April DY8 Reporting – Companion Document

Contents

OVERVIEW

This document includes information on reporting during the first reporting period of DY8 including timelines, DY7 carryforward instructions, use of HHSC reporting templates, Category A-D guidance, and an overview of payment and IGT processing.

Each DSRIP provider should review this entire Companion Document to understand the guidelines for how to report DSRIP achievement for the April DY8 reporting period. The Companion Document includes important information about changes to required documentation compared to what was required for October DY7 reporting.

Reporting Deadline: Providers should report using the DSRIP Online Reporting System: https://dsrip.hhsc.texas.gov/dsrip/login by **11:59 p.m.** on **April 30, 2019**.

APRIL REPORTING CHECKLIST

Please review this checklist to ensure you have completed all items for April reporting. This checklist is for informational purposes only and should not be submitted with April reporting materials.

- ☐ Demonstration Year (DY) 7 carryforward and DY8 reporting information entered and saved in the Delivery System Reform Incentive Payment (DSRIP) Online Reporting System. *Please note that DY7 carryforward Category B milestones appear with an asterisk on the current year's Project Reporting page. DY7 carryforward Category C milestones appear with an asterisk on the Category C reporting tab under their Category C measures.*
- ☐ "Reporting Status" tab indicates "Ready to Submit" or "Report Submitted" for all sections. (As long as the completed reports and supporting attachments have been **saved** by the reporting deadline, they will be considered officially submitted.)
- ☐ Semi-Annual Reporting (SAR) requirements met: For all providers, the "Provider Summary Report" is complete in the DSRIP Online Reporting System.
- ☐ (If applicable) DY7 Carryforward Category B PPP information entered into the online reporting system. DY8 Category B PPP is not eligible to report achievement until October (Round 2).
- ☐ Category C reporting Template uploaded to the Category C tab of the online reporting system.
    - Save as: RHPXX_TPIXXXXXXX_CatC_AprDY8.xlsm (RHP01_123456789_CatC_AprDY8)
- ☐ Category C Certification uploaded to the Category C tab of the online reporting system.
    - Save as: RHPXX_TPIXXXX_CatC_OctDY7_Certification.pdf
      NOTE: Please make sure to remove ".xlsm" from the title of the PDF file.
- ☐ Category D reporting template uploaded to the Category D tab of the online reporting system.
    - Save as: RHPXX_TPIXXXXXXXX_CatD_AprDY8.xlsm
- ☐ All applicable items listed above submitted through the DSRIP Online Reporting System no later than **11:59 p.m.** on **April 30, 2019**.
- ☐ (If applicable) IGT changes in entities or proportion of IGT among entities submitted to HHSC (TXHealthcareTransformation@hhsc.state.tx.us) using the *IGT Entity Change Form* no later than 5:00 **p.m.** on **May 31, 2019** (One IGT Entity Change Form per provider).

KEY POINTS FOR APRIL DY8 REPORTING

- **Carryforward Milestones:** April DY8 is the final opportunity to report achievement of DY7 carryforward Category B M-6 and Category C RM-1 and IM-1 milestones. Please note, although the funding for Category C milestones RM-2 and AM-7.x is tied to DY7, they are not considered carryforward as they were not eligible to report until DY8.
- **Reporting Achievement**: For any metric/milestone that HHSC does not find sufficient evidence of achievement and/or required documentation, the provider will only have one opportunity in June/July to submit additional information. If the provider cannot demonstrate during the June/July "needs more information" (NMI) period that the metric/milestone was completed during the appropriate measurement period for the given metric/milestone, the provider will no longer be eligible for payment for that metric/milestone.
- **Reporting Materials**: Companion documents and reporting templates can be found on the Bulletin Board in the DSRIP Online Reporting System. Separate templates are required for DY8 Category C and DY8 Category D reporting. Below is a list of companion documents and reporting templates that can be found on the DSRIP Online Reporting System.
    - User Guide for the DSRIP Online Reporting System
    - Category C Reporting Template
    - Category D Reporting Template
- Send reporting questions to the HHSC waiver mailbox at TXHealthcareTransformation@hhsc.state.tx.us. Please remember to include your Regional Healthcare Partnership (RHP) number, Project ID, and Metric ID when submitting your questions.
- For technical instructions on using the DSRIP Online Reporting System, refer to the *DSRIP Online Reporting System User Guide* posted on the Bulletin Board in the DSRIP Online Reporting System.
- Please note that the DSRIP Online Reporting System refers to April reporting as Round 1 and October reporting as Round 2.

APRIL REPORTING TIMELINE

- **April 1, 2019** – The DSRIP Online Reporting System will open for providers to begin April DY8 reporting. The templates for Category C and Category D will be posted to the Bulletin Board as soon as they are available.
- **April 24, 2019** – Final date to submit questions regarding Category C April reporting and inform HHSC of any issues with DY7 data in the Category C Reporting Template or DSRIP Online Reporting System.
- **April 26, 2019** – Final date to submit Category A, Category B, and Category D questions regarding April reporting and inform HHSC of any issues with DY7 data in the DSRIP Online Reporting System.
- **April 30, 2019, 11:59 pm** – Due date for providers' submission of April DY8 DSRIP reporting using the DSRIP Online Reporting System and upload of applicable Category C and Category D templates. Late submissions will not be accepted.
- **May 1, 2019** – HHSC will begin review of the April reports and supporting documentation.
- **May 16, 2019** – HHSC will post the estimated IGT due for April reporting based on milestones and metrics reported as achieved. Final IGT due will be based on HHSC review and approval.
- **May 20, 2019, 5:00 pm** – Due date for IGT Entities to approve and comment on their affiliated providers' April reported progress on metrics using the "IGT Entity Feedback Form" that is posted on the Bulletin Board for DY7 carryforward milestone and metrics or the IGT tab for DY8 projects.
    - This is not an opportunity to identify technical errors entered in the DSRIP Online Reporting System. Examples of issues to include are reported progress that was not actually achieved, changes in project scope that were not reported by the provider, and risks to the project that were not reported by the provider. If there are no issues, comments do not need to be submitted, and HHSC will assume the IGT Entity has approved the reported information.

      If technical errors are identified in the DSRIP Online Reporting System, please use the Waiver mailbox to communicate those errors by April 26, 2019, as stated above.

- **May 31, 2019, 5:00 pm** – Due date for submission of any IGT changes in entities or proportion of IGT among entities submitted to HHSC (TXHealthcareTransformation@hhsc.state.tx.us) using the IGT Entity Change Form that is posted under Other 1115 Medicaid Waiver Forms on the Bulletin Board.
- **June 10, 2019** – HHSC and the Centers for Medicare and Medicaid Services (CMS) will complete their review and approval of April DY8 reports or request additional information (referred to as NMI) regarding the data reported. Note that HHSC completes multiple levels of review prior to determining that a milestone/metric requires additional information.
    - If additional information is requested, the DSRIP payment related to the milestone/metric will not be included with July DSRIP payments.
- **June 17, 2019** – Estimated date for Rate Analysis to send IGT notification.
- **July 2, 2019** – IGT settlement date for April reporting.
- **July 8, 2019, 11:59 pm** – Due date for providers to submit responses to HHSC requests for additional information (NMI requests) on April reported SAR requirements and reported Category A-D milestones/metrics achievement. Providers should include "NMI" in the file name when uploading documentation in response to NMI requests.
- **July 17, 2019** – April reporting **DY8 DSRIP payments** processed for transferring hospitals.

- **July 31, 2019** – April reporting **DY6 and DY7 DSRIP payments** for all providers and **DY8 DSRIP payments** processed for providers that were not paid on July 17, 2019. There are separate transactions for each payment for each DY.
- **August 9, 2019** – HHSC and CMS will approve or deny the additional information submitted in response to HHSC comments on April reported milestone/metric achievement. Approved reports will be included for payment in the next DSRIP payment period, estimated for January 2020.

DY8 REPORTING

SAR REQUIREMENTS

According to the Program Funding and Mechanics Protocol (PFM), Semi-annual Progress Reports must be submitted to HHSC. DSRIP payments may be withheld until the complete report is submitted. Although the SAR requirements have been removed at the project and metric levels for DY7-8 provider-level projects, providers will still be required to complete the "Provider Summary Report" which is entered into the DSRIP Online Reporting System.

The "Provider Summary Report" should be a brief overview of your DSRIP program's current progress, activities conducted, findings, and outcomes achieved. Providers with multiple Core Activities may submit an executive summary overview of all of their activities in the Provider Summary. Responses should be succinct and provide brief relevant detail.

CATEGORY A

Section 15 of the PFM includes a requirement to report on Category A to be eligible for payment of Categories B-D. Category A reporting consists of reporting on Core Activities, Alternative Payment Models (APM), Costs and Savings, and Collaborative Activities. Providers report on Category A during the October (Round 2) reporting period of each DY. The data entry fields on the Category A tab will be locked and read-only during the April DY8 reporting period since providers will not be entering anything into the reporting system for Category A.

Core Activities

Even though providers are not reporting on Core Activities during April (Round 1 reporting), providers needing adjustments in current activities can implement them and update their list of Core Activities and corresponding change ideas in October (Round 2) reporting. Providers do not need to receive HHSC approval to make changes to the existing Core Activities but will need to describe the changes in subsequent reporting (October 2019).

Costs and Saving

To meet the Costs and Savings reporting requirement for Category A, providers who have a total valuation of one million dollars or more per DY are required to submit the costs of at least one Category A Core Activity of choice and the forecasted or generated savings of that Core Activity.

Providers will not report on the Costs and Savings portion of Category A during April (Round 1) reporting. The results of the Costs and Savings analysis and the accompanying narrative are not due until October DY8 reporting. The Costs and Savings guidance document that is posted to the DSRIP Online Reporting System contains additional information related to the Costs and Savings portion of Category A.

Alternative Payment Models

Providers will not report on APM arrangements in April 2019. Updates to this section will be provided in October of 2019 with the rest of Category A reporting.

Collaborative Activities

Although the provider will not be reporting on Category A during the April (Round 1) reporting period, it is important to note that the provider **must attend/participate in one learning collaborative, stakeholder forum, or other stakeholder meeting during DY8 in order to meet Category A reporting requirements during the October (Round 2) reporting period**.

CATEGORY B

April DY8 is the only opportunity for providers to report achievement of their DY7 carryforward Medicaid and Low-Income Uninsured (MLIU) Patient Population by Provider (PPP) metric for Category B. DY8 MLIU PPP metrics are not eligible to report until October (Round 2), so the data entry fields on the DY8 Category B tab will be locked and read-only.

To complete reporting of the DY7 carryforward MLIU PPP metric, providers will enter their reporting information directly into the DSRIP Online Reporting System on the carryforward Category B tab of their DY7-8 provider-level project. The carryforward Category B milestone tab is located at the end of the current A-D milestone tabs and has an asterisk (i.e., Category B*). Category B does not have a required template or other required documentation, but an upload button is available should the provider want to save documentation. For example, a provider may want to document and save the methodology they used to count their MLIU PPP so that it can be referenced by provider staff members in future DYs. Providers are not required to submit supporting documentation to demonstrate or validate achievement, but providers should maintain supporting documentation used to calculate their MLIU PPP in case of audit.

Reporting Achievement of DY7 Carryforward Category B Metrics

To report achievement of the DY7 carryforward MLIU PPP metric, the provider should go to the Current Reporting Values section of their carryforward Category B tab and select "Yes" in the "Reporting Achievement?" field. The provider should then complete the following required reporting fields:

- "Total PPP Numeric Achievement" - Enter the total number of unique individuals who received a face-to-face or virtual encounter (of equivalent service that would be provided within the physical confines of the defined system) within the provider's defined system during the DY7 measurement period (10/1/17 - 9/30/18). Note that the measurement period does not change for carryforward metrics.
- "MLIU PPP Numeric Achievement" - Enter the number of unique **MLIU** individuals who received a face-to-face or virtual encounter (that is the equivalent of a service that would be provided within the physical confines of the defined system) within the provider's defined system during the DY7 measurement period (10/1/17 - 9/30/18). **Note that the measurement period does not change for carryforward metrics.** In general, providers should be using the same methodology to count their DY7 MLIU PPP that they used to count their MLIU PPP baseline. If there has been a change to the MLIU methodology, the provider should document the change in the "Optional Provider Comments" field.
- "Explanation for MLIU Percentage Change" - If there is a significant difference between the baseline MLIU percentage and the calculated MLIU percentage for DY7, the provider should enter a brief explanation for this change (e.g., data errors, changes in population, etc.). Otherwise, the provider can note that there was not a significant change to their MLIU percentage. The provider can refer to

the baseline MLIU percentage displayed in the Metric Details section to compare it to the calculated MLIU percentage in the Current Reporting Values section.

Once Total PPP and MLIU PPP have been entered, the provider must save the project report in order for the "MLIU Percentage" and "Percentage of Goal Achieved" fields to calculate and be displayed. The "Percentage of Goal Achieved" field will display 100% achieved if the provider reports that they meet, exceed, or fall within the range of allowable variation of their MLIU PPP numeric goal; partial achievement at 90%, 75%, or 50% if their reported MLIU PPP numeric achievement falls within the appropriate ranges for partial achievement; or 0% achieved if reported MLIU PPP numeric achievement is below 50% of the MLIU PPP numeric goal. The percentage of goal achieved is not based on the MLIU percentage. There is also the "Optional Provider Comments" field, where the provider can communicate any additional information (e.g., changes in methodology, NMI responses, changes to previously reported information, etc.). As the field's title suggests, these comments are optional and not required in order to complete the Category B reporting tab when reporting achievement.

As a reminder of who should be included in the PPP count, the PFM provides the following description: "an individual is a patient receiving a face-to-face or virtual encounter (a service, billable or not) that is the equivalent of a service that would be provided within the physical confines of the defined system. This could include home-visits or other venue-based services that are documented. The service should be billable or charted. Providers are not allowed to count phone calls, text messages, or undocumented encounters." Providers will still be counting unique individuals who have received these types of services within the DY7 measurement period (10/1/2017 - 9/30/2018) for their DY7 carryforward MLIU PPP metric. Providers may want to refer to the Category B FAQ document for additional guidance on what should be included in the PPP count. The Category B FAQ document is posted on the DSRIP Online Reporting System's Bulletin Board.

Forfeiting Category B

A provider may opt to forfeit their DY7 carryforward Category B metric by selecting "No" for "Reporting Achievement." The provider will be required to enter an explanation in the "Optional Provider Comments" field to confirm their intentions.

CATEGORY C PART 1: REPORTING OVERVIEW & POLICIES

General Information

- The Category C Reporting Template and certification should be uploaded to the Category C Tab of the online reporting system.
  - The Chief Quality Officer or executive responsible for validating accuracy of Cat C reporting should print the summary tab of the reporting template and sign. A copy of the signed certification should be uploaded along with the reporting template.
  - Save the Category C Reporting Template as:
    RHPXX_TPIXXXX_CatC_OctDY7.xlsm
    (e.g., RHP01_123456789_CatC_OctDY7.xlsm).
  - Save the Category C Certification PDF as:
    RHPXX_TPIXXXX_CatC_OctDY7_Certification.pdf
    (e.g., RHP01_123456789_CatC_OctDY7_Certiciation.pdf)
  - NOTE: Please make sure to remove ".xlsm" from the title of the PDF file.
- All providers must submit a Category C Reporting Template in the April DY8 reporting period, regardless of April DY8 reporting status.
- Providers will not make any selections in the online reporting system related to Category C during the primary reporting period. HHSC will update the online reporting system with reporting selections in accordance with what is submitted in the Category C Reporting Template after reporting is submitted (estimated for mid-May).
- Send Category C questions related to Category C reporting to the Healthcare Transformation mailbox by **April 23, 2019**, especially if questions involve baselines flagged for TA, or making corrections to reporting templates.
- Providers that have previously reported a baseline that has been accepted by HHSC are eligible to report Performance Year (PY) 1. April DY8 is the first opportunity to report achievement of DY7 milestone AM-7.x.
- For measures approved for a delayed baseline, April DY8 is the last opportunity to report achievement of DY7 milestone RM-1.
- Measures reporting a baseline for the first time in April DY8 (RM-1 was not previously approved for payment October DY7 or October DY7 NMI) cannot report PY1 during April DY8 reporting.
- Measures with a baseline reported in Summer DY7 or October DY7 that is not currently flagged for TA will be eligible to submit a baseline correction if needed through the Category C Reporting Template, and can report PY1 at the same time.
- All Category C reporting is subject to compliance monitoring.

Category C Milestone Structure

Each Category C Milestone uses the following variables to determine what must be reported or achieved to earn payment for Category C milestones. Providers can review their milestone structures in the Category C Summary Workbook posted to the DSRIP Online Reporting System's bulletin board, as well as the Category C Reporting Template. Providers can also review certain aspects of a measure's milestone structure in the DSRIP Online Reporting System.

- **Baseline Measurement Period Type:** Each measure has been approved for either a standard baseline or a delayed baseline measurement period. The baseline measurement period type determines the end date for a measure's baseline measurement period.
    - Standard Baseline: A standard baseline is six to twelve months of data that ends on 12/31/2017. Measures with a standard baseline are eligible to earn achievement milestone payments beginning with Performance Year (PY) 1.
    - Delayed Baseline: a delayed baseline is six to twelve months of data the ends between 01/01/2018 and 9/30/2018. Providers were granted approval in the RHP Plan Update to use a delayed baseline for certain measures with good cause. Measures with a delayed baseline are eligible to earn achievement milestone payments beginning with PY2.
- **Goal Type:** Each measure has a goal type this is either P4P or P4R that indicates what milestones are associated with the measure.
    - Pay for Performance (P4P): All measures are P4P unless a measures is an innovative measure, a P4P measure that has been approved for P4R due to insignificant all-payer, or a PBCO measure that was approved as P4R in the RHP Plan Update. A P4P measure has reporting milestones and achievement milestones in DY7 and DY8.
    - Pay for Reporting (P4R) (insignificant volume): A measure is P4R if a provider has insignificant all-payer volume as approved in the RHP Plan Update or as a result of Baseline Technical Assistance. A measure that is P4R due to insignificant volume has reporting milestones only.
    - P4R (Population Based Clinical Outcome): as defined in the measure bundle protocol, certain providers were eligible to request in the RHP Plan Update to report PBCO measures as P4R. A PBCO measure that was approved as P4R in the RHP Plan Update has a reporting milestone only.
    - P4R (Innovative Measure): A measure is P4R if it is classified as an innovative measure. Innovative measures have innovative measure reporting milestones only.
- **Achievement Milestone Payer Type:** Each P4P measure has a defined achievement milestone payer-type (MLIU, All-Payer, Medicaid, or LIU) as approved by HHSC, which is the payer-type used to set goals and determine achievement for Category C achievement milestones. For most measures, the combined Medicaid and LIU rate will be used to determine achievement.
    - MLIU: The combined Medicaid and LIU rate is the achievement payer-type for most measures and is determined by combining the reported Medicaid and LIU rates.
    - All-Payer: The all-payer rate is the achievement payer-type for hospital safety measures and for certain measures with insignificant MLIU volume as approved in the RHP Plan Update.
    - Medicaid only: The Medicaid only rate is the achievement payer-type for Timeliness of Prenatal Care and for certain measures with data limitations as approved in the RHP Plan Update (not common).
    - LIU only: The LIU only rate is the achievement payer-type for certain measures with data

limitations as approved in the RHP Plan Update (not common).

- **Reporting Milestone Payer Types:** Each measure has defined reporting milestone payer-types (All-Payer, Medicaid, and LIU) as approved in the RHP Plan Update. Reporting milestone payer-types must be reported to earn payment for Category C reporting milestones. The reporting milestone payer-types will be one or more of Medicaid, LIU, and all-payer rates. Most measures will require all three payer- type rates be reported. If a reporting milestone is assigned more than one payer-type, all assigned payer-types must be reported to earn achievement of the reporting milestone.

Example A:

Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)

The above milestone structure means a measure has a standard baseline that ends 12/31/2017, the measure is P4P, the achievement milestone is based on the combined Medicaid and LIU rate, and the provider must report the Medicaid, LIU, and all-payer rates to earn the reporting milestone. This is the most common milestone structure.

Example B:

Delayed P4P (A: All-Payer; R: All Payer, Medicaid, LIU)

The above milestone structure means a measure has a delayed baseline that ends after 12/31/2017 but before 09/30/2018, the achievement milestone is based only the all-payer population, and the provider must report the Medicaid, LIU, and all-payer rates to earn the reporting milestone. This example represents a measure approved for a delayed baseline and with an approved exception to use the all- payer population for the goal achievement milestone because of insignificant MLIU volume.

Category C Milestones

Standard P4P Measures

DY	Milestone	Goal Type	Description	Associated Data Year	% of Measure Valuation
DY7	RM-1	P4R	Baseline Reporting	Baseline	25%
	RM-2	P4R	PY1 Reporting	PY1	25%
	AM-7.x	P4P	Achievement of DY7 Goal	PY1, PY2	50%
DY8	RM-2	P4R	PY2 Reporting	PY2	25%
	AM-8.x	P4P	Achievement of DY8 Goal	PY2, PY3	75%

Delayed P4P Measures

DY	Milestone	Goal Type	Description	Associated Data Year	% of Measure Valuation
DY7	RM-1	P4R	Baseline Reporting	Baseline	25%
	RM-2	P4R	PY1 Reporting	PY1	25%
	AM-7.x	P4P	Achievement of DY7 Goal	PY2	50%
DY8	RM-2	P4R	PY2 Reporting	PY2	25%
	AM-8.x	P4P	Achievement of DY8 Goal	PY2, PY3	75%

Standard or Delayed P4R due to insignificant volume or PBCO selected as P4R

DY	Milestone	Goal Type	Description	Associated Data Year	% of Measure Valuation
DY7	RM-1	P4R	Baseline Reporting	Baseline	25%
	RM-2	P4R	PY1 Reporting	PY1	25%
DY8	RM-3	P4R	PY2 Reporting	PY2	25%
*NOTE: The valuation percentage doesn't add up to 100% in each DY. The unassigned measure valuation is redistributed to the achievement milestones of other P4P measures in the measure bundle.					

P4R Innovative Measures

DY	Milestone	Goal Type	Description	Associated Data Year	% of Measure Valuation
DY7	IM-1	P4R	RY1 Reporting	RY1 (DY7)	100%
DY8	IM-2	P4R	RY2 Reporting	RY2 (DY8)	100%

Detailed Milestone Description

P4P Measures, measures that are P4R due to insignificant volume, and PBCO measures selected as P4R.

NOTE: All assigned reporting milestone payer-types must be reported to earn payment for reporting and achievement milestones. Providers must report all reporting milestone payer-types for a given measure at the same time.

- **DY7 Milestone RM-1** is the baseline *reporting* milestone.
  - Baseline reporting milestones can be earned by reporting the baseline rates for the approved reporting milestone payer-types for a given measure.
  - For measures with a standard baseline that ends 12/31/2017, RM-1 can be earned by reporting baselines in the early baseline reporting period or the DY7 R2 reporting period.
  - For measures with a delayed baseline that ends by 03/31/2018, RM-1 can be earned by reporting baselines in the early baseline reporting period or the DY7 R2 reporting period.
  - For measures with a delayed baseline that ends between 04/01/18 and 9/30/18, RM-1 can be earned by reporting baselines in the DY7 R2 reporting period or the DY8 R1 reporting period.
  - RM-1 is assigned 25% of a measures DY7 valuation.

- **DY7 Milestone RM-2** is the PY1 *reporting*.
  - The PY1 reporting milestone can be earned by reporting the PY1 rates for the approved reporting milestone payer-types for a given measure.
  - For all measures PY1 is 01/01/2018 - 12/31/2018.
  - RM-2 can be earned by reporting PY1 in the DY8 R1 reporting period or the DY8 R2 reporting period.
  - RM-2 is assigned 25% of a measures DY7 valuation.

- **DY7 Milestone AM-7.x** is the DY7 *achievement* milestone for P4P measures.
  - For P4P measures with a standard baseline that ends by 12/31/17, the achievement milestone can be earned by achieving or making progress towards the DY7 goal in the PY1 measurement period or the PY2 measurement period.
  - For P4P measures with a delayed baseline, the achievement milestone can be earned by achieving or making progress towards the DY7 goal in the PY2 measurement period only. The DY9 R1 primary reporting period is the last opportunity to report for achievement of Milestone AM-7.1.
  - Because of limitations on how long HHSC is able to issue payments for a DY7 milestone, if a measure has a delayed baseline or does not fully achieve the DY7 goal in PY1, PY2 achievement must be reported in the primary DY9 R1 reporting period and cannot be reported during the DY9 Rd 1 NMI period.
  - AM-7.x is assigned 50% of a measures DY7 valuation. If a measures is P4R due to insignificant volume, or a PBCO measure selected as P4R, the 50% measure valuation assigned to AM-7.x is redistributed proportionally to the other AM-7.x milestones associated with P4P measures in the measure bundle.
  - RM-2 and AM-7.x must be reported at the same time. Providers do not to need to fully or partially achieve AM-7.x in order to earn payment for RM-2. Measures with a delayed baseline can report RM-2, while carrying forward reporting of AM-7.

- **DY8 Milestone RM-3** is the PY2 *reporting* milestone.
    - The PY2 reporting milestone can be earned by reporting the PY2 rates for the approved reporting milestone payer-types for a given measure.
    - PY2 is 01/01/2019 - 12/31/2019.
    - RM-3 can be earned by reporting PY2 in the DY9 R1 reporting period or the DY9 R2 reporting period. While PY2 may be reported in the DY9 R2 reporting period for milestone RM-3, it must be reported in DY9 R1 if PY2 is being used to report achievement of DY7 milestone AM-7.1. RM-3 is assigned 25% of a measures DY8 valuation.

- **DY8 Milestone AM-8.x** is the DY8 *achievement* milestone for P4P measures.
    - For all (standard and delayed) P4P measures, the achievement milestone can be earned by achieving or making progress towards the DY8 goal in the PY2 measurement period or the PY3 measurement period. The DY10 R1 primary reporting period is the last opportunity to report for achievement of Milestone AM-8.1.
    - Because of limitations on how long HHSC is able to issue payments for a DY8 milestone, if a measure does not fully achieve the DY8 goal in PY2, PY3 achievement must be reported in the primary DY10 R1 reporting period and cannot be reported during the NMI period.
    - AM-8.x is assigned 75% of a measures DY8 valuation. If a measures is P4R due to insignificant volume, or a PBCO measure selected as P4R, the 75% measure valuation assigned to AM-8.x is redistributed proportionally to the other AM-8.x milestones associated with P4P measures in the measure bundle.
    - RM-3 and AM-8.x must be reported at the same time. Providers do not to need to fully or partially achieve AM-8.x in order to earn payment for RM-3.

Innovative P4R Measures/Quality Improvement Activities

- **DY7 Milestone IM-1** is the DY7 *reporting* milestone associated with innovative measures and quality improvement activity measures.
    - DY7 is the Reporting Year (RY) 1 measurement period for innovative measures.
    - October DY7 is the first opportunity to report RY1 for achievement of IM-1. April DY8 is the last opportunity to report RY1 for achievement of IM-1.

- **DY8 Milestone IM-2** is the DY8 *reporting* milestone associated with innovative measures and quality improvement activity measures.
    - DY8 is the RY 2 measurement period for innovative measures. October DY8 is the first opportunity to report RY2 for achievement of IM-2.
    - April DY9 is the last opportunity to report RY2 for achievement of IM-2.

Category C Payer Types

Category C measures will be reported with a payer-type stratification as outlined in the Category C Specifications. The Medicaid and LIU payer-types should include individuals that meet the following.

Medicaid

- Medicaid Fee-for-service
- Medicaid managed care
- Medicaid dual-eligible
- Medicaid as a wrap-around or secondary coverage
- Children's Healthcare Insurance Plan (CHIP)

Low-Income Uninsured

- Individuals who are uninsured (required)
- Individuals for whom a provider has appropriate documentation of income <200% FPL during the measurement year (optional)

The method for assigning a payer-type to a denominator case depends on the unit of measurement (individual or encounter). Providers should review the Category C Specifications Introduction for further guidance on stratifying a rate by payer-type for different units of measurement.

Category C Reporting Schedule (Baseline - PY3) for P4P Measures

Data Year	Associated Milestones	Measurement Period	Reporting Eligibility
Baseline (Standard)	DY7 RM-1	Ends 12/31/2017	Early, DY7 R2
Baseline (Delayed)		Ends 1/1/2018 - 03/31/18	
		Ends 04/01/18 - 9/30/18	DY7 R2, DY8 R1
PY1	DY7 RM-2 DY7 AM-7.1	CY2018	DY8 R1 DY8 R2
PY2	DY8 RM-3 DY8 AM-8.1 *DY7 AM-7.1 CF**	CY2019	DY8 R2 DY9 R1**
PY3	*DY8 AM-8.1 CF**	CY2020	DY10 R1**

*Carryforward of achievement if goal is not 100% met during first associated PY.

**If a PY is being reported for Carryforward of Achievement, due to limits on how long HHSC can make payments on carried forward milestones, the PY being reported to earn carried forward achievement must be reported in the primary reporting period and cannot be reported in the NMI reporting period.

Goal Calculation

Goals for DY7 and DY8 achievement milestones are determined using a standard formula as approved in the Program Funding and Mechanics Protocol (PFM). Goals for DY7 and DY8 are automatically calculated when a provider enters baseline numerator and denominator information in the Category C Reporting Template. Goals can also be calculated in the Category C Goal Calculator, and goals for previously reported baselines can be confirmed in the Category C Summary Workbook. The Goal Calculator and the Summary Workbook are both posted to the DSRIP Online Reporting System Bulletin Board.

Goals for DY7 and DY8 are set as an improvement over a reported baseline. Goals for DY8 are not impacted by achievement in DY7.

Each P4P Category C measure has an assigned goal calculation type identified in the Measure Specifications. Each measure is identified as either Quality Improvement System for Managed Care (QISMC) where goals are set relative to the reported baseline and national benchmarks or Improvement over Self (IOS) where goals are set relative to the reported baseline only.

If a measure's goal calculation type is QISMC, the formula used to determine DY7 and DY8 goals will be determined by the baseline relative to High Performance Level (HPL) and the Minimum Performance Level (MPL). In some cases where a provider's baseline is close to the HPL, the goal may be set using an "improvement floor." An improvement floor is a fixed amount of improvement rather than a gap closure.

Each measure has an assigned directionality that can be identified in the Category C Specifications. The directionality identifies the direction of improvement that represents improvement in the reported score. If an outcome has a positive directionality, higher scores indicate a better outcome. If an outcome has a negative directionality, lower scores indicate a better outcome.

QISMC Goal Calculation

Directionality	Baseline	DY7 Goal	DY8 Goal
Positive	Below MPL	MPL	MPL + .10 x (HPL - MPL)
	Equal to or greater than the MPL and lower than the HPL	The greater of: Baseline + .05 x (HPL - Baseline) or Baseline + .02 x (HPL - MPL)	The greater of: Baseline + .20 x (Baseline - HPL) or Baseline + .08 x (HPL - MPL)
	Equal to or greater than the HPL	The lesser of: Baseline + .02 x (HPL - MPL) or Baseline + .025 * (1 - Baseline)	The lesser of: Baseline + .08 x (HPL - MPL) or Baseline + .10 * (1 - Baseline)
Negative	Above MPL	MPL	MPL - .10 x (MPL - HPL)
	Equal to or less than the MPL and greater than the HPL	The lesser of: Baseline - .05 x (Baseline - HPL) or Baseline - .02 x (MPL - HPL)*	The lesser of: Baseline - .20 x (Baseline - HPL) or Baseline - .08 x (MPL - HPL)*
	Equal to or less than the HPL	The greater of: Baseline - .02 x (MPL - HPL)* or Baseline - .025 x Baseline	The greater of: Baseline - .08 x (MPL - HPL)* or Baseline - .10 x Baseline

*Improvement Floor Goal Calculation

IOS Goal Calculation

Directionality	DY7 Goal	DY8 Goal
Positive	Baseline + .025 x (1 - Baseline)	Baseline + .10 x (1 - Baseline)
Negative	Baseline - .025 x Baseline	Baseline - .10 x Baseline

Achievement Calculation

Providers earn incentive payments for Category C achievement milestones by achieving or making progress towards a goal in the PYs associated with each DY's achievement milestone. Providers earn 100% of the achievement milestone valuation if 100% of the goal is achieved. Providers may earn partial payment if some of the goal is achieved. Partial payment is available in quartiles as defined in the PFM.

Goal Achievement	Payment
Less than 25% achievement of Goal	No Payment for Achievement Milestone
At least 25% achievement of Goal	25% of funds for Achievement Milestone
At least 50% achievement of Goal	50% of funds for Achievement Milestone
At least 75 % achievement of Goal	75% of funds for Achievement Milestone
100% Achievement of Goal	100% of funds for Achievement Milestone

Unearned funds can be carried forward into the next Category C 12-month performance measurement period. Achievement may not be carried forward beyond the 12 months following the performance measurement period in which initial achievement was less than the goal.

Category C goal achievement formulas are determined by the measure directionality (positive or negative) and the baseline measurement period type (standard or delayed). Goal achievement can be confirmed in the Category C Goal Calculator and will be automatically calculated in the reporting template when performance is reported. Goal achievement is calculated as follows:

Achievement Calculations for Category C P4P Outcomes

DY	Milestone	PY	Positive Direction (higher rates indicate improvement)	Negative Direction (Lower rates indicate improvement)
DY7	AM-7.x *(standard baselines only)*	PY1	(PY1 achieved - baseline)/(DY7 goal - baseline)	(baseline - PY1 achieved)/(baseline - DY7 goal)
	Carryforward of AM-7.x	PY2	(PY2 achieved - baseline)/(DY7 goal - baseline)	(baseline - PY2 achieved)/(baseline - DY7 goal)
DY8	AM-8.x	PY2	(PY2 achieved - baseline)/(DY8 goal - baseline)	(baseline - PY2 achieved)/(baseline - DY8 goal)
	Carryforward of AM-8.x	PY3	(PY3 achieved - baseline)/(DY8 goal - baseline)	(baseline - PY3 achieved)/(baseline - DY8 goal)

Example of Goal Achievement Calculation with Positive Directionality

Baseline	0.5000
DY7 Goal	0.5125
DY8 Goal	0.5500
PY1 Achievement Reported in DY8 R1	0.5120
PY2 Achievement Reported in DY8 R2	0.5600

DY7 AM-7.1 % of goal achieved in PY1 = (PY1 achieved - baseline)/(DY7 goal - baseline)
(0.5120 - 0.5000)/(0.5125 - 0.5000) = .96 or 96%

AM-7.1 = 75% of goal achieved in PY1

DY7 AM-7.1 % of goal achieved in PY2 = (PY2 achieved - baseline)/(DY7 goal - baseline)
(0.5600 - 0.5000)/(0.5125 - 0.5000) = 4.8 or 480%

AM-7.1 = 100% of goal achieved in PY2

DY8 AM-8.1 % of goal achieved in PY2 = (PY2 achieved - baseline)/(DY8 goal - baseline)
(0.5600 - 0.5000)/(0.5500 - 0.5000) = 1.2 or 120%

AM-8.1 = 100% of goal achieved in PY2

In this example, the provider was eligible to receive 75% of funds associated with this AM-7.1 milestone when PY1 is reported in DY8 R1 and carried forward the unearned 25% to be potentially earned in PY2. Based on PY2 reporting in DY9 R1, the provider is eligible to receive the additional 25% of unearned funds carried forward from DY7 milestone AM-7.1 and is eligible to receive 100% of funds associated DY8 milestone AM-8.1.

Supporting Documentation for Category C Reporting

Providers should maintain internal records of the reports used to abstract the numerator and denominator for Category C outcomes to ensure comparable abstraction methods are used across measurement periods should HHSC or the compliance monitor ask to see additional details.

All reporting is subject to compliance monitoring. In cases where compliance monitoring determines that actual achievement is less than reported achievement, payments above actual achievement will be recouped.

Providers are required to adhere to measure specifications as outlined in the Measure Bundle Protocol (MBP) and Category C Specifications. Approval of a reported baseline or performance year does not constitute approval to report outside measure specifications. If at any point HHSC or a compliance monitor identifies that a provider is reporting a Category C measure outside measure specification, performance reporting payment may be withheld or recouped and the provider will be required to bring reporting into compliance with Category C Specifications.

Category C Corrections

All measures with a baseline that was previously reported and either accepted or accepted after TA will be eligible to submit a baseline correction if needed though the April DY8 Category C reporting template. Measures that are eligible to submit a correction will be indicated in the Category C Reporting Template. Measures that submit a correction will be asked the same questions as a measure that is newly reporting baseline and will also be asked to describe the need for the correction.

Providers should not request a measurement period change without explicit prior approval from HHSC.

Providers should not report performance against a baseline that is known to be incorrect.

E2-A01 Quality Improvement Collaborative Activity

There are no requirements for E1-A01 reporting in April DY8.

For October DY8 reporting, HHSC will provide a DSRIP specific reporting template for providers to certify that they have met the payment requirements, and indicate the dates that the required elements were complete. This template will be available prior to October DY8 (currently expected for August 2019). HHSC will also verify participation with DSHS. HHSC will not be asking for additional documentation beyond the certification (for example, we do not need copies of sign in sheets from collaborative events).

Category C Resources

Providers are encouraged to review all available resources to ensure they are reporting Category C measures accurately and in accordance with approved protocols. Available resources are posted to the waiver website or online reporting system bulletin board and include the following:

- Program Funding and Mechanics Protocol
- Measure Bundle Protocol
- Category C Specifications
  - Part 1: Introduction - FOR ALL PROVIDERS TO REVIEW
  - Part 2: Hospital/Physician Practices Measure Bundles
  - Part 3: Local Health Department (LHD) Measures
  - Part 4: CMHC Measures
- Category C Specifications FAQ
- Myers and Stauffer, LC (MSLC) Data Support Guide
- MSLC Data Support Guide FAQ
- MSLC tools for 30 day readmissions risk-adjusting
- Category C Goal Calculator (includes sampling guidance)

CATEGORY C PART 2: REPORTING TEMPLATE INSTRUCTIONS

1.0 Template Instructions Introduction

This document contains instructions for completing the Category C Reporting Template. The Category C Reporting Template allows providers to report on their selected Category C measures and/or Measure Bundles for the baseline, RY1, and PY1 measurement periods. The Category C Reporting Template can be found on the DSRIP Online Reporting System. For additional information on Category C that could be useful in completing the Category C Reporting Template, reference the MBP and the DSRIP Category C Measure Specifications Introduction and the Category C Goal Calculator that are on the DSRIP Online Reporting System's bulletin board.

Questions regarding the Category C Reporting Template or this documents should be sent to TXHealthcareTransformation@hhsc.state.tx.us. Providers must upload the completed Category C Reporting Template and the signed Measure Reporting Summary section document to the online reporting system.

2.0 Generating Template: The Step 1 Tab

This tab requires providers to input general provider information, input provider primary contact information, and displays information related to provider's selected measures and/or selected Measure Bundles. The sections below offer a brief overview of the type of information displayed and the types of information required for input in each subsections within the Step 1 tab.

2.1 *Information for Primary Contact (regarding information reported in this template)*

On the Step 1 tab, complete the yellow cells under the Information for Primary Contact (regarding information reported in this template) section, which includes the name, phone, and email of the primary contact regarding information reported in this template.

2.2 *Provider Information*

On the Step 1 tab, select the provider's RHP number and the provider's Texas Provider Identifier (TPI) number in the yellow cells from the drop-down menu under the Provider Information section.

Once the TPI is selected, the Provider and System Definition fields in the Provider Information section will populate.

2.3 *Measure Summary*

Once the TPI in the Provider Information section is selected, the Measure Summary section will populate with information related to provider's selected measures and/or Measure Bundles. The Measure

Summary section is for informational purposes only. Provider do not need to complete any fields in this section. The chart in this section displays the Measure ID, the Measure Title, the Milestone Structure, and the whether or not the measure is Eligible to Report Baseline.

Measure Summary

Measure ID	Measure Title	Milestone Structure	Eligibile to Report?
C1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	Yes
C1-113	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	Yes
C1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	Yes
C1-268	Pneumonia vaccination status for older adults	Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	Yes
C1-269	Preventive Care and Screening: Influenza Immunization	Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	Yes
C1-272	Adults (18+ years) Immunization status	Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	Yes
C1-280	Chlamydia Screening in Women (CHL)	Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	Yes
C1-389	Human Papillomavirus Vaccine (age 18 -26)	Standard P4P (A: MLIU; R: All Payer, Medicaid, LIU)	Yes
C1-502	PQI 91 Acute Composite (Adult Dehydration, Bacterial Pneumonia, Urinary Tract Infection A	Standard P4R (All Payer, Medicaid, LIU)	Yes

2.4 *Progress Indicators*

At this point, the Progress Indicator section at the top of the Step 1 tab will show "Complete" for the Contact Information and RHP and TPI Input cells. In order for this section to show "Complete" for the Create Measure Tabs in the Progress Indicators section, provider needs to select the blue Create Measure Specific Tabs button at the bottom of the tab. Do not select this button until the Contact Information and RHP and TPI Input cells show complete under the Progress Indicator section.

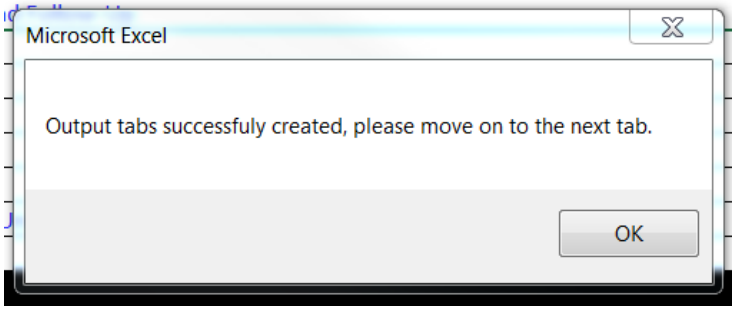
Progress Indicators

Contact Information:	Complete
RHP and TPI Input:	Complete
Create Measure Tabs:	Incomplete

2.5 *Create Measure Specific Tabs*

Select the Create Measure Specific Tabs button at the bottom of the Step 1 tab. This button will create measure-specific tabs — one tab for each of provider's measures — along with a Reporting Summary tab. Once this button is selected, it could take the Excel file about 30 seconds to 2 minutes to generate the measure-specific tabs.

Once the measure-specific tabs and the Reporting Summary tab have been generated, provider should see a dialogue box indicating that provider should continue to the next tab. At this point, the Create Measure Tabs in the Progress Indicators section row will show as "Complete."



There should now be a tab for each measure that the provider will be reporting on along with a Reporting Summary tab at the end. These measure-specific tabs should correspond to the list of measures that are outlined in the Measure Summary section of the Step 1 tab.

3.0 Overview of Generated Measure-Specific Tabs

Each measure-specific tab (e.g., C1-105, C1-147, etc.) contains up to six sections as follows:

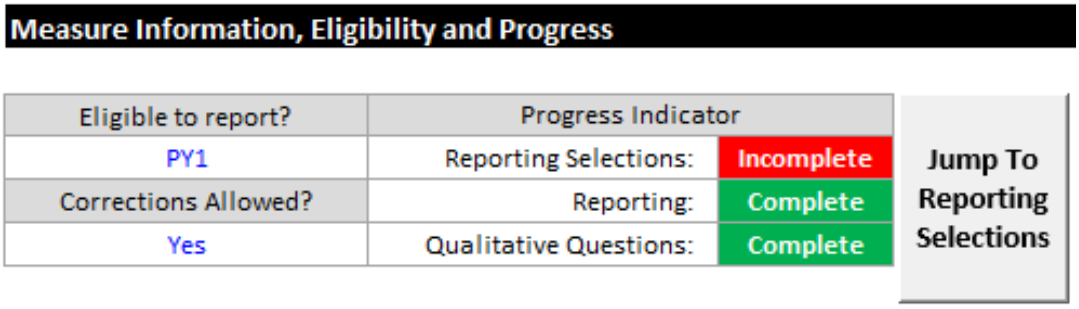
- the Measure Information, Eligibility, and Progress section;
- the Measure Summary section;
- the Summary of Past Reporting section;
- the Reporting Selections section;
- the Reporting section; and
- the Qualitative Questions section.

This document will provide additional information on these sections within each measure-specific tab. The number of sections displayed on each measure-specific tab could vary based on each measure's reporting requirements.

3.1 *Measure Information, Reporting Eligibility, and Progress Section*

The right side of this section displays the RHP number, TPI number, Provider name, Measure ID, and the Title of the measure. All of these fields are prepopulated — no user input is required.

The chart to the left includes a column that indicates progress made in completing the measure-specific tab (Progress Indicator). This chart also contains columns that indicate if the measure is eligible to report



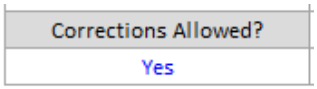
(Eligible to report?) and if corrections are allowed (Corrections Allowed?). These three columns are explained in more depth below. The rows in this chart include the names of the three sections in the measure-specific tab that require provider input.

For convenience, a "Jump To Reporting Selections" button is included as well. This button will jump the user to the Reporting Selections section — the first section that will require provider input on the measure-specific tabs.

3.1.1 *Progress Indicator Column*

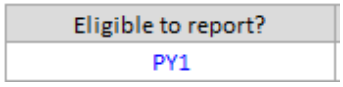
This column tracks the progress made in completing the measure-specific tab. Provider should continue through this document to see how and when this progress indicator will indicate "Complete."

3.1.2 *Corrections Allowed Column*



The corrections allowed column will indicate "Yes" if providers are allowed to make corrections to previously reported values through the reporting template. It will indicate "No", if there are no previously reported values to correct, or if the provider has a baseline TA flag that was not cleared prior to seeding of the reporting template. Providers with baseline TA flags that were cleared after the template was seeding that need to make corrections will need to contact HHSC to obtain directions on how to make corrections.

3.1.3 *Eligible to Report Column*



The eligible to report column header indicates if the measure is eligible to report baseline, RY1 or PY1. If the measure is not eligible to report or correct, go to the Measure not eligible to report or correct section of this document. If the measure is eligible to report, go to the Measure eligible to report and/or correct section of this document.

3.1.3.1 Measure not eligible to report or correct

If this column indicates "**No**" that the measure is not eligible to report and the provider is also not eligible to correct, then the Progress Indicator column should indicate "Complete" for all rows as there is nothing

to report for this measure.

Measure Information, Eligibility and Progress

Eligible to report?	Progress Indicator	
No	Reporting Selections:	Complete
Corrections Allowed?	Reporting:	Complete
No	Qualitative Questions:	Complete

If the measure is not eligible to report, then provider will still have the option to complete an additional comments field. If this applies to provider's measure, proceed to the Additional Comments Subsection of this document for further instructions.

The Measure Summary section does not require provider input, but additional details on the information found in this section can be found in the Measure Summary (refer to Measure Specifications for detailed information on how to report rates) Section of this document.

Note that measure E2-A01 AIM Quality Improvement Collaborative Activity will not report baseline or performance.

3.1.3.2 Measure eligible to report and/or correct

If the measure is eligible to report or correct, the provider will be prompted with additional questions under the Reporting Selections section, and the Progress Indicator column will indicate "Incomplete".

Measure Information, Eligibility and Progress

Eligible to report?	Progress Indicator	
PY1	Reporting Selections:	Incomplete
Corrections Allowed?	Reporting:	Complete
Yes	Qualitative Questions:	Complete

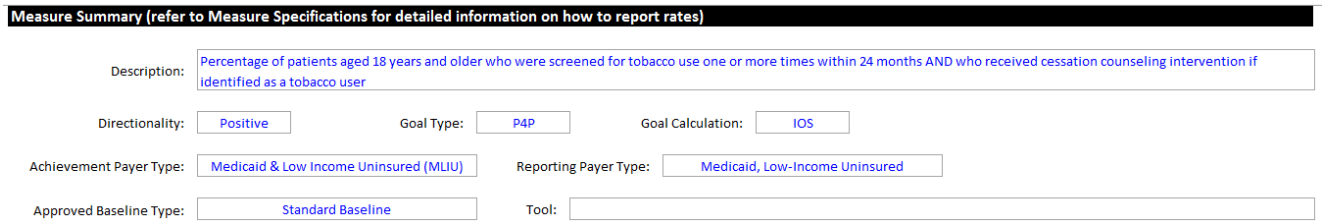
If this applies to provider's measure, proceed to the Reporting Selections Subsection of this document for further instructions. The Measure Summary section does not require provider input, but additional details on the information found in this section can be found in the Measure Summary (refer to Measure Specifications for detailed information on how to report rates) Section of this document.

3.2 *Measure Summary Section*

This section displays information related to the measure. The list below contains the type of information found in this section.

- Description of the measure;
- Directionality of the measure, which is either positive or negative;
- Goal Type, which is either P4P or P4R;
- Goal Calculation, which is either QISMC or IOS;
- Achievement Payer Type, which are All-Payer, LIU only, Medicaid only, and MLIU;
- Reporting Payer Type, which are a combination of All-Payer, LIU, and Medicaid;
- Approved Baseline Type (i.e., Standard Baseline, Shortened Standard Baseline, etc.); and

- Tool approved for use for in meeting measure specifications, if applicable to measure.



The Measure Summary section is for informational purposes only. Providers do not need to complete any fields in this section.

Proceed to the Reporting Selections Section of this document for further instructions if measure is eligible to report. If the measure is not eligible to report, then proceed to the Additional Comments Subsection of this document for further instructions.

3.3 Summary of Past Reporting Section

This section displays information related past reporting of the measure, including the reporting period in which the measure was original reported, the most recent source of reporting (e.g., DY7R2 NMI Reporting

Summary of Past Reporting

Baseline (BL): Reported: DY7R2 Source: DY8R1 Interim Correction Template

01/01/2017 - 12/31/2017

	Rate 1 of 1			
	Achievement	Reporting		
	MLIU	All Payer	Medicaid	LIU
Numerator:	217.0	893.0	180.0	37.0
Denominator:	349	1264	239	110
Rate:	0.6218	0.7065	0.7531	0.3364
DY7 Achievement Goal:	0.8298			
DY8 Achievement Goal:	0.8397			

Template, DY8R1 Interim Correction Template), the measurement period, and the reported rates.

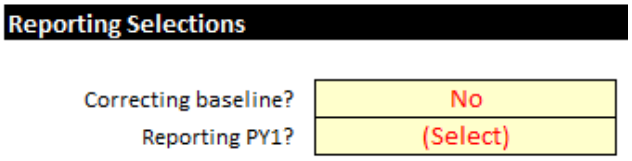
The Summary of Past Reporting section is for informational purposes only. Providers do not need to complete any fields in this section.

3.4 *Reporting Selections Section*

This section requires provider input related to reporting or corrections. The drop-down displayed in this section requires provider to indicate if they will be reporting or correcting baseline or eligible performance years. This is indicated by selecting “yes” or “no” in the yellow drop-down fields.

If the measure is eligible to report baseline for the first time, the following option will appear:

If the measure is eligible to submit a baseline correction and report PY1, the following option will appear:



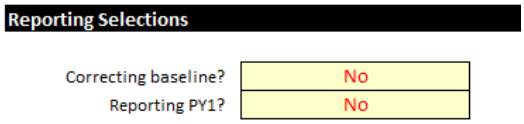
Once the provider, makes selections for all of the dropdowns under the Reporting Selections section, the Reporting Selections row in the Progress Indicator column in the Measure Information, Eligibility, and Progress section will indicate "Complete" as this section is now complete.

If provider selects "No" for all dropdowns indicating they will not be reporting or correcting baseline or performance, then go to the Selecting No for Reporting Baseline Field section of this document for further instructions.

If provider selects "Yes" they will be reporting or correcting baseline or "Yes" they will be reporting PY1, then go to the Selecting Yes for Reporting Baseline Field section of this document for further instructions.

3.4.1 *Selecting "No" for Reporting or Correcting Baseline Field*

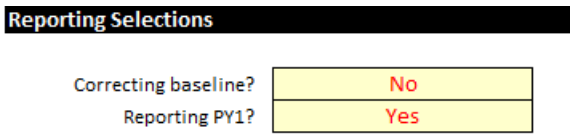
If provider selects "**No**" for all dropdowns, no further provider input is required in this section for this measure.



Providers indicating "No" in this section, should jump to the Additional Comments Subsection of this document for further instructions on completing the optional qualitative questions. If "No" is selected, provider will also notice that the Progress Indicator column in the Measure Information, Eligibility, and Progress section will indicate as "Complete" in all rows.

3.4.2 *Selecting "Yes" for Reporting or Correcting Baseline Field*

If "**Yes**" is selected for any of the dropdowns, the Reporting section will open below the Reporting Selections section. Proceed to the Reporting Section of this document for further instructions on

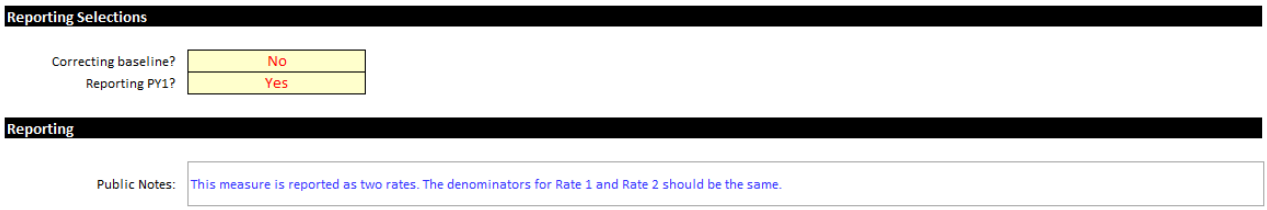


completing this section.

3.5 *Reporting Section*

The reporting section requires providers to input information about baseline and/or performance year measurements, including information regarding baseline start and end dates (if applicable), sampling, numerators and denominators, and data sources.

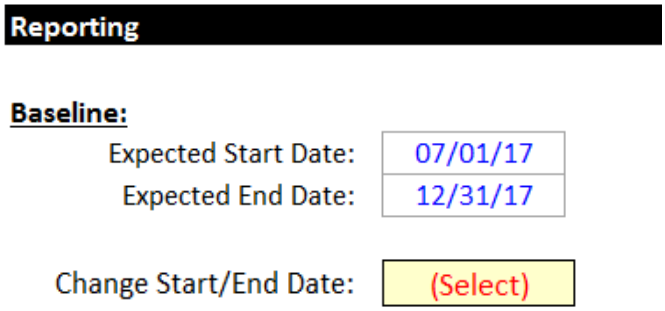
For select measures, providers will see Public Notes with important information to keep in mind when reporting the measure. Be sure to read Public Notes, when included, before entering baseline or performance year data.



If reporting or correcting baseline, please proceed to the Baseline Measurement Period Subsection section of this document for further instructions on completing the questions regarding baseline measurement periods. If you' not reporting or correcting baseline, proceed to the Sampling Subsection of this document.

3.5.1 *Baseline Measurement Period Subsection*

If reporting or correcting baseline, under the Baselines subsection in the Reporting section, the provider's Expected Start Date and Expected End Date for their baseline measurement period will be displayed.

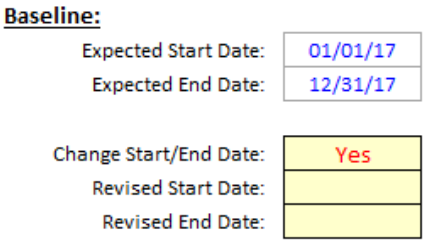


There will also be a Change Start/End Date field below the Expected Start Date and Expected End Date. Provider should select "Yes" or "No" from the yellow drop-down field to indicate if they would like to change the Expected Start Date or the Expected End Date from the fields above.

If selecting "No" go to the Selecting No for the Change Start/End Date field section of this document. If selecting "Yes" go to the Selecting Yes for the Change Start/End Date field section of this document.

3.5.1.1 Selecting Yes for the Change Start/End Date field

If "**Yes**" is selected for the Change Start/End Date field, two additional fields called Revised Start Date and Revised End Date will open below the Change Start/End Date field. Provider's needing to revise the start and/or end date for baseline reporting from what is displayed in the Expected Start Date and Expected End Date fields under the Baseline subsection in the Reporting section should enter the new start and end date into the Revised Start Date and Revised End Date fields.



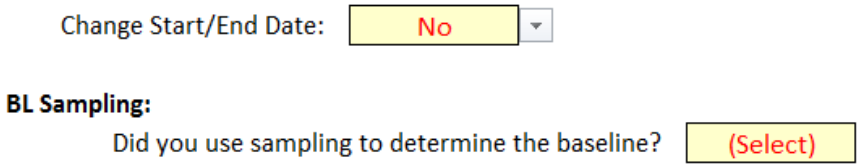
There are a few limits on the Revised Start Date and Revised End Date fields — the revised baseline measurement period must fall between 1/1/2017 and 9/30/2018 and cannot exceed 12 months. The template will display a warning message, if their Revised Start Date and Revised End Date fields do not conform to these limits, or if a provider attempts to enter an end date later than the end date previously approved by HHSC. Providers who wish to delay their baseline measurement period must have preapproval from HHSC.

For providers opting to revise the start and/or end date for baseline reporting, the BL Sampling subsection under the Reporting section will appear once the Revised Start Date and Revised End Date fields have been completed. Provider should proceed to the Sampling Subsection of this document for instructions on how to complete this subsection.

If the Revised Start Date and Revised End Dates are for a period of less than 12 months or if the Revised End Date does not end by 12/31/2017, then provider will need to answer up to two additional questions in the Baseline Reporting Questions subsection under the Qualitative Questions section. These additional questions will appear once the Revised End Date is entered. But first, please proceed to the Sampling Subsection of this document for instructions on how to complete this subsection.

3.5.1.2 Selecting No for the Change Start/End Date field

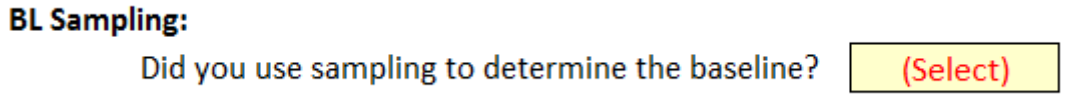
If "**No**" is selected for the Change Start/End Date field, then the subsection Baseline Sampling (BL Sampling) subsection will open below the Baseline subsection.



Proceed to the Sampling Subsection section of this document for further instructions on completing this subsection.

3.5.2 *Sampling Subsection*

The question under this subsection will ask the provider if sampling was used to determine baseline or a performance year. Select "Yes" or "No" for this field.



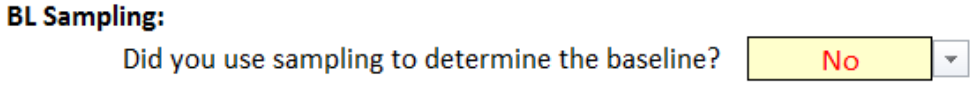
If selecting "No" for this field, proceed to the Selecting No if provider did not use sampling section of

this document.

If selecting "Yes" for this field, proceed to the Selecting Yes if provider used sampling section of this document.

3.5.2.1 Selecting No if provider did not use sampling

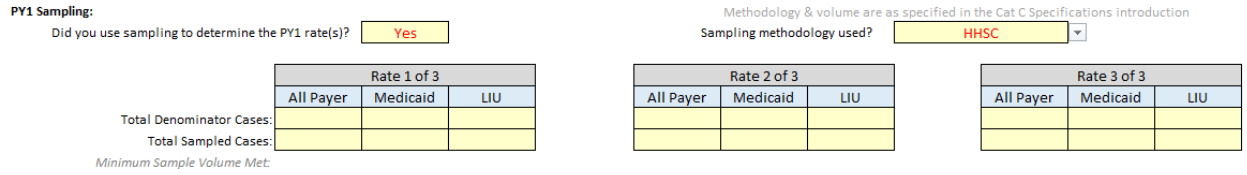
If "**No**" is selected because provider did not use sampling, then additional subsections under the Reporting section will open. These subsections are the Rate & Goals (for baseline) or the Rate & Achievement (for PYs) subsection; the Risk Adjusting subsection, if applicable for the measure; and the Data Sources subsection. Proceed to the Rate & Goals/Achievement Subsection section of this document for further instructions on reporting numerators and denominators.



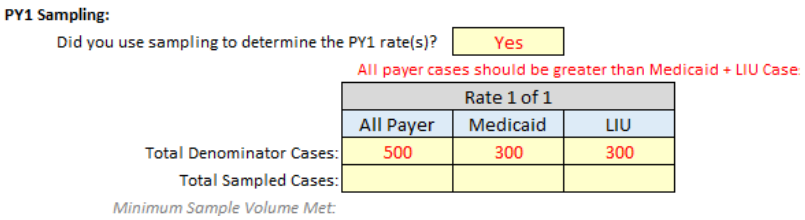
3.5.2.2 Selecting Yes if provider used sampling

If "**Yes**" is selected because provider did use sampling to determine baseline or performance, an additional field asking provider what sampling methodology was used will appear to the right. Provider should complete this field by selecting "HHSC" or "Measure Steward" from the drop-down menu in the yellow field.

Once this field is completed, additional fields related to the total cases that meet denominator inclusion requirements for All Payer, Medicaid, and LIU, and a field requesting the number of All Payer Sample Cases will appear. Providers should complete all yellow fields in these two tables for all rates present. Depending on the measure, providers will only be required to complete total cases that meet denominator inclusion requirements fields for certain populations, and certain measures must report on multiple rates.



The template will display a warning message, if the combined Medicaid and LIU total cases that meet denominator inclusion requirements exceeds the All Payer total cases that meet denominator inclusion requirements.



Additionally, provider may receive a warning, if the Sampled Cases field is not greater than or equal to the minimum required sample size as referenced in the Measure Specifications Introduction.

PY1 Sampling:

Did you use sampling to determine the PY1 rate(s)? Yes

	Rate 1 of 1		
	All Payer	Medicaid	LIU
Total Denominator Cases:	500	250	100
Total Sampled Cases:	200	100	40
Minimum Sample Volume Met:	*Yes*	*Yes*	*No*

If a provider receives a warning message in the Sampling subsection, they should reference the Category C Introduction document and the Category C Goal Calculator that is on the DSRIP Online Reporting System for guidance on allowable parameters for sampling numbers.

Once the total cases that meet denominator inclusion requirements and total sampled cases fields have been completed, two additional fields will open, if the provider is using HHSC sampling methodology. One field asks if a separate Medicaid sample was conducted, and the other asks if a separate LIU sample was conducted. If a separate sample is required, the field may be auto-filled and white.

	Rate 1 of 1		
	All Payer	Medicaid	LIU
Total Denominator Cases:	500	250	100
Total Sampled Cases:	200	100	76
Minimum Sample Volume Met:	*Yes*	*Yes*	*Yes*

Rate 1:

Conducted a Separate Medicaid Sample?

Conducted a Separate LIU Sample? Yes

Provider pulled additional sample cases for the LIU population that are not included in the all-payer cases.

3.5.3 *Rate & Goals/Achievement Subsection*

The Rate & Goals subsection (for Baseline) or Rate & Achievement subsection (for performance years) under the Reporting section requires provider to report Numerator(s) and Denominator(s) for the measure. The blue column headers in the table in this subsection will display the stratified populations that need to be reported, such as All Payer, Medicaid, and LIU. Depending on the measure, numerators and denominators for multiple rates might need to be reported.

BL Rate & Goals:

	Rate 1 of 2				Rate 2 of 2			
	Achievement	Reporting			Achievement	Reporting		
	MLIU	All Payer	Medicaid	LIU	MLIU	All Payer	Medicaid	LIU
Numerator:								
Denominator:								
Baseline Rate:								
DY7 Goal:								
DY8 Goal:								

Fill out the Numerator and Denominator values for each of the populations. Once the Numerator and Denominator rows are filled out for a population, the Rate row will populate for that population.

BL Rate & Goals:

	Rate 1 of 3			
	Achievement	Reporting		
	MLIU	All Payer	Medicaid	LIU
Numerator:		25		
Denominator:		80		
Baseline Rate:		0.3125		
DY7 Goal:				
DY8 Goal:				

Once all of the Numerator and Denominator values are completed for a reporting rate for all populations, then the Achievement column for this rate will populate with Numerator, Denominator, Rate, DY7 Goal, and DY8 Goal values (for baseline) or % of Goal Achieved (for performance years).

PY1 Rate & Achievement:

	Rate 1 of 1			
	Achievement	Reporting		
	MLIU	All Payer	Medicaid	LIU
Numerator:	400	500	250	150
Denominator:	800	1000	500	300
PY1 Rate:	0.5000	0.5000	0.5000	0.5000
% of AM-7.x Goal Achieved:	100%			

If the measure is using sampling, the fields in the Rate & Goals/Achievement subsection will look a little different. For reporting using sampling, providers only need to enter the Numerator from Sample row for the stratified populations listed under the blue reporting column heading for each rate listed. Additionally, if the measure is using sampling there will be an extra row in the Rate & Goals/Achievement subsection for a Projected Numerator.

PY1 Rate & Achievement:

	Rate 1 of 1			
	Achievement	Reporting		
	MLIU	All Payer	Medicaid	LIU
Numerator from Sample:	126	182	90	36
Projected Numerator	252.0	364.0	180.0	72.0
Denominator	700	1000	500	200
PY1 Rate:	0.3600	0.3640	0.3600	0.3600
% of AM-7.x Goal Achieved:	75%			

Provider should complete all yellow Numerator and Denominator or Numerator from Sample fields for each population and for each rate displayed.

Once all yellow fields are complete, provider should proceed to the Risk Adjusting Subsection of this document, if applicable, for further instructions. If the measure is not risk adjusting, then provider should proceed to the Data Sources Subsections of this document for further instructions on reporting the data sources used to arrive at the baseline numerators and denominator values from the BL Rate & Goals subsection of the Reporting sections.

3.5.4 *Risk Adjusting Subsection*

For measures with risk adjusting, providers are required to respond to additional questions in the Risk Adjusting subsection in the Reporting section. The provider will need to indicate the number of eligible cases for each reported payer-type in the yellow field to the right of the No. of eligible cases header.

	All Payer:	Medicaid:	LIU:
No. of eligible cases:	250	100	80

For baseline only, the provider will need to indicate the risk adjusting methodology used by selecting one of the following options from the yellow drop-down menu to the right of the Methodology header: Vendor, Indirect Standardization, or Other. Provider will also include a description of the risk adjusting methodology (vendor if applicable, source of expected readmissions for example indirect standardization, APR-DRG or DRG) that was selected in the preceding field.

	All Payer:	Medicaid:	LIU:
No. of eligible cases:	250	100	80
Methodology:	Vendor		
Description:	Your description here		

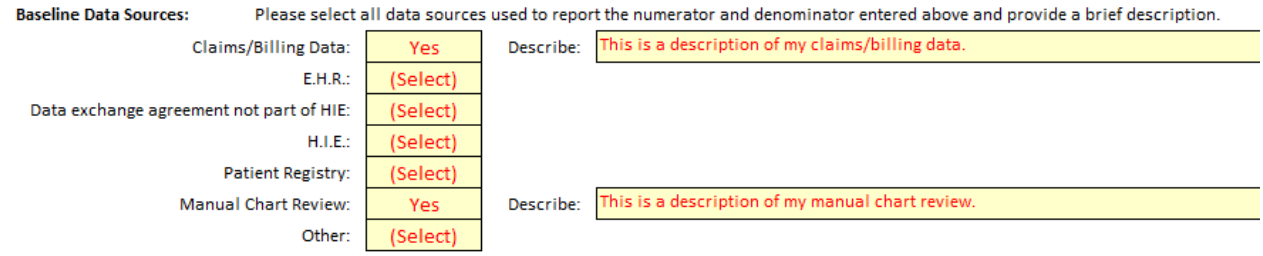
Once all required yellow fields are complete, proceed to the Data Sources Subsection of this document for further instructions.

3.5.5 *Data Sources Subsection*

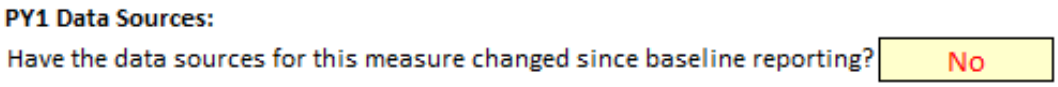
This subsection requires provider to select one or more data sources by selecting the dropdowns next to items in a list to communicate to HHSC the data sources used for the reported Numerators and Denominators. The data sources in this subsection are as follows: Claims/Billing Data, Electronic Health Record (E.H.R.), Data exchange agreement not part of Health Information Exchange (H.I.E.), H.I.E., Patient Registry, Manual Chart Review, and Other.

When displayed, the provider should select “Yes” from the dropdown next to each of the listed data sources that were used to report the numerators and denominators in that reporting section. Providers must select at least one data source, and should select all that are used to determine the baseline rate.

When the provider selects “Yes” for a listed data source from the yellow drop-down menu, a Describe field will appear to the right of the yellow drop-down menu. The provider should enter a description of the data source used to report the Numerator and Denominator values in the Rate & Goals subsection, not a description specifically related to or corresponding to the data sources outlined in the Category C measure specifications.



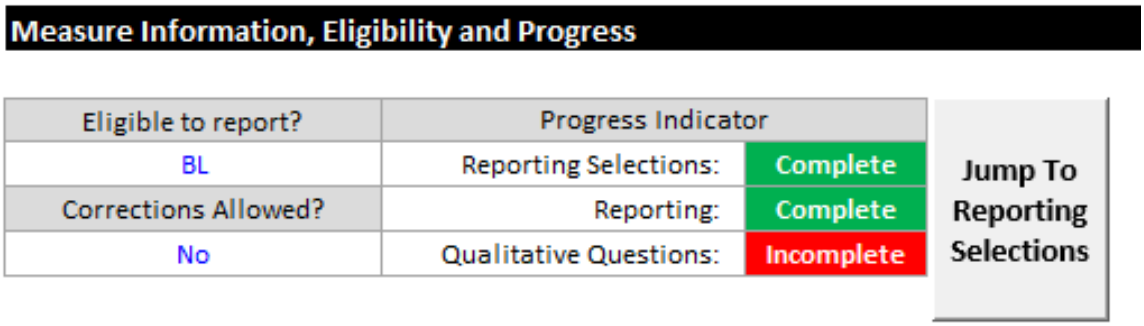
For PY1 and subsequent performance years, providers will be asked whether the data sources for the measure changed since baseline reporting. If the provider selects "No" from the dropdown, they will not be required to enter the data sources again. If they select "Yes", they will be required to enter data sources, like they did during baseline reporting.



Once at least one data source shows a "Yes" and a description has been entered for all "Yes" selections or if "No" is selected for the question "Have the data sources for this measure changed since baseline reporting", the Reporting progress indicator should show "Complete" in the Measure Information, Eligibility, and Progress section at the top of the tab. The provider should then move to the Qualitative Questions Section of this document for further instructions. Once the Reporting section is complete, provider should move to the Qualitative Questions Section of this document for further instructions.

3.6 Qualitative Questions Section

The Qualitative Questions section contains up to six subsections — the General Reporting Questions Subsection, the Baseline Reporting Questions Subsection, the Performance Reporting Questions Subsection, The Correction Reporting Questions Subsection, the Sampling Questions Subsection, and the Additional Comments Subsection. The number of subsections displayed in the Qualitative Questions Section could vary based on each measure's reporting requirements. Proceed to the link for the first subsection that is displayed under the Qualitative Questions section.

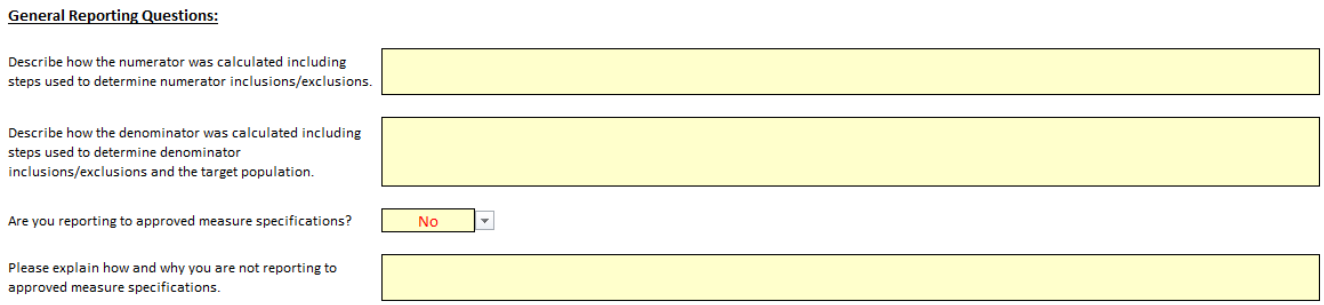


3.6.1 General Reporting Questions Subsection

The General Reporting Questions subsection asks the following questions:

- Describe how the numerator was calculated including steps used to determine numerator inclusions/exclusions.

- Describe how the denominator was calculated including steps used to determine denominator inclusions/exclusions and the target population.
- Are you reporting to approved measure specifications?



Provider's reporting baseline or performance must complete the two qualitative questions related to numerators and denominators and how they were calculated. The responses to these questions must describe the methodology used to calculate the numerators and denominators. The denominator and numerator qualitative responses should outline the steps used in determining the denominator or numerator, the data sources used, and should include a description for the broad eligible denominator or numerator populations. The denominator and numerator qualitative responses should provide enough information for HHSC to determine that the numerator and denominator are being calculated correctly. The response to these questions should be specific to the provider and not merely a summary of the Category C Measure Specifications themselves.

Providers who answer that they are no reported to approved measure specifications, will be asked to explain how and why they are not reporting to approved measure specifications

3.6.2 Baseline Reporting Questions Subsection

The Baseline Reporting Questions subsection contains five groups of questions — the Approximate Baseline Question, the reporting baseline with measurement period of less than 12 months question, and the reporting a delayed baseline that does not end by 12/31/2017 question, reporting a baseline with a low baseline rate, and reporting a baseline with no denominator volume for one or more payer type. The number of groups of questions displayed in the Baseline Reporting Questions subsection varies based on each measure's reporting requirements and selections made in the Reporting section. Proceed to the link for the first group of questions that is displayed under the Baseline Reporting Questions subsection.

3.6.2.1 Approximate Baseline Question

Under the Baseline Reporting Questions subsection in the Qualitative Questions section, provider should indicate if they are reporting an approximate baseline by selecting "Yes" or "No" from the drop-down menu. This question will only appear if providers are reporting baseline as indicated in the Reporting Selections section.

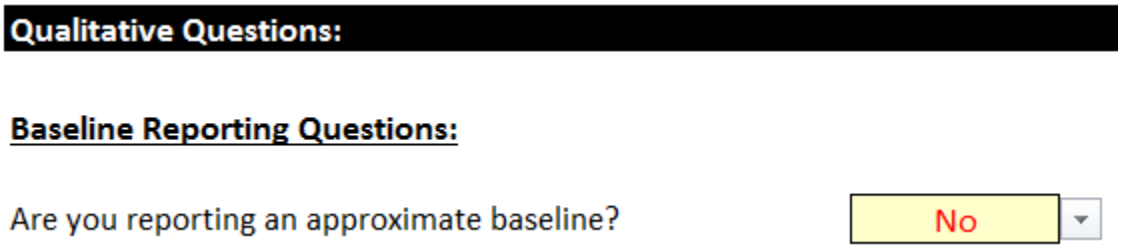
If selecting "No" for reporting an approximate baseline question from the drop-down menu, then go to the Selecting No for reporting an approximate baseline question section of this document for additional

instructions.

If selecting "Yes" for reporting an approximate baseline question from the drop-down menu, then go to the Selecting Yes for reporting an approximate baseline question section of this document.

3.6.2.1.1 Selecting No for reporting an approximate baseline question

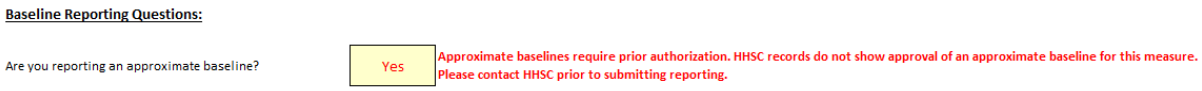
If provider selects "**No**" that they are not reporting an approximate baseline, then no further action is needed for this field.



3.6.2.1.2 Selecting Yes for reporting an approximate baseline question

If provider selects "**Yes**" that they are reporting an approximate baseline, and provider has received prior approval by HHSC to report an approximate baseline, then no further action is needed for this field.

If provider selects "**Yes**" that they are reporting an approximate baseline, and provider has not received prior approval by HHSC to report an approximate baseline, then provider will receive an error message. Providers must have prior approval from HHSC to report an approximate baseline. Please contact HHSC if provider thinks they are receiving this message in error.



Based on the measure and the options selected in the Reporting section, provider should answer additional questions in the Baseline Reporting Questions subsection, or provider should to go to the Sampling Questions subsection or the Additional Comments subsection to complete the measure- specific tab. See list below for options that apply to provider.

- Providers that opted to revise the baseline measurement period's start and end date in the Baseline subsection of the Reporting section will need to answer an additional question if the change to the start and end date caused the baseline measurement period to be for less than 12 months, therefore causing the baseline measurement period to be shortened. If this applies to the provider's measure, proceed to the reporting baseline with measurement period of less than 12 months question section of this document.
- Providers that opted to revise the baseline measurement period's start and end date in the Baseline subsection of the Reporting section will need to answer an additional question if the change to the start and end date caused the baseline measurement period to end after 12/31/2017, therefore causing the baseline measurement period to be

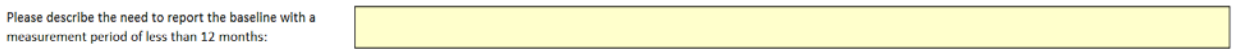
delayed. If this applies to the provider's measure, proceed to the reporting a delayed baseline that does not end by 12/31/2017 question section of this document.

- The Baseline Reporting Questions subsection should be complete if provider did not amend their baseline measurement period's start and end date to a delayed or shortened measurement period.
- The Baseline Reporting Questions subsection should be complete if provider did not amend their baseline measurement period's start and end date to a delayed or shortened measurement period. In addition, if provider indicated that they did not use sampling to determine the baseline in the BL Sampling subsection of the Reporting section, then provider should proceed to the Additional Comments Subsection of the Qualitative Questions section to complete the measure-specific tab.

3.6.2.2 Reporting baseline with measurement period of less than 12 months question

Providers that opted to revise the baseline measurement period's start and end date in the Baseline subsection of the Reporting section will need to answer an additional question if the change to the start and end date caused the baseline measurement period to be for less than 12 months, therefore causing the baseline measurement period to be shortened.

Provider should supply a qualitative response in the yellow cell to the right of the question in the Baseline Reporting Questions subsection. The response to this question should include a justification for the need to have a baseline measurement period for less than 12 months. Appropriate justification could include data limitations.



Based on the measure and the options selected in the Reporting section, provider should answer additional questions in the Baseline Reporting Questions subsection, or provider should to go to the Sampling Questions subsection or the Additional Comments subsection to complete the measure-specific tab. See list below for options that apply to provider.

3.6.2.2.1 If Provider revised the baseline measurement period's start and end date in the Baseline subsection of the Reporting section causing the end date to be after 12/31/2017 (delayed baseline measurement period), provider should proceed to the reporting a delayed baseline that does not end by 12/31/2017 question section of this document for further instructions.

3.6.2.2.2 If a delayed measurement period does not apply to provider's measure, then provider should proceed to the Sampling Questions Subsection of this document for further instructions if provider indicated that they used sampling to determine the baseline in the BL Sampling subsection of the Reporting section.

3.6.2.2.3 If a delayed baseline measurement period does not apply to provider's measure and sampling was not used to determine the baseline, then provider should proceed to the Additional Comments Subsection of this document for further instructions.

3.6.2.3 Reporting a delayed baseline that does not end by 12/31/2017 question

Providers that opted to revise the baseline measurement period's start and end date in the Baseline subsection of the Reporting section will need to answer an additional question if the change to the start

and end date caused end date to be after 12/31/2017, a delayed baseline measurement period.

Provider should supply a qualitative response in the yellow cell to the right of the question in the Baseline Reporting Questions subsection. The response to this question should include a justification for the need to have a delayed baseline measurement period, a baseline with a measurement period that ends after12/31/2017. If not previously approved for a delayed baseline, providers must state specifically why each preferable baseline planning scenario is not feasible (six or twelve months of electronic data ending 12/31/2017, six or twelve months of sampled data ending 12/31/2017, baseline numerator of zero if eligible, approximate baseline).

Please describe the need to report a delayed baseline (a baseline with a measurement period that does not end by 12/31/2017):	

The Baseline Reporting Questions subsection should be complete at this point, and provider should proceed to the Sampling Questions subsection or the Additional Comments subsection to complete the measure-specific tab. See list below for options that apply to provider.

3.6.2.3.1 Provider should proceed to the Sampling Questions Subsection of this document for further instructions if provider indicated that they used sampling to determine the baseline in the BL Sampling subsection of the Reporting section.

3.6.2.3.2 If provider did not use sampling to determine the baseline, then provider should proceed to the Additional Comments Subsection of this document for further instructions.

3.6.2.4 Reporting a baseline with a low baseline rate question

Providers that report a baseline rate for a process measure that is less than 10% if IOS or or less than the MPL if will need to answer an additional question regarding the reason for the low baseline.

Provider should supply a qualitative response in the yellow cell to the right of the question in the Baseline Reporting Questions subsection. The response to this question should include an justification for the low baseline rate and indicate if the low baseline is a true reflection of clinical practice, or if is because of limited access to required data elements, or other causes.

Describe the reason for your low baseline rate.	

3.6.2.5 Reporting a baseline with no denominator volume for one or more payer type question

Providers that report a baseline with a denominator of 0 for one or more payer types will need to answer an additional question regarding the reason for the denominator of 0.

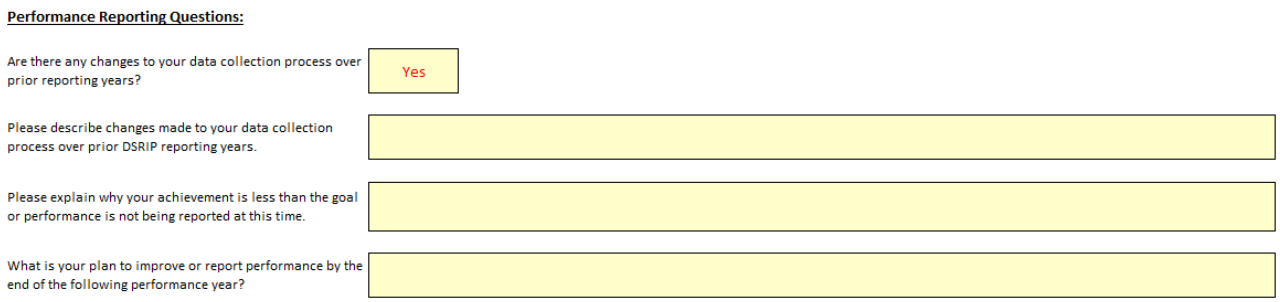
Provider should supply a qualitative response in the yellow cell to the right of the question in the Baseline Reporting Questions subsection. The response to this question should include a

justification for denominator of 0 for the specific payer type. For example, a provider does not provide services to the specific payer-type.

3.6.3 Performance Reporting Questions Subsection

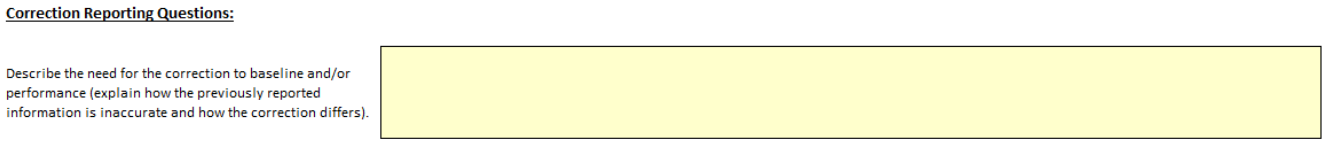
The Performance Reporting Questions subsection asks the following questions:

- Are there any changes to your data collection process over prior reporting years?
    - If "Yes" is selected, the provider is asked to describe changes made to data collection processes over prior DSRIP reporting periods.
- Please explain why your achievement is less than the goal or performance is not being reported at this time.
    - If a measure was achieved at 100% or is P4R, this question will not be asked.
- What is your plan to improve or report performance by the end of the following performance year?
    - If a measure was achieved at 100% or is P4R, this question will not be asked.



3.6.4 Correction Reporting Questions Subsection

Providers who submitted a correction are asked the following: Describe the need for the correction to baseline and/or performance (explain how the previously reported information is inaccurate and how the correction differs). Providers who did not submit a correction will not see this question.



3.6.5 Sampling Questions Subsection

The Sampling Questions subsection in the Qualitative Questions section will vary depending on whether or not provider used sampling to determine the baseline. This is determined based on provider's response to this question in the BL Sampling subsection of the Reporting section.

If sampling was not used to determine the baseline, proceed to the No, sampling was not used to determine the baseline section of this document.

If sampling was used to determine the baseline, proceed to the Yes, sampling was used to determine the baseline section of this document

3.6.5.1 No, sampling was not used to determine the baseline

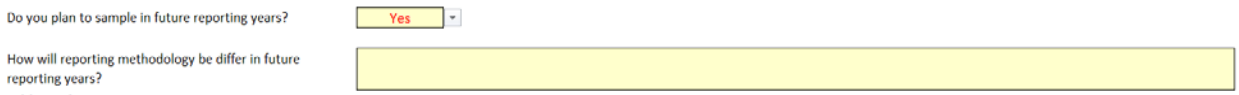
Providers that indicated that they did not use sampling to determine the baseline in the BL Sampling subsection of the Reporting section must answer an additional question in the Sampling Questions subsection of the Qualitative Questions section.

Sampling Questions:

Do you plan to sample in future reporting years?	(Select)

Provider should select "Yes" or "No" to indicate if provider plans to sample in future reporting years. If provider selects "No," then no further information is needed for this subsection. Proceed to the Additional Comments Subsection of this document for further instructions.

If provider selects "Yes," then an additional field will open asking provider how the reporting methodology will differ in future reporting years. Provider should supply a qualitative response in the yellow cell to the right of this question. The response to this question should be specific to the provider and specific to the provider's data source(s). This response should not be a mere reiteration of the sampling methodology outlined in the Category C Measure Specifications Introduction document. The response should clearly outline how the reporting methodology for reporting years is expected to differ as opposed to the sampling methodology used for baseline reporting.



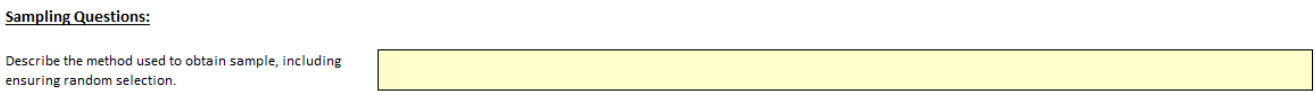
Once these two yellow fields are complete, proceed to the Additional Comments Subsection of this document for further instructions.

3.6.5.2 Yes, sampling was used to determine the baseline

Providers that indicated that they used sampling to determine the baseline in the BL Sampling subsection of the Reporting section must answer an additional question in the Sampling Questions subsection of the Qualitative Questions section.

This question asks the provider to describe the method for determining the random sample. Provider should supply a qualitative response in the yellow cell to the right of this question. The response to this question should be specific to the provider and specific to the provider's data source(s). This response should not be a mere reiteration of the sampling methodology outlined in the Category C Measure Specifications Introduction document. Sampling methodology may be reviewed by HHSC or a compliance monitor in the future and should explain how the random

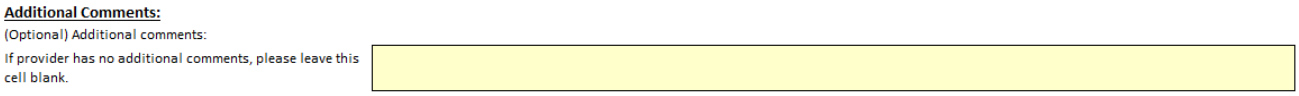
sample was conducted, how the eligible denominator population was identified, what data sources were reviewed, and any other additional information necessary for understanding or duplicating the sampling methodology.



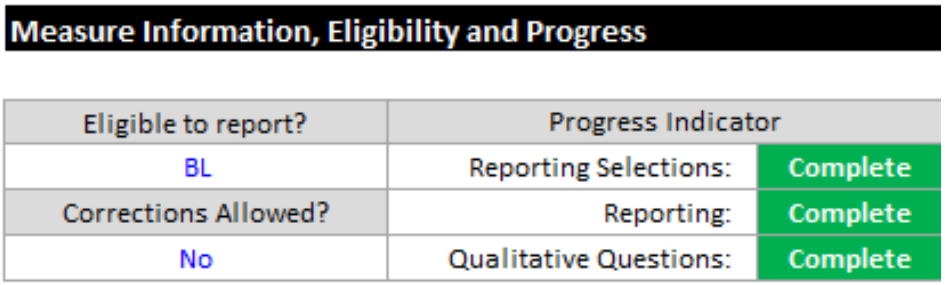
Once this field is complete, proceed to the Additional Comments Subsection of this document for further instructions.

3.6.6 Additional Comments Subsection

The Additional Comments subsection provides an optional field that providers can use to communicate any additional comments or status updates to HHSC. For providers that selected "No" to the reporting baseline question in the Reporting Selections section or for providers that are not eligible to report baseline measurements, this will be the only other field that could be completed for baseline reporting for the measure-specific tab.



Once all yellow fields in the Qualitative Questions section are complete (with the Additional Comments subsection being optional for completion), then the Qualitative Questions row should read as "Complete" in the Progress Indicator column in the Measure Information, Eligibility, and Progress section at the top of the tab.



Once the additional comments field is complete, if applicable, provider should proceed to the Overview of Generated Reporting Summary Tab of this document for further instructions on completing, certifying, and submitting the Category C Reporting Template.

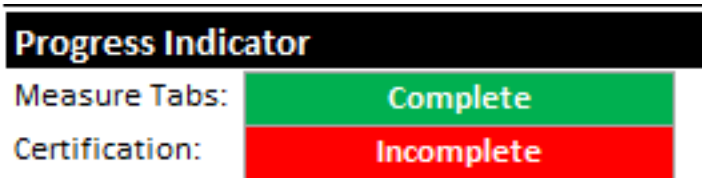
4.0 Overview of Generated Reporting Summary Tab

The Reporting Summary tab has four sections which are explained in more detail in the Progress Indicator Section, the Provider Information Section, the Measure Reporting Summary Section, and the Certification Section of this document. Read the sections below for additional information on how to complete these sections.

4.1 *Progress Indicator Section*

The Progress Indicator section contains a chart that indicates progress made in completing the

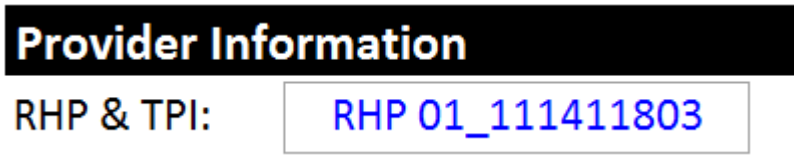
Category C Reporting Template. The Measure Tabs row indicates if the measure-specific tabs have been completed, and the Certification row indicates if the Reporting Summary tab has been completed. All measure-specific tabs should be complete, causing the Measure Tabs row in the Progress Indicator section to read as "Complete" before working on the Reporting Summary tab.



Once the Measure Tabs row reads as "Complete," proceed to the Provider Information Section of this document for further instructions.

4.2 *Provider Information Section*

The Provider Information section contains the provider's RHP and TPI numbers in a combined field. No provider input is required in this section.



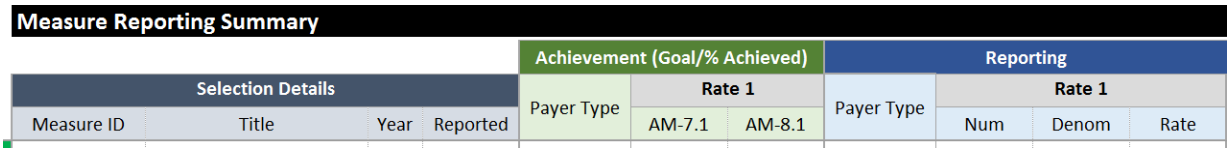
Proceed to the Measure Reporting Summary Section of this document for further instructions.

4.3 *Measure Reporting Summary Section*

This section contains a summary of reported and corrected values for all of provider's measures for the baseline reporting period and for PY1, PY2, and PY3 reporting periods. Corrected information will appear in bold text in this section.

This section also contains a summary of selected measures and achievement values for all of provider's measures for baseline and for PY1, PY2, and PY3 reporting periods.

This is a summary of the information provider input into the measure-specific tabs and the achievement output based on these inputs.

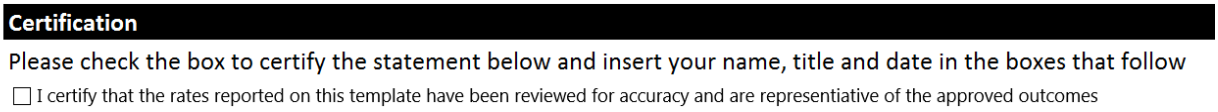


Provider should print out the Measure Reporting Summary section, review the information in this printed document, and certify that the information is correct. Provider can indicate that this information is correct by signing the printed Measure Reporting Summary section document, scanning this printed document, and uploading the printed and signed document to the DSRIP Online Reporting System.

Provider should also upload the completed Category C Reporting Template Excel file to the DSRIP Online Reporting System. Before submitting the Category C Reporting Template Excel file to the DSRIP Online Reporting System, provider should complete the Certification section. Proceed to the Certification Section in this document for further details on completing this section.

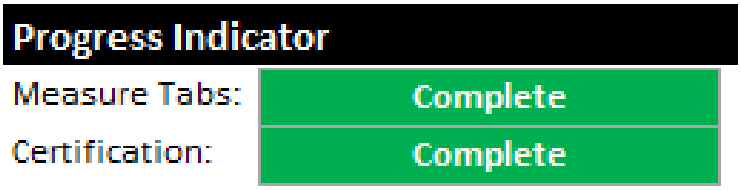
4.4 *Certification Section*

The Certification section requires the provider to check the check box to certify that the statement next to the check box is correct.



After checking the check box, provider should complete the three yellow fields with the Name of the individual certifying the template, the Title of the individual certifying the template, and the Date the template was certified.

At this point, the Certification row in the Progress Indicator section should read as complete.



Provider has now completed the Category C Reporting Template and should email this completed template along with the signed Measure Reporting Summary section document to TXHealthcareTransformation@hhsc.state.tx.us.

CATEGORY D

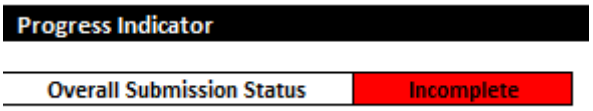
Category D includes a reporting on the Statewide Reporting Measure Bundles for each of the performing provider types:

- Hospitals,
- CMHC,
- Physician Practice, and
- LHDs.

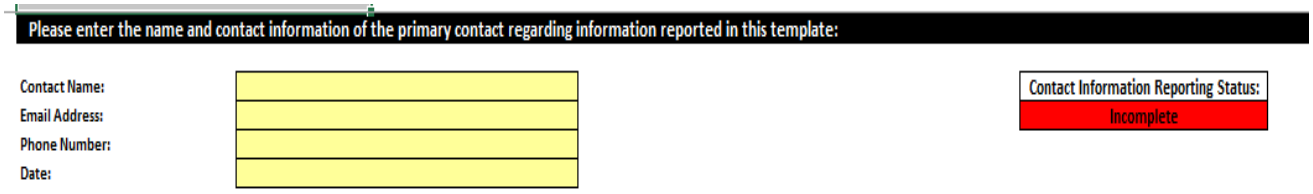
In April DY8, providers are eligible to report on all Category D metrics specific to their provider type. Hospital providers should ensure that they have data available for the specified measurement period (this applies to M-7.5 milestone). Responses to qualitative questions must be included for the metrics for which providers are reporting on. Providers can report on Category D metrics either in April or October of DY8, with October (Round 2) reporting as the last reporting period for Category D in DY8 since there is no carryforward for Category D. Providers who do not meet reporting specifications may be subject to NMI requests from HHSC following the April reporting period.

Template Highlights

- All providers will report by using a single Category D template, which will generate reporting questions for each provider based on the provider type after providers input their TPI.
- The template has an overall progress indicator that will show Incomplete in red until all cells in yellow are populated.

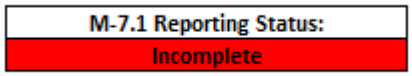


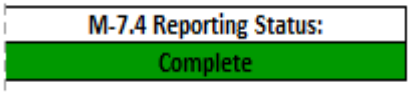
- Providers are required to include contact information of an individual responsible for reporting Category D measures.



- Providers will need to respond either Yes or No to the question *Will you be reporting on M-X.X in April?* If a provider does not wish to report on a specific metric in April of DY8, the response should be "No."

- Each metric has an indicator of completeness. When the provider inputs the information in yellow cells, the indicator will turn green. If a provider does not wish to report on a specific metric in April of DY8 and responds "No" to the question related to the reporting on a metric, the metric indicator will turn green.





Providers should save the file as: ***RHPXX_TPIXXXXXXXX_CatD_AprDY8_Provider Type***

Providers should add either H for hospitals, CMHC for Community Mental Health Centers, PP for Physician Practices, and LHD for Local Health Departments. (RHP01_123456789_CatD_AprDY8_H)

Providers are not required to submit additional documentation beyond the *Category D Reporting Template.* However, providers are subject to additional monitoring at any time and should maintain the documentation for their Category D data.

Category D Hospital Reporting

Hospital providers can report on Potentially Preventable Events (PPE) (Metrics M-7.1 through M-7.4) and Patient Satisfaction (Metric M-7.5).

Cat	Milestone ID	Milestone Description	Metric ID	Metric Description
D	M-7	Hospital Statewide Reporting Measures	M-7.1	Potentially Preventable Admissions (PPAs)
D	M-7	Hospital Statewide Reporting Measures	M-7.2	Potentially Preventable 30-day Readmissions (PPRs)
D	M-7	Hospital Statewide Reporting Measures	M-7.3	Potentially Preventable Complications (PPCs)
D	M-7	Hospital Statewide Reporting Measures	M-7.4	Potentially Preventable ED Visits (PPVs)
D	M-7	Hospital Statewide Reporting Measures	M-7.5	Patient Satisfaction

PPEs Reporting

- The Institute for Child Health Policy, which is Texas' Medicaid External Quality Review Organization (EQRO), prepared reports based on Calendar Year 2017 Medicaid and CHIP data for hospitals for reporting M-7.1 – PPAs; M-7.2 – PPRs; M-7.3 – PPCs; and M-7.4 – PPVs. HHSC provides the individual reports on Metrics 7.1 through 7.4 to hospitals at the end of March or in early April. HHSC will also provide a summary for each region showing a list of reports received by each hospital in the region. If a provider did not receive any report, contact HHSC at TXHealthcareTransformation@hhsc.state.tx.us

Patient Satisfaction

- Reporting questions M-7.5 will vary based on the category of the hospital, which HHSC assigned to each hospital after the review of the RHP Plan Update:
    - Hospitals that utilize the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS),
    - Children hospitals that utilize Child CAHPS Hospital Survey, and
    - Hospitals that requested and received HHSC's approval for an exemption from HCAHPS reporting because HCAHPS is not a required tool for the organization.
- Providers will report on Patient Satisfaction based on all-payer data available to the provider.
- DY8 measurement period is 12 months from **10/1/17 through 9/30/18**.

Category D Template Instructions — Hospitals

PPEs Reporting — Metrics M-7.1 through 7.4:

Providers will confirm that they received the relevant reports or that they did not have sufficient eligible admissions/readmissions to receive a given report and respond to qualitative questions for each reporting domain. All hospital providers are eligible to report and earn incentive payments if they submit qualitative responses to the questions included in the template. **Providers that do not receive a report because of low volume are still required to respond to qualitative questions to be eligible for incentive payments.**

Low volume providers, mostly providers who were exempt from a similar reporting in DY2-6, are providers that either do not receive reports from HHSC since the EQRO has no data for these providers or they receive reports from HHSC with the flag for low volume included in the report. These providers should respond to specific questions for this category of hospitals since they cannot compare PPE numbers across the years. However, providers still need to include qualitative description of activities they have that can impact a specific area that they are reporting on.

M-7.2 Reporting Status:
Incomplete

Low Volume Providers (no reports received or reports contain flag for low volume):
1. Do you track PPR rates for your broader all-payer population? And if so, what trends are observed?
2. If PPRs are zero, is it because of a low Medicaid service volume or processes/procedures in place that are effectively addressing potentially preventable events amongst all patients served in your facility?
3. Describe any established processes/policies/procedures in place to identify and address PPRs in your facility.
4. Do you have any Core Activities that can potentially impact your PPR rates? If yes, please list which ones.

Even if a provider does not receive any data for the reporting of a metric, in this case it is PPRs, provider can still submit a qualitative response describing processes and procedures to address readmissions (e.g., care coordination and care transition, follow up calls, home visits, etc.)

The EQRO has compiled data reports for PPAs, PPRs, PPCs, and PPVs, and providers that receive reports will use this data to populate the qualitative fields within M-7.1 though M-7.4 metrics.

Responses to qualitative questions must be included for all applicable submitted metrics. Providers cannot respond that PPE reports produced by EQRO are not used for the analysis without explaining what other sources of data are being utilized and how PPAs, PPRs, PPCs, and PPV trends look like. Providers are not required to validate EQRO reports in order to use them for Category D reporting purposes. If providers are using internal data to analyze PPEs, they should respond to qualitative questions by using their internal data to describe PPE trends and explain how it differs from EQRO data. **Not responding to qualitative questions with substantive analysis will result in HHSC requesting additional information via NMI.**

Example responses below may be brief statements that would need further elaboration depending on what exactly provider is doing or observing.

- How does the currently documented number of [PPAs, PPRs, or PPCs] represent an increase or a decrease over the last reporting period? What factors have contributed to any increase or decrease? (e.g., We had a 35% decrease in readmissions from last year, and we feel this is due to an increase in patient navigator retention. Patients that were previously frequent readmits are now receiving disease management in outpatient clinics as a result of navigator services.)

- How is this information used to inform any changes to your current processes and procedures? (e.g., We use the data in our quarterly Quality Committee, where leadership from all departments attend as a means of increasing organizational data transparency, demonstrating interdisciplinary collaboration, and supporting discord for evidence-based patient care. As a result, leaders are able to disseminate the information to their staff and exchange feedback on processes and procedures. When necessary, those communications are fielded to the Quality Department for collaboration in formal performance improvement).

- How does this Medicaid only rate compare to [PPAs, PPRs, or PPCs] rates for your broader population? (e.g., The Medicaid-only rate is higher than the Non-Medicaid rate because most of the patients we serve are Medicaid; We are unable to compare due to system limitations; We estimate that the Medicaid-only rate is lower than the Non-Medicaid rate because our payer mix shows that we served more Non-Medicaid patients).

- Do you track PPA/PPC/PPR rates for your broader all-payer population? And if so, what trends are observed? (e.g., Yes, it seems the [PPA/PPC/PPR] rates are higher for our Medicaid population because most of the patients we serve are Medicaid. The data collected by our Quality Department and lead patient navigator also seems to suggest the same as many readmissions and complications are Medicaid-derived. Like last year, top likely Medicaid-derived, DRGs were associated with conditions such as CHF, PNE, and COPD. We are hopeful that we can improve patient outcomes with our new outpatient clinic that focuses on internal medicine and the recruitment of a second interventional cardiologist).

- If PPAs/PPCs/PPRs are zero, is it because of a low Medicaid service volume, or processes/procedures in place that are effectively addressing PPEs amongst all patient served in your facility? (e.g., PPAs/PPCs/PPRs are zero/are low because we are a small provider and service a smaller population. When PPAs/PPCs/PPRs are increased during a particular quarter, we review cases with the appropriate performance improvement teams and take action as necessary).

- Do you have any Core Activities that can potentially impact your PPA, PPR, PPC or PPV rates? If yes, please list which ones. (e.g., Our Core Activity is care transition, which allows us to identify individuals without access to primary care/medical home during the discharge process. By assigning a care coordinator to these individuals, we attempt to impact PPRs, PPAs, and PPVs. By following a small group of individuals, we already see that the number of PPRs is reduced by 5 percent).

Below is an example from the previous reporting where provider submitted sufficient level of details for the analysis of the PPAs.

Example - PPA Reporting

1. Provider had an observed to expected potentially preventable admission (PPA) ratio of 1.04 in 2015 compared to a 1.15 ratio in 2016 reflecting an increase in PPA's from calendar year 2015 to 2016. Additionally, in 2016 our actual PPA rate of 14.72% was slightly higher than the state norm of 13.12%. The CMS 2 midnight rule is one factor that contributes to this increase as many of the PPA DRG's were formerly in observation status prior to the 2 midnight rule implementation. Because these patients require a hospital stay of more than 2 days, these patients are now in inpatient status. Fewer people in the county have medical insurance now as a result of certain insurance changes in the area. The majority of our PPA's are CHF (13.24%), COPD (23.53%), chest pain and coronary artery disease (10.29%), and pneumonia (17.65%) positively correlating with the increased rate of smoking, obesity and uncontrolled hypertension in the county.
2. The increase in potentially preventable admissions confirms the emphasis and resources we have placed on primary care and chronic disease management. This information will also guide future primary care expansion as access to primary care results in fewer non-emergent ED visits, potentially preventable admissions/readmissions, and reduced total healthcare costs.
3. The provider does not currently capture Potentially Preventable Admission rates on a broader population. We do not have the observed to expected ratio for the all payor population due to data limitations. Generally speaking, we estimate that our total payor PPA rates would be less than the Medicaid rates because our Medicare payor mix is much larger (45% Medicare versus 13.5% Medicaid) resulting in a larger denominator.
4. Using the same APR-DRG groups as the EQRO report, the provider had 1,834 admissions in the top 20 APR-DRG by number of PPAs. Generally speaking, the total payor PPA rates were less than the Medicaid rates. Specifically the all payor rates are as follows: CHF (17% all payor, 13.24% Medicaid), COPD (15% all payor, 23.53% Medicaid), chest pain and coronary artery disease (4.45% all payor, 10.29 Medicaid), and pneumonia (10% all payor, 17.65% Medicaid).
The provider had an observed to expected potentially preventable admission (PPA) ratio of 1.04 in 2015 compared to a 1.15 ratio in 2016 reflecting an increase in PPA's from calendar year 2015 to 2016. Additionally, in 2016 our actual PPA rate of 14.72% was slightly more than the state norm of 13.12%.
5. Both of our Core Activities, chronic care management and access to specialty care services will improve our PPA rates. Chronic care management implemented through our ED Navigation program, and Care Transitions coordinators will improve COPD, heart failure, coronary artery disease, diabetes, and asthma

potentially preventable admissions. Our specialty care program is targeted on improving access to mental health which should in turn prevent/reduce schizophrenia PPAs.

Patient Satisfaction Reporting: Metric M-7.5

For Patient Satisfaction or similar surveys approved by HHSC, providers will report the percentage of survey respondents who choose the most positive or "top-box" response for the measures included in Category D reporting.

Patient Satisfaction Reporting Measures for Providers Utilizing HCAHPS

- Percent of patients who reported that their doctors "Always" communicated well
- Percent of patients who reported that their nurses "Always" communicated well
- Percent of patients who reported that their pain was "Always" well controlled
- Percent of patients who reported that staff "Always" explained about medicines before giving it to them
- Percent of patients who reported that “Yes,” they were given information about what to do during their recovery at home
- Percent of patients who reported that their room and bathroom were "Always" clean
- Percent of patients who reported that the area around their room was "Always" quiet at night
- Percent of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)
- Percent of Patients who reported “Yes,” they would definitely recommend the hospital
- For additional information, visit: https://www.hcahpsonline.org/globalassets/hcahps/facts/hcahps_fact_sheet_november_2017.pdf

HHSC understands that there were changes in HCAHPS survey related to pain management questions. Providers will have several options in responding to this question:

- Leave the question as is if the provider had access to data.
- Manually replace existing language for the question related to pain management (e.g., communication related to pain, etc.) with the measure that the provider was tracking during specified measurement period.
- Report at 0 percent if nothing else is tracked.

Provider should include a description of the data used for responding to this question in the area for qualitative response (Please include any additional details regarding your reported information).

Data is publicly reported and available on Hospital Compare:
https://www.medicare.gov/hospitalcompare/About/Survey-Patients-Experience.html

Patient Satisfaction Reporting Measures for Providers Utilizing Child CAHPS Hospital Survey

Children's hospitals will report on CAHPS Child Hospital Survey (Child HCAHPS), which assesses the experiences of pediatric patients and their parents or guardians with inpatient care.

- Communication Between You and Your Child's Doctors Dimension Average: Percent of parents who reported that their doctors "Always" communicated well
- Communication Between You and Your Child's Nurses Dimension Average: Percent of parents who reported that their nurses "Always" communicated well
- Paying Attention to Your Child's Pain Dimension Average: Percent of parents who reported that their children's pain was "Always" well controlled/addressed
- Communication About Your Child's Medicines Dimension Average: Percent of parents who reported that staff "Always" collected information about the medicine taken by the a child and explained about medicines before prescribing or giving it to children
- Preparing You and Your Child to Leave the Hospital Dimension Average: Percent of parents who reported that "Yes," definitely, they were given information about what to do during their recovery at home
- Cleanliness of Hospital Room Percent of parents who reported that their room and bathroom were "Always" clean
- Quietness of Hospital Room Percent of parents who reported that the area around their room was "Always" quiet at night
- Overall Rating of Hospital Percent of parents who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)
- Willingness to Recommend the Hospital Percent of parents who reported "Yes," they would definitely recommend the hospital

Children's hospitals will also have an option to respond to questions from HCAHPS (optional reporting).

HHSC understands that there could have been changes in Child HCAHPS related to pain management questions. Providers will have several options in responding to this question:

- Leave the question as is if the provider had access to data.
- Manually replace existing language for the question related to pain management (e.g. communication related to pain, etc.) with the measure that the provider was tracking during specified measurement period.
- Report at 0 percent if nothing else is tracked.

Provider should include a description of the data used to respond to this question in the area for qualitative response (Please include any additional details regarding your reported information).

Performing Providers in this Category

Based on the approved RHP Plan Update, the following providers will be responding to questions related to Child CAHPS Hospital Survey. Questions will be generated by the template after providers enter their TPI.

RHP	TPI
3	139135109
4	132812205
6	020844903
7	186599001
9	138910807
15	291854201

Reporting for Hospitals with Other Type of Exemption

During the RHP Plan Update, some providers requested an exemption from reporting results on Patient Satisfaction by utilizing HCAHPS and provided justification for such exemption. Based on HHSC approvals, nine providers are reporting on a tool different than HCAHPS. The template is pre-populated with the patient satisfaction questions entered by the providers during October DY7 reporting period. Providers can update the measures they track by updating the questions in the template. Providers need to include a statement explaining what measures have changed and provide a reason for that change. Providers can input information for up to 15 questions/measures that they will be reporting on in DY8 and provide the percent result that providers are tracking (top box responses).

Based on the approved RHP Plan Update, the following providers will be able to report on the surveys and questions they are tracking and measuring:

RHP	TPI
6	112742503
6	133257904
7	307459301
10	021184901
12	136492909
12	094121303
13	020989201
13	121806703
13	130089906

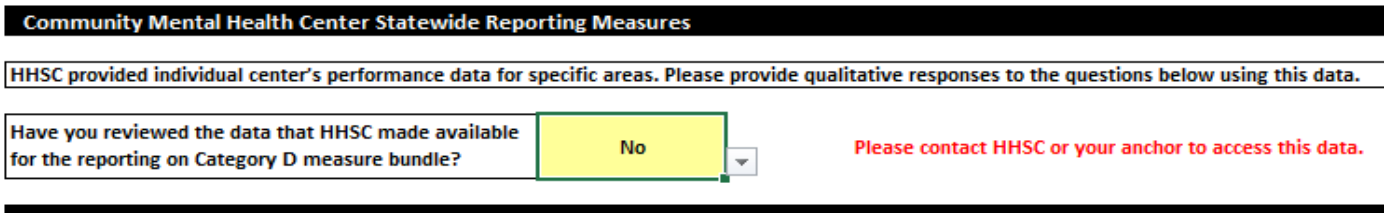
Category D CMHCs Reporting

CMHCs will report on their initiatives that impact selected measures:

- **Effective Crisis Response:** percent of individuals receiving crisis services who avoid inpatient admission after the crisis episode.

- **Crisis Follow Up:** percent of individuals receiving crisis services who receive crisis follow up services within a defined period of time.
- **Community Tenure (Adult and Child/Youth):** percent of individuals who successfully avoid psychiatric inpatient care.
- **Reduction in Juvenile Justice Involvement:** percent of children and youth who demonstrate improved on indicators of juvenile justice involvement.
- **Adult Jail Diversion:** percent of adults who demonstrate improvement on indicators of criminal justice involvement.

Providers will report by using Fiscal Year 2018 (September 1, 2017 - August 31, 2018) data provided by HHSC. If providers do not respond that they reviewed the data that HHSC made available for the reporting purposes, then they will not be able to complete reporting, because the overall progress indicator will remain Incomplete.



In April of DY8, CMHCs can report on five (5) metrics M-8.1 though M-8.5.

Cat	Milestone ID	Milestone Description	Metric ID	Metric Description
D	M-8	CMHC Statewide Reporting Measures	M-8.1	Effective Crisis Response
D	M-8	CMHC Statewide Reporting Measures	M-8.2	Crisis Follow Up
D	M-8	CMHC Statewide Reporting Measures	M-8.3	Community Tenure (Adult and Child/Youth)
D	M-8	CMHC Statewide Reporting Measures	M-8.4	Reduction in Juvenile Justice Involvement
D	M-8	CMHC Statewide Reporting Measures	M-8.5	Adult Jail Diversion

For each metric shown in the table above, providers will submit responses to qualitative questions:

a. What is your interpretation of your current rate? Is there a room for additional improvement?
b. What are your current initiatives that are impacting this rate?
c. What additional initiatives or activities are you planning to do that can impact this rate?
d. Is there a regional collaboration or other multi-provider collaboration to impact this rate? If yes, then please describe your participation in the collaboration.

Provider's responses should include sufficient details for each of the question. "NA" responses will result in HHSC following up with the provider via the NMI process. Below are some examples of how providers may approach reporting on Category D.

a. What is your interpretation of your current rate? Is there a room for additional improvement? Providers should elaborate on the current rates and discuss if their initiatives aim at increasing the rates further. If a provider does not have any initiative in place that impacts the measure, provider should include an explanation as to why none of the provider's activities impact the achievement. If a provider is doing exceptionally well in a specific area, provider can elaborate on possible drivers that contributed to this success.

b. What are your current initiatives that are impacting this rate?
Providers should describe any initiatives they have in place that directly or indirectly impact the percentages. If a provider has a Core Activity that can impact this rate, provider should state that and describe how that Core Activity can impact the rate. If a provider does not have any initiative in place that can impact the rates, provider should include an explanation as to why none of provider's activities impact the rate.

c. What additional initiatives or activities are you planning to do that can impact these rates
Providers should describe any initiative being planned that may potentially impact the rate. If a provider is proposing a new Core Activity that can impact the rate, provider should include that description. If a provider does not plan to have additional initiatives to impact the rates, provider should provide a short description of why additional initiatives may not be needed (e.g., sufficient activities in place to have an impact on this area, high achievement level already, etc.).

d. Is there a regional collaboration or other multi-provider collaboration to impact these rates? If yes, then please describe your participation in the collaboration.
If there is a regional collaboration, provider should include a description of who participates in it and how (e.g., sharing of the data, regional meetings, etc.).

Category D Physician Practices Reporting

Physician Practices will report on their activities that can potentially impact rates that are tracked as Prevention Quality Indicators (PQIs). Providers will report by using a regional summary provided by HHSC with the PQIs rates based on 2017 data for Medicaid and 2016 all-payer data. If providers do not respond that they reviewed the data that HHSC made available for the reporting purposes, then they will not be able to complete reporting, because the overall progress indicator will remain Incomplete.

Physician Practices Statewide Reporting Measures		
HHSC provided a regional summary with the Prevention Quality Indicators (PQIs) that are based on Medicaid-only data. Please provide qualitative responses to the questions below using regional data.		
Have you reviewed the data that HHSC made available for the reporting on Category D measure bundle?	No	Please contact HHSC or your anchor to access this data.

In April of DY8, Physician Practices can report on 13 metrics M-9.1 though M-9.13.

Cat	Milestone ID	Milestone Description	Metric ID	Metric Description
D	M-9	Physician Practices Statewide Reporting Measures	M-9.1	Diabetes Short-term Complications Admissions Rate
D	M-9	Physician Practices Statewide Reporting Measures	M-9.2	Perforated Appendix Admission Rate
D	M-9	Physician Practices Statewide Reporting Measures	M-9.3	Diabetes Long-term Complications Admissions Rate
D	M-9	Physician Practices Statewide Reporting Measures	M-9.4	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admissions Rate
D	M-9	Physician Practices Statewide Reporting Measures	M-9.5	Hypertension Admission Rate
D	M-9	Physician Practices Statewide Reporting Measures	M-9.6	Heart Failure Admission Rate
D	M-9	Physician Practices Statewide Reporting Measures	M-9.7	Low Birth Weight Rate
D	M-9	Physician Practices Statewide Reporting Measures	M-9.8	Dehydration Admission Rate
D	M-9	Physician Practices Statewide Reporting Measures	M-9.9	Bacterial Pneumonia Admission Rate
D	M-9	Physician Practices Statewide Reporting Measures	M-9.10	Urinary Tract Infection Admission Rate
D	M-9	Physician Practices Statewide Reporting Measures	M-9.11	Uncontrolled Diabetes Admission Rate
D	M-9	Physician Practices Statewide Reporting Measures	M-9.12	Asthma in Younger Adults Admission Rate
D	M-9	Physician Practices Statewide Reporting Measures	M-9.13	Lower-Extremity Amputation among Patients with Diabetes Rate

For each metric shown in the table above, providers will submit responses to qualitative questions:

a. As a physician practice, what are your current initiatives that are impacting this rate?
b. What additional initiatives or activities are you planning to do that can impact these rates?
c. Is there a regional collaboration or other multi-provider collaboration to impact these rates? If yes, then please describe your participation in the collaboration.

Provider's responses should include sufficient details for each of the question. "NA" responses will result in HHSC following up with the provider via the NMI process. Below are some examples of how providers may approach reporting on Category D.

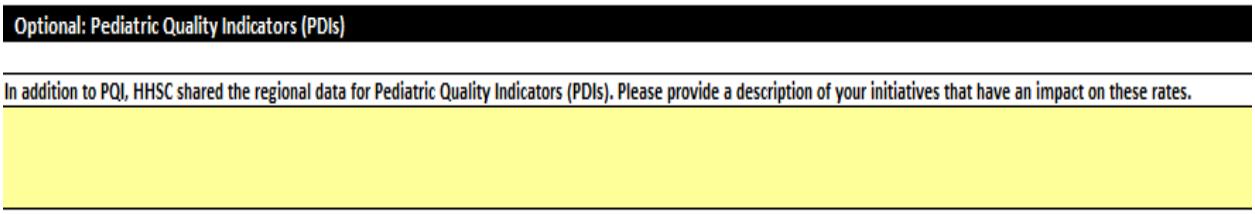
a. As a physician practice, what are your current initiatives that are impacting this rate? Providers should describe any initiatives they have in place that directly or indirectly impact the rates. If a provider has a Core Activity that can impact this rate, provider should state that and describe how that Core Activity can impact the rate. If a provider does not have any initiative in place that can impact the rates, provider should include an explanation as to

why none of the activities that provider has impact the rate.

b. What additional initiatives or activities are you planning to do that can impact these rates? Providers should describe any initiative that is being planned that may potentially impact the rate. If a provider is proposing a new Core Activity that can impact the rate, provider should include that description. If a provider does not plan to have additional initiatives to impact the rates, provider should provide a short description of why additional initiatives may not be needed (e.g., sufficient activities in place to have an impact on this area, rates are not high, etc.).

c. Is there a regional collaboration or other multi-provider collaboration to impact these rates? If yes, then please describe your participation in the collaboration.
If there a regional collaboration, provider should include a description of who participates in it and how (e.g., sharing of the data, regional meetings, etc.).

In addition to PQIs, HHSC also shared with providers regional data for Pediatric Quality Indicators (PDIs). Reporting for this area is not required in DY8, but HHSC encourages providers to include a brief description of initiatives that impact these rates.



Since this reporting is optional, providers will be able to complete and submit the template without completing this section.

Category D LHD Reporting

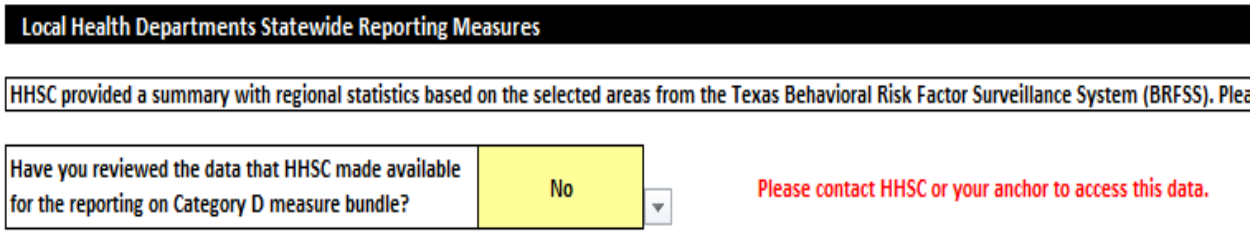
LHDs will report on their activities that can potentially impact access to health care services, health status of the population, access to selected immunization, and prevention of sexually transmitted diseases.

LHDs will report on their initiatives that impact the rates and trends of the following measures:

- Time Since Routine Checkup
- High Blood Pressure Status
- Diabetes Status
- Overweight or Obese
- Smoker Status
- Selected Immunizations: flu shot, pneumonia shot, tetanus shot, MMR vaccine, HPV vaccination
- Prevention of Sexually Transmitted Diseases – HIV testing

Providers will report by using a regional summary provided by HHSC with the 2017 data from the Texas Behavioral Risk Factor Surveillance System. This regional summary report now contains statewide information for these measures, so providers can compare the rates for their regions against statewide

rates. If providers do not respond that they reviewed the data that HHSC made available for the reporting purposes, then they will not be able to complete reporting, because the overall progress indicator will remain Incomplete.



Some RHPs maybe missing data for some or all measures. This happens if there is not enough data available for the region. Affected providers can review the data for similar RHPs and the statewide data.

In April of DY8, LHDs will report on seven (7) metrics M-10.1 though M-10.7.

Cat	Milestone ID	Milestone Description	Metric ID	Metric Description
D	M-10	LHD Statewide Reporting Measures	M-10.1	Time Since Routine Checkup
D	M-10	LHD Statewide Reporting Measures	M-10.2	High Blood Pressure Status
D	M-10	LHD Statewide Reporting Measures	M-10.3	Diabetes Status
D	M-10	LHD Statewide Reporting Measures	M-10.4	Overweight or Obese
D	M-10	LHD Statewide Reporting Measures	M-10.5	Smoker Status
D	M-10	LHD Statewide Reporting Measures	M-10.6	Selected Immunizations (Flu, Pneumonia, Tetanus, MMR Vaccine, and HPV)
D	M-10	LHD Statewide Reporting Measures	M-10.7	Prevention of Sexually Transmitted Diseases

For each metric shown in the table above, providers will submit responses to qualitative questions:

a. What initiatives does your Local Health Department have in place that can impact area of reporting (e.g., time since routine checkup, high blood pressure, etc.)?
b. What additional initiatives or activities are you planning to do that can impact this rate?
c. Is there a regional collaboration or other multi-provider collaboration to impact this rate? If yes, then please describe your participation in the collaboration.

Provider's responses should include sufficient details for each of the question. "NA" responses will result in HHSC following up with the provider via the NMI process. Below are some examples of how providers may approach reporting on Category D.

a. What initiatives does your Local Health Department have in place that can impact area of reporting (e.g., time since routine checkup, high blood pressure, etc.)?

Providers should describe any initiatives they have in place that directly or indirectly impact the rates. If a provider has a Core Activity that can impact this rate, provider should specify the Core Activity and describe how it can impact the rate. If a provider does not have any initiative in place that can impact the rates, then provider should include an explanation as to why none of the activities that provider has in place impact the rate.

b. What additional initiatives or activities are you planning to do that can impact these rates? Providers should describe any initiative that is being planned that may potentially impact the rate. If a provider is proposing a new Core Activity that can impact the rate, provider should include that description. If a provider does not plan to have additional initiatives to impact the rates, provider should provide a short description of why additional initiatives may not be needed (e.g., sufficient activities in place to have an impact on this area, high achievement level already, etc.).

c. Is there a regional collaboration or other multi-provider collaboration to impact these rates? If yes, then please describe your participation in the collaboration.

   If there a regional collaboration, provider should include a description of who participates in it and how (e.g., sharing of the data, regional meetings, etc.).

LHDs can report on all metrics even if a provider does not have specific activities that can directly impact certain areas. For example, if a provider does not have specific activities related to increasing access to routine checkups, provider can respond to qualitative questions explaining the reason for not working on this area and how the need in the region is addressed. Provider can meet the requirements of the reporting and be eligible for incentive payments by providing sufficient information in response to the questions.

PAYMENT AND IGT PROCESSING

CATEGORIES B PAYMENT CALCULATION

The amount of the incentive funding paid to a provider will be based on the amount of progress made and approved within the MLIU PPP milestone. The MLIU PPP milestone is valued at 100 percent of the Category B valuation. The MLIU PPP is eligible for partial achievement.

Based on the progress reported and approved, the MLIU PPP milestone will be categorized as follows:

- Achievement within allowable variation as determined for each provider up to full achievement (achievement value = 1)
- At least 90 percent achievement to allowable variation (achievement value = .90)
- At least 75 percent achievement (achievement value = .75)
- At least 50 percent achievement (achievement value = .50)
- Less than 50 percent achievement (achievement value = 0)

The provider is eligible to receive an amount of incentive funding for that milestone determined by multiplying the total amount of funding related to that milestone by the reported achievement value.

Example of Category B MLIU PPP disbursement calculation:

A provider's MLIU PPP is valued at $2 million and has an allowable variation of 3 percent with an MLIU PPP goal of 1500.

The provider reports MLIU PPP achievement of 1470. The achievement is within the allowable variation at 98 percent (1470/1500) and has an achievement value of 1. The provider is eligible for 100 percent of the Category B valuation.

Note that DSRIP funds are Medicaid incentive payments that are earned for achieving approved metrics at agreed upon values. Once those funds are earned, neither HHSC nor CMS is prescribing how the funds are to be spent, but HHSC certainly encourages providers to spend funds to improve healthcare delivery, particularly for the Medicaid and low-income uninsured populations.

CATEGORY C PAYMENT CALCULATIONS

April DY8 Category C payments are based on performance and remaining baselines reported in the *Category C Reporting Template* and approval of the submission by HHSC.

For process and reporting milestones (IM-1, IM-2, RM-1, and RM-2), a provider must fully achieve to qualify for the DSRIP payment related to these milestones.

For achievement milestones for an outcome with multiple components/rates, the 50% allocation toward achievement (AM-7) is split evenly between the number of components/rates, (e.g., AM-7.1 and AM-7.2) and these achievement milestones can be achieved or partially achieved independently.

Example milestone structure for outcomes with multiple components/rates

P4P outcome selected is D1-211 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents. This outcome has 3 components or parts (BMI documentation, counseling for nutrition, and counseling for physical activity) with a DY7 value of $200K and DY8 value of $400K. The following is a description of the milestone structure and payment allocation by milestone.

- DY7 Milestones
    - RM-1: Baseline reporting - $50K - not eligible for partial payment.
    - RM-2: PY1 reporting - $50K - not eligible for partial payment.
    - AM-7.1: Achievement of DY7 goal for component 1 (BMI documentation) - $33K - partial achievement and carryforward eligible.
    - AM-7.2: Achievement of DY7 goal for component 2 (counseling for nutrition) - $33K - partial achievement and carryforward eligible.
    - AM-7.3: Achievement of DY7 goal for component 3 (counseling for physical activity) - $33K - partial achievement and carryforward eligible.
- DY8 Milestones
    - RM-2: PY2 reporting - $100K - not eligible for partial payment
    - AM-8.1: Achievement of DY8 goal for component 1 (BMI documentation) - $100K - partial achievement and carryforward eligible.
    - AM-8.2: Achievement of DY8 goal for component 2 (counseling for nutrition) - $100K - partial achievement and carryforward eligible.
    - AM-8.3: Achievement of DY8 goal for component 3 (counseling for physical activity) - $100K - partial achievement and carryforward eligible.

For a detailed explanation of **Partial Achievement**, please refer to the *Category C Achievement Calculation* section of this document.

CATEGORY D PAYMENT CALCULATIONS

A provider will be eligible for a Category D DSRIP payment for each measure within the provider's Statewide Reporting Bundle completely reported in the *Category D Template* and approved by HHSC. Partial payments do not apply to Category D.

APPROVED OCTOBER 2018 NMI MILESTONES AND METRICS

In February 2019, HHSC completed review of October 2018 reporting submissions in response to HHSC requests for more information. Approved NMI milestones and metrics will be included in the July 2019 payment processing of April reports. NMI milestones and metrics that were not approved will no longer have access to the associated DSRIP funds.

IGT PROCESSING

In June 2019, HHSC Rate Analysis will notify IGT Entities and Anchors of the IGT amounts by affiliation and IGT Entity by RHP for July 2019 payment processing of approved April reports. The IGT amounts for July 2019 short IGT, approved NMI milestones and metrics, DY7 achievement, DY8 achievement, and DY8 monitoring will be indicated as well as a total IGT amount.

Per Texas Administrative Code §355.8204, HHSC may collect up to $5 million per DY from DSRIP IGT entities to serve as the non-federal share (50 percent IGT/50 percent federal funds) for DSRIP monitoring contracts. For DY8, HHSC will collect $5 million in Monitoring IGT. The monitoring amount for each IGT Entity is a portion of the $5 million based on the January 1, 2019 value of the IGT Entity's funded DY8 DSRIP out of all DY8 DSRIP in the state.

HHSC will request 100 percent of the DY8 IGT monitoring amount with July 2019 payment processing of April reports. If the full DY8 IGT monitoring amount is not submitted by an IGT Entity in July 2019, it will be requested with January 2020 payment processing of October reports.

An IGT Entity may either transfer the total IGT amount due for DSRIP and monitoring or an amount less than the total IGT due. If less than the total IGT amount is transferred, then HHSC will account for the IGT monitoring amount first and the remaining IGT will be proportionately used to fund DY7 and DY8 approved DSRIP payments. If an IGT entity does not fully fund its DSRIP payments in July, the remaining IGT amount due for its affiliated projects' achievement may be transferred with January 2020 payment processing of October DY8 reports.

DSRIP payments are made using the Federal Medical Assistance Percentage (FMAP) for the federal fiscal year (October 1 – September 30) during which the DSRIP payment is issued and is not based on the DY FMAP of the achieved milestone or metric. The FMAP for FFY2019 and used for July 2019 DSRIP payment processing of April reports is 58.19. The FFY2020 FMAP of 60.89 will be used for January 2020 DSRIP payment processing of October reports.

IGT Entity Changes

The IGT Entity(ies) and proportion of funding for each project/outcome/Category B/measure/Category D will be posted on the Bulletin Board in the DSRIP Online Reporting System. By May 16, 2019, HHSC will post the estimated IGT due for April reporting based on milestones and metrics reported as achieved to inform any needed IGT changes. Final IGT due will be based on HHSC review and approval of reporting. If you have changes to the IGT Entity, either in Entity or proportion

of payment among IGT Entities, listed in the reporting system, please complete the *IGT Entity Change Form* that is posted under Other 1115 Medicaid Waiver Forms on the Bulletin Board in the DSRIP Online Reporting System. IGT Entity changes must be received no later than **May 31st** at **5:00 p.m.** for April reporting DSRIP payment processing. Any changes received after May 31, 2019, will go into effect for the October DY8 DSRIP reporting, and payments will be delayed until that time. Note that IGT Entity changes submitted for April reporting will not impact the IGT monitoring amounts.

WARNING NOTICE REGARDING SUBMISSION OF SUPPORTING DOCUMENTATION

All information submitted for DSRIP reporting by Texas Healthcare Transformation and Quality Improvement Program §1115 Waiver participants is subject to the Public Information Act ("Act"), Chapter 552 of the Government Code. Certain information, such as commercial or financial information the disclosure of which would cause significant competitive harm, is excepted from public disclosure according to the Act. If you believe that the documentation submitted through this system is excepted from the Act, please note that belief at the beginning of your submission, including the particular exception you would claim.

Providers are required by the HHSC Medicaid Provider Agreement, as well as state and federal law, to adequately safeguard individually identifiable Client Information. While the DSRIP online reporting system is secure, and access is limited to HHSC program auditors, protected health information (PHI) is not required by HHSC and should not be transmitted. As such, Providers are prohibited from submitting Personally Identifiable Information about clients, HIPAA Protected Health Information or Sensitive Personal Information in connection with submittal of meeting the metric. Providers are required to only submit De-identified information [as evidence of meeting a metric]. If Provider inadvertently uploads individually identifiable client information or following discovery of an Event or Breach, the Provider should report this to HHSC Waiver Staff and the Provider's designated privacy official or legal counsel to determine whether or not this is a privacy breach which requires notice to your patients. HHSC will remove the PHI-containing files as necessary, but requests that providers submit de-identified versions of the original documentation and description of corrective actions for auditing and recordkeeping purposes. Providers will cooperate fully with HHSC in investigating, mitigating to the extent practicable and issuing notifications directed by HHSC, for any event or breach of confidential information to the extent and in the manner determined by HHSC. Provider's obligation begins at the discovery of an event or data breach and continues as long as related activity continues, until all effects of the event are mitigated to HHSC's satisfaction.

Definitions

"**Breach**" means any unauthorized acquisition, access, use, or disclosure of confidential Client Information in a manner not permitted by [this incentive program] or applicable law. Additionally:

(1) HIPAA Breach of PHI. With respect to Protected Health Information ("PHI") pursuant to HIPAA regulations and guidance, any unauthorized acquisition, access, use, or disclosure of PHI in a manner not permitted by the HIPAA Privacy Regulations is presumed to be a Breach unless Provider, as applicable, demonstrates that there is a low probability that the PHI has been compromised. Compromise will be determined by a documented Risk Assessment including at least the following factors:

i. The nature and extent of the Confidential Information involved, including the types of identifiers and the likelihood of re-identification of PHI;
ii. The unauthorized person who used or to whom PHI was disclosed;
iii. Whether the Confidential Information was actually acquired or viewed; and
iv. The extent to which the risk to PHI has been mitigated.

With respect to PHI, a "breach," pursuant to HIPAA Breach Regulations and regulatory guidance excludes:

(A) Any unintentional acquisition, access or use of PHI by a workforce member or person acting

under the authority of HHSC or Provider if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the HIPAA Privacy Regulations.

(B) Any inadvertent disclosure by a person who is authorized to access PHI at HHSC or Provider to another person authorized to access PHI at the same HHSC or Provider location, or organized health care arrangement as defined by HIPAA in which HHSC participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the HIPAA Privacy Regulations.

(C) A disclosure of PHI where Provider demonstrates a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information, pursuant to HIPAA Breach Regulations and regulatory guidance.

(2) Texas Breach of SPI. Breach means "Breach of System Security," applicable to electronic Sensitive Personal Information (SPI) as defined by the Texas Breach Law. The currently undefined phrase in the Texas Breach Law, "compromises the security, confidentiality, or integrity of sensitive personal information," will be interpreted in HHSC's sole discretion, including without limitation, directing Provider to document a Risk Assessment of any reasonably likelihood of harm or loss to an individual, taking into consideration relevant fact-specific information about the breach, including without limitation, any legal requirements the unauthorized person is subject to regarding confidential Client Information to protect and further safeguard the data from unauthorized use or disclosure, or the receipt of satisfactory assurance from the person that the person agrees to further protect and safeguard, return and/or destroy the data to the satisfaction of HHSC. Breached SPI that is also PHI will be considered a HIPAA breach, to the extent applicable.

(3) Any unauthorized use or disclosure as defined by any other law and any regulations adopted there under regarding Confidential Information.

"Client Information" means Personally Identifiable Information about or concerning recipients of benefits under one or more public assistance programs administered by HHSC.

"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. HHSC has determined that health information is not individually identifiable and there is no reasonable basis to believe that the information can be used to identify an Individual only if:

(1) The following identifiers of the Individual or of relatives, employers, or household members of the individual, are removed from the information:

(A) Names;

(B) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

(i) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(ii) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

All elements of dates (except year) for dates directly related to an Individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

(C) Telephone numbers;

(D) Fax numbers;

(E) Electronic mail addresses;

(F) Social security numbers;

(G) Medical record numbers (including without limitation, Medicaid Identification Number);
(H) Health plan beneficiary numbers;
(I) Account numbers;
(J) Certificate/license numbers;
(K) Vehicle identifiers and serial numbers, including license plate numbers;
(L) Device identifiers and serial numbers;
(M) Web Universal Resource Locators (URLs);
(N) Internet Protocol (IP) address numbers;
(O) Biometric identifiers, including finger and voice prints;
(P) Full face photographic images and any comparable images; and
(Q) Any other unique identifying number, characteristic, or code, except as permitted by paragraph (C) of this section; and
(2) Neither HHSC nor Provider has actual knowledge that the information could be used alone or in combination with other information to identify an Individual who is a subject of the information."

"Discovery" means the first day on which an Event or Breach becomes known to Provider, or, by exercising reasonable diligence would have been known to Provider and includes Events or Breaches discovered by or reported to Provider, its officers, directors, partners, employees, agents, work force members, subcontractors or third-parties (such as legal authorities and/or Individuals).

"Encryption" of confidential information means, as described in 45 C.F.R. §164.304, the HIPAA Security Regulations, the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without the use of a confidential process or key and such confidential process or key that might enable decryption has not been breached. To avoid a breach of the confidential process or key, these decryption tools will be stored on a device or at a location separate from the data they are used to encrypt or decrypt.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended by the HITECH ACT and regulations thereunder including without limitation HIPAA Omnibus Rules, in 45 CFR Parts 160 and 164. Public Law 104-191 (42 U.S.C. §1320d, *et seq*.); Public Law 111-5 (42 U.S.C. §13001 *et. seq.*).

"HIPAA Privacy Regulations" means the HIPAA Privacy Regulations codified at 45 C.F.R. Part 160 and 45 C.F.R. Part 164, Subpart A, Subpart D and Subpart E.

"HIPAA Security Regulations" means the HIPAA Security Regulations codified at 45 C.F.R. Part 160 and 45 C.F.R. Part 164 Subpart A and Subpart C, and Subpart D.

"HITECH Act" means the Health Information Technology for Economic and Clinical Health Act (P.L. 111-5), and regulations adopted under that act.

"Individual" means the subject of confidential information, including without limitation Protected Health Information, and who will include the subject's Legally authorized representative who qualifies under the HIPAA privacy regulation as a Legally authorized representative of the Individual wherein HIPAA defers to Texas law for determination, for example, without limitation as provided in Tex. Occ. Code § 151.002(6); Tex. & S. Code §166.164; and Texas Prob. Code § 3. "Legally authorized representative" of the Individual, as defined by Texas law, for example, without limitation as provided in Tex. Occ. Code § 151.002(6); Tex. H. & S. Code §166.164; and Texas Prob. Code § 3, includes:
(1) a parent or legal guardian if the Individual is a minor;
(2) a legal guardian if the Individual has been adjudicated incompetent to manage the Individual's

personal affairs;

(3) an agent of the Individual authorized under a durable power of attorney for health care;
(4) an attorney ad litem appointed for the Individual;
(5) a guardian ad litem appointed for the Individual;
(6) a personal representative or statutory beneficiary if the Individual is deceased;
(7) an attorney retained by the Individual or by another person listed herein; or
(8) If an individual is deceased, their personal representative must be the executor, independent executor, administrator, independent administrator, or temporary administrator of the estate.

"Personally Identifiable Information" or "PII" means information that can be used to uniquely identify, contact, or locate a single Individual or can be used with other sources to uniquely identify a single Individual.

"Protected Health Information" or "PHI" means individually identifiable health information in any form that is created or received by a HIPAA covered entity, and relates to the Individual's healthcare condition, provision of healthcare, or payment for the provision of healthcare, as further described and defined in the HIPAA. PHI includes demographic information unless such information is De-identified, as defined above. PHI includes without limitation, electronic PHI, and unsecure PHI. PHI includes PHI of a deceased individual within 50 years of the date of death.

"Unsecured Protected Health Information" means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized Persons through the use of a technology or methodology specified by the HITECH Act regulations and HIPAA Security Regulations. Unsecured PHI does not include secure PHI, which is:

(1) Encrypted electronic Protected Health Information; or
(2) Destruction of the media on which the Protected Health Information is stored.