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RHP Plan Update

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Healthcare Transformation Waiver
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Overview

- DY7-8 RHP Plan Update Template
- Timeline
- Category C:
  - Overview
  - Requirements
  - Attribution & Eligible Denominator Population
  - Exception Requests
  - Valuation

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DY7-8 RHP Plan Update Template

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Template Overview

- **Category B**
  - Requires definition of system through the selection and description of system components.
  - Requires entry of Medicaid and Low-income Uninsured (MLIU) Patient Population by Provider (PPP) that must be maintained or increased in DY7-8.
  - Requires selection of the population(s) included in the MLIU PPP.
  - Allows requests to use DY5 or DY6 instead of the average of DY5-6 as the baseline with strong justification.

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Template Overview (cont.)

- **Category C**
  - Requires selection of Measure Bundles/measures to meet or exceed the Minimum Point Threshold (MPT).
  - Allows requests for measure volume changes, shortened or delayed baselines, baseline numerators of zero, and payer-type reporting exceptions.
  - Allows distribution of Category C valuation among Measure Bundles/measures within minimum and maximum requirements.

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Template Overview (cont.)

- **Category A**
  - Requires indication of transition from DY2-6 projects to DY7-8 Core Activities.
  - Requires descriptions of Core Activities.
  - Each selected Measure Bundle/measure must be associated with a Core Activity.
- **Category D** lists measures and requires confirmation of understanding of reporting.
- Allows updates to Intergovernmental Transfer (IGT) information.
- Requires certification of information entered and understanding of limited allowed changes.

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Template Completion

- **Current providers** must complete the main provider template.
  - This includes providers that previously withdrew and are eligible to participate in DY7-8.
  - Providers that previously participated in multiple regions, must complete the template in their "home" RHP.
- **New providers** that are participating in DSRIP through one of the eight regions that received additional funds must complete the *new* provider template.

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Template Completion (cont.)

- Hospitals and physician practices with a **limited scope of practice** (e.g., children's hospitals, specialty hospitals, cancer centers, and Institutions for Mental Disease) that wish to request a reduced MPT must submit the request to HHSC by March 2, 2018.
  - Providers must list the Measure Bundles that they believe they can reasonably report in their request.
  - Rural hospitals are not considered to have a limited scope of practice.
  - Providers requesting a reduced MPT should **not** complete the current provider template until their MPT has been finalized and HHSC has provided them with an updated template.

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Template Notes

To ensure the template works properly, be sure to:

- Enable macros
- Enable editing
- Enable content
- Enable automatic calculation of formulas
- Allow 1-4 seconds for the template to calculate after an entry
- Click on another cell if the template does not immediately populate/expand after an entry

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RHP Plan Update Timeline

- **February 28, 2018** – Due date for RHP Plan Update submission to be eligible to report Category C baselines and Category D in April DY7.
- **April 30, 2018** – Final due date for RHP Plan Update submission.
- **Estimated 30 days after submission** – HHSC will complete review of each RHP Plan Update and request any additional information (NMI).
- **Estimated 14 days after HHSC review** – NMI responses due to HHSC.
- **June 30, 2018** – HHSC will approve or disapprove each RHP Plan Update.

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Resources

Providers should review the following documents posted on the reporting system Bulletin Board before sending questions to HHSC:

- RHP Plan Update Companion Document
- Category B FAQ
- Category C Specifications – these are final, HHSC will only update for errors
- Category C Specifications Introduction
- Category C Specifications FAQ

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Category C Overview

Category C Objective

- Quality measures are standardized tools that help quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care.
- The intent of Category C is to incentivize delivery system reform. While the technical aspects of measurement are demanding, the ultimate goal is improvements in the healthcare delivery system including better health outcomes and lower costs of care.

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Category C Measurement

- Category C is not reimbursement for services and is not volume driven.
- Providers should continue to provide high quality care including elements that are not measured in Category C.
- Quality measures are a tool for measuring delivery of healthcare services and population health outcomes built on best practices and clinical guidelines but they are not a standalone recommendation for best practices or clinical guidelines.
- Providers earn incentive payments for demonstrating *incremental* improvements in key quality measures.

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Category C and B

- Category B system definition is the starting point for Category C. Category C is not the PPP reported under Category B.
- Category C *denominators* are determined by the DSRIP system. *Numerators* do not necessarily need to measure activities that occur exclusively in the DSRIP system.
  - For example, immunizations, cancer screenings, eye exams, follow-ups may occur outside of the system so long as the provider has appropriate documentation of the required numerator elements.

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Category C Requirements

CMHC & LHD
Measure Selection Requirements

- CMHCs and LHDs select measures to meet or exceed their MPT and maintain their valuation.
- CMHCs and LHDs must select at least two measures.
- CMHCs and LHDs with valuation >$2.5M must select at least one 3-point measure.

- Exception for depression response measures:
  - If a CMHC selects more than one of the depression response measures M1-165, M1-181, or M1-286, only 3 points will be counted towards the Performing Provider's MPT.

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Hospital & Physician Practice
Measure Selection Requirements

- Hospitals and physician practices select Measure Bundles to meet or exceed their MPT and maintain their valuation.
- Each hospital or physician practice with valuation >$2.5M, must select at least one Measure Bundle with a 3-point measure.
- Only hospitals with valuation <$2.5M may select K1 or K2.
- Each hospital or physician practice with an MPT of 75 must select at least one Measure Bundle with a Population Based Clinical Outcome (PBCO).

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Hospital & Physician Practice
Population Based Clinical Outcomes

- Denominator is Target Population
  - Denominator is based primarily on diagnosis and ambulatory care relationship/high ED utilization.
- Numerator is the rate of specified ED visits or admissions for individuals in the target population
  - Numerator elements do not need to occur within the DSRIP performing provider system.
- For Measure Bundle D4 and D5, PBCOs are required as P4P if the bundle is selected.

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Hospital & Physician Practice
Population Based Clinical Outcomes

For Measure Bundles A1, A2, C1, D1, H2

- Providers with an MPT of 75:
  - PBCOs are REQUIRED if Measure Bundle is selected.
  - PBCO points (+4) are added to the Measure Bundle and are not impacted by state priority multipliers.

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Hospital & Physician Practice Population Based Clinical Outcomes

For Measure Bundles A1, A2, C1, D1, H2:

- Providers with an MPT less than 75 AND any numerator volume:
  - PBCOs are required if Measure Bundle is selected. Providers may chose to report as P4P (RECOMMENDED) or P4R.
  - If reported as P4P, PBCO points (+4) are added to the Measure Bundle points and are not impacted by state priority multiplier.
  - If reported as P4R, no points (+0) are added to the Measure Bundle points and measure valuation is treated as a measure with insignificant volume where the measure receives a valuation, but the achievement milestone valuation is distributed to other P4P measures in the bundle.
- Providers requesting no numerator volume will be reviewed closely by HHSC.

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Hospital & Physician Practice
I1 Specialty Care Bundle

- Measure Bundle I1 can only be selected once for a total of two points.
- Requires prior authorization (provider must have had a specialty care project in place in DY6; instrument does not have to have been in place as part of the project)
- Some approved instruments are included in the specifications.
- Providers will define instrument (and justification for use in accordance with specifications if not on the pre-approved list), and DY6 specialty care project in the RHP Plan Update Template.
- HHSC can provide guidance prior to RHP Plan Update Submission to providers interested in using instruments that are not on the pre-approved list. Providers may email the waiver mailbox for review. HHSC is developing additional guidance on details to submit with a request.

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Category C
Attribution & Eligible Denominator Population

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Eligible Denominator Population

Step 1: Determine the DSRIP attributed population using the prescribed attribution methodology.

Step 2: Determine the individuals from step one that are included in the Measure Bundle or measure target population.

Step 3: Determine the individuals from the Measure Bundle target population that meet the measure specific denominator inclusion criteria.

Step 4: Determine payer type for individuals or encounters in the denominator following standardized specifications to determine the all payer, Medicaid, and uninsured rate for each.

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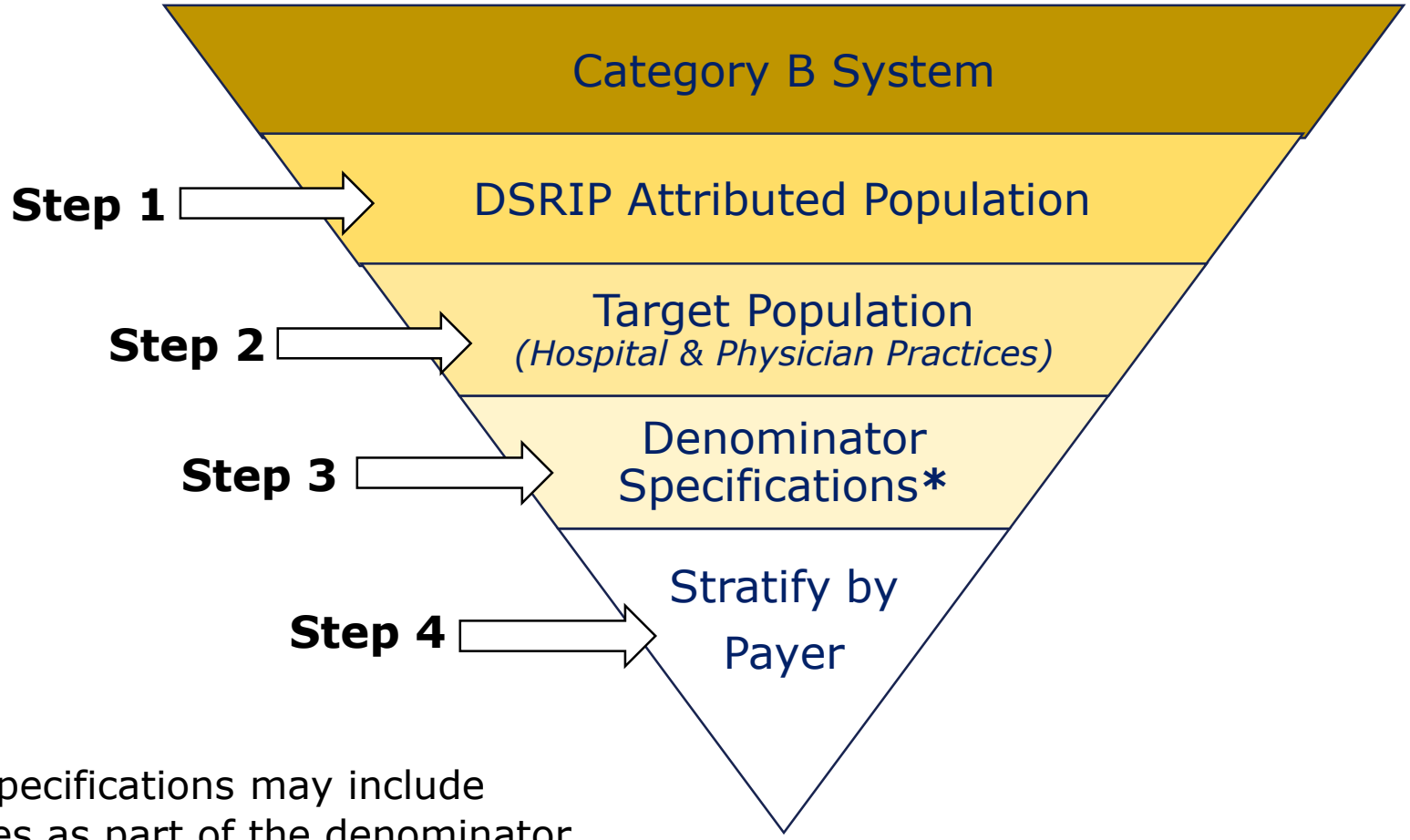
Category C Attribution



*Denominator specifications may include specific visit types as part of the denominator inclusion criteria.

Step 1: DSRIP Attributed Population

- The DSRIP attributed population is the broadest pool of individuals under the Category B system for which a Performing Provider is accountable under DSRIP incentive arrangements.
- Based on Provider Type and relevant pieces of the DSRIP Attributed System.
- There is no reporting activity specific to just the DSRIP attributed population.

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Hospital & Physician Practice
DSRIP Attributed Population

Individuals from the DSRIP system defined in Category B that meet at least one of the criteria below	
a. Medicaid beneficiary attributed to the Performing Provider during the measurement period as determined by assignment to a primary care provider (PCP), medical home, or clinic in the performing providers DSRIP defined system	b. Individuals enrolled in a local coverage program (for example, a county-based indigent care program) assigned to a PCP, medical home, or clinic in the performing providers DSRIP defined system
c. One preventive service provided during the measurement period	d. One ambulatory encounter during the measurement year and one ambulatory encounter during the year prior to the measurement year
e. Two ambulatory encounters during the measurement year	f. Other populations managed with chronic disease in specialty care clinics in the performing providers DSRIP defined system
g. One emergency department visit during the measurement year	h. One admission for inpatient or observation status during the measurement year
i. One prenatal or postnatal visit during the measurement year	j. One delivery during the measurement year
k. One dental encounter during the measurement year	l. Enrolled in a palliative care or hospice program during the measurement year
m. Other populations not included above that should be included in a measure bundle target population included in the RHP plan submission and approved by HHSC (for example, individuals enrolled in community based education programs)	

CMHC & LHD
DSRIP Attributed Population

Individuals from the DSRIP system defined in Category B that meet at least one of the criteria below	
CMHC	i. One encounter with the performing providers system during the measurement year and one encounter during the year prior to the measurement year
	ii. Two encounters with the performing providers system during the measurement year
	iii. Other populations defined by the CMHC in the RHP Plan Submission and approved by HHSC
LHD	i. Individuals with one eligible encounter during the measurement period
	ii. Other populations defined by the LHD in the RHP Plan Submission and approved by HHSC

DSRIP Attributed Population Exclusions

Allowable Exclusions for all provider types:

- Performing providers may remove from the DSRIP attributed population any individual for which the provider has documentation of any one of the following during the measurement year:
  - The individual that was previously assigned a PCP, medical home, or clinic with the provider but has changed their care to a PCP, medical home, or clinic that is not with the performing providers DSRIP system.
  - The individual has had a total time of incarceration during the measurement period that exceeded 45 days.

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Step 2: Target Population

- Identifies a targeted segment of the DSRIP attributed population that should be included in the Measure Bundle.
- A target population narrows the DSRIP attributed population. Some of the narrowing criteria include:
  - Age
  - Diagnosis
  - Visit history (including visit types)
  - Program enrollment
- There is no reporting activity requirement specific to just the Target Population (for PBCOs, the denominator is equal to the target population)
- Not applicable to CMHCs and LHDs

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Target Population Measurement

- Target population and visit requirements do not need to be met before a numerator element can be conducted (unless explicitly specified in the Measure Specifications).
- An individual does not need to qualify for the DSRIP attributed population and target population before required numerator elements are completed.
- *Example:*
  - BMI Assessment – an individual does not need to meet the target population requirements before a BMI assessment can be conducted.

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Step 3: Denominator Specifications

- Measures include encounter type requirements for denominator inclusion.
- For some providers that do not use the specified visit codes, these codes may need to be mapped to a local definition.

Examples
A1-207 Diabetes BP Control (Claims Based)
- Denominator Includes: Patient encounter during the performance period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439
H1-146 Screening for Depression (eMeasure)
- Denominator includes: AND: "Encounter, Performed: Depression Screening Encounter Codes" during "Measurement Period" - Additional Information includes: "Encounter, Performed: Depression Screening Encounter Codes" using "Depression Screening Encounter Codes Grouping Value Set (2.16.840.1.113883.3.600.1916)"

Step 4: Payer Type Stratification

- For measures with standard payer type reporting requirements (all-payer, Medicaid, uninsured), payer type is determined by the unit of measurement identified in the Measure Specifications (Individual or Encounter)
  - Encounter: payer-type is based on the recorded encounter
  - Individuals: payer type is based on most recent payer type of record at the end of the reporting period (OR provider may align with PPP payer type definition where any Medicaid enrollment in the year is counted as Medicaid)
- Some measures are reported as all-payer or Medicaid only as defined in the Measure Specifications.
- Providers may request exceptions to the payer type reporting with good cause in the RHP Plan Update.

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Denominator Example (Pt 1)

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H1-146: Screening for Clinical Depression & Follow-Up Plan

Target Population
Medicaid beneficiary attributed to the Performing Provider during the measurement period as determined by assignment to a primary care provider (PCP), medical home, or clinic in the performing providers DSRIP defined system.
Individuals enrolled in a county based local coverage program assigned to a PCP, medical home, or clinic in the performing providers DSRIP defined system
One preventive service provided during the measurement period
One ambulatory encounter during the measurement year and one ambulatory encounter during the year prior to the measurement year
Two ambulatory encounters during the measurement year
Three emergency department visits during the 24 month period ending with the end of the measurement period

Denominator Example (Pt 2)

H1-146: Screening for Clinical Depression & Follow-Up Plan

Measure Denominator
AND: Age>= 12 year(s) at: "Measurement Period" AND: "Encounter, Performed: Depression Screening Encounter Codes" during "Measurement Period" "Encounter, Performed: Depression Screening Encounter Codes" using "Depression Screening Encounter Codes Grouping Value Set (2.16.840.1.113883.3.600.1916)" • *OID 2.16.840.1.113883.3.600.1916 86 includes codes (SNOMED, CPT, HCPS) of the visit types that this measure is looking at. Visit types include both* ***preventive visits****, gyn. visits, psych visits, other specialty care visits.*

Denominator Example (Pt 3)

H1-146: Screening for Clinical Depression & Follow-Up Plan

Target Population
Medicaid beneficiary attributed to the Performing Provider during the measurement period as determined by assignment to a primary care provider (PCP), medical home, or clinic in the performing providers DSRIP defined system.
Individuals enrolled in a county based local coverage program assigned to a PCP, medical home, or clinic in the performing providers DSRIP defined system
One preventive service provided during the measurement period
One ambulatory encounter during the measurement year and one ambulatory encounter during the year prior to the measurement year
Two ambulatory encounters during the measurement year
Three emergency department visits during the 24 month period ending with the end of the measurement period

Denominator Example (Pt 4)

Exclude from the denominator individuals who met the denominator specified visit but did meet the target population.

- The individual does not meet the target population if ALL of the following are true:
  - The denominator specified visit type is not a preventive service AND
  - The individuals is not covered by Medicaid or a local coverage program and assigned to the DSRIP system AND
  - The individual had only one ambulatory visit in the measurement year and the year prior AND
  - The individual had fewer than three ED visits on record in the DSRIP performing providers system during the measurement year and the year prior (3 visits in 24 months) AND
  - The individual has been incarcerated for more than 45 days during the measurement period.

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Denominator Example (Pt 5)

H1-146: Screening for Clinical Depression & Follow-Up Plan

- Provider will report the baseline rate for individuals that meet the denominator criteria for the measure stratified by payer type (all-payer, Medicaid, and uninsured)
- Based on the combined Medicaid and uninsured rate for the baseline (with some exceptions), goals will be set for DY7 and DY8 achievement milestones.
- Provider will follow same steps to report PY1 and PY2. **Note**, the eligible denominator patient population will change each year.

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Payer-Type Stratification for Category C

- **Medicaid**
  - Medicaid Fee-for-service
  - Medicaid managed care
  - Medicaid dual-eligible
  - Medicaid as a wrap-around or secondary coverage
  - CHIP
- **Low-Income Uninsured**:
  - Individuals that are uninsured (required) OR
  - Individuals for which a provider has appropriate documentation of income <200% FPL during the measurement year (optional)
- *NOTE: For Category B, providers will report a single combined MLIU rate and will not stratify PPP by payer type.*

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Category C
Exception Requests

RHP Plan Update Requests

- The following Category C baseline details are requested in the RHP Plan Update:
  - Baseline Numerator of Zero
  - Shortened Baseline Measurement Period
  - Delayed Baseline Measurement Period
  - No or insignificant volume for a measure (Hospitals & Physician Practices Only)
  - Payer-type reporting milestone exceptions

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Baseline Requirements

- Standard Baseline Measurement Period:
  - Six or twelve months of data ending by 12/31/2017.
- For measures that do not have six or twelve months of data ending by 12/31/2017, some exceptions are allowed to be requested in the RHP Plan Update.
  - Providers should review the baseline data planning guidelines for possible resolutions before requesting an exception.

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Baseline Data Planning Guidelines

Providers should report baselines using one of the following scenarios organized in order of preference.

1. Twelve months of data ending 12/31/17 using electronic or administrative data or sampling
2. Six months of data ending 12/31/17 using electronic or administrative data or sampling
3. Baseline Numerator of Zero (if measure is eligible)
4. Twelve months of approximate data ending 12/31/17
5. Six months of approximate data ending 12/31/17
6. Delayed baseline ending by 09/30/2018

Intent of Policy:

- Ensure meaningful goals
- Providers can begin improvement as early in DY7 as possible

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Baseline Numerator of Zero

- Measures that are QISMC (national benchmarks available) and designated as process measures may be eligible to report with a baseline numerator of zero, essentially skipping the baseline collecting period.
- Can only be used in cases where a provider has no measureable numerator because the required numerator inclusions and exclusions are not tracked.
- DY7 and DY8 goals for measures approved for a baseline numerator of zero are indicated in the Cat C Measure Specifications.
- Providers will request and provide justification for a numerator of zero in the RHP Plan Update Template.

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Approximate Baselines

- Subset of system (data from the DSRIP performing provider's system that may not include all elements of the system for baseline)
- Clinically similar modifications to required elements of denominator specifications for baseline only
  - Foot exam
  - Suicide assessment
- Providers requesting to use an approximate baseline should e-mail HHSC a detailed description of the approximate element, its utilization, and how it is approximate to the required measure specification element.
- HHSC will maintain a record of approvable approximate baseline resolutions in the Category C FAQ, but providers should still seek specific approval from HHSC.

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Delayed Baselines

- *If no prior options are possible for a selected measure*, providers may request a delayed baseline ending no later than 09/30/18.
- At least six months of data are required.
- Does not result in decreased funding.
- Results in a change to the DY7 milestone so that achievement can only be earned in PY2 (CY2019).
- Providers will request and provide justification for a delayed baseline in the RHP Plan Update Template.

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Payer-type Exceptions (Pt 1)

Example A:

A small hospital has insignificant volume for a given measure for the combined MLIU rate, but has significant volume for the all-payer rate.

- Achievement milestone exception needed: **Yes** → *request use of all-payer rate on selection tab*
- Reporting milestone exception needed: **No**

Payer-type Exceptions (Pt 2)

Example B:

An LHD does not gather payer-type information for a selected measure that requires a standard payer-type stratification.

- Achievement milestone exception needed: **Yes** → *request use of all-payer rate on selection tab*
- Reporting milestone exception needed: **Yes** → *request exemption from reporting on Medicaid-only and LIU-only rate on additional details tab*

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Category C Valuation

Hospital & Physician Practice
Minimum Bundle Valuation

- Providers have flexibility in distributing valuation among Measure Bundles in the RHP Plan Update Template.
- Each selected Measure Bundle has a minimum valuation and a maximum valuation based on the point value of the Measure Bundle and the total point value of all selected Measure Bundles.
- Providers do NOT have flexibility to distribute valuation among measures within a Measure Bundle.

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Hospital & Physician Practice
Bundle Valuation Calculations

Where:

A = Measure Bundle Point Value

B = The sum of all selected Measure Bundles Point Values

C = Category C valuation

- Minimum Measure Bundle Valuation: **(A/B)*.75 * C**
- Maximum Measure Bundle Valuation for bundles with no P4P clinical or PBCO measure selected: **(A/B) * C**
- Maximum Measure Bundle Valuation for bundles with a P4P selected clinical or PBCO measure selected: **(A/B)*1.25 *C**

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Hospital & Physician Practice Valuation Example

- Selected Bundles Total 28 Points
- Category C DY7 Valuation of $7,700,000

Selected Bundles	Selected Points	Default Valuation	Min DY7 Valuation	Max DY7 Valuation
E1 Improved Maternal Care (P4P 3-point measure)	10	(10/28) = 35.75% ***$2,750,000***	(10/28) x .75 = 26.79% ***$2,062,500***	(10/28) x 1.25 = 44.64% ***$3,437,500***
E2 Maternal Safety (P4P 3-point measure)	8	(8/28) = 28.57% ***$2,200,000***	(8/28) x .75 = 21.43% ***$1,650,000***	(8/28) x 1.25 = 35.71% ***$2,750,000***
H3 Chronic Pain Management (No 3-point measure)	10	(10/28) = 35.78% ***$2,750,000***	(10/28) x .75 = 26.79% ***$2,062,500***	(10/28) = 35.71% ***$2,750,000***

- Providers must provide justification in the RHP Plan Update Template for valuation changes greater than one percent over the default valuation.
  - If the provider opts to increase E1 to 36%, then no justification is needed because it is less than a one percent change.
  - If the provider opts to increase E1 to 40%, then a justification is required addressing amount of improvement required, level of effort required for improvement, and size of population impacted compared to other Measure Bundles.

CMHC & LHD
Measure Valuation

- CMHC and LHD providers have flexibility in distributing valuation among measures in the RHP Plan Update Template.
- All measures have a minimum and maximum valuation.
- Providers must provide justification in the RHP Plan Update Template for valuation changes greater than one percent over the default valuation.

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CMHC & LHD
Measure Valuation Calculations

Where:

C = Total Category C Valuation

D = Number of Measures Selected

Minimum measure valuation: **(C/D)*.75**

Maximum measure valuation for 1-point and 2-point measures: **(C/D)**

Maximum valuation for a 3 point measure: **(C/D)*1.25**

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CMHC & LHD
Measure Valuation Example

Measure Selection	Point Value	Default DY7 Valuation	Min DY7 Valuation	Max DY7 Valuation
M1-165: Depression Remission at 12 Months	3 +1	1/10 = 10% $5 mil./10 $500,000	(1/10) x .75 = 7.5% $5 mil. /10*.75 $375,000	(1/10) x 1.25 = 12.5% $5 mil./10*1.25 $650,000
M1-181: Depression Response at 12 Months- Progress Towards Remission	(3 +1)*			
M1-241: Decrease in MH admissions to criminal justice settings	3			
M1-387: Reduce ED visits for BH and Substance Abuse	3 +1			
M1-257: Care Planning for Dual Diagnosis	1			1/10 = 10% $5 mil./10 $500,000
M1-259: Assignment of PCP to Individuals with Schizophrenia	1			
M1-260: Annual Physical Exam for Persons with Mental Illness	1 +1			
M1-265: Housing Assessment for Individuals with Schizophrenia	1 +1			
M1-340: Opioid Addiction Counseling	1 +1			
M1-342: Time to Initial Evaluation	1			
Selected Measures Total 20 points		Cat C DY7 Valuation of $5,000,000		

*M1-181 does not count towards MPT but functions like a 3-point measure for valuation

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Thank you

Mailbox:
TXHealthcareTransformation@hhsc.state.tx.us

Website:

https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver