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DY8 Round 1 (April) DSRIP Reporting

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Reporting Overview

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- Providers must complete reporting on their DSRIP activities in April using the DSRIP Online Reporting System and applicable reporting materials.
  - If the Texas Health and Human Services Commission (HHSC) does not find sufficient evidence of achievement in the submitted documentation, the provider will have only one opportunity in June/July to submit additional information.
  - If HHSC and the Centers for Medicare & Medicaid Services (CMS) do not approve the additional information, the provider will no longer be eligible for payment for that metric/milestone.
- April semi-annual reports are due by **April 30, 2019, 11:59 p.m.**

April DY8 Reporting

April DY8 Reporting Key Dates

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April DY8 Reporting Key Dates, 1

- April 1, 2019 – The DSRIP Online Reporting System opened for providers to begin April DY8 reporting.
- April 24, 2019 – Final date to submit Cat C questions and data issues.
- April 26, 2019 – Final date to submit Cat A, Cat B, and Cat D reporting questions and inform HHSC of any data issues in the reporting system.
- April 30, 2019, 11:59 p.m. – Due date for April DY8 reporting, including required semi-annual progress reporting due to HHSC.
- May 20, 2019, 5:00 p.m. – Due date for IGT Entities to notify HHSC of any issues with their affiliated providers' April DY8 reports.

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April DY8 Reporting Key Dates, 2

- May 31, 2019, 5:00 p.m. – Deadline for changes in IGT entities or proportion of IGT among entities.
- June 10, 2019 – HHSC and CMS will complete their review and approval of April DY8 reports or request additional information (referred to as NMI) regarding the data reported.
- July 2, 2019 – IGT settlement date for April DY8 reporting DSRIP payments and Monitoring IGT.
- July 8, 2019, 11:59 p.m. – Due date for providers to submit responses to HHSC requests for additional information on April DY8 reported milestone/metric achievement and incomplete semi-annual progress reports.

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April DY8 Reporting Key Dates, 3

- July 17, 2019 – April reporting DY8 DSRIP payments processed for transferring hospitals.
- July 31, 2019 – April reporting DY6, DY7, and DY8 DSRIP payments processed for all providers that were not paid on July 17. Note that 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 and semi-annual progress reports.

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April DY8 Reporting

Key Items for DY8 Reporting

- DSRIP Online Reporting System Access
- Semi-Annual Reporting (SAR)
- Category A Reporting
- Category B Reporting
- Category C Reporting
- Category D Reporting
- Helpful Reporting Tips
- Reporting Resources

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DSRIP Online Reporting System Access

- To request access or to update user roles in the reporting system, please contact the waiver team at TXHealthcareTransformation@hhsc.state.tx.us.
- For users with multiple roles, you should be logged in as a **Provider** or **Lead Provider** user to complete your project reports.
- Users can reset their account passwords through the **Forgot Password / Login?** link on the DSRIP Online Reporting System login screen.

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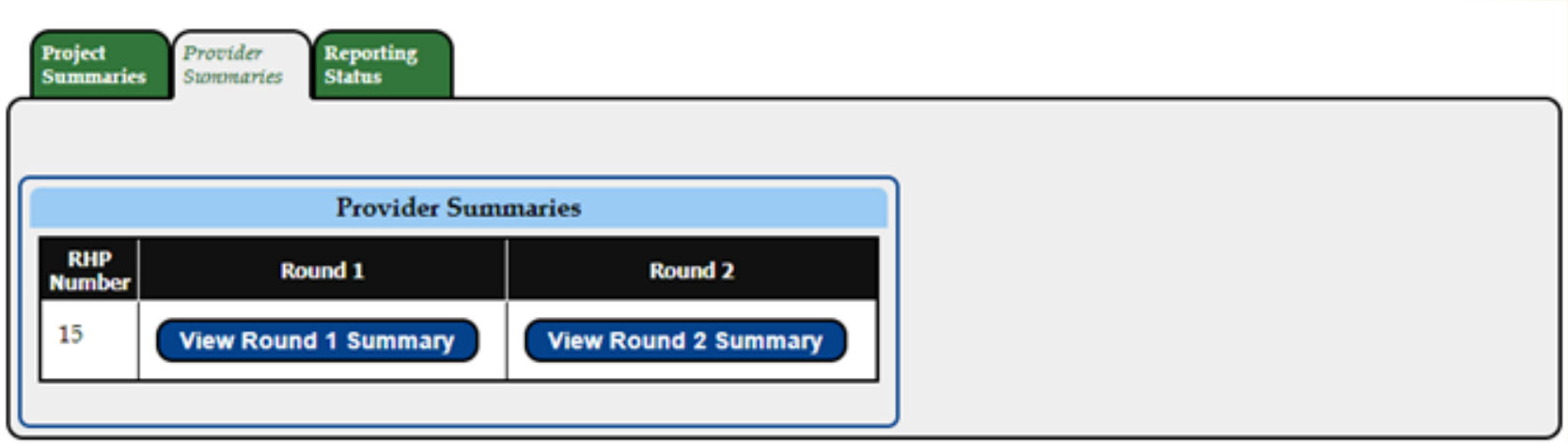
Semi-Annual Reporting (SAR)

- All Providers must complete the Provider Summary as part of SAR requirements.
  - This is a brief, high-level overview of your DSRIP program's current progress, activities conducted, findings, and outcomes achieved.
  - The report is accessible from the Provider Summaries tab on the Provider's home page.



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Category A Reporting, 1

- Category A is not eligible to report during the April (Round 1) reporting period. The Category A reporting tab will be read-only.
- **Reminders:**
  - Even though providers are not reporting on Core Activities during April 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 of 2019).
  - All providers must attend at least one learning collaborative, stakeholder forum, or other stakeholder meeting during DY8 (10/1/18-9/30/19) in order to meet Category A reporting requirements for DY8. Not meeting this requirement during the October DY8 reporting period will impact payments for other categories.

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Category A Reporting, 2

- **Reminders:**
  - The Costs and Savings analysis, including the completed tool and the narrative, will be due during October DY8 reporting (October 2019). Although there is no reporting on Costs and Savings during April DY8, providers are encouraged to work on this analysis now, if possible. Please refer to the Costs and Savings guidance document that is posted to the DSRIP Online Reporting System Bulletin Board for more information on the Costs and Savings analysis requirements and requesting to use an alternative tool. HHSC will work with providers that determined after the deadline that they need to request to use an alternative tool for this analysis.

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Category B Reporting, 1

Category B DY7 Carryforward Metric (if applicable)

- April DY8 is the first and final opportunity to report on the DY7 carryforward Category B metric for payment.
- The carryforward Category B reporting tab is indicated with an asterisk (i.e., Category B*). This is similar to Category 1 and 2 milestone tabs from DY2-6 reporting.
- The provider will still utilize the DY7 measurement period (10/1/17-9/30/18) to report achievement on their DY7 carryforward Category B metric.

Category B DY8 Metric

- The Category B metric for DY8 is not eligible to report during the April (Round 1) reporting period. The DY8 Category B reporting tab will be read-only.

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Category B Reporting, 2

Patient Population by Provider (PPP)

- Total PPP is the total number of unduplicated individuals served by the provider's defined system. MLIU PPP is the unduplicated number of MLIU individuals served by their defined system.
- For purposes of PPP, an individual is a 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.
- Please refer to the Category B FAQ document for additional guidance on what can be counted towards PPP. The Category B FAQ document can be found on the DSRIP Bulletin Board.

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Category B Reporting, 3

Reporting Achievement

- Select “Yes” in the “Reporting Achievement?” dropdown field
- Enter values and responses for the following required reporting fields:
  - Total PPP Numeric Achievement
  - MLIU PPP Numeric Achievement
  - Explanation for MLIU Percentage Change
    - Providers can compare the baseline MLIU percentage displayed in the Metric Details section to the MLIU Percentage in the Current Reporting Values section. Provider must save the Total and MLIU PPP information for the system to calculate the MLIU Percentage.
    - Provider can state that there was no change or insignificant change to their MLIU Percentage, if that is the case. Otherwise, it requires an explanation.

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Category B Reporting, 4

- The reporting system will calculate and display the Percentage of Goal Achieved once the Total and MLIU PPP numbers are entered and **saved**.
  - MLIU PPP is 100% achieved if the provider meets, exceeds, or falls within the range of allowable variation of their MLIU PPP numeric goal.
  - MLIU PPP is eligible for partial achievement at 90%, 75%, and 50%.
  - If a provider's MLIU PPP numeric achievement falls below 50% of their MLIU PPP goal, then the milestone is considered 0% achieved.
- The "Optional Provider Comments" field is available, but not required. This field is only required to be completed if the provider is forfeiting their Category B metric.
- An Upload button is available to providers. However, there is no required template or documentation to submit for Category B. Providers are responsible for maintaining documentation in case of audit.

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Category B Reporting, 5

- Providers should be using the same methodology they used to calculate their PPP baseline data. If there has been changes to this methodology or to who they are including in their MLIU population then they should describe these changes in the “Optional Provider Comments” field.
- Significant changes to the provider’s system definition that impact MLIU PPP baseline and goals or a request to reduce the MLIU PPP numeric goal require a plan modification.
  - For April DY8, the deadline for plan modifications has passed and HHSC is no longer accepting Category B changes that impact April DY8 reporting.
  - Plan modifications that impact October DY8 reporting should be submitted 90 days before the start of the October DY8 reporting period (i.e., July 3, 2019).

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Category C Reporting

- Providers will upload Category C reporting templates using the upload button on the Category C tab of the DY8 Round 1 Project Reporting page.
  - Reporting templates should use the standard naming convention: RHP01_ProviderTPI_CatC_AprDY7.xlsm
    (e.g., RHP01_123456789_CatC_AprDY7.xlsm)
- Providers must save the DY8 Round 1 Project Reporting page in order to view their uploaded reporting template and other documentation.
- Detailed guidance regarding the Category C reporting template will be covered later in the reporting webinar.

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Category D Reporting, 1

- In April DY8, providers are eligible to report on all Category D metrics specific to their provider type.
- All providers 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 as well as indicators for each section that is being reported
  - Providers are required to include contact information for an individual reporting Category D
  - 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."
- Providers are not required to submit additional documentation, but should maintain supporting documentation.
- Provider should follow HHSC's instructions for naming the template prior to submission.

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Category D Reporting, 2

Hospital Reporting

- Hospitals report on Potentially Preventable Events via Metrics M-7.1 – M.7.4
  - HHSC sent out reports to all hospital providers with PPAs, PPRs, PPCs and PPVs
- Responses to qualitative questions must be included for all metrics that provider is reporting on
  - HHSC will not accept responses that PPE reports are not used without providers explaining what other sources of data are used and how providers' internal data is compared to the reports provided by HHSC
  - Providers are not required to validate the data included in the reports
  - Not responding to qualitative questions with substantive analysis will result in HHSC requesting additional information via NMI
  - Examples in the Reporting Companion show how providers may approach this reporting

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Category D Reporting, 3

Hospital Reporting

- Low volume providers
  - Were previously exempt from a similar reporting in DY2-6
  - Do not receive EQRO reports or their reports do not contain meaningful data
- Low volume providers can report with the qualitative responses and be eligible for Category D incentive payments if sufficient information is submitted
  - Providers respond to a different set of questions since they cannot compare the numbers across the years
  - Need to include qualitative description of activities they have that can impact a specific area that they are reporting on

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Category D Reporting, 4

Hospital Reporting

- Low volume providers need to respond to the following questions (e.g. PPR):

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.

- If a provider does not receive any data from EQRO for 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.).

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Category D Reporting, 5

Hospital Reporting

- Providers also report on Patient Satisfaction via Metric M-7.5
  - DY8 measurement period is 12 months from 10/1/17 through 9/30/18
  - Reporting questions vary depending if a provider is
    - using HCAHPS, or
    - a children's hospital utilizing Child CAHPS survey, or
    - a hospital that requested and received HHSC's approval for an exemption from HCAHPS reporting because HCAHPS is not a required tool for the entity
- HHSC specified which providers are included in the category of children's hospitals and exempt hospitals on p. 52 of the reporting companion

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Category D Reporting, 6

Hospital Reporting

- Providers reporting on HCAHPS or Child CAPS hospital survey may no longer have data for Metric M-7.5 pain management questions. Providers have an option for reporting:
    - Leave the question as is if the provider had access to data during the measurement period
    - 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

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Category D Reporting, 7

Hospital Reporting

- Hospitals with the approved exemption from HCAHPS track and report on the measures they reported on in DY7
  - The template is pre-populated with the questions entered by 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 change in measures they track and provide a reason for that change

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Category D Reporting, 8

Community Mental Health Centers (CMHCs) Reporting

- CMHCs will report on their initiatives that impact selected measures via Metrics M-8.1 through M-8.5:
  - Effective Crisis Response, Crisis Follow up, Community Tenure (Adult and Child/Youth), Reduction in Juvenile Justice Involvement, and Adult Jail Diversion
  - Providers will respond to four (4) questions for each metric
- HHSC posted state Fiscal Year 2018 data on the bulletin board
  - Providers have to review this data and indicate in the template that they reviewed it
- Not responding to qualitative questions with substantive analysis will result in HHSC requesting additional information via NMI
  - Examples in the Reporting Companion show how providers may approach this reporting

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Category D Reporting, 9

Physician Practices (PP) Reporting

- PP will report on their initiatives that impact selected measures via Metrics M-9.1 through M-9.13
  - PPs will report on activities and interventions related to Prevention Quality Indicators (PQIs)
  - Providers will respond to three (3) questions for each metric
- HHSC posted on the bulletin board 2017 Medicaid data and 2016 all-payer data that should be used by the providers to assess current trends in their region
  - Providers have to review this data and indicate in the template that they reviewed it
- Not responding to qualitative questions with substantive analysis will result in HHSC requesting additional information via NMI
  - Examples in the Reporting Companion show how providers may approach this reporting
- Providers are encouraged to report on Pediatric Quality Indicators, however, this reporting is not a required reporting in DY8

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Category D Reporting, 10

Local Health Departments (LHDs) Reporting

- LHDs will report on their initiatives that impact selected measures via Metrics M-10.1 through M-10.7
  - Selected measures relate access to health care services, health status of the population, access to selected immunization, and prevention of sexually transmitted diseases
  - Providers will need to respond to three (3) questions for each metric
- HHSC posted on the bulletin board 2017 data from the Texas Behavioral Risk Factor Surveillance System (BRFSS) that should be used by the providers to assess current trends in their region
- This data also contains statewide information for these measures, which enables providers to compare the rates for their regions against statewide rates
  - 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

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Category D Reporting, 11

Local Health Departments (LHDs) Reporting

- LHDs can report on all metrics within their reporting bundle, even if a provider does not have specific activities impacting 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 be eligible for incentive payments if sufficient responses are provided
- Not responding to qualitative questions with substantive analysis will result in HHSC requesting additional information via NMI
- Examples in the Reporting Companion show how providers may approach this reporting

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Helpful Reporting Tips, 1

Saving and Submitting Reports

- Save your reporting progress often. The system will logout if idle for 20 minutes. If a user does not save prior to being logged out, any unsaved data will be lost.
- Only one user at a time should enter and save data on the Provider Summary page or an individual project reporting page. If multiple users are entering data at the same time on the same reporting page, the one who saves last will overwrite anything that was saved by the previous user(s).
- As long as the completed reports and supporting attachments have been **saved** by the reporting deadline, they will be considered officially submitted.
- Users designated as a “Lead Provider” have access to the Submit button on the reporting pages. Once a Lead Provider clicks Submit, editing data entry fields is no longer possible.

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Helpful Reporting Tips, 2

Supporting Documentation

- Required reporting templates should use the standard naming conventions that contain the provider's RHP, TPI, Category, and Reporting Period. For example:
  - **Category C:**
    RHP01_123456789_CatC_AprDY8.xlsm
  - **Category D:**
    RHP01_123456789_CatD_AprDY8_H.xlsm
- Do not use symbols (e.g., @, #, %, &, etc.) when naming documents.
- Supporting attachments cannot be edited or deleted after they are uploaded by the user. However, the user can save over documents by uploading a revised document with the same name and file extension.

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Reporting Resources, 1

- Providers can find updated reporting materials (companion documents, reporting templates, user guide, etc.) on the DSRIP Bulletin Board:
  - https://dsrip.hhsc.texas.gov/dsrip/viewBulletinBoard
    - Please note that the provider will need to be logged into the reporting system in order for this link to work.
  - Providers should review the April DY8 Reporting Companion document for additional guidance.
  - New users should refer to the DSRIP Online Reporting System User Guide and previous reporting webinars for a walk through of the reporting system.

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Reporting Resources, 2

- Previous Reporting Webinars
  - https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/recorded-webinars-conference-calls
  - For a walk through of the DSRIP Online Reporting System please refer to the October DY3 General Reporting Webinar slides.
  - For a walk through of the new DY7-8 provider-level project structure, please refer to the October DY7 General Reporting Webinar recording and slides found on the bulletin board in the DSRIP Online Reporting System.

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Reporting Resources, 3

- HHSC distributed the PPE reports needed for Category D reporting to hospital providers on **April 3, 2019**. If a hospital provider did not receive their PPE reports, please contact the waiver mailbox at TXHealthcareTransformation@hhsc.state.tx.us.
- Please submit all reporting questions to TXHealthcareTransformation@hhsc.state.tx.us.
  - Please remember to include RHP, Project ID, and Milestone ID with your question(s).

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Thank you

Please contact the Healthcare Transformation Waiver team at TXHealthcareTransformation@hhsc.state.tx.us.