

Changes to the Measure Bundle Protocol for Demonstration Years 7- 10

**Summary of Stakeholder Feedback
and HHSC Responses**



TEXAS
Health and Human
Services

Table of Contents

Table of Contents	1
1. Introduction	2
2. Category A	3
Core Activities.....	3
Costs and Savings	3
3. Category B	7
4. Category C	8
Graduated Measures	8
Discontinued Measures.....	8
Related Strategies	9
Related Strategies Reporting.....	17
Menu of Measures.....	19
Other Comments on Category C	19

1. Introduction

On June 5, 2019, HHSC released the draft changes to the DSRIP Measure Bundle Protocol (MBP) for Demonstration Years (DY) 7-10 for stakeholder feedback. The MBP was updated to include Related Strategies reporting to Category C, add additional Category A Core Activities to the menu of Core Activities, and update the MBP to align with the updated PFM requirements for DY9-10. HHSC hosted a webinar on June 10, 2019 to provide an overview of the DY7-10 MBP proposed changes and answer questions. Stakeholders submitted feedback through an online survey that closed on June 27, 2019.

This document summarizes the stakeholder feedback HHSC received through the 44 responses to the online survey. The DSRIP team reviewed stakeholder comments, grouped similar comments together, drafted responses, and determined MBP changes through team meetings and a discussion with leadership. Changes made to the MBP because of stakeholder feedback and leadership direction are reflected in the updated MBP and are noted in the responses herein.

HHSC submitted the updated PFM Protocol to the Centers for Medicare & Medicaid Services (CMS) on March 29, 2019 and the updated MBP to CMS on July 31, 2019 for review and feedback. All DY9-10 requirements in the PFM Protocol and DY7-10 requirements in the MBP are subject to CMS approval, and HHSC will continue to work with CMS to achieve timely approval. Additionally, HHSC may further update the MBP based on negotiations with CMS. HHSC is targeting September 2019 for CMS approval of the DSRIP protocols.

2. Category A

Core Activities

1. Eight (8) stakeholders provided feedback on new additions to Core Activities related to provision of coordinated prenatal and postpartum care and hospital safety and quality. Several providers commented that new measures appear to be appropriate. One provider wanted to know if HHSC will adjust existing Core Activities and move them into the new categories, as appropriate.

HHSC Response: HHSC will develop further guidance on adjusting the Core Activities area and grouping based on the new additions. This guidance will be available prior to the release of the DY9-10 RHP Plan Update templates. HHSC intends to make appropriate adjustments to Core Activities prior to the DY9-10 RHP Plan Update.

2. Three (3) stakeholders provided suggestions for additional Core Activities.

HHSC Response: HHSC reviewed providers' suggestions. All of the suggested activities can be reflected based on the existing Core Activities menu, which includes an "other" option that is available for provider's selection in case other Core Activities do not reflect provider's activities.

Costs and Savings

3. One provider asked if they could take their Cost and Savings analysis from DY7-8, which was based on a pilot program with a smaller patient population, and complete the Cost and Savings analysis on the broader patient population in DY9-10.

HHSC Response: If a provider's Cost and Savings analysis from DY7-8 was based on a pilot program with a smaller patient population, then a provider can complete the Cost and Savings analysis in DY9-10 on the broader patient population if both analyses reflect the Core Activity under examination. As required by the PFM, providers must analyze 1) a different Core Activity for the Costs and Savings analysis in DY9-10 than was used for the Costs and Savings analysis in DY7-8; or 2) a different aspect of the same Core Activity for the Costs and Savings analysis in DY9-10 than was used for the Costs and Savings analysis in DY7-8. The Costs and Savings analysis should illustrate the costs of at least one Category A Core Activity of choice and the forecasted or generated savings (or losses) of that Core Activity. The payer-types and patient populations included in the analysis should reflect those individuals benefiting or being targeted with the intervention(s) associated with the Core Activity. Ultimately, the scope of the analysis should reflect the Core Activity chosen. If the intervention(s) associated with the provider's Core Activity that are under analysis for DY7-8 only targeted the smaller

patient population and the intervention(s) associated with the provider's Core Activity that are under analysis for DY9-10 target the broader patient population, then, yes, the provider could analyze its Core Activities in this manner.

4. Two providers commented that the tools recommended to complete the Costs and Savings analysis are MCO-oriented and not provider-oriented, making it difficult to define value for provider organization when incentives are not in alignment.

HHSC Response: While the Recommended Tools are MCO-oriented, they are not restricted for use by MCOs. The Recommended Tools can produce a return on investment ratio based on the scope of data input into the tool, regardless of how the input fields on the tools are labeled. Providers can create a crosswalk in the narrative indicating what provider costs make up the category of costs as displayed in the tool. Additionally, providers are required to submit a narrative along with the results from the analysis to explain the scope of the analysis and further analyze the results. A part of this narrative should also include which entities are benefiting from the intervention(s) as quality improvement interventions can create benefits to entities outside of the provider accruing the costs to implement and maintain the intervention(s). Providers are also allowed to request to use an Alternative Tool to complete their analysis per the Costs and Savings guidance document. This was allowed in DY7-8 and will continue to be allowed in DY9-10.

5. One provider requested that HHSC allow providers to use Alternative Tools that were approved in DY7-8 to complete the Costs and Savings analysis in DY9-10.

HHSC Response: HHSC will consider adding a list of pre-approved Alternative Tools to the Costs and Savings guidance document for DY9-10.

6. One provider stated that HHSC should provide additional approved Cost and Savings Tools for providers during DY9-10 as the current Recommended Tools are not inclusive of all the possible Core Activities.

HHSC Response: HHSC will consider adding approved Alternative Tools from DY7-8 to the list of Recommended Tools when revising the Costs and Savings guidance document for DY9-10. Additionally, providers may request to use an Alternative Tool to complete their analysis per the Costs and Savings guidance document. This was allowed in DY7-8 and will continue to be allowed in DY9-10. Core Activities and provider types vary among providers participating in DSRIP. As such, HHSC relies on providers to request to use Alternative Tools, if needed, that can fit better with providers' Core Activities or account for other differences among provider types.

7. One provider stated that smaller providers who only report on one Core Activity may have trouble meeting the requirements for DY9-10, especially if their Core Activity is very specific and does not have another aspect to conduct the analysis on.

HHSC Response: Providers may revise Core Activities in DY7-8 and in DY9-10 and add Core Activities in DY9-10 if needed; however, it is not required. Expansion of the initiative(s) related to the Core Activity under analysis to a broader population or modifying intervention(s) to improve outcomes may constitute meeting the requirements of a “different aspect” of the same Core Activity. HHSC has not yet developed specific guidance for the Costs and Savings analysis for DY9-10, but providers should review this guidance once available. If, after this clarification, providers that only have one Core Activity still feel they cannot meet the requirements of a “different aspect” of the same Core Activity for the analysis in DY9-10, then they should contact HHSC for additional guidance.

8. One provider asked if a new Core Activity will need to be selected for the Costs and Savings analysis in DY9-10 if the Core Activity chosen for analysis in DY7-8 does not have another component on which to complete the analysis in DY9-10.

HHSC Response: Yes, providers that completed the Costs and Savings analysis in DY7-8 over a Core Activity that does not have another component on which to complete the analysis in DY9-10 should select a different Core Activity to analyze in DY9-10.

9. Two providers stated that MCOs are unwilling to work with rural providers.

HHSC Response: The Costs and Savings analysis can be used to engage MCOs in an Alternative Payment Model (APM), to illustrate a business case for quality improvement to provider’s internal management or to secure funding, to illustrate sustainability of quality improvement intervention(s) post-DSRIP, etc. The Costs and Savings analysis can be used for a variety of purposes and is not limited to providers seeking to reach an APM with an MCO.

10. Two rural providers requested to combine Costs and Savings analyses across providers.

HHSC Response: If it is beneficial to the region, then providers may complete and submit a combined narrative and analysis, but each individual provider also must meet all reporting requirements related to Costs and Savings analysis as outlined in the Costs and Savings guidance document. In other words, providers wishing to complete and submit a combined narrative

and analysis will also have to complete and submit a Costs and Savings analysis and narrative specific to the individual provider's Core Activity.

11. One provider requested that HHSC host a webinar and/or provide training on the use of the Recommended Tools using a DSRIP project.

HHSC Response: HHSC has provided the following guidance related to the Costs and Savings analysis, which is available on the DSRIP Online Reporting System Bulletin Board: examples of how to define the scope of the Costs and Savings analysis, a document responding to frequently asked questions regarding the analysis, and a guidance document including links to user guides for the Recommended Tools. HHSC is also pursuing a Costs and Savings session during the upcoming State Learning Collaborative. Providers are also encouraged to collaborate with other providers in their region and/or at events such as learning collaboratives.

12. One provider requested to know if there will be additional parameters surrounding how HHSC defines a "different aspect" of a Core Activity for the analysis in DY9-10, and one provider wanted clarification on what constitutes a "different aspect" of the same Core Activity.

HHSC Response: HHSC has not yet developed specific guidance for the Costs and Savings analysis for DY9-10, but the scope of the Core Activity used for analysis in DY9-10 cannot wholly overlap with the scope of the analysis from DY7-8. Expansion of the initiative(s) related to the Core Activity under analysis to a broader population or modifying intervention(s) to improve outcomes may constitute analysis of a "different aspect" of the same Core Activity. HHSC could approach determining if a provider is evaluating another aspect of the same Core Activity for the DY9-10 analysis by requiring providers to respond to questions regarding how the scope of the analysis for DY9-10 is different from the scope of the analysis for DY7-8. Also, providers may revise Core Activities in DY7-8 and in DY9-10 and add Core Activities in DY9-10 if needed; however, it is not required.

13. One provider requested to know how information submitted through the Costs and Savings analysis will be used to help inform future work or negotiation with Medicaid/MCOs and/or other health partners or payers for future sustainability.

HHSC Response: HHSC plans to use reported information for various analyses, including identification of Core Activities that have a good return on investment as this information could inform future policy. The Costs and Savings analysis also encourages providers to analyze if the quality improvement interventions established during DSRIP are resulting in a positive return on investment, making them potentially sustainable post-DSRIP. In addition, this analysis is needed to meet the requirements of Rider 38 included for HHSC in the General Appropriations Act.

3. Category B

14. A couple of stakeholders requested clarification on what "breakout of MLIU" individuals means and asked if HHSC could provide details of the MLIU breakout so programming can plan for a breakout that might be different from their current system. (i.e. Medicaid, Dual Medicaid, Low Income and Uninsured reported separately)

HHSC Response: "Breakout of MLIU" means that in addition to reporting the MLIU PPP numeric achievement, HHSC is requiring providers to report separate values for Medicaid and LIU individuals for a given DY. For example, if a provider saw 800 MLIU individuals during DY9 – the provider would also report a breakout of 545 Medicaid individuals and 255 LIU individuals.

Additional guidance regarding who to include in the separate Medicaid and LIU buckets will be provided through an updated Category B FAQ document.

15. One stakeholder asked if underinsured individuals will be included in the separate Medicaid and LIU counts?

HHSC Response: Individuals who are underinsured can be included in the low-income or uninsured (LIU) count **IF** they meet the criteria of being below 200 percent of the federal poverty level (FPL).

16. One stakeholder asked if there are going to be separate goal requirements for Low-Income and Medicaid individuals in DY9-10 in addition to the MLIU goal as providers will be reporting separate values for Medicaid and LIU.

HHSC Response: As stated in response #4 under "Category B in RHP Plan Update for DY9-10" in the Summary of Stakeholder Feedback on the first draft PFM and HHSC Responses for DY9-10 PFM Changes, achievement of Category B will continue to be based on the MLIU PPP numeric goal. Providers will be reporting the breakout of Medicaid and LIU individuals for informational purposes only and will not be held to their DY9-10 Medicaid and LIU breakout estimates. No additional funding is attached to reporting the Medicaid and LIU breakout for Category B.

4. Category C

Graduated Measures

17. Stakeholders submitted a number of questions and comments regarding the inclusion of graduated measures, including suggestions for additional measures that should be considered for graduation.

HHSC Response: CMS has determined that the concept of “graduating measures” is inconsistent with their overall vision for the DSRIP program; therefore, there will be no measures eligible for graduation in DY9-10.

Discontinued Measures

18. One stakeholder inquired why E1-193 Contraceptive Care – Postpartum Women Ages 15–44 is being discontinued.

HHSC Response: The measure steward (US Office of Population Affairs) has recommended that states exercise caution in using this measure for payment purposes because performance on this measure is a function of a woman’s preference. HHSC reviewed the baseline rates of measures selected in DY7-8 and recommended discontinuation for certain providers where continued improvement may not be a reflection of improvements in access to contraceptive care. HHSC has opted to discontinue this measure as Pay-for-Performance (P4P) in DY9-10. For further information, see <https://www.hhs.gov/opa/performance-measures/most-or-moderately-effective-contraceptive-methods/index.html>.

19. Two stakeholders requested more information regarding reporting baselines for E2-601 and E2-602.

HHSC Response: New measures E2-601 and E2-602 will follow the same requirements as newly-selected P4P measures in DY9-10. The baseline measurement period for E2-601 and E2-602 will be 01/01/2019-12/31/19, similar to measures newly-selected for DY9-10. As many providers will not have data for a full calendar year, these measures are eligible for shortened baselines which can be requested in the DY9-10 RHP Plan Update templates. The performance year data should be reported for the entire baseline measurement period, not simply for the quarter as currently required by DSHS.

20. Stakeholders nominated the following measures for discontinuation due to the difficulty providers may experience in improving annual rates for the measures: C1-272: Adults (18+ years) Immunization status; L1-241: Decrease in mental health admissions and readmissions in criminal justice settings such as jails or prisons; E1-232: Timeliness of prenatal care; and

A1-207, L1-207, and M1-207 Diabetes care: BP control. One stakeholder requested discontinuation of D1-237 due to difficulty in accessing data for individuals seeking care outside of the provider's system.

HHSC Response: HHSC and CMS do not support discontinuing measures from a Measure Bundle based on an individual provider's difficulty in demonstrating improvement in a given measure. Most Hospitals and Physician Practices were able to demonstrate improvement over baseline for measures C1-272 (81% of providers reporting PY1 in April DY8), E1-232 (73% of providers reporting PY1 in April DY8), A1-207 (85% of providers reporting PY1 in April DY8). CMS has given HHSC guidance that it prefers for providers to be reporting on the same measures for the sake of continuity into DY9-10.

HHSC has modified the MBP to indicate that measure D1-237 Well Child Visits in the first 15 Months of Life is an optional measure for DY9-10.

Related Strategies

21. A few stakeholders requested that particular Related Strategies be combined into fewer Related Strategies. Stakeholders suggested different combinations of the Related Strategies listed below.

- 1.00: Same-day and/or walk-in appointments in the outpatient setting
- 1.01: Night and/or weekend appointments in the outpatient setting
- 1.10: Integration or co-location of primary care and specialty care (physical health only) services in the outpatient setting
- 1.20: Integration or co-location of primary care and psychiatric services in the outpatient setting
- 1.22: Integration or co-location of psychiatry and substance use disorder treatment services in the outpatient setting
- 1.40: Integration or co-location of primary care and dental services in the outpatient setting
- 1.11: Telehealth to provide virtual medical appointments and/or consultations with a primary care provider
- 1.12: Telehealth to provide virtual medical appointments and/or consultations with a specialty care physician (physical health only)
- 1.21: Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist
- 1.41: Telehealth to provide virtual appointments and/or consultations with a dentist
- 2.10: Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, community health worker, medical assistant, etc.)
- 2.11: Care team includes personnel in a care coordination role requiring clinical licensure (e.g. registered nurse, licensed clinical social worker, etc.)

- 2.12: Hotline, call center, or other similar programming staffed by personnel with clinical licensure to answer questions for patients (and their families) related to medications, clinical triage, care transitions, etc.
- 2.20: Formal closed loop process for scheduling a follow-up visit with a primary care provider and/or assigning a primary care provider when none is identified
- 2.30: Formal closed loop process for scheduling referral visits as needed
- 2.60: Formal closed loop process for coordinating the transition from pediatric to adult care
- 2.40: Data sharing connectivity or arrangement with Medicaid Managed Care Organization(s) for patient claims data
- 2.50: Data sharing connectivity across care settings within provider's integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
- 2.51: Data sharing connectivity or Health Information Exchange (HIE) arrangement across care settings external to provider's office/integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
- 3.30: Formal partnership or arrangement with post-acute care facilities (e.g. skilled nursing facility, inpatient rehabilitation facility, long-term acute care hospital, home health agency, hospice, etc.) to track/share quality measures such as length of stay and readmission rates, etc.
- 3.40: Formal partnership or arrangement with schools/school districts to track/share data such as absenteeism, classroom behaviors, etc.
- 4.00: Care team includes a clinical pharmacist(s)
- 4.01: Care team includes a behavioral health professional such as a psychologist, licensed clinical social worker, licensed counselor (LPC, LMHC), etc.
- 4.02: Care team includes a registered dietician(s)
- 4.10: Group visit model
- 4.20: Home visit model
- 4.30: Classes for patients focused on disease self-management (e.g. lifestyle changes, symptom recognition, clinical triage guidance, etc.)
- 4.31: Classes for patients focused on diet, nutrition counseling, and/or cooking
- 4.32: Classes for patients focused on physical activity
- 4.60: Patient educational materials or campaigns about preventive care (e.g. immunization, preventive screenings, etc.)
- 4.61: Patient educational materials or campaigns about advance care planning/directives
- 4.80: Hospital hand hygiene protocol/programming
- 4.81: Checklist(s) (or similar standardized protocol) tailored to prevent hospital safety-related events
- 4.82: Formal process for monitoring compliance with hospital safety-related protocols (includes reviews, "secret shopper" approaches, etc.)
- 5.00: Screening patients for food insecurity

- 5.01: Formal partnership or arrangement with food resources to support patient health status (e.g. local food banks, grocery stores, etc.)
- 5.10: Screening patients for housing needs
- 5.11: Formal partnership or arrangement with housing resources to support patient health status (e.g. affordable housing units, transitional housing, rental assistance, etc.)
- 5.12: Screening patients for housing quality needs
- 5.13: Formal partnership or arrangement with housing quality resources to support patient health status (e.g. housing inspections, pest control management, heating and other utility services, etc.)
- 5.20: Screening patients for transportation needs
- 5.21: Formal partnership or arrangement with transportation resources to support patient access to care (e.g. public or private transit, etc.)
- 5.30: Formal partnership or arrangement with schools/school districts to collaborate on health-promoting initiatives (e.g. addressing environmental triggers, healthy lunch options, field day activities, etc.)

HHSC Response: To support the most meaningful analysis of Related Strategies reporting, HHSC will keep the specificity that distinguishes the descriptions of these Related Strategies from each other, rather than combining these individual Related Strategies as suggested.

For example, HHSC intends there to be a level of specificity when distinguishing:

- same-day access versus extended hours of access (e.g. RS-IDs 1.00 and 1.01);
- access to traditionally fragmented services across the clinical disciplines of primary care, specialty care - physical health, specialty care - psychiatry, and specialty care - substance use disorders (e.g. RS-IDs 1.10, 1.20, 1.22, and 1.40; RS-IDs 1.11, 1.12, 1.21, and 1.41);
- clinical licensure versus non-clinical licensure (e.g. RS-IDs 2.10 and 2.11); when distinguishing coordination of primary care services versus specialty services (e.g. RS-IDs 2.20, 2.30, and 2.60);
- data sharing access with a payer entity (Medicaid Managed Care Organizations) versus that with internal and external provider entities (e.g. RS-IDs 2.40, 2.50, and 2.51);
- external partnerships with post-acute care facilities versus school/school districts (e.g. RS-IDs 3.30 and 3.40);
- a clinical pharmacist, versus a behavioral health professional, versus a registered dietician (e.g. RS-IDs 4.00, 4.01, and 4.02);
- the subject areas of disease self-management, versus nutrition, versus physical activity (e.g. RS-IDs 4.30, 4.31 and 4.32);
- clinical objectives of preventive care versus advance care planning (e.g. RS-IDs 4.60 and 4.61);

- an individual protocol for hand hygiene, versus a methodology that utilizes checklists, versus a systematic compliance monitoring process (e.g. RS-IDs 4.80, 4.81, and 4.82); and
- the four types of social determinants from each other (e.g. food insecurity, housing, housing quality, and transportation) and in order not to assume that screening processes and the actions taken to address identified social needs are occurring simultaneously, HHSC will keep the specificity that distinguishes the screening processes from the act of addressing the identified needs (e.g. RS-IDs 5.00, 5.01, 5.10, 5.11, 5.12, 5.13, 5.20, 5.21, and 5.30.).

22. A few stakeholders requested revisions to the descriptions of the Related Strategies listed below.

- 1.30: Mobile clinic or other community-based delivery model to provide care outside of the traditional office
- 1.31: Mobile clinic or other community-based delivery model to provide care at school(s)
- 2.10: Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, community health worker, medical assistant, etc.)
- 2.11: Care team includes personnel in a care coordination role requiring clinical licensure (e.g. registered nurse, licensed clinical social worker, etc.)
- 2.20: Formal closed loop process for scheduling a follow-up visit with a primary care provider and/or assigning a primary care provider when none is identified
- 2.30: Formal closed loop process for scheduling referral visits as needed
- 2.60: Formal closed loop process for coordinating the transition from pediatric to adult care
- 3.30: Formal partnership or arrangement with post-acute care facilities (e.g. skilled nursing facility, inpatient rehabilitation facility, long-term acute care hospital, home health agency, hospice, etc.) to track/share quality measures such as length of stay and readmission rates, etc.
- 3.40: Formal partnership or arrangement with schools/school districts to track/share data such as absenteeism, classroom behaviors, etc.
- 4.00: Care team includes a clinical pharmacist(s)
- 4.01: Care team includes a behavioral health professional such as a psychologist, licensed clinical social worker, licensed counselor (LPC, LMHC), etc.
- 4.02: Care team includes a registered dietician(s)
- 4.10: Group visit model
- 4.20: Home visit model
- 4.70: SBIRT (Screening, Brief Intervention, Referral, and Treatment) workflow
- 4.71: Medication-Assisted Treatment (MAT) services

- 5.01: Formal partnership or arrangement with food resources to support patient health status (e.g. local food banks, grocery stores, etc.)
- 5.11: Formal partnership or arrangement with housing resources to support patient health status (e.g. affordable housing units, transitional housing, rental assistance, etc.)
- 5.13: Formal partnership or arrangement with housing quality resources to support patient health status (e.g. housing inspections, pest control management, heating and other utility services, etc.)
- 5.21: Formal partnership or arrangement with transportation resources to support patient access to care (e.g. public or private transit, etc.)

HHSC Response: HHSC will provide more guidance regarding the Related Strategies descriptions in a forthcoming Companion Document.

HHSC will also revise the following descriptions of RS-IDs 1.30, 1.31, 4.10, 4.20, 4.70, and 4.71.

- To address the overlapping similarity that a school is an example of an area “outside of the traditional office”, HHSC will revise RS-ID 1.30 as “Mobile clinic or other community-based delivery model to provide care outside of the traditional office (excludes home-based care)” and remove RS-ID 1.31.
- To clarify the definitions of a group visit model and a home visit model, HHSC will revise RS-ID 4.10 as “Group visit model or similar non-traditional appointment format that includes at least one provider and a group of patients with shared clinical and/or social experiences” and RS-ID 4.20 as “Home visit model of providing clinical services at a patient’s residence (may be restricted to specific patient subpopulations).”

To clarify the context of a workflow or service being in place, HHSC will revise RS-ID 4.70 as “SBIRT (Screening, Brief Intervention, Referral, and Treatment) workflow actively in place” and RS-ID 4.71 as “Medication-Assisted Treatment (MAT) services actively offered.”

HHSC will not revise the descriptions of the following RS-IDs 2.10, 2.11, 2.20, 2.30, 2.60, 3.40, 4.00, 4.01, 4.02, 5.01, 5.11, 5.13, 5.21, and 5.30.

- Since HHSC does not intend or claim that the Related Strategy descriptions themselves should define proven strategies that guarantee positive impact, HHSC will not revise the descriptions of RS-IDs 2.10, 2.11, 4.00, 4.01, or 4.02 as suggested to specify actions of the individuals that impact change.
- Since the intention is to describe complete referral processes between the referring body and the receiving body, rather than an incomplete, one-way referral process, HHSC will not revise the descriptions of RS-IDs 2.20, 2.30, or 2.60 as suggested to remove “closed loop.”

- Since the intention is to describe working partnerships or arrangements, rather than informal collaborations between medical providers and external partners, HHSC will not revise the description of RS-IDs 3.30, 3.40, 5.01, 5.11, 5.13, 5.21, or 5.30 as suggested to replace “formal partnership or arrangement” with “collaboration.”

23. A few stakeholders requested new Related Strategies be added that involve an “Other” option, patient outreach methods (e.g. phone calls, text messages, and e-mails), a licensed or non-licensed navigator, immunization improvement focus, patient-centered care focus, financial assistance, social cohesion, and jail diversion.

HHSC Response:

- To support the most meaningful analysis of Related Strategies reporting while continuing to omit a qualitative component in Related Strategies reporting, HHSC does not intend to add an “Other” Related Strategy to any of the Related Strategies Lists.
- Since HHSC intends for multiple existing Related Strategies to involve patient outreach such as RS-IDs 2.10, 2.11, 3.00, and 3.01, HHSC will not isolate the specific modes of patient outreach (e.g. phone calls, text messages, and e-mails) into a new Related Strategy.
- Since existing RS-IDs 2.10 and 2.11 describe the addition of a licensed or non-licensed care team member in a care coordination role, HHSC will not add a new Related Strategy.
- Since HHSC intends for multiple existing Related Strategies to involve a focus on immunization care such as 2.01, 2.02, 3.00, and 4.60, HHSC will not add a new Related Strategy; however, to clarify this intention, HHSC can revise RS-IDs 2.01, 2.02, 3.00, and 4.60 to include immunization as an example within their descriptions.
- Since HHSC intends for many of the Related Strategies under the Access to Care and Social Determinants of Health Themes and other existing Related Strategies to involve the principles of and focus on patient-centered care such as RS-IDs 2.00, 2.12, 3.20, 4.10, 4.20, 4.40, and 4.50, HHSC will not add a new Related Strategy.
- Since financial assistance, social cohesion, and jail diversion were broadly suggested, HHSC will not add a new Related Strategy.

24. A few stakeholders requested the removal of Related Strategies, as listed below, from particular Lists.

- 3.20: Analysis of appointment “no-show” rates
- 3.40: Formal partnership or arrangement with schools/school districts to track/share data such as absenteeism, classroom behaviors, etc.
- 5.00: Screening patients for food insecurity
- 5.01: Formal partnership or arrangement with food resources to support patient health status (e.g. local food banks, grocery stores, etc.)
- 5.10: Screening patients for housing needs

- 5.11: Formal partnership or arrangement with housing resources to support patient health status (e.g. affordable housing units, transitional housing, rental assistance, etc.)
- 5.12: Screening patients for housing quality needs
- 5.13: Formal partnership or arrangement with housing quality resources to support patient health status (e.g. housing inspections, pest control management, heating and other utility services, etc.)
- 5.20: Screening patients for transportation needs
- 5.21: Formal partnership or arrangement with transportation resources to support patient access to care (e.g. public or private transit, etc.)

HHSC Response: HHSC will remove RS-ID 3.20 from the Hospital Safety List (H/PP) as suggested. HHSC will also remove RS-IDs 5.00, 5.01, 5.10, 5.11, 5.12, 5.13, 5.20, and 5.21 from the Palliative Care and Specialty Care (H/PP) List as suggested, given the advanced stages of disease for patients receiving palliative care services.

HHSC will not remove RS-ID 3.40 since it is only included in two Hospital/Physician Practice Lists, two Local Health Department Lists, and one Community Mental Health Center List, all of which are Related Strategy Lists that are associated with pediatric Measure Bundles/measures; HHSC maintains that RS-ID 3.40 is appropriately included in the Related Strategy Lists associated with pediatric Measure Bundles/measures.

25. One stakeholder suggested that RS-IDs 4.81 and 4.82 be categorized under the Care Coordination Theme and RS-ID 4.83 be categorized under the Data Analysis Theme instead of their current categorization under the Disease Management Theme.

- 4.81: Checklist(s) (or similar standardized protocol) tailored to prevent hospital safety-related events
- 4.82: Formal process for monitoring compliance with hospital safety-related protocols (includes reviews, "secret shopper" approaches, etc.)
- 4.83: Formal process for analyzing and addressing hospital safety-related events (includes root-cause analyses, remediation policies, etc.)

HHSC Response: Understanding that the Related Strategies Themes are not perfect categorizations for all individual Related Strategies, HHSC will keep RS-IDs 4.81, 4.82, and 4.83 under the Disease Management Theme rather than re-categorizing them as suggested. Since these three Related Strategies are only included in the Hospital Safety (H/PP) List, HHSC intends to view these Related Strategies as strategies for managing the "disease" or occurrence of a hospital-safety related event.

26. While most stakeholders did not express any concerns regarding the average number of Related Strategies in a List, eight stakeholders generally expressed their opinion that there should be less Related Strategies in a List,

and one stakeholder suggested that less Related Strategies be included specifically in the Rural Primary Care (H/PP) List and the Rural Emergency Care (H/PP) List.

HHSC Response: Other than the removals noted in the previous responses, (the removal of RS-IDs 1.31 from all associated Lists and the selective removal of RS-ID 3.20 from the Hospital Safety (H/PP) List and the selective removal of RS-IDs 5.00, 5.01, 5.10, 5.11, 5.12, 5.13, 5.20, and 5.21 from the Palliative Care and Specialty Care (H/PP) List), HHSC does not intend to remove any other Related Strategies from any Lists. For example, HHSC will not remove any more Related Strategies specifically from the Rural Primary Care (H/PP) List or from the Rural Emergency Care (H/PP) List.

As a reminder, reporting on the Related Strategies will not require any qualitative information. Instead, drop-down selections will be provided for reporting on each Related Strategy. A provider's previous reporting indication selections will also be pre-populated when providers are required to make updates to their Related Strategies reporting indications.

27. A few stakeholders expressed their opinion that new Related Strategies should be added to focus on unnecessary inpatient admissions and ED visits as well as transitions of care in rural settings. A few stakeholders suggested selectively including existing Related Strategies under the Disease Management Theme into the Hospital Readmissions and Emergency Department Utilization (H/PP) List, and two stakeholders specifically suggested adding the following three new Related Strategies into the Hospital Readmissions and Emergency Department Utilization (H/PP) List:

- Improve identification and coordination of care into a primary medical home for patients without one including patients who are uninsured.
- Provision of home therapies (example: photo therapy blanket) to uninsured patients after discharge or in the outpatient setting.
- Include Palliative Care Coordination for patients with high disease burden, high risk disease processes for improved end of life management.

HHSC Response: Since most stakeholders did not request the addition of Related Strategies in a List, HHSC will not add more Related Strategies specifically to the Hospital Readmissions and Emergency Department Utilization (H/PP) List. Although HHSC will not add the three newly-suggested Related Strategies into the Hospital Readmissions and Emergency Department Utilization (H/PP) List, the first and third newly-suggested Related Strategies (c.i. and c.iii.) are described within the existing RS-IDs 2.20 and 2.30, which are already included in the Hospital Readmissions and Emergency Department Utilization (H/PP) List.

Related Strategies Reporting

28. Approximately half of the stakeholders wanted clarification about Related Strategies reporting requirements. Ten stakeholders wanted clarification about how the Related Strategies reporting requirements will impact associated DY9-10 payments.

HHSC Response: As part of the DY9-10 RHP Plan Update, providers are required to complete the Category C Related Strategies reporting tab. As part of the DY9 and DY10 Category C reporting milestone payments, providers are required to update the Related Strategies reporting indications (based on the reporting indications made in the DY9-10 RHP Plan Update). A provider's Related Strategies reporting indications made in DY9 and in DY10 will not impact payments associated with DY9 and DY10 Category C reporting milestones, unless the Related Strategies reporting tab is submitted incompletely and/or incorrectly.

29. Many stakeholders wanted guidance regarding how to determine which reporting indications to select for a given Related Strategy and how HHSC would review and approve Related Strategies reporting year to year.

HHSC Response: As determined by DY9-10 Measure Bundle (H/PP) or measure selection (LHD, CMHC), providers will be required to report on one or more associated Related Strategies Lists. As a reminder, reporting on the Related Strategies will not require any qualitative information. Instead, for each Related Strategy within a required Related Strategies List, providers will make two reporting indications regarding the strategy's implementation (e.g. Implementation Date and Implementation Status) using drop-down selections for each reporting indication. A provider's previous reporting indication selections will be pre-populated when providers are required to make updates to their Related Strategies reporting indications.

Even if a provider has not implemented one of the Related Strategies in a List, there will be drop-down selections for both reporting indications that would capture the appropriate response. For example, for the first reporting indication (Implementation Date), providers may expect drop-down selections such as "Before DSRIP", "DY1-6", "DY7-8", "Planned for DY9-10", and "Not applicable." For the second reporting indication (Implementation Status), providers may expect drop-down selections such as "Implemented in small scale", "Implemented throughout system", "Implemented then discontinued", "Not yet implemented", and "Not applicable." Thus, if a provider has not implemented a Related Strategy, then for the first reporting indication (Implementation Date), that provider would likely select either "Planned for DY9-10" or "Not applicable", and for the second reporting indication (Implementation Status), that provider would then likely select either "Not yet implemented" or "Not applicable."

HHSC will provide additional guidance on Related Strategies reporting (including examples as requested) in a forthcoming Companion Document. However, HHSC does not intend to review and/or approve Related Strategies reporting based on progress made or volume of Related Strategies implemented from year to year.

HHSC will also provide more information about the Related Strategies reporting template when available; however, providers can expect the Related Strategies reporting to occur via a reporting tab (within an Excel file) similar to previous Category C reporting templates. Moreover, the "Related Strategies Crosswalk" sheet in the accompanying Excel file ("Related Strategies_20190605") found on the online reporting system bulletin board is a helpful preview for what providers can expect the Related Strategies reporting template to look like.

30. One stakeholder suggested reporting only on Related Strategies in a List that showed positive impact so that providers could learn from each other.

HHSC Response: Rather than restricting Related Strategies reporting based on "positive implementation impact", HHSC is requiring providers to make two reporting indications per Related Strategy, e.g. Implementation Date and Implementation Status. By structuring Related Strategies reporting in this way, HHSC aims to analyze "impact" by way of the relationship between Related Strategies and Category C performance achievement, rather than analyzing the Related Strategies themselves; in fact, HHSC intends for Related Strategies reporting analyses to examine both positive and null/negative relationships with Category C performance achievement. Furthermore, HHSC will share Related Strategies reporting with providers.

31. One stakeholder expressed concerns with possible reporting duplication between Core Activities (Category A) and Related Strategies (Category C).

HHSC Response: Related Strategies (Category C) and Core Activities (Category A) are similar in that they both involve better understanding what kinds of strategies providers are implementing to meet Category C achievement goals. In fact, the individual Related Strategy descriptions were informed by, but not limited to, Core Activity descriptions.

However, there are key differences between Related Strategies and Core Activities. First, the Lists of Related Strategies include strategies a provider may have implemented, even apart from DSRIP, which may not be included in Core Activities reporting. Second, unlike Core Activities reporting, Related Strategies reporting will not include a qualitative reporting component. Third, even if multiple Category C measures are selected, providers are only required to report on at least one Core Activity, leaving a gap in understanding what strategies were implemented across all selected Measure Bundles/measures for a given provider or across providers selecting shared

Measure Bundles/measures. Related Strategies reporting will allow HHSC to examine the relationship between Related Strategies and providers demonstrating higher Category C performance achievement among shared Measure Bundles or measures.

32. Two stakeholders asked if HHSC can provide updates on value-based purchasing initiatives associated with Related Strategies reporting.

HHSC Response: Yes, HHSC will provide updates to stakeholders if there are any value-based purchasing initiatives associated with Related Strategies reporting.

Menu of Measures

33. One stakeholder requested the addition of the following measures to the local health department menu: M1-262 Assessment of Risk to Self/Others, M1-263 Assessment of Psychosocial Issues of Psychiatric Patients, M1-265 Housing Assessment for Individuals with Schizophrenia, and M1-342 Time to Initial Evaluation: Evaluation within 10 Business Days.

HHSC Response: HHSC has added the requested measures to the Local Health Department Menu as measures L1-262, L1-263, L1-265, and L1-342.

34. One stakeholder requested clarification on the point value assigned to innovative measures that are P4P in DY9-10.

HHSC Response: HHSC has proposed that only one innovative measure be converted to P4P in DY10 (F1-T03 Oral Cancer Screening). This measure will be optional and worth one additional point if selected in DY9-10. All other innovative measures have been discontinued in DY9-11 due to lack of support from participating entities for converting to P4P.

Other Comments on Category C

35. One stakeholder requested clarification on the status of providers approved for a limited scope of practice designation in DY7-8.

HHSC Response: Providers approved for a limited scope of practice for DY7-8 will maintain that limited scope of practice designation if needed in DY9-10.

36. A number of providers submitted questions and comments about goal setting indicated in the Program Funding and Mechanics Protocol.

HHSC Response: The Program Funding and Mechanics Protocol is still under negotiation with CMS.