

# October DY6 Quantifiable Patient Impact (QPI) Reporting Companion Document

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While some of the content below repeats information from the October DY6 Reporting Companion Document, this document provides important details regarding QPI reporting that are not included elsewhere. Please read both documents carefully to ensure that QPI reporting is completed correctly.

### **General Tips for Using the New DY6 QPI Template:**

- Paste Values! You should use the Paste Values Function not only for entering the encounter data in Step 6 of the QPI template, but also if you copy and paste from one cell to another. Using paste values will allow you to edit the new text in the cell.
- Users have had difficulty generating tabs in Step 4 of the Template when they are working on a Mac computer. We recommend utilizing a PC for the template to function smoothly and properly.
- A Template Progress tab helps providers to see if the template is complete and ready to submit to HHSC, or which section of the template may be outstanding.
- The provider may save as they work through the template. HHSC is no longer requiring the template to be completed in one sitting.
- Please review the companion. There are many new aspects of DY6 QPI reporting -- MLIU QPI, P4R, exemption from encounter/individual reporting. Please review the Companion Document carefully!
- Any DY5 projects that combined under a new Project ID for DY6 will be found under the new DY6 Project ID.
- Changes in pre-DSRIP baselines or data end/start dates validated by independent assessors and confirmed by HHSC have been incorporated into the data seeding files for October DY6 reporting templates. Please contact HHSC via the waiver mailbox if you believe that the seeded data is incorrect.

### **Reporting on QPI**

The QPI Reporting Template is required when reporting achievement for designated DY5 QPI metrics (marked "Yes" in the QPI Metric cell in the reporting system) and DY6 QPI metrics (M-1.1 and M-2.1). The template is also required to fulfill the metric-level Semi-Annual Reporting (SAR) requirements in October.

### **Semi-Annual Reporting (SAR)**

Every October, as part of the metric-level progress update required for Semi-Annual Reporting (SAR), HHSC will require all projects with a designated QPI metric in the demonstration year (DY) to submit the number of individuals served/ encounters provided in the DY due to the DSRIP project via a QPI Reporting Template. Providers who reported achievement of DY6 QPI milestones in April 2017 will still be required to update their QPI data in October 2017 for SAR purposes.

### **Metric Achievement**

While providers are required to submit Semi-Annual Reporting (SAR) progress updates in the QPI template in October reporting, they may report achievement of metrics for payment in *either* April or October of the demonstration year (DY). Alternatively, in October, if the metric is not fully achieved by September 30, a provider may request to carry forward the metric to the subsequent demonstration year.

QPI metrics (like all Category 1 or 2 metrics and Category 3 milestones) should only be reported for achievement if the provider is confident that the metric was fully achieved during the [allowable dates of service](#) and can be clearly demonstrated.

## Allowable Dates of Service

Only individuals served/ encounters provided during the demonstration year (DY), or during the DY and the subsequent DY if reporting as carryforward, may be counted as QPI. While QPI metrics may be achieved in a subsequent demonstration year as carryforward, they may not be achieved in an earlier demonstration year. For example, if a project includes a QPI metric in DY3 and serves more individuals or provides more encounters in DY3 than included in the DY3 goal, the additional individuals/encounters from DY3 cannot be counted toward the DY4 QPI goal. Early achievement of QPI metrics is not allowed in order to ensure that each project's impact on patients continues to grow throughout the waiver demonstration period.

The allowable dates of service for QPI metrics are as follows:

Metric DY	Not Reporting as Carryforward	Reporting as Carryforward
DY3	Oct. 1, 2013 – Sep. 30, 2014	Oct. 1, 2013 – Sep. 30, 2015
DY4	Oct. 1, 2014 – Sep. 30, 2015	Oct. 1, 2014 – Sep. 30, 2016
DY5	Oct. 1, 2015 – Sep. 30, 2016	Oct. 1, 2015 – Sep. 30, 2017
DY6	Oct. 1, 2016 – Sep. 30, 2017	Oct. 1, 2016 – Sep. 30, 2018

**For October DY6 reporting, the services end date for QPI individuals/encounters is September 30, 2017 for both DY5 carryforward reporting and DY6 reporting.** Individuals/encounters submitted with dates after September 30, 2017, cannot be counted as QPI for the October DY6 reporting period.

Please note that, if a QPI metric is carried forward for late achievement, the provider will need to demonstrate achievement of the carryforward metric before the subsequent year's QPI metric is approvable. Providers must report achievement of their DY5 QPI metric (or at least one of their DY5 QPI metrics, if the project has multiple QPI metrics) OR forfeit their DY5 QPI metric before they are eligible to report achievement of their DY6 Total or MLIU QPI metrics.

## Multiple Metric Goals

All goals in a metric must be achieved to be eligible for DSRIP payment (e.g., if a metric has two goals - expanding clinic hours and providing 200 visits - both the expanded hours and 200 visits would need to be completed). Providers should not report a metric as achieved until all goals are fully completed. Please note that this applies to DY3-5 QPI metrics. DY6 QPI and MLIU QPI metric goal language has been standardized in order to focus on individuals served or encounters provided for the project.

- For QPI metrics that include a QPI goal as well as another goal that is not a percentage (e.g., establishing a specialty care clinic), both goals must be completed to be eligible for metric payment. **The provider must report on both aspects of the goal to be eligible for payment.**
- For QPI metrics that include a percentage goal similar to the QPI goal (e.g., percent of target population served, percent increase in number served) as well as the numeric QPI goal, the numeric goal is the primary goal, while HHSC may accept variances in the percentage goal with explanation (e.g., lower than expected denominator size for target population). Please note that these variances do not apply to percentage goals that are part of a QPI designated metric, but not directly related to QPI (e.g., percent of sites with registry functionality, percent of primary care clinics using medical home model). **The provider must report on both aspects of the goal to be eligible for payment.**

- For 4-Year projects with QPI metrics that require a Medicaid/ Low Income Uninsured (MLIU) QPI in addition to the total QPI (designated by a "Yes" in the Medicaid/ Low Income Uninsured cell), both the total QPI goal and the Medicaid/ Low Income Uninsured QPI numeric goal must be met.

While the QPI Reporting Template will generally serve as the only required supporting documentation needed to demonstrate achievement of the QPI-related goal of a metric (see the [Project Area Level Guidance section](#) for exceptions), providers will need to submit additional supporting documentation to support other non-QPI related goals included as part of QPI-designated metrics. Also, providers should retain backup documentation to support achievement of all goals, which is subject to compliance monitoring or other audit.

## **Determining QPI**

### **Defining Individuals and Encounters**

HHSC has received a variety of questions regarding the individuals and types of encounters that can be counted towards QPI. The [General Guidance section](#) includes broad information about defining individuals and encounters that applies to all or most projects and should be reviewed by all providers. HHSC has also attempted to address QPI as it relates to certain project areas for which we have received many questions. This information can be found in the [Project Area Level Guidance section](#).

Providers should base their QPI submission on the information included in these sections, as well as their metric language and project narrative. Approved changes to pre-DSRIP baselines apply to all years. Changes in pre-DSRIP baselines or data end/start dates validated by independent assessors and confirmed by HHSC have been incorporated into the data seeding files for October DY6 reporting templates.

### **General Guidance**

#### *Individuals:*

- Individuals must have received a service consistent with the project during the allowable dates of service to be counted.
- For QPI individuals, all persons served through the project during the allowable dates of service should be included, even if those same individuals received services through the project in a prior year.
- Dual eligible patients (Medicare/Medicaid) can be counted towards Medicaid/ Low-Income Uninsured (MLIU) QPI.
- Patients with Medicare, CHIP, insurance through the exchange, or a local coverage option who are below 200% of the Federal Poverty Level (FPL) may be counted toward the Low-Income population.
- Individuals identified as Low-Income or Uninsured should be at or below 200% of FPL or uninsured.
- Providers may base their MLIU QPI on an individual's payer status at the time of the first project encounter. Therefore, if a client was served through the DSRIP project and was counted as MLIU, and their payer status changed during the waiver, they can continue to be counted as MLIU. If a client changes payer status from Medicaid to uninsured during the DY, the client should be counted as Medicaid.

#### *Encounters:*

- A provider may only count encounters if they are providing the visit. They cannot count the encounter if they are simply making a referral, unless this is specifically included as part of their metric language.
- Patient contacts can only be considered as unique QPI encounters wherein a unique service is delivered. Often this can be thought of as a unique billable event. For example, a registered nurse encounter typically is not a

service distinct from “visit with physician”, so it is considered part of the same visit/service/encounter and counted as one encounter for QPI purposes.

- Telephone calls (including outgoing) may only be counted as a separate QPI events if the call is clinical in nature, the call is specifically related to a project with a goal of telephone outreach, calls are specified in the approved project's metric language / narrative, and the call was completed (e.g., the caller reached the intended person - not just their voicemail - and spoke with them about their care). Outgoing calls that would be appropriate would be a follow-up call to check on a patient's status with symptoms to determine if additional care is needed, a call completed through a nurse advice line created as part of the project, or a follow-up call with a patient who called into the urgent medical advice line. Telephone calls generally are not considered as QPI for other types of projects, such as expanding access to primary or specialty care. Administrative calls, such as satisfaction with services or follow-up as to whether a patient went to the ED or PCP, would not be appropriate, as they are still part of the same initial encounter. Appointment reminder calls also would not count as QPI encounters.
- Text and email messages generally are not allowable QPI encounters, unless specifically mentioned in a project's metric language/ narrative.
- Group visits may be counted as multiple encounters equal to the number of individuals targeted by the project that attend the group visit.

## Project Area Level Guidance

While not all project options are specifically addressed below, HHSC has attempted to include additional information on those for which we have received the most questions. (See the [Recommended QPI Metrics by Project Option](#) document for recommended QPIs for project areas not listed below.)

### *1.1: Expand primary care capacity*

Recommended QPI metric: Primary care encounters provided.

- Generally, encounters should only include office visits. They should not include pharmacy visits, lab visits, reminder or follow-up phone calls, etc. that result from or are related to the office visit.
- Visits may include prevention services such as screening for chronic disease, monitoring of disease state markers (e.g. cholesterol levels), and vaccinations.
- Encounters outside of the clinic as part of outreach may be counted towards QPI if they mirror the types and levels of encounters that would be allowable if conducted in the clinic.

### *1.2: Increase training of primary care workforce*

Recommended QPI metric: Primary care encounters provided by residents, trainees, or additional staff (depending on project area option)

- See [1.1](#).

### *1.3: Implement a chronic disease management registry*

Recommended QPI metric: Individuals managed in registry

- The registry should be designed to allow for the tracking of patient interactions and clinical studies (e.g. lab reports, patient histories) as necessary and pertinent to the DSRIP project. Individuals counted towards QPI should be in the registry and have received some level of interaction during the demonstration year.

### *1.6: Enhance urgent medical advice*

Recommended QPI metric: Urgent care encounters provided

- See [1.1](#).

### *1.9: Expand specialty care capacity*

Recommended QPI metric: Specialty care encounters provided.

- Encounters should generally only include office visits. They should not include pharmacy visits, lab visits, reminder or follow-up phone calls, etc. that result from or are related to the office visit.
- In most cases, no more than one encounter per unique patient per day should be counted unless a patient saw two different specialists that day for two separate specialty care visits (e.g. a cardiologist and a psychiatrist).

### *1.10 Enhance performance improvement and reporting capacity*

Recommended QPI metric: Individuals positively impacted by improvements

- QPI should equal the number of individuals who experience the improvement(s) in the demonstration year. Individuals must have received some level of service during the demonstration year to be counted.
- The QPI may be equivalent to the total number of individuals served during the demonstration year, or it may be limited to a subset of those served. If the project implemented improvements across the provider's entire system, the QPI would equal the number of patients served by the system in the demonstration year. If the project impacted only patients in one department, for example, the QPI would be limited to the patients served by that department.
- In addition to submitting the QPI Reporting Template showing the number of unique individuals impacted, the provider should also submit documentation that demonstrates that the proposed improvement was achieved.

### *1.12: Enhance service availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care*

Recommended QPI metric: Individuals receiving community-based behavioral health/ substance abuse services

- For a QPI metric that has a goal of providing behavioral health and substance abuse services, a screening/assessment does not constitute a service. A diagnostic assessment and a diagnosis review would count as a service because the client is already in care. These would have to be updated at regular intervals for all consumers receiving services.

### *2.1: Enhance/ expand medical homes*

Recommended QPI metric: Individuals receiving care under patient-centered medical home model

- Individuals must have received some level of service during the demonstration year to be counted towards QPI.

### *2.2: Expand chronic care management models*

Recommended QPI metric: Individuals receiving care under chronic care model

- Individuals must have received some level of service during the demonstration year to be counted towards QPI.

### *2.3: Redesign primary care*

Recommended QPI metric: Individuals positively impacted by improvements

- See [1.10](#).

### *2.4: Redesign to improve patient experience*

Recommended QPI metric: Individuals positively impacted by improvements

- For a variety of reasons, it is often not possible to survey every patient seen in a demonstration year to determine whether their personal satisfaction increased. Provided a sampling method that is statistically sound (e.g., a sufficient number of individuals were sampled for the results to be statistically significant, the sampling was random, etc.) is used, individuals that were not surveyed can be counted as those impacted by improvements if they would be expected to also have experienced an improvement in satisfaction during the demonstration year (e.g., they were part of the group targeted by the improvements).
- Individuals must have received some level of service during the demonstration year to be counted.
- In addition to submitting the QPI Reporting Template showing the number of unique individuals impacted, the provider should also submit documentation that demonstrates that there was an improvement in patient satisfaction and an explanation of the sampling method if applicable.

### *2.5: Redesign for cost containment*

Recommended QPI metric: Individuals positively impacted by improvements

- See [1.10](#).

### *2.8: Apply process improvement methodology to improve quality/ efficiency (except 2.8.11)*

Recommended QPI metric: Individuals positively impacted by improvements

- See [1.10](#).

### *2.10: Use of palliative care programs*

Recommended QPI metric: Palliative care consults provided

- Consults, as well as additional visits (post consults), may be counted toward QPI if these are included in the project.

### *2.11: Conduct medication management*

Recommended QPI metric: Number of unique individuals receiving medication management services

- Medication management activities may include providing and discussing written materials related to medications with patients to ensure that they understand the purpose of various medications, when they should be taken, consequences of drug omission, precautions related to over-the-counter drugs, toxic side effects, etc.

### *2.15: Integrate primary and behavioral health care services*

Recommended QPI metric: Number of unique individuals receiving integrated physical and behavioral health care

- To be counted towards QPI, an individual must be under the care of both a primary care and behavioral health care provider. Behavioral health services must be provided by a behavioral health provider, like a psychiatrist, psychologist, licensed clinical social worker (LCSW), licensed professional counselor (LPC), or licensed marriage and family therapist (LMFT). Services provided by non-behavioral health providers, even if related to behavioral health, do not meet the criteria for a behavioral health encounter.

## Running the Numbers

### What is QPI?

QPI templates are intended to capture the additional individuals served or encounters provided in a given demonstration year due to the DSRIP project (compared to the service volume that was provided before the DSRIP project was implemented, otherwise known as the pre-DSRIP baseline). QPI metrics are important to help show the impact of DSRIP on healthcare access and quality in Texas, particularly for Medicaid and low-income uninsured individuals.

### Determining the Pre-DSRIP Baseline

A general goal of DSRIP is to show increased capacity and enhanced services compared to what existed prior to DSRIP. To determine the level of service that existed prior to the implementation of the DSRIP project, the provider must determine the pre-DSRIP baseline. Every QPI metric will have one (and only one) pre-DSRIP baseline. While the QPI will change from one DY to the next, the pre-DSRIP baseline will not change.

The pre-DSRIP baseline should be calculated based on the number of individuals served or encounters provided in the year prior to the year the DSRIP project started serving individuals. Depending on when a DSRIP project began serving individuals, the pre-DSRIP baseline year might be based on DY1 or DY2 service volume (for providers who have a DY3 QPI metric) or on DY3 service volume (for providers who did not begin seeing clients as part of DSRIP until DY4).

For projects that provide a new program or service (e.g., the opening of a new primary care clinic when no clinics previously existed), the pre-DSRIP baseline would be 0 individuals or encounters. For projects that expand an existing program or service (e.g., increasing hours and staff at an existing primary care clinic), there is a pre-DSRIP baseline greater than 0 that the project seeks to build on (e.g., the number of encounters provided at the clinic prior to the increase in hours and staff). The pre-DSRIP baseline provides the comparison point over the life of the waiver for the level of services provided in any demonstration year. The QPI template will subtract the pre-DSRIP baseline from the total number of encounters or individuals served in a demonstration year to get to the incremental impact of DSRIP. A project's demonstration year goal is the increment above the pre-DSRIP baseline.

The pre-DSRIP baseline should reflect the QPI metric:

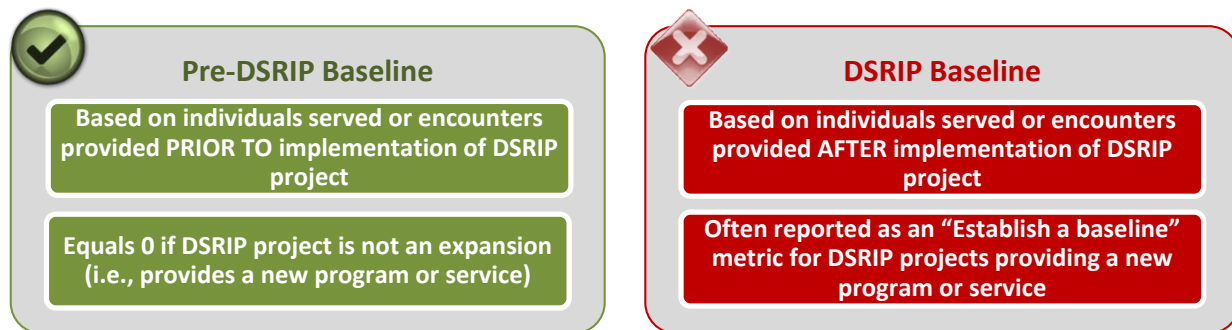
- If the project's QPI metric is individuals-based, the pre-DSRIP baseline will be based on the number of unique individuals served during the pre-DSRIP period. If the project's QPI is encounters-based, the pre-DSRIP baseline will be calculated based on the number of encounters provided during the pre-DSRIP period.
- The pre-DSRIP baseline should also reflect the project's goal. If, for example, a provider already operates a primary care clinic that serves patients of all ages, and the goal of the project is to increase primary care capacity for the community by hiring an additional physician, the pre-DSRIP baseline would be the number of primary care clinic office visits provided in the year prior to the hiring of the new physician. If, however, the goal of the project is to increase primary care capacity for children by hiring a pediatrician, the provider may



choose to base their pre-DSRIP baseline on the number of primary care clinic office visits provided to *children* in the year prior to the hiring of the new physician.

HHSC has already calculated and the provider has already verified the pre-DSRIP baselines for the DY6 Total QPI and MLIU QPI metrics. The MLIU QPI pre-DSRIP baseline was calculated by multiplying the Total QPI pre-DSRIP baseline by the earliest reported MLIU percentage achievement during DY3-5. Projects that had MLIU-specific QPI metrics during DY3-5, will have the same pre-DSRIP baseline for DY6 MLIU QPI.

When discussing QPI, it is important to distinguish between a pre-DSRIP baseline and a DSRIP baseline. In contrast to pre-DSRIP baseline, which measures service volume PRIOR to DSRIP project implementation (i.e., prior to serving individuals), a DSRIP baseline measures service volume AFTER the project starts serving individuals (typically in the first year of implementation). In their metrics, some providers refer to "establishing a baseline" in their first year of project implementation and increasing the number of individuals served or encounters provided by X% over the baseline in subsequent years. For example, a project may have a DY2 (non-QPI) metric to establish



the first year's number of visits for a new primary care clinic (1000 visits), and then have QPI metrics in DY3-5 to increase that volume by 200 additional visits each year to 1200, 1400 and 1600 visits per year, respectively. In this case, since the 1000 visits in DY2 were provided as part of the DSRIP project, they are considered a DSRIP baseline, and are not the same as the pre-DSRIP baseline that HHSC is requesting when providers report on QPI metrics.

### Total and MLIU QPI Calculation

To determine the number of individuals served or encounters provided in a given demonstration year (DY) that are a result of the DSRIP project (the QPI), the template will subtract the Pre-DSRIP baseline of individuals served/ encounters provided from the total individuals served/ encounters provided in the DY.



HHSC has included some examples of how to calculate QPI below.

**QPI Example 1 (New Project - Encounters):** A provider is opening its first primary care clinic as part of their DSRIP project during DY2. Consequently, their pre-DSRIP baseline is 0 visits. The clinic provided 1,000 visits in DY2 (its first year of operation as a DSRIP project - so a DSRIP baseline), and the QPI goals are to provide an additional 400 visits

over DY2 in DY3, 600 visits over DY2 in DY4 and 800 visits over DY2 in DY5. Therefore, the project's QPI goals are 1,400 visits in DY3, 1,600 visits in DY4, and 1,800 visits in DY5. For DY6, the provider should maintain their DY5 QPI encounter levels. In order to meet their Total QPI metrics, the provider would need to provide 1,400 total visits in DY3, 1,600 in DY4, 1,800 in DY5, and 1,800 in DY6.

Total QPI			
DY	Pre-DSRIP Baseline	QPI Encounters	Total Encounters
DY3	0	1,400	1,400
DY4	0	1,600	1,600
DY5	0	1,800	1,800
DY6	0	1,800	1,800

Since this is a new project, the pre-DSRIP MLIU baseline is zero. HHSC calculated the DY6 MLIU QPI goal by multiplying the DY5 MLIU percentage goal by the DY6 QPI goal (1,800). In this example, the MLIU percentage goal was 50%. In order to meet the DY6 MLIU QPI goal, the provider would need to provide 900 MLIU encounters over the pre-DSRIP MLIU baseline of zero encounters in DY6.

MLIU QPI			
DY	Pre-DSRIP Baseline	QPI Encounters	Total Encounters
DY6	0	900	900

**QPI Example 2 (Expansion Project - Encounters):** Through their DSRIP project, a provider will expand primary care capacity at an existing clinic by hiring new staff beginning in DY3. The provider provided 1,000 visits in DY2 (the year prior to the clinic expansion), which is the pre-DSRIP baseline. The provider's QPI **goals** are that the new staff will provide an additional 1,400 visits in DY3, an additional 1,600 visits in DY4, an additional 1,800 visits in DY5, and an additional 1,800 visits in DY6. In order to meet their Total QPI goals, the provider must provide a total of 2,400 visits at the clinic in DY3, 2,600 total visits in DY4, 2,800 total visits in DY5, and 2800 total visits in DY6.

Total QPI			
DY	Pre-DSRIP Baseline	QPI Encounters	Total Encounters
DY3	1,000	1,400	2,400
DY4	1,000	1,600	2,600
DY5	1,000	1,800	2,800
DY6	1,000	1,800	2,800

HHSC calculated the MLIU QPI pre-DSRIP baseline by multiplying the earliest MLIU percentage achievement on record for the project by the Total QPI pre-DSRIP baseline. In this example, the earliest MLIU percentage achievement on record of 40% was multiplied by the Total QPI pre-DSRIP baseline (1,000), for a pre-DSRIP MLIU baseline of 400 encounters. The MLIU QPI goal was determined by multiplying the Total QPI goal (1,800) by the DY5 MLIU percentage goal (50%). In order to meet the DY6 MLIU QPI goal, the provider would need to provide 900 MLIU encounters over the pre-DSRIP MLIU baseline of 400 encounters, for a total of 1,300 MLIU encounters in DY6.

MLIU QPI			
DY	Pre-DSRIP Baseline	QPI Encounters	Total Encounters
DY6	400	900	1300

**QPI Example 3 (New Project - Individuals):** A new diabetes care management program is being established through DSRIP, so the pre-DSRIP baseline is 0 individuals receiving care under the chronic care model. Through DSRIP, the project plans to serve 50 patients in DY2 (a non-QPI metric), and enroll 50 more patients in the program in each subsequent DY, making the QPI goals 100 individuals receiving care under the chronic care model in DY3, 150 individuals receiving care in DY4, 200 individuals receiving care in DY5, and 200 individuals receiving care in DY6. To meet their QPI metrics, they must provide care to 100 unique individuals in DY3, 150 in DY4, 200 in DY5, and 200 in DY6.

Total QPI			
DY	Pre-DSRIP Baseline	QPI Individuals	Total Individuals
DY3	0	100	100
DY4	0	150	150
DY5	0	200	200
DY6	0	200	200

Since this is a new project, the pre-DSRIP MLIU baseline is zero. HHSC calculated the DY6 MLIU QPI goal by multiplying the DY5 MLIU percentage goal by the DY6 QPI goal (200). In this example, the MLIU percentage goal was 30%. In order to meet the DY6 MLIU QPI goal, the provider would need to serve 60 MLIU individuals over the pre-DSRIP MLIU baseline of zero individuals in DY6.

MLIU QPI			
DY	Pre-DSRIP Baseline	QPI Individuals	Total Individuals
DY6	0	60	60

**QPI Example 4 (Expansion Project - Individuals):** A diabetes care management program is being expanded through DSRIP. Prior to DSRIP, in DY2, a hospital had a care management program that served 50 individuals with diabetes each year (the pre-DSRIP baseline). Beginning in DY3, the hospital intends to enroll 50 additional patients to the program in each DY as part of their project, making the QPI goals 50 additional individuals served in DY3, 100 in DY4, and 150 in DY5. In DY6, the provider will maintain the goal of 150 additional individuals served. To meet the QPI metrics, the provider will have to serve a total of 100 individuals in DY3, 150 in DY4, 200 in DY5, and 200 in DY6.

Total QPI			
DY	Pre-DSRIP Baseline	QPI Individuals	Total Individuals
DY3	50	50	100
DY4	50	100	150
DY5	50	150	200
DY6	50	150	200

HHSC calculated the pre-DSRIP baseline for the DY6 MLIU QPI for this project by multiplying the earliest MLIU percentage reported on record (30%) by the Total QPI pre-DSRIP baseline, 50. The MLIU QPI pre-DSRIP baseline is 15 individuals. The DY6 MLIU QPI goal is the product of the DY5 MLIU percentage multiplied by the DY6 QPI goal (150). In this example, the MLIU percentage goal was 30%. In order to meet the DY6 MLIU QPI goal, the provider would need to serve 45 MLIU individuals over the pre-DSRIP MLIU baseline of 15 individuals, for a total of 60 individuals in DY6.

MLIU QPI			
DY	Pre-DSRIP Baseline	QPI Individuals	Total Individuals
DY6	15	45	60

## QPI Reporting Template

Please note that QPI data has been updated with the most recent MSLC findings (as of 9/15/2017) for QPI metrics that were validated as achieved and confirmed by HHSC. These updates include pre-DSRIP baseline changes or any date adjustments within the allowable time frames. Providers will see the updated data in the October DY6 QPI templates and as applicable, in the online reporting system.

## How the Template Calculates QPI and Why

The QPI Template calculates QPI by subtracting the annualized pre-DSRIP service volume (either individuals served or encounters provided) entered or seeded in [Step 5](#) from the total service volume (individuals or encounters) entered in [Step 6](#). Below is a detailed explanation of how the QPI Template calculates QPI (with the example focusing on DY3 QPI) and why this is the case.

QPI is intended to measure the service volume provided during the eligible dates of service that is a result of implementing the DSRIP project. [Step 5](#) in the QPI Template is used to determine the pre-DSRIP baseline. Again, the pre-DSRIP baseline is intended to show that, prior to the DSRIP project serving individuals, the provider had the capacity to serve X number of individuals or to provide X number of encounters per year. This is the service capacity one would expect the provider to have in DY3 if the DSRIP project had not been implemented. So, for example, if a provider operates a primary care clinic with 2 PCPs and is implementing a DSRIP project to increase primary care capacity by hiring 1 additional PCP, the pre-DSRIP baseline would equal the number of encounters (in this case, office visits) provided by the 2 existing PCPs during the year prior to the hiring date of the new PCP. One would expect that at a minimum this service volume would continue after the implementation of the DSRIP project. The QPI Template will already include the pre-DSRIP baseline for DY5 metrics if QPI has previously been reported for achievement. The pre-DSRIP baselines for both DY6 Total QPI and MLIU QPI will already be seeded in the template, unless the provider has not yet reported a QPI metric for achievement.

[Step 6](#) is used to calculate the total service volume actually provided in a DY. In this step, the provider pastes records for all of the individuals served/ encounters provided in the DSRIP project during a DY (or the allowable date range). (If a provider implemented a system to track individuals served or encounters provided by the DSRIP project expansion separately from individuals served or encounters provided outside of the DSRIP project, they will need to combine these two data sources to get the total number of individuals served or encounters provided within the DY date range.) To be clear, **[Step 6](#) should include all individuals served or encounters provided relative to the project, whether the individuals/ encounters are due to the DSRIP expansion or due to capacity that was in place prior to DSRIP project implementation.** So, in the example above, in [Step 6](#), the provider should include all of the office visits provided in DY3, those that were provided by the 2 PCPs that were on staff before the DSRIP project was implemented and those provided by the newly hired PCP.

The template calculates the total DY service volume based on the data entered into [Step 6](#) in one of two ways, depending on the project's QPI grouping. If the QPI grouping is encounters, the template counts each encounter entered in [Step 6](#) that is between the allowable date range as one encounter and adds those up. If the grouping is individuals, the template takes the encounters that fall within the allowable DY date range and determines, based on patient ID, how many unique individuals were served in the DY.

The template then takes the total service volume calculated based on [Step 6](#) and subtracts the annualized pre-DSRIP service volume entered in [Step 5](#). What is left is the QPI - or the service volume due to the DSRIP project. This number must equal or exceed a project's QPI goal for the metric to be considered achieved. So, in the example above, assume the pre-DSRIP baseline was 2,000 encounters (each PCP provided 1,000 office visits during the year prior to hiring the new PCP), which was entered in [Step 5](#). Also, assume that, in DY3, the 3 PCPs together provided 3,100 office visits, and these records were pasted into [Step 6](#). The QPI (or the service volume in DY3 that can be attributed to the DSRIP project) calculated by the template would be 1,100 (3,100 total office visits minus 2,000 pre-DSRIP baseline office visits).

## Step-by-Step Instructions for Completing the Template

Note: In this section, provider actions will be in **red font**.

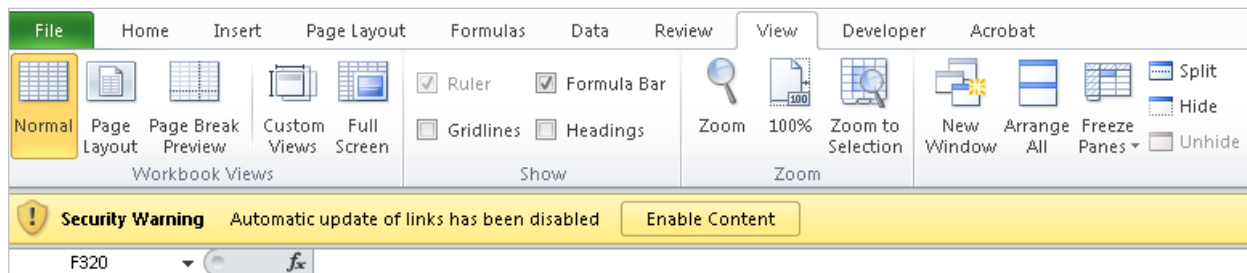
Providers should only submit one QPI Reporting Template per project. The template will serve to meet metric achievement and SAR requirements for DY5, and DY6. Any DY5 projects that combined under a new Project ID for DY6 will be found under the new DY6 Project ID.

The QPI Template relies on a number of complex calculations and macros to operate correctly and is password protected for this reason. Providers should not attempt to bypass the password or alter the template in any way. If a provider believes the template is operating or calculating incorrectly, please refer to the section of this document that addresses the step causing the issue as well as the [Troubleshooting](#) section. If your issue is not addressed in this document, please contact HHSC for assistance.

In the template, provider entries are highlighted in yellow. Blue text on the QPI summary tabs indicates information that is auto-filled based on previous provider inputs. Information entered into QPI templates submitted in previous reporting will auto-fill into the October DY6 QPI template.

Please note that the instructions below sometimes differ based on whether or not, in addition to a DY6 Total QPI and MLIU QPI metrics, a provider has a DY5 QPI metric that was carried forward. Please be sure you are following the instructions that pertain to your project's situation.

To ensure the QPI Reporting Template's interactive features work properly, be sure to **click the *Enable Macros* button** if it pops up upon opening the file (see image below). Also, confirm that workbook calculations are set to **Automatic**. (**Under the *File* tab in Excel, click *Options*, followed by *Formulas*. Under *Calculation Options*, select *Automatic for Workbook Calculation*.)**



Providers should consider running the client database query (see Step 6) prior to entering any information into the QPI template. This will expedite completion of the template.

## Instructions tab

### Step 1:

Before entering any information in the QPI Reporting Template, carefully read the *QPI Reporting Companion Document*. The Instructions tab in the QPI Reporting Template also includes general instructions included in the *QPI Companion Document* and may be used as a quick reference while completing the template. **Check the yellow box at the bottom of the Instructions tab** (see image below) to confirm you have read the *Companion Document* and that you understand that QPI data must be de-identified prior to submission to HHSC.

<input checked="" type="checkbox"/> By checking this box, I confirm that I have read the QPI Reporting Companion Document and understand that QPI data must be de-identified before submission to HHSC.
---

Checking the box on the Instructions tab will change your progress for "Instructions" on the Project Data Entry tab and the Template Progress tab from a red Incomplete to a green Complete.

PROGRESS INDICATOR	
Step 1: Instructions	Complete
Step 2: Project Selection Inputs	Incomplete
Step 3: Metric Selection Inputs	Incomplete
Step 4: Data Entry & Summary Tabs	Incomplete

## Project Data Entry tab

Providers will enter general provider, Medicaid/ Low-Income Uninsured (MLIU), and QPI metric information on the Project Data Entry tab. Providers also will enter reporting status for each DY metric eligible to report. This selection is important for generating the tabs for metric-specific data. The Metric Achievement Reporting Status should match the reporting status selected in the DSRIP Online Reporting System. For example, if the provider has selected "Reporting DYX metric achievement in DY6 reporting period" then they should select "Yes-Completed" in the reporting system, as they are reporting achievement of their metric.

### Step 2:

#### Project Information:

Under Step 2 (see image below), providers will **select their region (RHP) number**, their **TPI** and the **project's ID** from the dropdown menus. As indicated above, any DY5 projects that combined under a new Project ID in DY6 will be found under the DY6 Project ID. To report on a DY5 Carryforward metric, the provider will need **to select the RHP number, TPI and project ID for the new DY6 Project**.

2 - PROJECT INFORMATION	
Region:	<input type="text"/>
TPI:	<input type="text"/>
Provider:	<input type="text"/>
Project ID:	<input type="text"/>
Project Area:	<input type="text"/>

Making these selections will open up and complete auto-filled cells with the project's MLIU and QPI goal information. Providers with a DY3, DY4 and/or DY5 QPI metric will see the previously reported information auto-fill in the DY3, DY4 and DY5 cells. If a provider had multiple metrics in DY3-5 that combined for DY6 or if a provider

had multiple projects that combined for DY6, all historical information will be auto-filled in the template. The layout is slightly different for DY6 in order to accommodate combined metrics and combined projects. See image below for an example of the layout of combined projects.

% of Individuals Served that are Medicaid/Low-Income Uninsured

RHP 1_751281410.2.100		% Medicaid	% Low-Income Uninsured	Total % MLIU	Description of MLIU (payer sources income levels etc.)
<a href="#">DY3</a>	MLIU % Goal:	25.00%	30.00%	55.00%	We did not have a strong way to predict the patient mix that would end up utilizing this program, thus our estimates were conservative (low).
	MLIU % Actual:	27.20%	69.40%	96.60%	
<a href="#">DY4</a>	MLIU % Goal:	25.00%	30.00%	55.00%	We have actively worked to increase the MLIU proportion of the participant pool. Henderson County has a very high rate of persons at or below the federal poverty guidelines.
	MLIU % Actual:	9.80%	89.20%	99.00%	
<a href="#">DY5</a>	MLIU % Goal:	25.00%	30.00%	55.00%	We have actively worked to increase the MLIU proportion of the participant pool. Henderson County has a very high rate of persons at or below the federal poverty guidelines.
	MLIU % Actual:	25.00%	61.00%	86.00%	
<b>RHP 1_751281410.2.3</b>					
<a href="#">DY3</a>	MLIU % Goal:	30.00%	25.00%	55.00%	we underestimated the numbers of MLIU individuals as we did not have any pre-established methodology for doing such an estimate.
	MLIU % Actual:	22.50%	67.40%	89.90%	
<a href="#">DY4</a>	MLIU % Goal:	30.00%	25.00%	55.00%	We have increased our preference for MLIU persons within available project slots, which has consequently increased these percentages commensurately.
	MLIU % Actual:	17.80%	79.40%	97.20%	
<a href="#">DY5</a>	MLIU % Goal:	30.00%	25.00%	55.00%	We find we are seeing more LIU individuals than anticipated, and fewer Medicaid enrolled persons. Andrews Center is working to provide assistance where possible to help these LIU persons who qualify to file the required documents to enroll.
	MLIU % Actual:	26.00%	59.00%	85.00%	

Medicaid/ Low-Income Uninsured (MLIU) Percentages:

Enter the percentage of Medicaid and Low-income/uninsured population your project has served in the open % Medicaid and % Low-Income Uninsured. This information for your project should be updated each time you report QPI, which must be at least once each demonstration year. The percentages should reflect the individuals served by your project between the encounter dates you are using to report that DY's QPI (i.e., dates entered in [Step 7](#)).

- Projects with a DY5 Carryforward QPI Metric: Providers who requested carryforward for a DY5 QPI metric will need to report their DY5 MLIU percentages if they are reporting any DY5 Carryforward metric achievement. If the provider is forfeiting all remaining DY5 Carryforward metrics, the provider will not need to complete Step 2.
- Be sure to review the instructions under [Step 7](#) for directions on how to determine the date ranges for MLIU percentages.

The combined MLIU percentage will be calculated for you. Enter a description of the MLIU for the DY5 QPI metric that includes the basis of your percentage: payer sources that are included, income levels, and other helpful information. If your total MLIU percentage is more than 20% lower than the total MLIU goal, the combined MLIU will be red, and you will need to include an explanation of why this is the case in the description box. Descriptions may not include "Not Applicable" and should indicate the population you are counting in your MLIU percentages (i.e. CHIP, Medicaid, Dual-eligibles, uninsured, self-pay, etc.)

For the DY6 Total QPI and MLIU QPI milestones, enter the Medicaid actual and LIU actual percentages. The template will calculate the total MLIU percentage for you. For the DY6 Description of the MLIU population, the provider will check all boxes that apply to the MLIU population included in the QPI count. If the provider checks, Other, the provider will need to fill out the open description field in cell H62 in order for Step 2 to be complete.

<a href="#">DY6</a>	MLIU % Goal:	24.98%	29.98%	54.95%	
	MLIU % Actual:			0.00%	
DY6 Description of MLIU:	Medicaid <input type="checkbox"/>	Dual Eligible (Medicaid and Medicare) <input type="checkbox"/>	CHIP <input type="checkbox"/>	Local Coverage Option (Below 200% FPL) <input type="checkbox"/>	Insured on the Exchange (Below 200% FPL) <input type="checkbox"/>
	Low-Income (Below 200% FPL) <input type="checkbox"/>	Self-Pay <input type="checkbox"/>	Uninsured <input type="checkbox"/>	Other (explain to the right) <input type="checkbox"/>	

**- QPI METRIC SELECTION**

The checked boxes will automatically fill in the MLIU QPI data description fields in Step 7 on the MLIU QPI data tabs, once the tabs are generated. Or, if the MLIU QPI metric is exempt from reporting at the encounter/individual level, the check boxes will auto-fill in Step 3 for the MLIU QPI description field.

Once Step 2 inputs are complete, the "Project Selection Inputs" Progress Indicator on the Project Data Entry tab and the Template Progress tab will change to Complete.

*Step 3:*

Providers should repeat the instructions below for each DY5 carryforward metric, DY6 Total QPI and DY6 MLIU QPI metric, as applicable. Step 3 will have a separate section for Total QPI metrics (DY5 and DY6) and MLIU QPI metrics (DY5 if applicable and DY6). Metric Achievement Reporting Status:

In order for the QPI template to work properly (generate applicable data entry tabs, lock when reporting on a DY is completed, remain unlocked when reporting on a DY has not been fully completed), providers need to carefully **select a Metric Achievement Reporting Status** from the dropdown list for all open (i.e., highlighted yellow) DYs.

If a provider has a metric for the DY that has not yet been reported for achievement, the Metric Achievement Reporting Status options will include those listed below (with the # sign listed below referring to the QPI metric’s DY). The options that are available for selection by the provider are dependent upon whether the QPI metric is a current year metric or a carryforward metric. QPI metrics that have not previously been reported on for metric achievement will be blank when the template is auto-filled, and provider input cells for these metrics will be unlocked.

- Forfeiting DY5 metric achievement (**New in DY 6**):
  - This Metric Achievement Reporting Status is only available for a DY5 QPI Carryforward metric.
  - A provider should choose this if they were unable to achieve their DY5 QPI Carryforward goal by the end of DY6 (September 30, 2017), as October DY6 is the last time a provider can report on DY5 carryforward metrics.
  - Selecting the reporting status of Forfeiting a "DY5 metric achievement" will allow DY6 Total QPI and DY6 MLIU QPI data start dates (in Step 7) to begin October 1, 2016 if there are no other DY5 Carryforward QPI metrics with end dates later than September 30, 2016.
  - Providers who have previously submitted DY5 QPI data for October DY5 SAR requirements will not be required to fill in any other DY5 information if they have selected to forfeit the DY5 QPI metric. However, if a provider still has a DY5 QPI metric with an "Incomplete" SAR status from the October DY5 reporting period, they should include their DY5 information in their DY6 QPI Reporting Template to clear the "Incomplete" status. Failure to do so may result in delayed payments and impact future eligibility for payments.



- Not ready to report DY# metric achievement:
  - A provider should choose this status if they are not ready to report for achievement on the DY6 Total QPI metric or the DY6 MLIU QPI metric. This will also indicate that the provider is carrying forward their QPI metric(s) into DY7.
  - If the provider chooses this option for a DY6 Total QPI or MLIU QPI metric, they should be sure to request carryforward in the online reporting system, too.
  
- Reporting DY# metric achievement as carryforward:
  - This Metric Achievement Reporting Status will only be available for metrics that were carried forward from the prior demonstration year. In October DY6, this applies to DY5 carryforward metrics.
  - When a provider who requested carryforward for their DY5 metric is ready to report their metric for achievement, they should select “Reporting DY5 metric achievement as carryforward”.
  - If a provider makes this selection and no other DY5 QPI metrics have been reported previously for achievement, the provider will become eligible to report on DY6 Total QPI and MLIU QPI metric achievement.
  
- Reporting DY# metric achievement in DY# reporting period:
  - QPI metrics that were reported on for achievement during DY5 reporting period will show this Metric Achievement Reporting Status when the template is auto-filled, and provider input cells for this metric will be locked.
  - This Metric Achievement Reporting Status option will only be available in the dropdown box for current demonstration year metrics (i.e., for DY6 metrics).
  - When a provider is ready to report a DY6 QPI metric for achievement, they should select “Reporting DY6 metric achievement in DY6 reporting period” as their Metric Achievement Reporting Status. They should also indicate in the online reporting system that the metric is “Yes - Complete”.
  - Providers with a Pay-For-Reporting (P4R) MLIU QPI metric should select this if they are reporting without achieving their goal. As a reminder, the provider must have provided at least one encounter/served at least **one individual ABOVE the MLIU QPI pre-DSRIP baseline** to demonstrate "achievement" of the P4R MLIU QPI metric. Reporting status in the online reporting system should reflect “Yes - Complete”, if the provider is reporting for achievement (even if the achievement level does not meet or exceed the actual MLIU QPI goal).

Metric-level SAR Reporting Status:

All providers with a QPI metric in a demonstration year (DY) are required to submit a QPI Template for SAR purposes in October of that DY. To keep the QPI Template from locking before SAR is reported, the proper selection(s) for the Metric-level SAR Reporting Status as well as the Metric Achievement Reporting Status are required. HHSC has worked with our contractor to automate the selection of the Metric-level SAR Reporting Status, so provider input is no longer needed here.

- For all DY6 metrics, the QPI template is required for SAR reporting purposes during October DY6 reporting. As such, "Reporting QPI for Oct DY6 SAR purposes" will show under DY6 during October DY6 reporting. Even if a provider previously reported for achievement of their DY6 metrics in April, they will need to fill out the QPI template with updated data -- MLIU and patient encounters and relevant dates (reporting through September 30, 2017)-- for the purposes of SAR.

- Providers with a P4R MLIU QPI metric who report in April 2017 will also be required to update all MLIU QPI data in October 2017 for purposes of SAR.

#### Total and MLIU QPI Actual:

Providers reporting on a DY's QPI Total or MLIU metric should **enter the QPI Actual** for each open DY, with the exception of a DY5 metric that the provider has selected to forfeit. The QPI Actual, also referred to as the Provider Calculation, is the total number of DY encounters/individuals served minus the pre-DSRIP baseline. It should be based on the data entered in Step 6 and the dates entered in [Step 7](#). If you are reporting a Pay-for Performance (P4P) QPI metric for achievement and believe your metric should be approved for payment, this number should equal to or be greater than the QPI goal. If you are reporting a P4R DY6 MLIU QPI metric for achievement, this number may be lower than the DY6 MLIU QPI goal, but should demonstrate at least one encounter/one individual above the MLIU pre-DSRIP baseline to be approved for achievement. If you are not yet ready to report for DY6 Total QPI achievement, the QPI Actual can be lower than the QPI goal. Please note that the QPI Actual is what is referred to as the Provider Calculation on the Metric [QPI Summary Tab](#) that is created during [Step 4](#).

#### DY5 MLIU QPI Required:

In addition to the total QPI goal referenced above the [QPI Actual](#), some Dy3-5 projects must meet a Medicaid, Low-Income Uninsured (MLIU) QPI. If MLIU QPI Required equals "No", a MLIU QPI is not required and this step can be skipped. If DY5 MLIU QPI Required equals "Yes", this section is required.

MLIU QPI represents the number of individuals served that were MLIU or the number of encounters provided to individuals that are MLIU (based on the QPI metric grouping). **As such, providers should be entering whole numbers, not percentages, into these cells.** In addition, because MLIU QPI is a subset of the total QPI, the MLIU QPI Goal should not exceed the Total QPI Goal auto-filled for the metric, and the MLIU QPI Actual should not exceed the Total QPI Actual entered by the provider in the cell above.

To **enter the MLIU QPI goal**, the provider should find the MLIU QPI goal listed in the provider's DY5 QPI metric. This goal is typically found in the metric's baseline/ goal statement, but may be included in the milestone or metric description language. If the MLIU QPI goal is listed as a percentage in the metric language, the provider will need to calculate the numeric MLIU QPI Goal by multiplying the Total QPI Goal by the MLIU percentage goal listed in the metric (e.g., if the provider's total QPI goal is 100 individuals and the MLIU QPI goal is 80%, the MLIU QPI numeric goal would be 80 individuals).

Next, the provider will **enter the MLIU QPI achieved**. Like the total QPI achieved, the MLIU QPI should not include the pre-DSRIP baseline. The MLIU QPI should be similar to the total QPI achieved that was reported in the QPI Actual cell multiplied by the Total MLIU % reported in Step 2 (e.g., if the total QPI is 100 and the MLIU % is 90%, the MLIU QPI should be 90). The template will display a pop-up warning if the MLIU % multiplied by the QPI actual is not equal to the numeric goal entered into the MLIU QPI achieved cell.

The box below the MLIU QPI Actual will auto-fill with the DY5's MLIU percentage description entered in [Step 2](#). Generally, the description should be the same for overall MLIU % and MLIU QPI. If for some reason the descriptions differ (which may be the case if a provider has more than one QPI metric in a DY), please update the cell under Step 3.

Once you complete all inputs under Step 3, "Metric Selection Inputs" under the Progress Indicator will change from a red Incomplete to a green Complete.

(New for DY6) DY6 MLIU QPI - Exempt from reporting at the Encounter/Individual Level:

If a provider's DY6 MLIU QPI metric is exempt from reporting at the Encounter/Individual Level, the template will indicate a "yes" in the first cell of the MLIU QPI Metric information in Step 3. The cell immediately below this will be open and the provider **must fill in a description of their methodology for calculating the MLIU population.** (See image below.) **If the provider does not complete this description with a methodology that clearly indicates how they arrived at their reported MLIU QPI number, they will receive an NMI.** The methodology should be specific to the provider -- not a general description of multiplying the MLIU percentage by the number of patients served. For example, if a provider is using a proxy calculation, the provider should input a detailed explanation of their proxy (i.e. the population in county X that lives below 200% FPL is 25%; therefore we applied a percentage of 25% to the total population served to arrive at our QPI count of XXX).

**MLIU QPI Metric**

**DY6**

Exempt From Reporting at the Encounter/Individual Level:	Yes
MLIU Population Calculation Methodology Description:	
MLIU QPI Metric ID:	M-2.1
Metric Language:	397 encounters provided to MLIU patients above the MLIU QPI pre-DSRIP baseline.
Metric Grouping:	Encounters
Metric Achievement Payment Method:	P4P
Metric Achievement Reporting Status:	
Metric-Level SAR Reporting Status:	Not reporting MLIU QPI for Oct DY6 SAR purposes
MLIU QPI Goal:	397
MLIU QPI Actual (Provider Calculation):	
MLIU QPI Description:	

**The MLIU QPI is Not Achieved**

If the provider is reporting for achievement of the DY6 MLIU QPI metric that is exempt from reporting at the encounter/individual level, the provider will need **to select the applicable Metric Achievement Reporting Status, "Reporting DY6 metric achievement in DY6 reporting period"**. The template will remind the provider if they have not already described their DY6 MLIU QPI population in Step 2 by checking the boxes that apply, to do so at that time. Finally, the provider will need **to enter the DY6 MLIU QPI Actual**. For P4P MLIU QPI metrics, the provider will need to fill out an explanation cell if the MLIU QPI Actual is not equal to the reported MLIU QPI percentage entered into Step 2 multiplied by the Total QPI Actual. Once the provider has entered all required sections in Step 3 for the DY6 MLIU QPI metric that is exempt, and assuming the MLIU QPI Actual is equal to or greater than the DY6 MLIU QPI goal (or demonstrates at least one encounter/individual served above the MLIU QPI pre-DSRIP baseline for P4R metrics), the template will indicate that the metric has been achieved. (See image below.)

MLIU QPI Goal:	397
MLIU QPI Actual (Provider Calculation):	400
MLIU QPI Description:	Dual Eligible, CHIP, Uninsured
Explanation:	The EMR MLIU percentages are input into Step 2. Since this project is school based, we do not have EMR records and have instead used the percentage of children receiving free-and-reduced lunch for our MLIU proxy in the project. This is why the MLIU Provider calculation does not equal the Total QPI actual multiplied by the Step 2 reported DY6 MLIU percentages.

**The MLIU QPI is Achieved - P4P**

**The MLIU QPI Actual should equal the MLIU % Actual entered in Step 2 times the Total QPI Actual entered in Step 3. Please correct your entries or provide a justification for the discrepancy to the left. If this is a P4R MLIU QPI metric and you are not reporting full achievement of the goal, you may indicate that as your explanation.**

#### Step 4:

Once steps 1 - 3 are complete, **click on the "Create QPI Data and Summary Tabs" button** (see image below). You will receive a pop-up warning if any of Steps 1-3 are incomplete, and you will not be able to create the new tabs until they are complete.

You will also receive a pop-up reminder asking you to check the selection of the *Metric Achievement Reporting Status*. Once you have created the metric-tabs, you will not be able to change the *Metric Achievement Reporting Status* selection. If you have made an error in the *Metric Achievement Reporting Status* selection and want to change it, select "no" and make your changes. Once you have created the metric data entry tabs, if you find you have made an error in the *Metric Achievement Reporting Status* selection, you will need to download a new QPI template and start again.

Once you have confirmed your *Metric Achievement Reporting Status* is correct, click "yes". Two new tabs for each QPI metric set will be created if applicable. If you are exempt from reporting the DY6 MLIU QPI metric at the encounter/individual level, those tabs will not be generated.

Proceed to the QPI Data Entry tab.

**Please note:** If a provider is having difficulties creating the QPI Data Entry and Summary tabs, [1] please make sure that macros and automatic calculations are enabled for the template and [2] if the provider is working on a Mac, please try completing the template on a PC (Windows OS). If this does not resolve the issue, then please contact the waiver mailbox at TXHealthcareTransformation@hhsc.state.tx.us.

### Total and MLIU QPI Data Entry tabs

#### Step 5:

When completing the QPI Reporting Template for the first time for any metric, the provider must provide information regarding the pre-DSRIP baseline in Step 5 (see image below). Providers who completed a QPI template in the past (i.e., providers with projects with a DY3, DY4, or DY5 QPI metric that was reported for achievement) cannot complete this step again. Once a QPI metric in the metric set has been reported for achievement, Step 5 is locked and editing is not possible.

- For DY3, DY4, and DY5 QPI metrics previously reported for achievement, Step 5 will include the previously entered data, and providers will not be able to edit this information. The template will auto-fill the DY6 Total QPI and MLIU QPI pre-DSRIP baselines for projects that have previously reported for achievement. For these metrics, the provider should proceed to [Step 6](#).
- For projects without a DY3 or DY4 metric and for which DY5 QPI metrics were reported for Semi-Annual-Reporting purposes in October DY5 reporting, but not reported for achievement (i.e., carried forward metrics), Step 5 will include the data entered during DY5, and this information will not be locked. Providers should only make changes to Step 5 pre-DSRIP information if they were unable to provide information based on 12 months of data when they last reported, because they had not yet started seeing individuals, or if this section included an error. Any boxes changed by the provider will highlight green. The provider should explain the reasons behind any changes in the description box included in this Step.
- For a project that has not previously reported on a DY5 QPI metric for achievement, the DY6 pre-DSRIP baseline will be the same as the DY5 QPI pre-DSRIP baseline annualized. The MLIU QPI pre-DSRIP baseline will be calculated using the Total QPI annualized pre-DSRIP baseline multiplied by the DY5 MLIU percentage goal.

Providers who are entering information into Step 5 should carefully read the [Determining the Pre-DSRIP Baseline](#) section of this document to confirm that they are correctly entering their pre-DSRIP baseline information, and that they understand the difference between the pre-DSRIP baseline required here and a DSRIP baseline, which should not be entered here.

In the dropdown box in Step 5, providers will indicate whether their "DSRIP project provides a new program or service" or their "DSRIP project expands an existing program or service". If the project provides a new program or service, the pre-DSRIP baseline service volume and dates will gray out and the annualized pre-DSRIP baseline will auto-fill to 0. If the project is an expansion, the provider will need to enter the pre-DSRIP baseline that they calculated for their project, as well as the dates used for the calculation. Only projects that provide a new program or service should have a pre-DSRIP baseline equal to 0, while projects that expand an existing program or service should have a pre-DSRIP baseline greater than 0. As such, providers should not select "DSRIP project expands an existing program or service" and enter 0 into the Service Volume During Pre-DSRIP Baseline Period cell.

Whenever possible, providers should use 12 months of data immediately preceding the implementation of the DSRIP project (i.e., the time when the project began to serve individuals) to calculate their pre-DSRIP baseline. If a project begins seeing patients on November 1, 2014, for example, the provider could base their pre-DSRIP baseline on the service volume (encounters provided or individuals served depending on their QPI metric grouping) between November 1, 2013 and October 31, 2014. If the provider is not able to obtain dates exactly one year prior to the date of implementation, they may submit data from a period close to these dates (e.g., their fiscal or calendar year data) that is more readily available. The pre-DSRIP baseline date range cannot overlap with the QPI DY date range the provider will provide in [Step 7](#).

If a provider is unable to obtain 12 months of data on which to calculate the pre-DSRIP baseline or if the 12 months of data were reported over a leap year, the template will calculate an annualized pre-DSRIP baseline based on the data entered. If you are having issues with the annualization of your pre-DSRIP baseline, please see the [Troubleshooting](#) section of this document.

In the space provided, all providers should **provide a description of the data used to determine their pre-DSRIP baseline** (including the target population, the types of encounters included, etc.) and the reason the date range for the calculation was used. If the provider did not use 12 months of data to calculate their pre-DSRIP baseline and/or did not use 12 months immediately preceding the implementation of their project, they should provide justification here. If a provider's pre-DSRIP baseline is 0, they should clearly explain why they consider their project to be a new project and not an expansion. If the pre-DSRIP baseline entered in the QPI Template differs from what is included in the project narrative or in the metric baseline/ goal statement(s), providers should also include an explanation for this change in this box.

HHSC is not asking providers to submit supporting documentation or data to demonstrate the calculation of their project's pre-DSRIP baseline. However, this information, like all information submitted for reporting, is auditable by the compliance monitor.

#### *Step 6:*

In order to properly document and calculate Total and MLIU QPI achievement, HHSC is asking providers **to paste patient ID and encounter date data from their EHR system, client database, or spreadsheet into Step 6** (see image below). Please note only the first cells of the columns for provider data input are outlined and highlighted in yellow. However, the provider is still able to paste up to 530,000 patient encounters. Providers will enter both

patient IDs and encounter dates data regardless of their QPI metric grouping. **Please note:** in the DY6 Template, providers will only see Step 6 entry fields for DY5 (if applicable) and DY6 metrics.

HHSC recognizes that each provider has their own unique way of collecting data, so we've kept flexibility in mind when designing the QPI Reporting Template.

- Patient IDs can include letters, numbers, or a combination of both and must be inputted such that unique individuals have unique IDs. The provider is ultimately responsible for ensuring that the data submitted to HHSC excludes confidential or personally identifiable information. Providers should not use names, as scrambling methodologies may not be sufficient to adequately de-identify certain names. When possible, providers should assign more generic values to individuals (e.g., Patient 1, Patient 2, etc.) or assign a de-identifiable patient ID PRIOR to pasting this type of information into the QPI Template. As a cautionary step, the template includes a de-identification macro ([Step 9](#)) that applies scrambling methodologies to the inputted Patient ID data. Prior to template submission, the provider must review the patient IDs to ensure that the final data submitted excludes confidential or personally identifiable information.
- Encounter dates need to include month, day, and year. If a provider has only tracked encounters by month or quarter, for example, they may assign a date (e.g., the first or last day of the month or quarter) as the encounter date, but should include how the encounter dates were assigned when they describe their QPI data in [Step 7](#). This documentation should be maintained for any potential audit.

#### 6 - TOTAL QPI DATA ENTRY

RHP 4_020973601.1.3 Metric 1 Encounters DY5		RHP 4_020973601.1.3 Total QPI Encounters DY6	
Patient ID	Encounter Date	Patient ID	Encounter Date
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
--			

In order to obtain the data you want to paste into the QPI Reporting Template, follow the steps below:

1. Run a query from provider's data source that includes patient ID and encounter date variables and reflects the QPI metric and pre-DSRIP baseline data the provider submitted:
  - Providers will need to limit the query to the types of encounters and that are relevant to the DSRIP project based on the project option, metric ID, and metric language. A primary care (1.1) project, for example, should typically only include office visits (and not appointment reminder calls, lab visits, etc.) in their query. Please refer to the [Defining Individuals and Encounters](#) section of this document, as well as the QPI metric language when determining the patient contact types to include in your query.
  - Providers will also need to limit the query to the types of individuals that are relevant to the DSRIP project. For example, if a provider's goal is to increase the number of women served, the query

should be limited to women. For the MLIU QPI metric, the query should be limited to the relevant payer groups.

- Providers will also need to limit the query to the appropriate dates. See [Step 7](#) for instructions on determining start and end dates for your Step 6 data.

The resulting query should be similar to the sample on the right where each encounter date is a separate record and patient IDs are repeated if an individual has received more than one encounter.

Patient ID	Encounter Date
Client01	10/1/2013
Client02	10/22/2013
Client02	12/3/2013
Client03	11/4/2013
Client04	1/25/2014
Client05	4/17/2014
Client05	7/8/2014
Client06	6/28/2014

2. Once the provider has run a query limiting the data to the appropriate encounters, individuals, and date parameters, they should highlight and copy the data from the query, so it can be pasted into the QPI Reporting Template. If the query includes the Patient ID and Encounter Date fields side by side and in the same order as they are in the QPI Reporting Template (i.e., Patient ID in the first column, Encounter Date in the second column), the provider can highlight and copy all of the data in these two columns (minus the field names). If the query does not display the fields side-by-side and/ or does not display them in the same order as the template, the provider will need to copy and paste the data from each field one at a time.
3. Once the provider has highlighted and copied the data (minus the field names) from the query, return to the QPI Data Entry tab of the QPI Reporting Template, and find the columns that correspond with the DY of the metric on which you are reporting.
4. Right click on the first cell highlighted yellow in the applicable DY's Patient ID column (or the Encounter Date column if you're pasting fields one-by-one) under the DY that corresponds to the QPI metric on which you are reporting and select **Paste Values**. Please be sure to use the Paste Values, as the template will not calculate properly if the data checking and formatting functions are overridden. If the Paste Values option is not available, please select Match Destination Formatting when pasting data.

Please note that the QPI Reporting Template can accommodate up to 530,000 encounters in each demonstration year. If you have a large number of records, it may take some time to paste all of the data. Please be patient and do not attempt to do any other actions in the template until the paste is complete. If a provider's query returns more than 530,000 records for a demonstration year, please email the [Waiver mailbox](#) to discuss how to report QPI in that year.

**All providers** need to input data into Step 6 for SAR purposes in October reporting, even if the provider previously reported for completion of a DY metric in April or is not ready to report for achievement of the metric in October. The progress indicator will remain red and incomplete until step 6 is completed.

#### *Step 7:*

##### Description of Data Entered in Step 6:

Once Patient ID and Encounter Date data have been pasted into the template, providers will need to **describe the data that was pasted into the spreadsheet** in the box provided in Step 7 (see image below).

**7 - TOTAL QPI DATA DETAILS**

Describe the data entered in Step 6 detailing the types of individuals (e.g. children attending a particular school, individuals with behavioral health issues, age groups, etc.) and patient contacts (e.g., office visits, phone calls, screenings, admissions, discharges, etc.) that are included.

<b>RHP 2_081844501.1.1 Metric 1</b>
<b>DY5</b>
Adults, with a mental health diagnosis, not otherwise eligible for services through the DSHS contract. Encounters counted include visits with an APN or MD for psychiatric evaluations and medication monitoring as well as visits with the case manager for assessments and clinical monitoring. All encounters were face to face.

<b>RHP 2_081844501.1.1 Total QPI</b>
<b>DY6</b>

Start Date for DY QPI Data:

10/1/2015

10/1/2016

End Date for DY QPI Data:

9/30/2016

9/30/2017

In the text box, specify:

- the types of encounters (e.g., office visits, nurse line calls completed, screenings, pharmacy consultations, etc.) included in the data; and
- the types of individuals (ages, diagnoses, discharges, etc.) included in the data.
- To copy and paste DY5 information into DY6 and ensure that the information is editable, the provider should **Paste Values.**

Please be as detailed as possible. Providers who do not provide adequate detail may receive a request for additional information to confirm QPI is being calculated correctly, which will result in delay of payment of the metric.

Start and End Dates for Step 6 Data:

In Step 7, providers will also need to **enter the date ranges for QPI encounters** included in [Step 6](#). Encounter dates in Step 6 fields will not be counted until the start and end dates have been entered into Step 7. Start and end dates must fall within the [allowable dates of service](#) for the metric’s DY. The table below outlines the allowable dates of service as they apply to October DY6 Reporting period:

QPI Metric DY	Start Date Rules	End Date Rules
DY5(Carryforward)	<ul style="list-style-type: none"> <li>▪ After Step 5 end date if no DY3 or 4 metric</li> <li>▪ Between 10/1/15 or DY4 Carryforward End Date &amp; 9/30/2017</li> </ul>	<ul style="list-style-type: none"> <li>▪ After DY5 Step 6 Start Date</li> <li>▪ On or between 10/1/15 or the DY4 Carryforward End Date &amp; 9/30/2017</li> </ul>
DY6	<ul style="list-style-type: none"> <li>▪ Between 10/1/16 &amp; 9/30/2017</li> <li>▪ <b>On</b> or after DY5 Carryforward End Date (if applicable)</li> </ul>	<ul style="list-style-type: none"> <li>▪ After the DY6 Step 6 Start Date</li> <li>▪ On or between 10/1/16 or the DY5 Carryforward End Date &amp; 9/30/2017</li> </ul>

The template will allow the End Date for a DY5 Carryforward metric to be the same as the Start Date of a DY6 Total and MLIU QPI metric. **It will not allow a gap between these dates.** Because of these restrictions, if you enter dates



into Step 7 and need to edit the DY5 Carryforward End Date or DY6 Start Date, you should delete the entries and start again. The template has auto-filled the DY6 Total QPI and MLIU QPI End Date.

Please do not include encounters that occurred after September 30, 2017 in Step 6 or include an end date after September 30, 2017 in Step 7 during October DY6 reporting. Encounter dates in the data of Step 6 that are outside of the allowable date range will be highlighted in red, and will not be counted toward the QPI totals.

## Total and MLIU QPI Summary tabs

### Step 8:

Once the provider enters their information on the QPI Data Entry page, but before they click the Step 9 button to de-identify the information they entered, they should click on the QPI Summary tab to view the QPI Template calculations. Clicking on the summary tab will start the QPI data match calculation.

QPI calculations will be based on the project's QPI grouping. If the grouping is encounters, all encounters within the Start and End Dates specified in [Step 7](#) will be counted. If the grouping is Individuals, the number of unique individuals (i.e., unique Patient IDs) with encounters within the date range will be calculated. The QPI will equal the total eligible encounters provided or individuals served minus the pre-DSRIP baseline. (See the [QPI Calculation](#) section of this document for more information.)

The provider should **view the Data Calculation Match Indicator** (see image below) on the QPI Summary tab to confirm that the QPI Template calculation matches what the provider entered as their actual QPI on the Project Data Entry tab (also referred to as the Provider Calculation).

DATA CALCULATION MATCH INDICATOR			
Year	Actual QPI Individuals		
	Provider Calculation	Template Calculation	Calculations Match
DY3	1,705	1,705	Yes
DY4	5	5	Yes
DY5	5	5	Yes

If the template calculation matches the provider entry, the Calculations Match column will indicate "Yes" in green. If there is a discrepancy between the template calculation and the provider entry, the provider will see a red "No" the Calculations Match column.

If the template calculation and the provider entry do not match, the provider should **carefully review the [Running the Numbers](#) section** of this document to be sure they understand how QPI is calculated through the template. The provider should also **re-read the [Step-by-Step Instructions](#) and check template inputs to confirm data was entered correctly**. Finally, providers should reference the [Troubleshooting the QPI Template](#) section in this document for tips for resolving common issues. During review, HHSC finds QPI template calculations to be highly reliable and believes that the vast majority of provider/ template calculation discrepancies can be resolved by providers reviewing the referenced sections.

It is important that the provider and HHSC agree upon the QPI achieved by the project, since this information will likely be used in future analyses and data requests. **Please attempt to address any discrepancies so that the**

**Calculations Match box shows a green Yes.** If after further review, the provider finds that the value they entered on the Project Data Entry tab as the Actual QPI (i.e., the provider calculation) is incorrect, please return to that tab and **change the QPI Actual to the correct number**. If the provider finds that the provider calculation is correct, but information, such as the Step 6 data or Step 7 start and end dates, was incorrectly entered into the template, please **correct the provider inputs, so that the QPI calculation is corrected**.

After taking these steps, if the provider is still unable to reconcile provider and template discrepancies (i.e., template and provider calculations still do not match), please **provide a detailed explanation of how provider entries were calculated in the Step 8 comment box** on the QPI Summary tab. In addition, the provider should submit **DE-IDENTIFIED supporting documentation** (see the [April DY6 Reporting Companion Document](#) for more information) that clearly supports the provider’s calculation, along with the QPI Template, to HHSC through the online reporting system.

TOTAL QPI PROGRESS SUMMARY (based on template calculations)						
<b>DY6 Project Information</b>						
Region:	RHP 7					
TPI:	133542405					
Provider:	Austin Travis County MHMR Center					
Project ID:	133542405.2.4					
Total QPI Metric ID:	M-1.1					
Project Option:	2.13.1					
Grouping:	Individuals					
Metric Description:	55 individuals served over pre-DSRIP baseline.					
Reporting Status:	Reporting DY6 metric achievement in DY6 reporting period					
<b>Pre-DY6 Project and Metric Information</b>						
Region_Project ID	Metric #	Year	Metric ID	Metric Description	Reporting Details	
RHP 7_133542405.2.4	1	DY3	P-3.1	50 individuals	Reporting DY3 metric achievement as carryforward	
		DY4	I-101.1	Increase by 5% over baseline. DY4 impact of 53 individuals.	Reporting DY4 metric achievement in DY4 reporting period	
		DY5	I-101.1	Increase by 10% over baseline DY 2-4. DY5 impact of 55 individuals.	Reporting DY5 metric achievement in DY5 reporting period	
Region_Project ID	Metric #	Year	Total QPI Goal	Total QPI Actual	METRIC ACHIEVEMENT	
RHP 7_133542405.2.4	1	DY3	50	50	Achieved	
		DY4	53	57	Achieved	
		DY5	55	62	Achieved	
RHP 7_133542405.2.4	Total QPI	DY6	55	56	Achieved	

DY	Goal	Actual
DY3	50	50
DY4	53	57
DY5	55	62

The QPI Progress Summary table (see above) displays the QPI Goals and QPI Actuals side-by-side by demonstration year and indicates whether QPI goals were achieved according to template calculations. **Do NOT submit a metric for payment if the Total QPI and/or the MLIU QPI (if applicable) show Not Achieved.** Providers will not be eligible to report at a later date if they indicate that they are reporting for achievement, but do not demonstrate achievement.

**New for DY6 Please note:** A P4R MLIU QPI metric will not indicate achievement until the provider has run Step 9. The provider should first check the MLIU QPI Summary Tab to make sure the provider calculation and template calculation match. If so, then the provider may proceed to Step 9. Finally, the provider should check back on the summary tab to see if the P4R MLIU QPI metric achievement status has changed to Achieved.

If a provider’s QPI Actual is less than what the provider achieved for their DY3, DY4 or DY5 QPI, the provider should enter an explanation for the decrease in their progress update in the online reporting system.

### De-Identifying Personally Identifiable Information

Providers are required by the HHSC Medicaid Provider Agreement, as well as state and federal law, to adequately safeguard individually identifiable Patient Information. Providers are required to submit only de-identified information as evidence of meeting a metric. (De-Identified Information means health information, as defined in the [HIPAA privacy regulations](#) as not [Protected Health Information](#), regarding which there is no reasonable basis to

believe that the information can be used to identify an [Individual](#). See the "WARNING NOTICE Regarding Submission of Supporting Documentation" in the April DY6 Reporting Companion Document for more information on Protected and De-Identified Health Information.)

The QPI Reporting Template includes a step to help de-identify the patient IDs that were pasted into the template. During this process, a macro will apply a scrambling methodology to the Patient IDs entered by the provider. As was stated under [Step 6](#), providers are ultimately responsible for ensuring that the data submitted to HHSC excludes confidential or personally identifiable information. Providers should review the data in the template prior to submission to ensure it conforms to HIPAA and other privacy regulations.

#### *Step 9:*

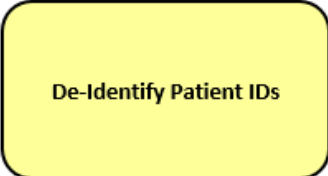
**Providers should be sure they have completed steps 1 - 8 and require no changes before completing Step 9.**

Once the provider verifies that all data has been correctly entered and they are ready to submit the information entered for this metric, they will return to the Metric QPI Data Entry tab and run the macro to de-identify the QPI data (patient IDs). Providers will need to complete Step 9 for each of the data entry tabs, Total QPI and MLIU QPI. To run the macro, click on the applicable "De-Identify Patient IDs" button. (See image below.) If a provider has entered a large number of patient IDs, this process may take a little time. Please do not attempt any other actions in the QPI Reporting Template until this step has been completed.

**9 - DE-IDENTIFY PATIENT IDS (Step 8 can be found on the QPI Summary tab)**

Once data entry is complete and calculations on Summary tab are confirmed, click on the button below to de-identify the Patient IDs.

- > Only click on the button when the data has been FINALIZED. Once Patient IDs are de-identified, the data will be locked and no further changes can be made.
- > Please note, the de-identifying macro may take several seconds to run depending on how many fields are entered in Step 6.



Once de-identifying is complete, the Patient IDs De-Identified progress indicator will show complete for the applicable QPI metric.

After Step 9 is run, DY data under Step 6 on the QPI Data Entry tab may be greyed out and locked. This will occur once a provider has indicated they have reported for metric achievement for the DY and they have reported for SAR purposes for the DY. Providers may now save the template (see [Naming and Submitting QPI Reporting Template](#) below).

## Submission of QPI Reporting Template

### Progress Indicators

Before submitting the QPI Reporting Template, please confirm that the Progress Indicators on the Project Data Entry tab, Progress Indicators on the Total QPI and MLIU Data Entry tabs, and the Progress Indicators on the Template Progress tab show a green "Complete" for all sections (see image below). The easiest way to see if a step is incomplete is to check the Template Progress tab. Please do not submit the QPI Template if there is a red incomplete on the progress indicator tab. Please see the troubleshooting section of this document to address any issues before contacting HHSC for additional help.

## QPI TEMPLATE PROGRESS: **Template is COMPLETE!**

Please confirm that the QPI template progress shows complete above. If it shows that the template is not ready for submission, please complete any missing steps and correct any outstanding issues before submitting to HHSC.

### INSTRUCTIONS AND PROJECT DATA ENTRY

Step 1: Instructions	Complete
Step 2: Project Information	Complete
Step 3: QPI Metric Selection	Complete
Step 4: Create Tabs	Complete

### TOTAL QPI

Step 5: Total QPI Pre-DSRIP Baseline	Complete
Step 6: Total QPI Data Entry	Complete
Step 7: Total QPI Data Details	Complete
Step 8: Total QPI Calculation Check	Complete
Step 9: De-Identify Patient IDs	Complete

### MLIU QPI

Step 5: MLIU QPI Pre-DSRIP Baseline	Complete
Step 6: MLIU QPI Data Entry	Complete
Step 7: MLIU QPI Data Details	Complete
Step 8: MLIU QPI Calculation Check	Complete
Step 9: De-Identify Patient IDs	Complete

## Naming and Submitting QPI Reporting Template

In order to allow HHSC to locate QPI Templates after they are downloaded from the online reporting system more easily, providers are asked to **name their QPI Reporting Template as follows: RHPXX\_ProjectID\_QPI\_OctDY6.xlsm** (e.g., RHP08\_123456789.1.1\_QPI\_OctDY6.xlsm). Please be sure to follow this naming convention, as it takes a significant amount of staff time to change file names.

Providers that are reporting on DY5 Carryforward QPI metrics that have been combined under a new Project ID for DY6 should name the QPI template with the DY6 Project ID. However, they should upload the template under the DY5 QPI Carryforward metric. If they are also reporting on a DY6 QPI metric (MLIU QPI or Total QPI), they may indicate in the progress update field where the QPI template has been uploaded, or they may choose to upload the template again for the DY6 metric(s).

Also, be sure to continue to **save the file as a macro-enabled file** [with an .xlsm (preferred) or .xlm file extension]. A provider will receive an NMI if the file is not saved as macro-enabled; HHSC cannot guarantee the functionality of the template is accurate without the appropriate macros. The QPI Reporting Template should be uploaded to the online reporting system along with all other applicable supporting documentation as described in the October DY6 Reporting Companion and the DSRIP Online Reporting System Users Guide.

## Troubleshooting QPI Template Issues

The section below includes many of the issues providers contacted us about during completion of their QPI Templates along with the tips we provided to get these issues resolved.

"I have a P4R MLIU QPI metric, but the template is indicating that I did not achieve the metric on the MLIU QPI Summary tab."

- To "achieve" a DY6 P4R MLIU QPI metric, a provider must demonstrate that they have served one MLIU individual or provided at least one encounter to an MLIU patient above the MLIU pre-DSRIP baseline within the allowable DY6 period. The provider must also have achieved or forfeited either their DY5 Total QPI metric or their DY5 MLIU-specific QPI metric, if applicable. If the provider does not meet this criteria, they should select "Not ready to report DY6 metric achievement."
- The MLIU QPI Summary tab will not indicate that a P4R metric has been achieved until the provider has run Step 9 for this MLIU QPI metric. After the provider is confident they have completed all required steps in the template for the DY6 MLIU QPI metric, the provider should run Step 9. Then the provider may check back to the MLIU QPI Summary tab to see if the template indicates that the MLIU QPI P4R is achieved.

"I received a run time error while working on my template".

- If you receive a run-time error 91 upon opening the QPI Reporting Template, please click "End" and continue working through the workbook. All functions should still be available.

I did not serve any clients and do not have any Step 6 data to enter, so my progress indicator is red and I cannot complete Step 9.

- Enter NA in the first cell under Patient ID. Do not enter a date under Encounter Date. This will change Step 6 to complete. It will also allow the template calculation to equal 0, since an encounter date between the eligible dates of service is not present.

"The QPI Template is calculating my QPI incorrectly." or "The Provider and Template Calculations in my QPI Template don't match."

- Confirm you have enabled macros in the QPI Template and have set the template to auto calculate formulas.
- Confirm that dates were correctly pasted into the Encounter Dates column in Step 6. Dates incorrectly entered may be omitted from QPI Template calculations.
  - Confirm the PASTE VALUES option was used when pasting encounter dates (and patient IDs).
  - Check the Encounter Dates column for dates in red text. These dates have some sort of issue that is not allowing them to be counted towards QPI.
  - Confirm that all encounter dates include a month, a day, and a year.
  - If you are including times in your encounter dates, it is possible that the template is not including dates that equal your end date. In order to have those dates included in the template calculation, you may need to include a time in your Step 7 end date. To add a time stamp to the end date, you must click into the formula bar, type " 11:59:00 PM" after the date, and press enter. Please note that there are two spaces preceding the time stamp, and one space between "00" and "PM." The time stamp must be entered in this exact format.
  - Check encounter dates to be sure they do not include spaces before or after the date.
  - Check that the encounter dates you are counting in your provider calculation fall within the date ranges entered in Step 7.
- Confirm that the annualized pre-DSRIP baseline in [Step 5](#) matches the pre-DSRIP baseline you are using to calculate QPI. Providers who enter a full year of pre-DSRIP data based on DY2 (i.e., with a pre-DSRIP baseline start date of 10/1/2011 and end date of 9/30/2012) will see that their pre-DSRIP baseline is actually lower

than the annual service volume they entered when it annualized. This difference is due to 2012 being a leap year and including an extra day. This difference should not alarm providers, as it will actually result in a higher QPI achieved than the provider would have seen if the non-annualized pre-DSRIP baseline had been used.

- If you accept the annualized pre-DSRIP baseline, please be sure the QPI Actual on the Project Data Entry tab is updated to reflect this lower pre-DSRIP baseline.
- If you prefer your pre-DSRIP baseline not be annualized due to the leap year, change your pre-DSRIP baseline (Step 5) start date to one day later and note this was done in the Step 5 description box.
- Confirm your understanding of pre-DSRIP baseline and QPI calculation is correct.
  - Some providers continue to be confused about pre-DSRIP baseline. Providers should re-review the Determining Pre-DSRIP Baseline section of this document to confirm they understand the difference between pre-DSRIP and DSRIP baseline and that they correctly entered their pre-DSRIP baseline in Step 5.
  - Some providers continue to be confused about how QPI is calculated and how pre-DSRIP baseline affects the calculation. Providers with a project that expands an existing service or program should re-review the QPI Calculation and the How the QPI Template Calculates QPI and Why sections of this document. They should confirm that they entered all applicable individuals served/ encounters provided in Step 6 and note that the annualized pre-DSRIP baseline number of individuals or encounters entered in Step 5 is being subtracted from the total number of unique individuals or encounters (depending on the QPI grouping) entered in Step 6.
- Confirm that your calculation aligns with the QPI grouping listed in your template. For QPI metrics that are individuals-based, providers should confirm that they are not counting an individual (i.e., a Patient ID) more than once in the DY in their calculations. The QPI Template will only count a unique patient ID once towards an individuals-based QPI count.

“The QPI metric information (e.g., numeric goal, baseline/goal, etc.) included in the QPI Reporting Template is incorrect.”

- If you believe your QPI goal, baseline/goal statement, MLIU percentage goal, etc. are incorrect, please take the following steps:
- Compare what’s in the QPI template with what is listed in the Online Reporting system. If there is a mismatch between the template and the reporting system, email HHSC as soon as possible, so we can identify any mistakes and get them corrected. If the template matches the online system, please continue with the next step.
- Check the Change Request tracker and workbook for any feedback that might be included regarding your QPI metric. It is possible that a Change Request was not approved or that a metric was revised somehow during that process. If the QPI template does not match information included in the Change Request tracker regarding your metric and/or does not match the Change Request workbook (for DY4 or DY5 QPI metrics only), please contact the Waiver mailbox. If there is no discrepancy here, please continue with the next step.
- Check the Phase 4 workbook to determine if a change was requested and made during Phase 4 or if a change you requested and thought was made was not approved during Phase 4. If there is a discrepancy between the QPI template and what was agreed upon during Phase 4, please contact the Waiver mailbox. If there is no discrepancy, please continue with the next step.

- For 4-year projects, check your final Phase 2 (QPI) submission to confirm that the information in the QPI Template matches what was agreed upon during Phase 2. If there is a discrepancy, please contact the Waiver mailbox.