

**Texas Health Care Transformation and Quality Improvement Program
1115 Waiver**

Frequently Asked Questions

RHP PLAN SECTION:

<p>Q1: RHP PLAN Do non-hospital Performing Providers need affiliation agreements and certifications?</p>	<p>A: No, HHSC only needs an Indigent Care Affiliation Agreement and Certification Form (private and government) if a <u>private hospital</u> is entering into an affiliation with a governmental entity (e.g. county, hospital district, city).</p> <p>Certification forms may be found at this link: http://www.hhsc.state.tx.us/rad/hospital-svcs/uc-dsrip.shtml</p>
<p>Q2: RHP PLAN Is there a page limit on providing supplemental community needs assessment information in the addendums?</p>	<p>A: HHSC prefers that RHPs limit additional supplemental materials to essential supporting community needs information. A list of web pages may be provided to link to additional documents. HHSC prefers the supplemental information be limited to no more than 50 pages.</p>
<p>Q3: RHP PLAN The Section V Project Tables don't include a place to reference the community needs that a project is addressing. Where should I include this information?</p>	<p>A: Please list the community need(s), including the unique Identification Number(s) from the table in Section III (e.g., CN.#), that the project will address in the "Rationale" section of the narrative for each project. We suggest listing the community needs in bulleted form, so that they are easy for reviewers to identify.</p>

ELECTRONIC WORKBOOK SECTION:

<p>Q1: ELECTRONIC WORKBOOK Can project valuation exceed the amount of IGT plus entered in the workbooks?</p>	<p>A: No. Your project value cannot exceed the amount of estimated available IGT plus related matching funds.</p>
---	--

CATEGORY 1 & 2 SECTION:

<p>Q1: CATEGORY 1 & 2 If my project uses customized milestones P-X and I-X, do I have to use the "other" project option?</p>	<p>A: No, you can use customized milestones P-X and I-X and insert them into defined project options.</p>
<p>Q2: CATEGORY 1 & 2 Must providers complete all metrics that are listed under a selected milestone or can they complete a subset of the metrics?</p>	<p>A: Providers do not have to select all metrics associated with a milestone. Providers can select one metric, a subset of metrics, or all metrics associated with a milestone.</p>
<p>Q3: CATEGORY 1 & 2 Must Category 1 and 2 improvement metric goals increase from one demonstration year to the next?</p>	<p>A: If you have an improvement metric in successive demonstration years, the goal of the improvement metric should increase in later years. For example, if the same improvement metric appears in DY 4 and DY 5, the goal in DY 5 should be higher than the goal in DY 4.</p>
<p>Q3: CATEGORY 1 & 2 If you have a Category 1 or 2 improvement metric in DY4, should you have it in DY5 also?</p>	<p>A: Providers only are required to have one improvement milestone during the years of the waiver; however, the provider could have more. Therefore, it is not required that a provider have the same improvement milestone in DY 5 that is in DY 4.</p>

CATEGORY 2 SECTION:

<p>Q1: CATEGORY 2 For project option 2.17.1, component (f) a bulleted list was inadvertently left off. How should the component appear?</p>	<p>A: 2.17.1 (f) Implement two or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population. Examples of interventions include, but are not limited to, implementation of:</p> <ul style="list-style-type: none">• Discharge checklists• “Hand off” communication plans with receiving medical and behavioral health providers• Wellness initiatives targeting high-risk behavioral health patients, such as WRAP, health planning and motivation strategies, Screening, Brief Intervention and Referral to Treatment (SBIRT) for substance use disorders,• Individual and family education initiatives including self-management skills.• Post-discharge medication planning• Early follow-up such as homecare visits, primary care outreach, and/or patient call-backs.• Transition and wellness support from certified peer specialists for mental health and /or substance use disorders.• More intensive follow-through programs, such as CTI or other evidence-informed practices, for individuals with more severe behavioral health disorders and other challenges, such as homelessness.• Electronic data exchange for critical clinical information to support excellent continuity of care.
<p>Q2: CATEGORY 2 What should be included in P-2.2 in Project 2.9 Establish/Expand a Patient Navigation Program?</p>	<p>A: P-2.2 should start with the last sentence on page 244: P-2.2 Metric: Number of unique patients enrolled in the patient navigation program.</p>

CATEGORY 3 SECTION:

<p>Q1: CATEGORY 3 Does a performing provider (PP) need to create one table for each outcome?</p>	<p>A: Yes the PP will need to create a table for each outcome (consists of process milestone(s) in DY 2 and DY3 and one outcome Improvement Target in DY 4 and DY5. The Outcome Improvement Target can be reported on in earlier years as well.</p>
---	--

<p>Q2: CATEGORY 3 When can a provider use TBD in Category 3?</p>	<p>A: As referenced in the PFM, a hospital performing provider should select which process milestones and which Outcome Improvement Targets will be used for DY2-DY5; however, the hospital performing provider may select TBD for the actual achievement level for the improvement target. (e.g 5% reduction in ED use, etc. – can use TBD instead of 5%). Outcome IT achievement levels will need to be established in DY3. A non-hospital provider may defer identifying Outcome Improvement Targets (referenced as IT-X.X) until DY3.</p>
<p>Q3: CATEGORY 3 In what case would a provider be required to add a non-standalone measure to a stand-alone measure as described in the 2nd bullet on page 358?</p>	<p>A: Performing providers are not required to add a non-standalone measure to a stand-alone measure to meet the requirements of Category 3. The second bullet gives an option to providers to add a non-standalone measure from a different domain. You may want to add a non-standalone measure if it complements the selected stand-alone measure. This option will also allow you to distribute valuation for Category 3 between multiple Outcome Improvement Targets.</p>
<p>Q4: CATEGORY 3 (<i>Template</i>) If a project is in Category 1 or 2, do we have to write a separate narrative for Category 3 or can that be incorporated in the Category 1 or 2 narrative in the “Related Category 3 Outcome Measure” section?</p>	<p>A: In the Category 1 and 2 description the provider needs to include a narrative about which Category 3 measure the provider is selecting and explain why this specific outcome or a combination of outcomes is selected for the project. In the Category 3 description, the provider will explain why specific improvement target achievement levels are selected. For example, the provider’s goal is to reduce PPRs by 4% in DY4 and 6% in DY5. The provider will need to include a narrative explaining why these outcome improvement target achievement levels were selected. The provider will also need to include in the narrative a description of the Process Milestones that will support selected Outcome Improvement Targets.</p>

<p>Q5: CATEGORY 3 Do performing providers need to select all Category 3 Process Milestones listed on page 363?</p>	<p>A: A provider does not need to select all Process Milestones for Category 3 that are listed on page 363. The provider can select one or more Process Milestones depending on what works for the project.</p>
<p>Q6: CATEGORY 3 Does a provider need to include all questions in the Patient Satisfaction Survey?</p>	<p>A: For a stand-alone measure, all questions need to be included in the survey. For example, the Getting timely appointments, care and information module has five questions. All of these questions need to be included in the provider's survey.</p>
<p>Q7: CATEGORY 3 Can a provider include different non-standalone measures in different demonstration years?</p>	<p>A: To meet the requirements of Category 3 by using non-standalone measures, a provider needs to include all three non-standalone measures in one year and measure the progress across the demonstration years (at least DY4 and DY5).</p>
<p>Q8: CATEGORY 3 Can a provider pick similar measures as Improvement Milestones in Category 1 and 2 and Outcome Improvement Targets?</p>	<p>A: The provider cannot select the same measures for the Improvement Milestones in Category 1 and 2 and Outcome Improvement Targets in Category 3.</p>

<p>Q9: CATEGORY 3 In Category 3 Outcome IT- 9.2, do PPs have to report/achieve improvement on each of the bulleted items or can they select one? For example, could a provider select “Reduce pedi ED visits” OR “Reduce ED visits for Diabetes”?</p>	<p>A: A PP can select one of the bullets in IT-9.2 as one outcome improvement target. In the 3rd bullet the provider can choose one or more sub-bullets depending on the project (e.g. Reduce ED visits for Diabetes)HHSC has also provided additional information related to IT-9.2 based on the providers’ questions:The respective provider needs to document the number of visits at baseline and the number of visits at the end of one year following the intervention taken to reduce the number of ED visits. The reporting can be as a proportion (percentage) as well. Included below are specifics for IT-9.2:</p> <ul style="list-style-type: none"> • Reduce all ED visits (including ACSC)HEDIS Measure Definition: This measure summarizes utilization of ambulatory care by calculating the number of ED visits per measurement year. • Reduce pediatric Emergency Department visits (CHIPRA Core Measure)Measure: Ambulatory Care: Emergency Department Visits Metric: The number of visits per member per year as a function of all child and adolescent members enrolled and eligible during the measurement year. • Reduce Emergency Department visits for target conditions – use the model for IT-9.3 adapted for the respective population and target condition.
<p>Q10: CATEGORY 3 Can a provider propose to use two other screening measures (total of three) that will be tracked and reported for IT-12.5 to meet the requirements of Category 3?</p>	<p>A: Yes, that should meet Category 3 outcome requirements - 3 non-standalone measures, which is in this case represented by the selection of three screening measures.</p>
<p>Q11: CATEGORY 3 Is IT - 12.5 a standalone or non-standalone measure?</p>	<p>A: IT-12.5 is a non-standalone measure. All measures in OD-12 are non-standalone.</p>

<p>Q12: CATEGORY 3 Which are validated and accepted tools that could be used by the performing providers?</p>	<p>A: Please note that this is not an all-inclusive list. The providers are encouraged to check with HHSC and CMS on the use of specific tools outside of the RHP menu.</p> <ul style="list-style-type: none"> - CAHPS Clinician & Group Surveys (adult and children surveys) - CAHPS Health Plan Survey - CAHPS In-Center Hemodialysis Survey - CG CAHPS – Clinician & Group CAHPS for ACOs - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) - Home Health Care Consumer Assessment of Healthcare Providers and Systems Survey (HHCAHPS) - Client Satisfaction Questionnaire (CSQ Scales) - Daily Living Activities (DLA-20) - Consumer Assessment of Behavioral Health Services (CABHS) - ECHO 3.0 - Experience of Care and Health Outcomes - RAND SF-36, SF-12, SF-8 - The Duke Health Profile. <p>Additional information can be found on the referenced website¹.</p>
--	--

CATEGORY 4 SECTION:

<p>Q1: CATEGORY 4 Do you have to report on all measures within the domains?</p>	<p>A: Yes, the providers have to report on all measures within the domain unless hospitals are exempt. Exemptions are specified in the companion document. See Companion Doc link below: http://www.hhsc.state.tx.us/1115-docs/CompanionDoc.pdf</p>
<p>Q2: CATEGORY 4 If a performing hospital provider doesn't participate in Domain 6, can the 5% (difference between 15% and 10%) be allocated to the other categories (1,2 & 3) or is it lost?</p>	<p>A: The difference between 10% and 15% can be allocated to other categories.</p>

¹ <http://www.integration.samhsa.gov/search?query=Patient+Satisfaction+Survey>

Q3: CATEGORY 4

In what year does Category 4 reporting begin?

A:

Category 4 reporting in most cases begins in DY 3, with the exception of reporting on PPCs, which begins in DY 4.

(Note: On p. 423 of the RHP Planning Protocol, there is a typo that indicates that reporting for item 1 under RD-4 begins in DY 3. This is inaccurate. Category 4 reporting on Patient Satisfaction begins in DY3.)