Anchor Update 6/7/18

Good Morning Region 10 Providers,

Please see the below updates from HHSC.

Common Questions about RHP Plan Update Feedback

- Reporting PBCOs as P4R for providers with <75 MPT: HHSC gave an NMI comment to providers who requested to report PBCO as P4R if they did not provide any rationale other than stating they have an MPT below 75. Although this is correct, given the importance of PBCO measures in demonstrating the impact of delivery system reform initiatives, HHSC is asking all providers with larger valuations to evaluate their ability to report as P4P, and in cases where a provider cannot report as P4P HHSC is asking for a more detailed rationale. The RHP Plan Update is a public document that will be available to CMS, the legislature, and the public and should include sufficient rationale for significant decisions like opting to report a PBCO measure as P4R. The rationale should include best available data if relevant to their rationale. Providers with an MPT below 75 are not required to report PBCOs as P4P, but HHSC would like a more substantive reason documented in the RHP Plan Update.

- Category D: Providers were given an NMI if they do not report the HCAHPS to measure patient satisfaction because they are a hospital that is exempt from reporting due to low volume or they are a children's hospital.
    - Most children's hospitals will be utilizing the Child CAHPS survey for their patient satisfaction, which is acceptable. HHSC is interested in what domains the children's hospital has reported to them with the Child CAHPS survey and how it relates to the HCAHPS domains. Alternatively, a children's hospital can provide us with the Child CAHPS survey questions, but HHSC may follow-up at a later date just to make sure we know what the hospital will be reporting under Category D (this will not delay approval of the RHP Plan Update). If a hospital submits their information via email to HHSC prior to June 15, they should indicate they did so in the Provider Response field in the RHP Plan Update template.
    - Hospitals with low volume should indicate what survey they use for patient satisfaction, and what HCAHPS Reporting Measures they will be able to report on for Category D using that survey. The HCAHPS Reporting Measures can be found under Patient Satisfaction in the Category D section of the Measure Bundle Protocol. If they do use the HCAHPS, HHSC would like to know if all Reporting Measures are used, and if not, which ones are reported. HHSC may follow-up at a later date to make sure we know what the hospital will be reporting under Category D, but this will not delay approval of the RHP Plan Update.

- Category C: Providers may request changes to selected measure bundles through the RHP Plan Update NMI response with strong cause. This requires significant administrative effort on HHSC's part, and providers should be prepared to respond promptly to any HHSC requests for additional information via email after the RHP Plan Update feedback is received as adding measure bundles impacts multiple tabs of information in the RHP Plan Update regional tracker.

- If a provider is requesting to add a new measure bundle or measure, in the RHP Plan Update, providers should include the following information:
  - 1) indicate which Core Activity impacts the measure/bundle and describe how it does; or
  - 2) indicate a new Core Activity with a description of the Core Activity, at least one Secondary Driver, at least one Change Idea related to the Secondary Driver, and how the Core Activity impacts the measure/bundle.

  The Core Activity information may be entered on the Category A - Core Activities tab of the Regional Tracker.

- As HHSC reviews the RHP Plan Update NMI responses, HHSC will be following up with providers via email and copying Anchors on NMI responses that are unclear and will require a response within a day due to the tight timeline so that we can get plans approved by June 30th. Future Category B and C changes are limited to the Plan Modifications stated below. As allowed in the protocols, Category A - Core Activities may be updated during reporting with explanation.

Timeline for Plan Modifications

- Category B -
  - The PFM states that providers must submit requests to HHSC no later than 90 days prior to the first day of the semi-annual reporting period, which would be July 1 for the October DY7 reporting period. Please bear in mind that when the PFM was drafted, we expected the RHP Plan Updates to occur earlier than the current time period. Since July 1 is so close to the RHP Plan Update approval timeline, HHSC would prefer that any requests for system definition modifications or MLIU PPP changes be requested as part of the RHP Plan Update process, including any provider who did not receive an NMI in this area, so that modifications can be approved or denied by June 30.
  - Providers should have good rationale for making a change to MLIU PPP if it is not just a technical correction. The acceptable rationales for these changes are outlined in the PFM:

    i. A significant change to the Performing Provider's system definition as approved under paragraph 12.a.;

    ii. An error in the data uncovered subsequent to baseline reporting;

    iii. A significant policy change at the state or federal level that redefines eligibility for Medicaid or other eligibility-based programs that would be captured in the MLIU population; or

    iv. A significant shift in the demographic served by the Performing Provider.
  - A provider's MLIU PPP in the approved RHP Plan Update will be their goal for October DY7 reporting. The number of MLIU individuals served must be maintained or increased in DY7-8 with an allowable variation. HHSC will inform providers of their allowable variation with the final RHP Plan Update approvals.

- Category C -

Modification	Eligible	Deadline for Submission

	Providers	
Achievement Milestone Payer Type	All Providers	Prior to reporting baseline & no later than 09/01/18 (07/26 for early baseline reporting)
Reporting Milestone Payer Type	All Providers	Prior to reporting baseline & no later than 10/01/2018 (07/26/18 for early baseline reporting)
Replace a measure	CMHCs & LHDs	Prior to reporting baseline & no later than 09/01/2018 (07/19/18 for possible early baseline reporting, depending on HHSC availability)
Remove an Optional Measure	Hospital/ Physician Practice	Prior to reporting baseline & no later than 09/01/2018

- If a provider did not request an alternate achievement milestone denominator in the RHP Plan Update (for example, a provider has insignificant MLIU volume but significant all-payer volume for a measure), providers should indicate this request in the "Provider Response" column for the measure and include a detailed description of the measure's MLIU and all-payer denominator for a 12-month baseline measurement period.
- Providers who need to request a change to a measure's achievement or reporting milestone payer type after RHP Plan Update NMI responses are submitted will submit a request through the Category C Modification Request Form (which will be posted to the Online Reporting System Bulletin Board July 1st), and HHSC will begin reviewing requests after the RHP Plan Updates are approved. Providers should submit these request forms to the waiver mailbox as soon as possible, and no later than 07/26/18 for a measure that will be reporting a baseline in the early baseline reporting template, and no later than 09/01/18 for a measure that will be reporting a baseline in October DY7.
- Once a measure's baseline is reported, HHSC will review reported baselines to ensure the measure reported has significant volume for the achievement payer type. If HHSC identifies that a provider has insignificant volume for the achievement payer type, or no volume for any payer type, HHSC will be able to make modifications through the HHSC baseline technical assistance process even if the deadline for provider submission has passed. HHSC encourages providers to report baselines as early as possible to identify any concerns that might impact the milestones associated with a selected measure or measure bundle.

DY7-8 Protocols

- HHSC recently received approval from CMS for technical corrections to the DY7-8 DSRIP Protocols. The updated versions have been posted to the waiver website and the online reporting system bulletin board. The changes were:

- PFM, paragraph 23.c- updated the RHP 9 private hospital participation amounts to account for a private hospital closure;
- PFM, paragraph 22.a. - removed "not to exceed the HPL" for QISMC goals; the removal does not impact how goals are being calculated;
- MBP, measure E2-A01 - clarified that the OB Hemorrhage Safety Bundle collaborative is coordinated through the DSHS TexasAIM initiative.

April DY7 Reporting

- Reporting results will be sent out today, Friday 6/8, to providers who reported DY6 carryforward in April.

DSRIP Calendar

July 2018			
RHP	**Date**	**Topic**	**Contact**
15	7/13/18	RHP 15 Learning Collaborative	Oscar Perez
2	7/29/18	Behavioral Health Learning Collaborative Register Here	Susan Seidensticker