFY 2025.

   HHSC Response: HHSC declines to make changes in response to this comment. HHSC understands that some hospitals may not have implemented food insecurity screening and follow-up plan processes associated with this measure in 2023. However, having a low baseline rate will not negatively affect provider performance or payments in subsequent years.

4. One stakeholder noted this measure places additional measurement burden upon hospitals since the proposed CHIRP measure does not align with the CMS Social Drivers of Health measures in the Hospital Inpatient Quality Reporting Program.

   HHSC Response: HHSC declines to make changes in response to this comment. The CHIRP measure requires that hospitals screen only for food insecurity. The two CMS SDOH measures require hospitals to screen for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

5. Ten stakeholders requested HHSC allow flexibility in food insecurity screening tools and not exclusively require the use of Hunger Vital Sign food insecurity tool. Multiple stakeholders stated their hospitals may already be using an alternate food insecurity screening tool that is incorporated into their processes and electronic health records (EHR). However, these stakeholders did not clarify which alternate food insecurity screening tools their hospitals are using.

   HHSC Response: HHSC has modified the specifications to allow the Hunger Vital Sign or another standardized, age-appropriate food insecurity screening tool for the CHIRP measure in SFY2025.

The Hunger Vital Sign™ tool is a validated 2-question food insecurity screening tool. It uses 2 questions from the USDA U.S. Household Food Security Survey Module (18 total questions), which is considered the gold standard for identifying households at risk of food insecurity. The two questions paired in the Hunger Vital Sign tool have been validated for high rates of sensitivity and specificity (up to 97% and 83%, respectively) for accurately identifying food insecurity among pediatric, adolescent, and adult populations[1].

Additionally, according to the University of California San Francisco Social Interventions Research & Evaluation Network (SIREN) SDOH Screening Tool Comparison Table[2], the Hunger Vital Sign is the most common food insecurity screening tool used among stakeholders and in SDOH assessment tools. For example, the CMS AHC HRSN tool, the American Academy of Family Physicians SDOH tool, and many EHR systems, including EPIC, use the Hunger Vital Sign tool as the food insecurity screening tool.[3,4]

Hospitals should prioritize food insecurity screening tools like the Hunger Vital Sign that have evidence of accuracy and reliability as a screening tool.

6. Several stakeholders requested HHSC consider limiting the denominator to inpatients aged 18 years or older. Some also recommended that HHSC consider changing the denominator for this measure to exclude outpatient encounters (i.e., the emergency department, radiology and laboratory services).

   HHSC Response: HHSC has updated the denominator specifications to exclude encounters that are limited to radiology or laboratory services.

   HHSC declines to limit the denominator to adults. The 2 questions paired together for the Hunger Vital Sign™ tool have been validated for high rates of sensitivity and specificity for accurately identifying food insecurity among pediatric, adolescent, and adult populations[5]. The CHIRP program provides rate enhancements for the STAR and

[1] Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Cook, J. T., Ettinger de Cuba, S. E., Casey, P. H., Chilton, M., Cutts, D. B., Meyers A. F., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146.

[2] https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison

[3] https://childrenshealthwatch.org/wp-content/uploads/Hunger-Vital-Sign-National-Community-of-Practice_goals-priorities-accomplishments.pdf

[4] https://www.epicshare.org/share-and-learn/food-as-medicine-addressing-hunger-in-the-community

[5] Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Cook, J. T., Ettinger de Cuba, S. E., Casey, P. H., Chilton, M., Cutts, D. B., Meyers A. F., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146.

STAR+PLUS populations, and the STAR population includes children. Including children in this measure is essential to ensuring the program is advancing the goals and objectives of the state's quality strategy as required by 42 CFR 438.6(c)(2)(ii)(C).

7. One stakeholder requested allowable exclusions for death or when the patient is unable to answer and the legal guardian is unavailable.

   HHSC Response: HHSC has added a denominator exclusion for individuals who cannot complete the screening and have no legal guardian or caregiver able to do so on behalf of the individual. HHSC has also added a denominator exception for patient death.

8. Two stakeholders requested that HHSC modify its measure specifications to remove the requirement that providers have a documented follow-up plan. The stakeholder reported most providers have not incorporated this into any templates in their electronic medical records, so to pull this information, a manual chart review may be needed. A stakeholder noted high ED volumes and concerns about what level of control hospitals have on the follow-up plan.

   HHSC Response: HHSC declines to make changes in response to this comment. The measure does not require that a follow-up plan be executed within 30 days of a positive food insecurity screening result. Patients must be screened once during a measurement period and have a follow-up plan *documented* within 30 days of a positive screening result. For additional information on what would meet documentation of a follow-up plan, review the measure numerator specifications.

9. A stakeholder requested that HHSC remove the requirement that this data be stratified by payer since these screenings are typically performed on admission or intake when nursing staff does not have any knowledge about a patient's payer.

   HHSC Response: HHSC declines to make changes in response to this comment. The CHIRP payment arrangement is for STAR and STAR+PLUS, and measures in the program must be tied to the STAR and STAR+PLUS populations. CMS requires that quality measurement in state directed payment program is specific to the populations served by the providers under the payment arrangement.

C3-NEW3/171 IMM-2 Influenza Immunization

10. A stakeholder noted that this measure does not specify if 100% of the population is required for the metric or if sample size submission will suffice and requests clarification from HHSC. CMS allows for sampling of this metric,

so requiring 100% of this measure would create additional burden on hospitals.

HHSC Response: Providers may sample for this measure using the HHSC sampling methodology or the CMS sampling methodology. No changes to the measures or specifications were made in response to this request for clarification.

11. A stakeholder requested removal of this measure. CMS phased out the influenza immunization as a core measure approximately five years ago, and many providers do not have a system in place to effectively track and improve on this measure.

HHSC Response: HHSC did not make changes in response to this comment. This measure was proposed following stakeholder requests to limit influenza immunization requirements for hospitals to inpatient services. The measure is still used in SFY 2025 in certain CMS programs, such as the Inpatient Psychiatric Facility Quality Reporting (IPFQR) program[6].

Urban Hospitals Process Measures

C3-NEW4/174 Safe Use of Opioids – Concurrent Prescribing

12. Stakeholders did not submit concerns about Safe Use of Opioids.

Urban Hospitals – Outcome Measures

C3-NEW1/173 All-Cause Readmissions

13. A stakeholder requested clarification of the unit of measurement. It is listed as encounters but the denominator description states to count patients.

HHSC Response: The denominator unit of measurement is encounters, which allows patients to be included in the denominator more than once in each measurement period. The measure specifications are consistent with the measure steward (NCQA) and are correct as posted.

14. A stakeholder suggested that the state leverage claims data to calculate readmission performance. Readmission measures that are calculated by the state using claims data would ensure standardization in reporting. The stakeholder noted that state-level data would also capture readmissions to different hospitals, as opposed to limiting hospital data to readmissions to their own facility.

[6] https://qualitynet.cms.gov/ipf/ipfqr/measures

HHSC Response: HHSC declines to make changes in response to this comment. The majority of CHIRP participants have voiced a preference to report their own data for measures. This measure is limited to patients who are admitted to the same hospital to ensure providers are tracking data consistently and that the measurement is feasible for hospitals.

C3-130 Cesarean Birth (PC-O2)

15. Two stakeholders requested that the baseline period be delayed to calendar year 2024 to allow hospitals to implement changes at their facilities and in their communities.

    HHSC Response: HHSC declines to make changes in response to this comment. HHSC understands that some hospitals may not have implemented programs related to this measure for 2023. Poor performance at baseline will not negatively affect provider performance or payments in subsequent years.

16. A stakeholder suggested non-maternal hospitals may benefit from a different measure as a substitute for the Cesarean Birth measure since they have CMS exemptions from reporting CAUTI. The stakeholder suggested C3-NEW1/173 Plan All-Cause Readmission (PCR-AD) measure as a substitute, or that non-maternal hospitals be considered to have "Full Achievement" instead.

    HHSC Response: HHSC will not make any changes to the proposed measures. The substitute measure C3-132 CAUTI can be calculated by the hospitals and does not require calculation by CMS. Additionally, hospitals are already required to report C3-NEW1/173 Plan All-Cause Readmission in Component 3.

17. A stakeholder noted full support for the inclusion of all four outcome measures. However, the stakeholder requested HHSC change the goal calculation for C3-130 – PC02 Cesarean Birth, noting that the proposed target sets an unreasonably high standard, and recommended using an achievement target of an average benchmark calculation, with a benchmark value of 26.4%.

    HHSC Response: HHSC declines to make changes in response to this comment. The provider is proposing to change the benchmark for PC-02 from 23.6% to 26.4%. However, the median Medicaid Managed Care rate reported for this measure during SFY24R1 reporting was 23.2%, so most providers are already at least meeting the 23.6% benchmark. Given this, a benchmark of 23.6% is reasonable.

18. A stakeholder asked whether birthing hospitals are required to report both C3-130 PC-02 Cesarean Birth and C3-164 PSI 13 Postoperative Sepsis Rate.

HHSC Response: Birthing hospitals are required to report both PC-02 Cesarean Birth and PSI 13 Postoperative Sepsis Rate under Component 2. For Component 3, birthing hospitals' pay-for-performance will be based on PC-02 Cesarean Birth as one of six measures. For non-birthing hospitals, pay-for-performance will be based on CAUTI instead of PC-02 Cesarean Birth. Note that there was an error in the presentation that listed PSI 13 Postoperative Sepsis Rate as the alternative to PC-02 Cesarean Birth.

C3-132 Catheter-Associated Urinary Tract Infection (CAUTI)

19. A stakeholder recommended that the methodology surrounding this measure be altered so that hospitals with 12 months of CAUTI data but an incalculable standardized infection ratio (SIR) due to low volume and with zero actual infections be considered to have achieved the goal and be paid for having done so.

    HHSC Response: HHSC did not make changes in response to this comment. The issue of low volume for CAUTI occurs with rural hospitals. Rural hospitals are not required to report CAUTI for CHIRP.

Children's Hospitals – Process Measures

C3-115 Preventive Care and Screening: Screening for Depression and Follow-Up Plan

20. A stakeholder requested HHSC consider implementing the "extra credit points concept" to make this measure more meaningful during the first transitional years of implementation. The concept is explained fully in the General Comments section of this document. The stakeholder also relayed that hospitals that are Joint Commission accredited already conduct suicide screenings and this measure somewhat duplicates this effort. The stakeholder suggested that extra credit points could be given for measuring the number of children screened for suicide risk to determine the impact of adding depression screening.

    HHSC Response: HHSC did not make changes in response to these comments. HHSC added C2-115 Preventive Care and Screening: Screening for Depression and Follow-Up Plan to CHIRP SFY 24 following stakeholder workgroups and a public hearing.

Children's Hospitals – Outcome Measures

C3-158 Pediatric Central Line Associated Bloodstream Infection (CLABSI)

21. A stakeholder noted support for this measure and requested HHSC compare the all-payer rate performance to the all-payer benchmark if HHSC cannot

calculate a STAR-only CLABSI benchmark rate (i.e., compare the same measure population and benchmark). Another stakeholder requested HHSC keep this measure as an all-payer measure as it is difficult to extract patient level detail as a National Healthcare Safety Network (NHSN) measure.

HHSC Response: HHSC updated the performance to be based on the all-payer rate. Children's hospitals will report Pediatric CLABSI stratified by payer type as a condition of participation under Component 2.

22. A stakeholder requested clarification on how HHSC is addressing the inclusion of Mucosal Barrier Injuries (MBIs) for this measure. The stakeholder recommended that MBIs be excluded from this measure because hospitals that treat patients with MBIs are more likely to have CLABSIs in this patient population.

HHSC Response: HHSC did not make changes in response to these comments. Based on the measure specifications from measure steward Children's Hospitals' Solutions for Patient Safety National Children's Network, the mucosal barrier injuries (MBIs) are specifically included in this measure's specifications: "All patients are included who are defined as inpatient or under observation at the hospital including one calendar day post discharge (including CLABSI's related to MBIs)." Since stakeholders proposed using the benchmark from this measure steward, measure specifications need to be followed for consistency in data.

C3-NEW6/175 Pediatric Lower-Respiratory Infection Readmissions

23. A stakeholder expressed that their organization does not support this outcome measure being included as a pay for performance measure as it was proposed outside of the workgroup timeline and there are too many unknowns that have not been worked through between HHSC and providers. The unknowns include:
1) If the proposed benchmark is well calibrated to Texas in 2024, as the benchmark data is from 26 states from 2008-2009. This will be comparing pre-COVID readmission patterns to post-COVID readmission patterns.
2) How annual changes in respiratory infections will impact an individual hospital's readmissions. Respiratory admissions during 2023 were particularly high. Early indicators, including increasing pneumonia hospitalizations in children in China, show this year may also have high respiratory admissions.
3) How HHSC plans to address any potential impact of the RSV vaccine.

HHSC Response: HHSC replaced the pediatric lower-respiratory readmissions measure with the pediatric all-condition readmission measure from the same measure steward. HHSC will work the External

Quality Review Organization (EQRO) during 2024 to calculate a benchmark using Texas STAR data for 2022.

24. A stakeholder requested HHSC provide the APR-DRGs for inclusion criteria.

HHSC Response: HHSC replaced the pediatric lower-respiratory readmissions measure with the pediatric all-condition readmission measure from the same measure steward.

C3-NEW5/176 Follow-Up After ED Visit for Mental Illness

25. A stakeholder requested HHSC consider implementing the "extra credit points concept" to make this measure more meaningful during the first transitional years of implementation and to help mitigate the unknowns that cannot be addressed before the performance period starts on January 1, 2024. The concept is explained fully in the General Comments section of this document. The stakeholder relayed several unknowns for this measure:
1) When hospitals will receive their baseline data, as this is an EQRO measure.
2) How hospitals can improve on their performance in light of the managed care organizations already having this as a quality goal.
3) How regional variations on access will impact a hospital's ability to find available follow-up visits.
4) If using a managed care organization statewide average is a fitting benchmark.

HHSC Response: HHSC did not make changes in response to these comments. HHSC will work with the EQRO to provide data on a quarterly basis beginning in 2024. Hospitals can focus on the ED discharge process and their own outpatient clinics for follow-up visits. HHSC used the Texas STAR average of 56.57% for the benchmark. This benchmark is lower than the statewide Medicaid average of 57.83% and lower than the national 50th percentile of 69.57%.

26. A stakeholder requested clarification on this measure, asking whether this is a managed care organization measure that the hospital is required to monitor the managed care organization's process. The stakeholder suggested it would be preferred for providers to put a process in place to ensure patients are navigated and receiving their follow-ups and not use EQRO data.

HHSC Response: HHSC did not make changes in response to these comments. HHSC will work with the EQRO to provide data on a quarterly basis beginning in 2024. Hospitals may track patients navigated and receiving follow-up visits to monitor their progress. However, EQRO data will be used for the SFY2025 measurement of follow-up after an ED visit for mental illness.

Scoring Methodology

Payment Tiers

27. Sixty-two percent of survey respondents agreed with the proposed Component 3 **payment tiers**.

    Eight stakeholders recommended reducing the Tier 1 threshold from ≥60% to ≥50% to ease into the pay-for-performance transition.

    > **HHSC Response:** In response to stakeholder feedback, HHSC is reducing the percentage for payment tier 1 to ≥50 percent (9 points) in SFY 2025. This percentage may be adjusted in future years. HHSC will communicate a multi-year plan to stakeholders and CMS.

Achievement Targets

Measures with Benchmarks

28. Seventy-three percent of survey respondents agreed with the proposed achievement targets for Component 3 **measures with benchmarks.** A stakeholder requested HHSC clarify the definition of "exceeds 5% gap closure over the baseline" to specifically state the 5% closure is based on a relative calculation (i.e., [final value minus initial value] divided by initial value); and not an absolute 5% (e.g., hospital baseline at 40% and gap closure needs to be 34.99% or lower).

    > **HHSC Response:** HHSC has added the following footnote to the Component 3 - Achievement Targets table in the requirements document:
    >
    > "The 5% gap closure over baseline calculation for measures where higher rates are better is: baseline + 0.05 x (perfect – baseline). For measures where lower rates are better, the calculation is: baseline - 0.05 x (baseline)."

Point Values

29. Eighty-six percent of survey respondents agreed with the proposed Component 3 **measure point values.**

    A hospital association generally supported the scoring approach and proposed HHSC consider the following. Average Benchmark: For measures that are scored with an "Average Benchmark," the stakeholder suggests that HHSC allow hospitals to earn three points when they remain above the benchmark but are below their individual hospital baseline. The association noted that this could address the issue that CMS had in QIPP when nursing homes received full credit. This approach would continue to value a hospital's

performance that remains above the benchmark but penalizes the hospital by a point for dropping below its baseline.

Two other stakeholder organizations noted support for this proposal.

HHSC Response: HHSC did not make changes in response to these comments. The quality goals for CHIRP aim to improve the median rate of performance. Maintaining average performance does not support the requirement to advance the goals and objectives of the quality strategy. CHIRP allows for flexibility in how a hospital earns its points to account for instances of high performance. A hospital that is high performing at baseline can keep its performance above average and focus its improvement efforts on another measure to earn enough points for full payment. Notably, the QIPP program does not allow for partial credit.

30. A hospital association generally supported the scoring approach and proposed HHSC consider the following for margin of error for scoring: For all measures, the stakeholder requests that HHSC include a margin of error when comparing an individual hospital's performance to its previous year's baseline and to the benchmark, if applicable. This approach could help address high performers that have minor fluctuations in performance year-over-year.

    Two other hospital associations noted support for this proposal.

    HHSC Response: HHSC did not make changes in response to these comments. The quality goals for CHIRP are to improve the median rate of performance, not to maintain average performance. An allowable margin of decline introduces unnecessary program complexity and makes the program harder for hospitals to understand. CHIRP allows for flexibility in how a hospital earns its points to account for instances of high performance, rather than implementing an allowable margin of decline.

31. A stakeholder requested HHSC allow high achievers to receive full payment for maintaining performance.

    HHSC Response: HHSC did not make changes in response to this comment. CMS requires that measures demonstrate improvement at the provider and state-level over time. This would include providers that are performing above the state average. Additionally, the process measures have a goal calculation method of improvement-over-self (IOS), which considers the amount of improvement that a provider can make toward perfect achievement.

Measures with Actual/ Expected (A/E) Ratios

32. Eighty-two percent of survey respondents agreed with the proposed achievement targets for Component 3 **measures with actual/expected ratios.** A stakeholder suggested that full achievement should be at 1, since facility actual rate is what was expected.

    HHSC Response: HHSC did not make changes in response to this comment. Providers fully achieve when performance is below 1 under current requirements, so long as performance is also better than the baseline. HHSC does expect providers to continue to improve over their baseline to fully achieve the measure until performance is below 0.8.

Measures without Benchmarks

33. Forty-one percent of survey respondents agreed with the proposed achievement targets for Component 3 **measures without benchmarks** (i.e., improvement-over-self only measures).

    A stakeholder noted that the option for high performing hospitals at baseline should be provided in addition to the improvement over baseline as payment achievement option. Another stakeholder expressed that with a 10% gap closure over baseline with hospitals that are already high performers that are in the 90th percentiles, the improvement-over-self will not be sustainable long-term as there is minimal room for improvement. It would be ideal that these would change from improvement-over-self only to benchmarks in later years.

    Another stakeholder expressed appreciation for the use of improvement-over-self targets since the proposed measures are new to CHIRP urban facilities and many providers will be starting from ground zero. The stakeholder suggested two revisions:

    1. The stakeholder suggested HHSC change the performance measures for all improvement-over-self measures to account for high performing providers, noting that high performing providers may have greater difficulty meeting the performance thresholds established by HHSC. Therefore, high performing providers (as compared to other providers in their class) should be rewarded for maintaining high performance as opposed to performance over self.
    2. For the proposed achievement target for process measures requiring 10% closure over baseline, the stakeholder recommended HHSC consider an annual incremental increase similar to the way Delivery System Reform Incentive Payment (DSRIP) was implemented. For example, DSRIP DY7 had a 2.5% gap closure for Category C measures which increased in subsequent reporting years.

HHSC Response: HHSC did not make changes in response to this comment. Improvement-over-self (IOS) calculations naturally take high performance into account, as they are based on closing the gap from baseline towards perfect. As a provider nears perfect performance, less improvement is needed to achieve the gap closure goal.

34. A stakeholder requested HHSC allow high achievers to receive full payment for maintaining performance for all process measures.

    HHSC Response: HHSC declines to make changes in response to this comment. CMS requires that measures show improvement at the provider and state levels over time, which includes providers that are performing above the state average. Additionally, the process measures have a goal calculation method of improvement-over-self (IOS), which considers the amount of improvement that a provider can make toward perfect achievement. Since process measures are within the control of the hospital, high performance is a reasonable expectation over time.

35. Seven stakeholders proposed lowering the achievement targets.

    HHSC Response: HHSC did not make changes in response to this comment. Concerns with the level of difficulty of the measures have been addressed through lowering the total points needed for the top payment tier.

36. A stakeholder requested HHSC reduce the goals to half of their current threshold since the metrics are being received by hospitals close to the first performance year and to reflect that providers will really only have the second half of the year to truly improve performance. They suggested another option would be to push the pay for performance measurement period to the second half of 2024 to allow for report development, performance improvement planning, resource deployment, and workflow optimization prior to the measurement period.

    HHSC Response: HHSC did not make changes in response to this comment. Baselines are based on calendar year (CY) 2023 data, while performance is based on CY 2024 data. The performance period has not yet begun, so providers have a full year to achieve performance.

Reporting Frequency

37. Sixty-eight percent of survey respondents agreed with the proposed Component 3 **pay for performance once a year reporting and payment.** Stakeholders who disagreed with the proposed reporting frequency preferred twice a year reporting and payment. For example, one stakeholder suggested

having two reporting periods in the first year – one with baseline information for 2023 and the first half of 2024, and a second reporting period tied to pay for performance for the second half of 2024. After the first year, the stakeholder agrees with a single year of reporting with all 12 months driving incentives.

HHSC Response: HHSC did not make changes to reporting frequency in response to these comments. Twice a year reporting and payment would require two overlapping 12-month performance periods (e.g., (A) July 2023 – June 2024 and (B) January – December 2024) and two baseline periods (e.g., (A) July 2022 – June 2023 and (B) January – December 2023). Reporting baseline alone during Round 1 reporting would not be eligible for a Component 3 payment as it would be considered pay-for-reporting.

Payment frequency will be determined by the TAC.

38. Two stakeholders expressed concerns about potential financial challenges due to the timing between the submission of IGT and when the incentive payment is received.

HHSC Response: Payment frequency will be determined by the TAC.

39. Several stakeholders expressed concern with the baseline and performance period timeframes. They suggested using CY 2024 as the baseline period and CY 2025 as the performance period. Several stakeholders noted concerns that some of the proposed measures have not been implemented yet, so they are not currently collecting data on those measures.

HHSC Response: HHSC did not make change in response to these comments. HHSC understands that some hospitals may have not implemented requirements associated with several measures during the CY 2023 baseline period. However, low baseline rates will not negatively affect provider performance or payments in subsequent years.

Component 3 General Comments

40. A stakeholder requested providing actual CPT codes that are allowable for measures, which would be helpful for auditing purposes.

HHSC Response: HHSC provides the measure source to ensure that any changes made to CPT codes or measure specifications are always current. HHSC expanding upon a measure steward's specifications may create opportunities for the information being outdated and not in line with measure steward updates. For this reason, HHSC will continue to provide links to the original measure specifications source.

41. A hospital association proposed HHSC consider incorporating "extra credit points." The stakeholder proposed that an individual hospital's total points would remain the same (e.g., 18 points), but a hospital could earn "extra credit points" for engaging in additional measures or set of activities defined by HHSC that help explore a certain area of need, test a new theory or approach, or bridge a data gap.

    The stakeholder identified possible optional quality activities:

    - Hospital reports on HHSC-specified measures with measure stewards that HHSC wants to assess for future quality programs. Example: Asthma or all-cause readmissions for children's hospitals.

    - Hospital reports additional detail about a measure or area of need that HHSC wants to understand more fully. Examples: Follow-up 30-days after ED mental health visits - HHSC may want the hospital to do an assessment on the barriers a family experiences to completing a follow-up to help target strategies to reduce the most impactful barriers. Depression Screening and Follow-Up Plan: HHSC may want the hospital to also measure the number of children screened for suicide risk as required by the Joint Commission to determine the impact of adding the depression screening for the STAR population seen in children's hospitals.

    Another stakeholder noted support of this extra credit proposal and noted there is value in HHSC supporting optional quality activities that are responsive to local needs, while also serving as a way for HHSC to assess certain measures for potential future statewide use.

    HHSC Response: HHSC did not make changes in response to these comments. CMS does not allow pay-for-reporting as stated in the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver STC 29: payment cannot "be conditioned upon completion of submission of a report." Extra credit points for optional quality activities like reporting on specific measures or submitting assessments would be considered pay-for-reporting or structure measures. CMS also has not supported structure measures in a Texas pay-for-performance arrangement. Additionally, other CHIRP components already allow reporting as a condition of participation. The CHIRP program must advance the goals and objectives of the state's quality strategy as required by 42 CFR 438.6(c)(2)(ii)(C). Directed payment programs authorized under 42 C.F.R. §438.6(c), including CHIRP, are expected to continue to evolve over time so that the program can continue to advance the quality goal or objective the program is intended to impact.

42. A stakeholder expressed significant concerns with the administration of the program performance tiers in the Component 3 program regarding the hospitals they represent. The stakeholder noted significant barriers for providers to report and perform on several of the new pay for performance measures and it may be difficult if not impossible for these providers to hit full achievement and earn the CHIRP dollars that are critical to their continued operation. The stakeholder noted this would have a disproportional impact on the hospital they represent, which is located close to the Texas-Mexico border in a provider shortage area where private hospitals are functioning as the safety net for the heavy Medicaid and uninsured population and is heavily dependent on programs such as CHIRP to allow it to continue providing high quality care to its patients. The stakeholder described that their hospital is not in a position to lose any of their projected funding from Component 3 and requests that HHSC either modify its performance goals/payment tiers to account for this issue or treat their hospital and similarly situated hospitals as rural facilities solely for the purposes of CHIRP reporting and payment.

    HHSC Response: HHSC did not make changes in response to these comments. Hospital classifications are defined in the TAC and are outside the scope of the quality requirements. The purpose of the proposal is to pursue modifications to the CHIRP payments beginning with the SFY 2025 rating period to promote advancing the quality goals and strategies the program is designed to advance. HHSC has not made significant modifications to CHIRP since its inception in SFY 2022. Directed payment programs authorized under 42 C.F.R. § 438.6(c), including CHIRP, are expected to continue to evolve over time so that the program can continue to advance the quality goal or objective the program is intended to impact. Therefore, HHSC is proposing these modifications for SFY 2025.