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Health and Human
Services

Cat C Reporting
DY7 Round 2

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Healthcare Transformation Waiver
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Agenda

1. Category C Overview
2. Category C Policies
   - Reporting Timeline
   - Goal Calculation
   - Supporting Documentation
3. Attribution & Eligible Denominator Population Review
4. Reporting Template
5. Cat C Modification Requests
6. Baseline Payment and Baseline Review
7. Specifications Walkthrough
8. Additional Resources

Questions

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Part 1:
Category C Overview

What is Category C

- Category C is one of four reporting categories of the Delivery System Reform Incentive Payment (DSRIP) Program of the Texas 1115 Waiver, introduced in Demonstration Years 7 – 8.
- DSRIP Performing Providers earn Category C incentive payments by reporting on and demonstrating improvements in standardized provider-reported healthcare quality measures.
- Category C builds on the foundation set in the initial waiver period (Demonstration Years 2 – 6) while providing additional opportunities for transforming the healthcare system and bending the cost curve.

Category C Objective

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

Category C Measurement

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

Category C and B

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

Category C Measure Selections

- Providers selected measure bundles or measures as part of the RHP Plan Update for DY7 – 8.
- Each provider was required to select a minimum number of measure bundles or measures. The minimum number was determined primarily by a provider's valuation.
- Category C measure bundle and measure selections were approved by HHSC on June 29th, 2018.
- August 2018 was the first opportunity to report baselines for Category C measures, and April 2019 is the first opportunity to report performance for Category C measures.

Hospital & Physician Practice Measure Bundle Selections (Pt 1)

ID	Measure Bundle	Provider Selections	Preliminary Total Category C Valuation DY7/DY8
A1	Improved Chronic Disease Management: Diabetes Care	74	$ 656,269,433
A2	Improved Chronic Disease Management: Heart Disease	38	$ 331,450,212
B1	Care Transitions & Hospital Readmissions	22	$ 176,899,862
B2	Patient Navigation & ED Diversion	27	$ 87,939,471
C1	Primary Care Prevention - Healthy Texans	34	$ 365,186,555
C2	Primary Care Prevention - Cancer Screening	35	$ 162,337,905
C3	Hepatitis C	7	$ 38,474,483
D1	Pediatric Primary Care	15	$ 319,031,512
D3	Pediatric Hospital Safety	8	$ 40,518,365
D4	Pediatric Chronic Disease Management: Asthma	9	$ 50,218,489
D5	Pediatric Chronic Disease Management: Diabetes	4	$ 22,849,200

Hospital & Physician Practice Measure Bundle Selections (Pt 2)

ID	Measure Bundle	Provider Selections	Preliminary Total Category C Valuation DY7/DY8
E1	Improved Maternal Care	19	$ 148,727,196
E2	Maternal Safety	24	$ 107,548,324
F1	Improved Access to Adult Dental Care	4	$ 22,956,450
F2	Preventive Pediatric Dental	4	$ 6,155,050
G1	Palliative Care	15	$ 96,284,804
H1	Integration of Behavioral Health in a Primary or Specialty Care Setting	13	$ 137,926,636
H2	Behavioral Health and Appropriate Utilization	10	$ 101,699,434
H3	Chronic Non-Malignant Pain Management	4	$ 36,470,114
H4	Integrated Care for People with Serious Mental Illness	3	$ 26,526,842
I1	Specialty Care	4	$ 6,114,949
J1	Hospital Safety	39	$ 173,342,232

Hospital & Physician Practice Measure Bundle Selections (Pt 3)

ID	Measure Bundle	Provider Selections	Preliminary Total Category C Valuation DY7/DY8
K1	Rural Preventive Care	47	$ 41,185,373
K2	Rural Emergency Care	32	$ 26,816,831

CMHC Common Selections

Measure	Title	Selections	Preliminary Total Category C Valuation DY7/DY8
M1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	33	$ 45,480,820
M1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	31	$ 41,332,556
M1-319	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (eMeasure)	25	$ 34,055,228
M1-317	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	23	$ 32,509,658
M1-160	Follow-Up After Hospitalization for Mental Illness	22	$ 29,119,036
M1-146	Screening for Clinical Depression and Follow-Up Plan (CDF-AD)	20	$ 28,132,769
M1-261	Assessment for Substance Abuse Problems of Psychiatric Patients	16	$ 25,878,208
M1-305	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-CH)	16	$ 25,386,454
M1-257	Care Planning for Dual Diagnosis	13	$ 18,472,423
M1-390	Time to Initial Evaluation: Mean Days to Evaluation	13	$ 20,917,906

LHD Common Selections

Measure	Title	Selections	Preliminary Total Category C Valuation DY7/DY8
L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	10	$ 16,452,905
L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	8	$ 14,913,315
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	6	$ 10,180,435
L1-269	Preventive Care and Screening: Influenza Immunization	6	$ 5,588,042
L1-280	Chlamydia Screening in Women (CHL)	6	$ 11,645,015
L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	5	$ 8,001,347
L1-207	Diabetes care: BP control (<140/90mm Hg)	5	$ 9,462,524
L1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	4	$ 6,681,500
L1-268	Pneumonia vaccination status for older adults	4	$ 4,971,901
L1-344	Follow-up after Treatment for Primary or Secondary Syphilis	4	$ 7,292,413

Part 2:
Category C Policies

Cat C Milestone Structure

Each measure has a milestone structure that contains four elements:

- Measurement Period: Standard or Delayed
- Goal Type: P4P or P4R
- Achievement Payer-Type: MLIU, Medicaid only, LIU only, or All-payer
- Reporting Payer-Type: Medicaid, LIU and/or All-payer

Example:
Delayed P4P (A: MLIU; R: All-payer, Medicaid, LIU)

Standard P4R (All-payer, Medicaid, LIU)

Measurement Periods

P4P Measures and P4R due to low volume

Data Year	Standard Baseline	Delayed Baseline
Baseline	Six to twelve months ending 12/31/2017	Six to twelve months ending no later than 09/30/2018
Performance Year (PY) 1	CY2018	CY2018 NOTE: will duplicate baseline and cannot be used for achievement of DY7 AM-7.x
PY2	CY2019	CY2019
PY3	CY2020	CY2020

P4R Innovative Measures

Data Year	Standard Baseline
Reporting Year (RY) 1	DY7 (all data available)
RY2	DY8

Category C Milestones – P4P Measures

DY	Milestone	Description	Associated Data Year
DY7	RM-1	Baseline Reporting	Baseline
	RM-2	PY1 Reporting	PY1 CY2018
	AM-7.x	DY7 Goal Achievement	PY1 (Standard baseline only) PY2 (Carryforward if not earned in PY1 including delayed baseline)
DY8	RM-3	PY2 Reporting	PY2 CY2019
	AM-8.x	DY8 Goal Achievement	PY2 PY3 CY2020 (Carryforward if not earned in PY2)

Category C Milestones - P4R Measures

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P4R Due to Low Volume

DY	Milestone	Description	Associated Data Year
DY7	RM-1	Baseline Reporting	Baseline
	RM-2	PY1 Reporting	PY1 CY2018
DY8	RM-3	PY2 Reporting	PY2 CY2019

P4R Innovative Measures & Quality Improvement Collaborative Activities

DY	Milestone	Description	Associated Data Year
DY7	IM-1	RY1 Reporting	RY1 (DY7)
DY8	IM-2	RY2 Reporting	RY2 (DY8)

Baseline Reporting Timeline

Reporting Opportunity	Eligible Baseline Measurement Period	Submission Method	Template Available	Question Deadline	Submission Deadline
DY7 R2	Standard and Delayed Baselines ending by 09/30/2018	Upload to the online reporting system	10/01/2018	10/23/18	10/31/18
DY8 R1	Delayed Baselines ending 04/01/18 - 09/30/18	Upload to the online reporting system	*~04/01/19*	*~04/24/19*	*~04/30/19*

Performance Reporting Timeline

Data Year	Associated Milestones	Measurement Period	Reporting Opportunities
PY1	DY7 RM-2 DY7 AM-7.x (Standard Baseline Only)	CY2018	DY8 R1 DY8 R2
PY2	DY8 RM-3 DY8 AM-8.x DY7 AM-7.x CF*	CY2019	DY9 R1** DY9 R2
PY3	DY8 AM-8.x CF*	CY2020	DY10 R1**

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

**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.

Innovative Measure & Quality Collaborative Reporting Timeline

Data Year	Associated Milestones	Measurement Period	Reporting Opportunities
RY1	IM-1	DY7	DY7 R2 DY8 R1
RY2	IM-2	DY8	DY8 R2 DY9 R1

Category C Corrections

- The process for correcting a previously reported baseline or performance year will be similar to the correction process in prior years.
- Providers that reported a baseline that was accepted or flagged for TA during the summer baseline reporting period will be able to submit baseline corrections through the DY7 R2 reporting template.
- Providers will also be able to submit a baseline correction through the DY8 R1 reporting template. As long as a measure has no active TA flags, a baseline can be corrected at the same time performance is reported.
- Providers will be able to submit baseline and performance corrections through an interim correction form (typically available between reporting periods) after DY8 R1.

Goal Calculation for Achievement Milestones

- Each P4P measure has a goal for the DY7 and DY8 achievement milestones that is an improvement over the reported baseline.
- All measures must demonstrate improvement to earn incentive payments associated with the goal achievement milestone.
- Achievement may be carried forward if not fully earned in the first performance year associated with a milestone.
- If a measure has a perfect baseline (100% for example), provider's goals for DY7 and DY8 will be 100%.
- DY8 goals are not impacted by achievement or non-achievement of DY7 goals.
- Measures with multiple parts will have one reporting milestone and multiple achievement milestones.
- Each measure has a defined goal setting type in the Category C Specifications
  - QISMC – goals are set as an improvement over baseline relative to national benchmarks.
  - IOS – goals are set as an improvement over baseline only.

QISMC Goal Calculation

Directionality	Baseline	DY7 AM-7.x Goal	DY8 AM-8.x 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 (HPL - Baseline) 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

What is an improvement floor?

- 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.
- The improvement floor ensures that a measure with a baseline just below the HPL does not have a smaller absolute value of improvement required as compared to a measure with a baseline just above the HPL.

IOS Goal Calculation

Directionality	DY7 AM-7.x Goal	DY8 AM-8.x Goal
Positive	Baseline + .025 x (1 - Baseline)	Baseline + .10 x (1 - Baseline)
Negative	Baseline - .025 x Baseline	Baseline - .10 x Baseline

Goal Achievement

- Providers earn 100% of the achievement milestone value 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

Goal Achievement Calculation

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)

Goal Achievement Example

Measure Class	Directionality	Goal Calculation	Standard Payer-Type for DY7 and DY8 Achievement Milestones
Process	Positive	IOS	Medicaid and Uninsured

Rate 1 Baseline

Rate Part 1 of 1

				Baseline Rate	DY7 Goal	DY8 Goal
Baseline (CY2017)	Medicaid	25	50	0.5000		
	LIU	25	50	0.5000		
	Total	**50**	**100**	**0.5000**	**0.5125**	**0.5500**
				Performance Rate	**DY7 % of Goal Achieved**	**DY8 % of Goal Achieved**
PY1 (CY2018)	Medicaid	24	50	0.4800		
	LIU	27	50	0.5400		
	Total	**51**	**100**	**0.5100**	75% Achieved	
PY2 (CY2019)	Medicaid	29	50	0.5800		
	LIU	27	50	0.5400		
	Total	**56**	**100**	**0.5600**	100% Achieved	100% Achieved

Part 3: Category C Attribution & Eligible Denominator Population Review

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Eligible Denominator Population

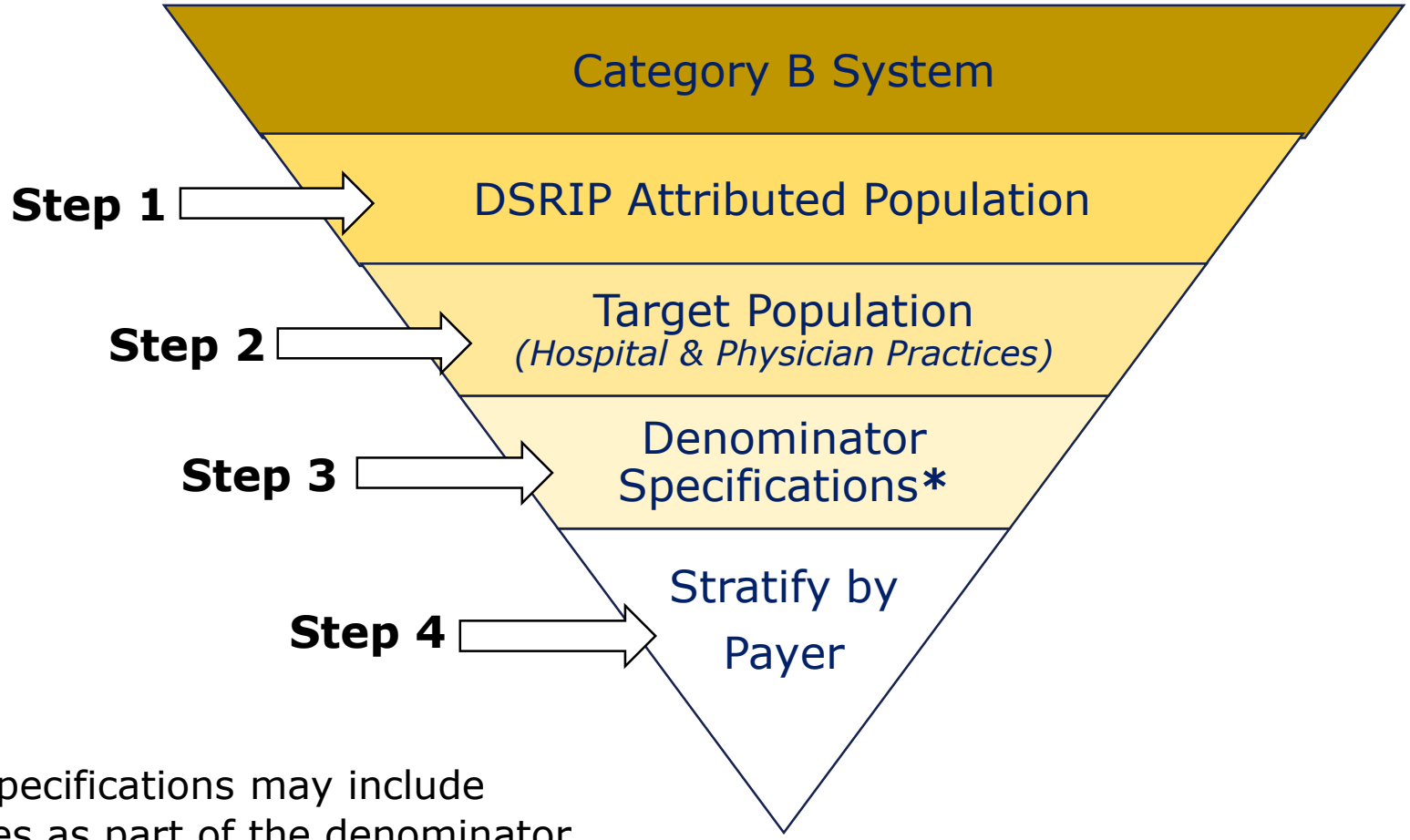
Step 1: Determine the DSRIP attributed population using the prescribed attribution methodology.

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

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

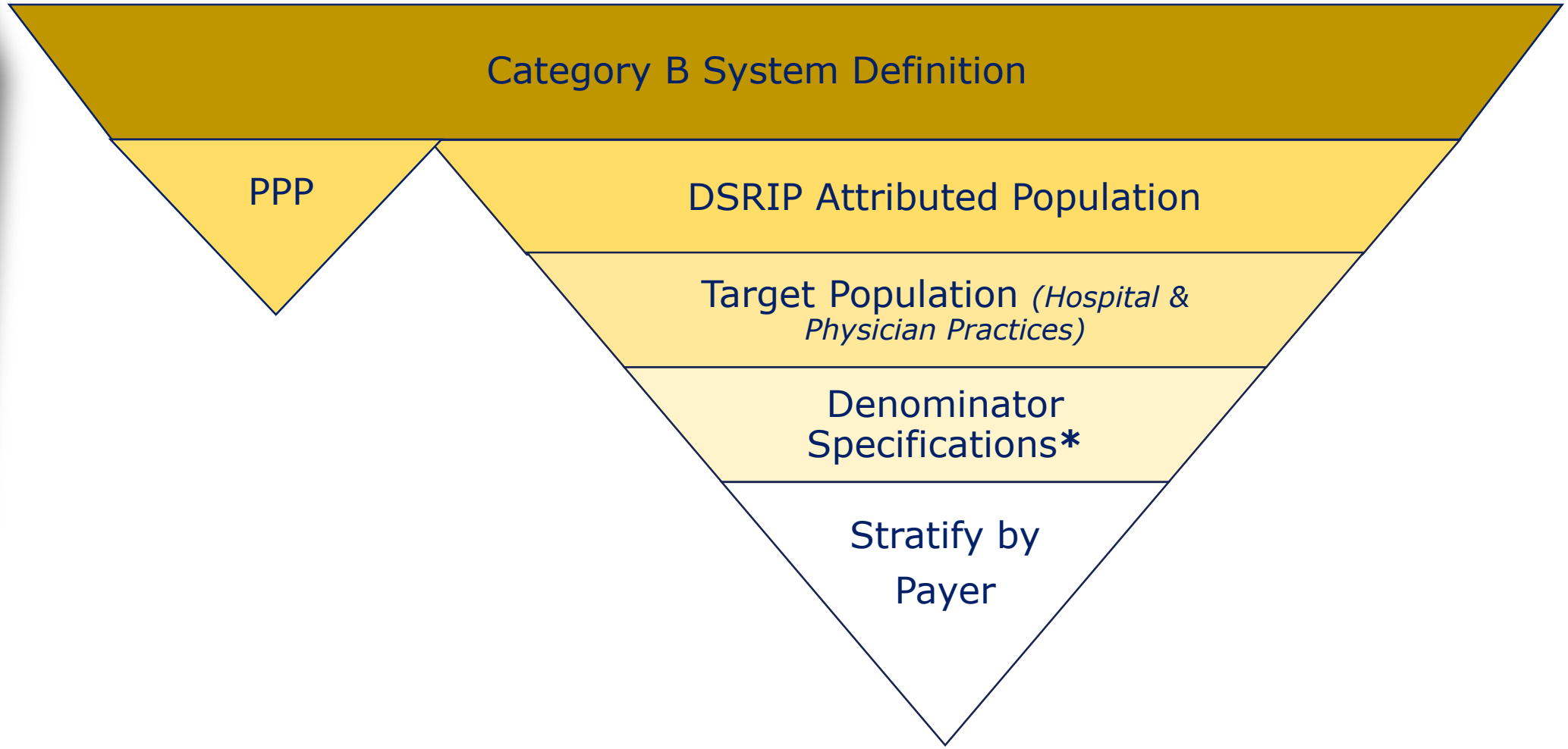
Step 4: Determine payer type for individuals or encounters in the denominator following standardized specifications to determine the all-payer, Medicaid, and uninsured rate for each.

Category C Attribution



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

Category B & C


Category B System Definition
PPP
DSRIP Attributed Population
Target Population (Hospital & Physician Practices)
Denominator Specifications*
Stratify by Payer

Step 1:
DSRIP Attributed Population

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

Step 2:
Target Population

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

Target Population Measurement

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

- *All individuals included in the measure must meet the target population requirements, including age requirements.*

Step 3:
Denominator Specifications

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

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

Step 4:
Payer Type Stratification

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

Payer-Type Stratification for Category C

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

Denominator Example (Pt 1)

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

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

Denominator Example (Pt 2)

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

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

Denominator Example (Pt 3)

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

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

Denominator Example (Pt 4)

Exclude from the denominator individuals who met the denominator specified visit but did not meet the target population.

- The individual does not meet the target population if ALL of the following are true:
  - The denominator specified visit type is not a preventive service AND
  - The individual is not covered by Medicaid or a local coverage program and assigned to the DSRIP system AND
  - The individual had only one ambulatory visit in the measurement year and the year prior (1 in 24 months) AND
  - The individual had fewer than three ED visits on record in the DSRIP performing provider's system during the measurement year and the year prior (3 visits in 24 months)

Denominator Example (Pt 5)

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

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

Hospital & Physician Practice Population Based Clinical Outcomes

- Denominator is Target Population
  - Denominator is based primarily on diagnosis and ambulatory care relationship/high ED utilization.
- Numerator is the rate of specified ED visits or admissions for individuals in the target population
  - Numerator elements do not need to occur within the DSRIP performing provider system.
  - Individuals may be included in the numerator more than once since the numerator is reporting the total number of ED visits or admissions.

Tips for Understanding Measure Specifications

- "Individual" unit of measurement: If a unit of measurement is individual, a person can be in the denominator only once. For most measures, an individual can also only be in the numerator once, unless the measure clearly indicates otherwise. PBCOs are an exception as they are a rate with each ED visit or admission included in the numerator.
- Value Sets: Value sets (primarily used for eMeasures) are referencing lists of values (CPT codes, diagnosis codes, other codes) not included in the specifications and will need to be referenced online.
- Data Sources: Measures specify a specific data source but providers may need to utilize alternative data sources to identify required data elements. Alternative data sources do not require HHSC approval, but should be documented when baseline is reported.
- AND criteria vs. OR criteria: In general, AND means the listed criteria must be included. OR means the presence of one or more of the listed criteria results in inclusion. OR does not mean a provider can chose to ignore the criteria, or can chose to look at only one of the criteria.
- Numerator must come from an eligible denominator case

Tips for Understanding Measure Specifications (Cont'd)

- For Hospital and Physician Practices, "Related System Components" are not a part of determining denominator inclusion. They are included for planning purposes, to ensure a provider has the appropriate system components for selecting a measure bundle.
- For measures that allow a provider to narrow certain office visits to primary care and specialty care where primary care is managed, or specialty care where a measure bundle specific chronic disease is managed, providers should apply that criteria consistently across measures in a given measure bundle.

Common baseline reporting issues

- The all-payer rate includes all **payer types**, including Medicaid, LIU, Medicare, commercial pay, etc. The all-payer denominator should not be smaller than the combined Medicaid and LIU denominator. ALL PAYER MEANS ALL PAYERS.
- Take note of the age requirements for both the measure specifications and the target population.

Part 4: Category C Reporting Template

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DY7 R2 Reporting

- October DY7 Reporting Template is required for all providers.
- Signed certification submitted as a PDF is required for all providers reporting or correcting.
- A separate template will be made available for NMI reporting.

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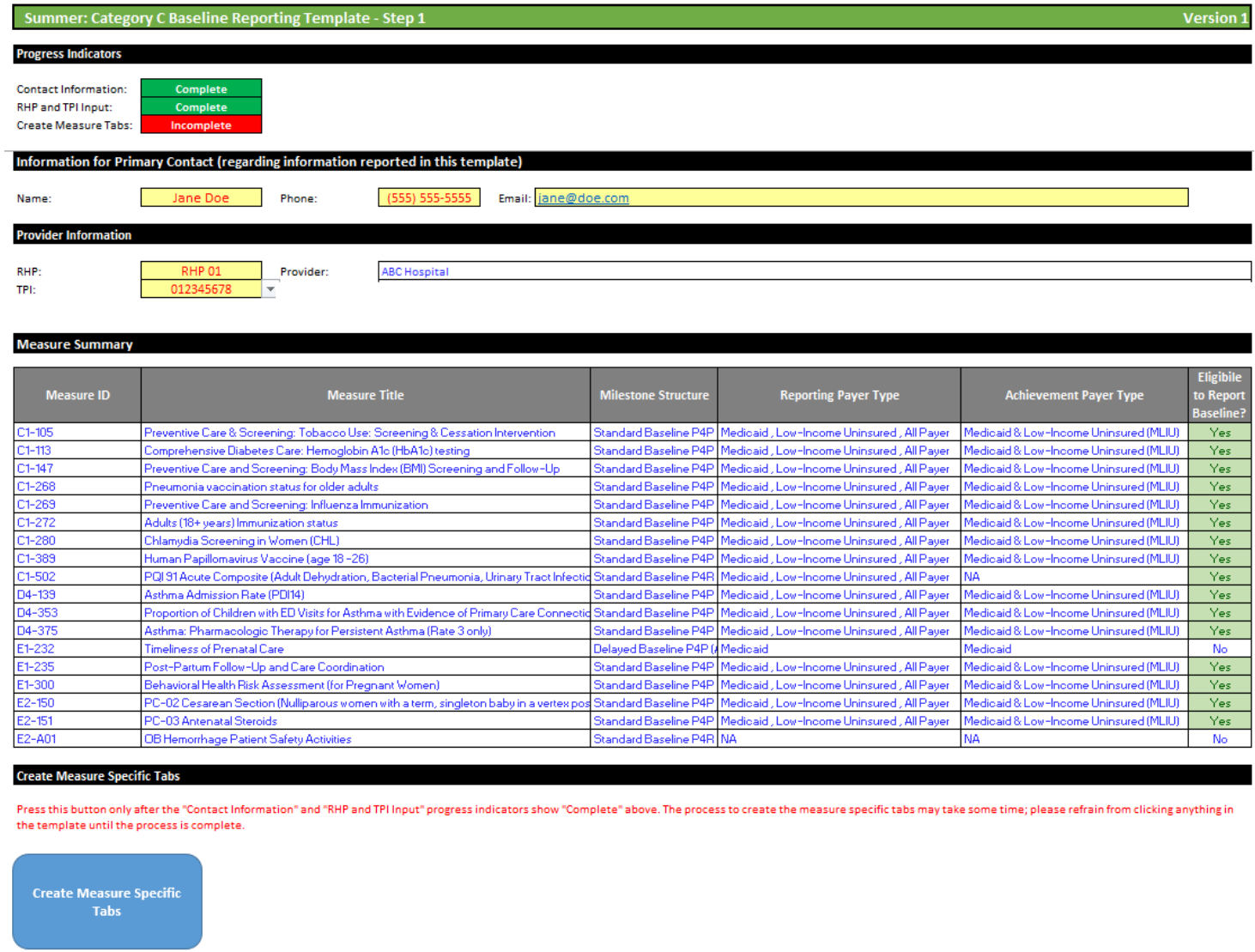
Category C Reporting Template

- The template is used for reporting or correcting baselines of Cat C measures and will use a similar structure for performance reporting.
- Providers will complete **one** Cat C Reporting Template, which contains all of provider's Category C measures.
- The template requires certification by the Chief Quality Officer or executive responsible for validating accuracy of Cat C reporting.
- Once completed, save the Category C Reporting Template as RHPXX_TPIXXXXXXXX_CatC_OctDY7.xlsm.
- Save the certification PDF as RHPXX_TPIXXXXXXX_CatC_OctDY7_Certification.pdf
  - Please make sure to remove ".xlsm" from the PDF's file name
- The completed Category C Reporting Template, along with a PDF of the signed Reporting Summary tab, should be **uploaded once to the online reporting system on the Category C tab.**

Step 1 Tab

- Enter Primary Contact information and select provider's RHP and TPI from the drop-down menu
- Template will display Cat C measures and indicate whether measures are eligible to report
- Click "Create Measure Specific Tabs" button to create a tab for each measure as well as a Reporting Summary tab
- Generating the measure-specific and Reporting Summary tabs may take some time
- All Step 1 Progress Indicator rows should show "Complete" once the measure-specific tabs are generated



Summer: Category C Baseline Reporting Template - Step 1 — Version 1

Progress Indicators

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

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

Name: Jane Doe Phone: (555) 555-5555 Email: jane@doe.com

Provider Information

RHP: RHP 01 Provider: ABC Hospital
TPI: 012345678

Measure Summary

Measure ID	Measure Title	Milestone Structure	Reporting Payer Type	Achievement Payer Type	Eligibile to Report Baseline?
C1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Standard Baseline P4P	Medicaid , Low-Income Uninsured , All Payer	Medicaid & Low-Income Uninsured (MLIU)	Yes
C1-113	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	Standard Baseline P4P	Medicaid , Low-Income Uninsured , All Payer	Medicaid & Low-Income Uninsured (MLIU)	Yes
C1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Standard Baseline P4P	Medicaid , Low-Income Uninsured , All Payer	Medicaid & Low-Income Uninsured (MLIU)	Yes
C1-268	Pneumonia vaccination status for older adults	Standard Baseline P4P	Medicaid , Low-Income Uninsured , All Payer	Medicaid & Low-Income Uninsured (MLIU)	Yes
C1-269	Preventive Care and Screening: Influenza Immunization	Standard Baseline P4P	Medicaid , Low-Income Uninsured , All Payer	Medicaid & Low-Income Uninsured (MLIU)	Yes
C1-272	Adults (18+ years) Immunization status	Standard Baseline P4P	Medicaid , Low-Income Uninsured , All Payer	Medicaid & Low-Income Uninsured (MLIU)	Yes
C1-280	Chlamydia Screening in Women (CHL)	Standard Baseline P4P	Medicaid , Low-Income Uninsured , All Payer	Medicaid & Low-Income Uninsured (MLIU)	Yes
C1-389	Human Papillomavirus Vaccine (age 18 -26)	Standard Baseline P4P	Medicaid , Low-Income Uninsured , All Payer	Medicaid & Low-Income Uninsured (MLIU)	Yes
C1-502	PQI 91 Acute Composite (Adult Dehydration, Bacterial Pneumonia, Urinary Tract Infectio	Standard Baseline P4R	Medicaid , Low-Income Uninsured , All Payer	NA	Yes
D4-139	Asthma Admission Rate (PDI14)	Standard Baseline P4P	Medicaid , Low-Income Uninsured , All Payer	Medicaid & Low-Income Uninsured (MLIU)	Yes
D4-353	Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connectio	Standard Baseline P4P	Medicaid , Low-Income Uninsured , All Payer	Medicaid & Low-Income Uninsured (MLIU)	Yes
D4-375	Asthma: Pharmacologic Therapy for Persistent Asthma (Rate 3 only)	Standard Baseline P4P	Medicaid , Low-Income Uninsured , All Payer	Medicaid & Low-Income Uninsured (MLIU)	Yes
E1-232	Timeliness of Prenatal Care	Delayed Baseline P4P (	Medicaid	Medicaid	No
E1-235	Post-Partum Follow-Up and Care Coordination	Standard Baseline P4P	Medicaid , Low-Income Uninsured , All Payer	Medicaid & Low-Income Uninsured (MLIU)	Yes
E1-300	Behavioral Health Risk Assessment (for Pregnant Women)	Standard Baseline P4P	Medicaid , Low-Income Uninsured , All Payer	Medicaid & Low-Income Uninsured (MLIU)	Yes
E2-150	PC-02 Cesarean Section (Nulliparous women with a term, singleton baby in a vertex pos	Standard Baseline P4P	Medicaid , Low-Income Uninsured , All Payer	Medicaid & Low-Income Uninsured (MLIU)	Yes
E2-151	PC-03 Antenatal Steroids	Standard Baseline P4P	Medicaid , Low-Income Uninsured , All Payer	Medicaid & Low-Income Uninsured (MLIU)	Yes
E2-A01	OB Hemorrhage Patient Safety Activities	Standard Baseline P4R	NA	NA	No

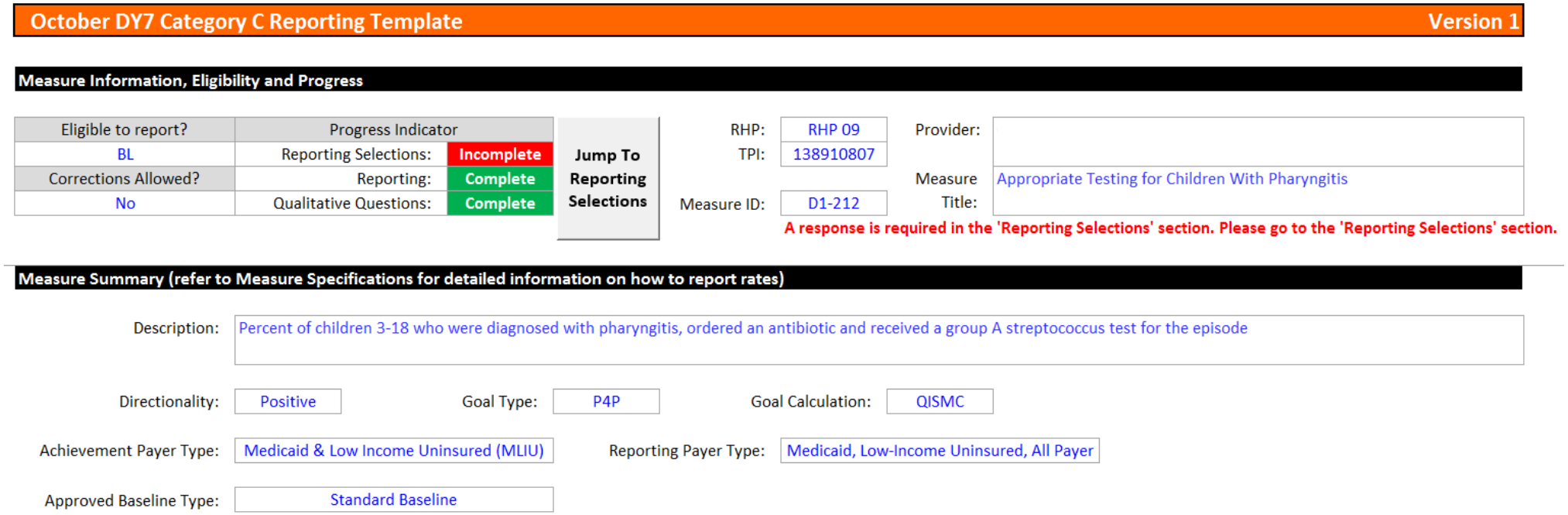
Create Measure Specific Tabs

Press this button only after the "Contact Information" and "RHP and TPI Input" progress indicators show "Complete" above. The process to create the measure specific tabs may take some time; please refrain from clicking anything in the template until the process is complete.

Create Measure Specific Tabs

Measure-Specific Tabs

- The first two sections of each tab show reporting eligibility, progress made in completing the measure-specific tab and a measure summary.
- Providers may use the "Jump to Reporting Selections" button to jump to the first provider entry section.



October DY7 Category C Reporting Template — **Version 1**

Measure Information, Eligibility and Progress

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

Jump To Reporting Selections

RHP: RHP 09 — Provider:
TPI: 138910807
Measure ID: D1-212 — Measure Title: Appropriate Testing for Children With Pharyngitis

A response is required in the 'Reporting Selections' section. Please go to the 'Reporting Selections' section.

Measure Summary (refer to Measure Specifications for detailed information on how to report rates)

Description: Percent of children 3-18 who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus test for the episode

Directionality: Positive — Goal Type: P4P — Goal Calculation: QISMC

Achievement Payer Type: Medicaid & Low Income Uninsured (MLIU) — Reporting Payer Type: Medicaid, Low-Income Uninsured, All Payer

Approved Baseline Type: Standard Baseline

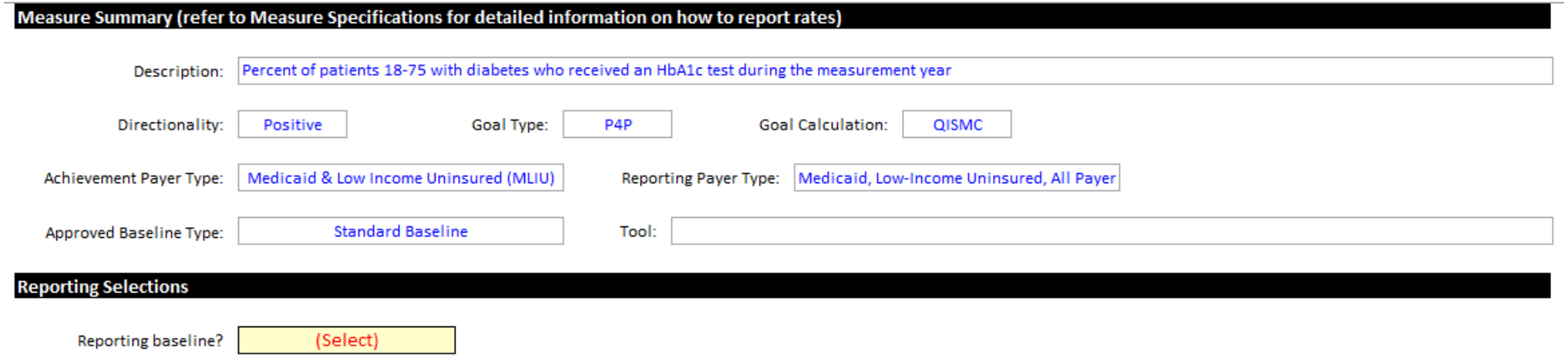
Determining Eligibility to Report

- The table at top of the measure-specific tab will indicate whether the provider is eligible to report a measure's baseline.
  - All baselines that have not yet been reported will be eligible to report.
  - All baselines that were reported during the early baseline reporting period and were either accepted or flagged for TA will be eligible to correct.

Eligible to report?	Progress Indicator		
BL	Reporting Selections:	Incomplete	Jump To Reporting Selections
Corrections Allowed?	Reporting:	Complete	
No	Qualitative Questions:	Complete	

Reporting Selections Section

- The Reporting Selections section is the first section on the measure-specific tab that requires provider input, if the measure is eligible to report.
- If the measure is not eligible to report baseline, the provider will not see this section on the measure-specific tab.
- Providers reporting baseline will be required to answer additional questions and input baseline values in the Reporting section of the measure-specific tabs.



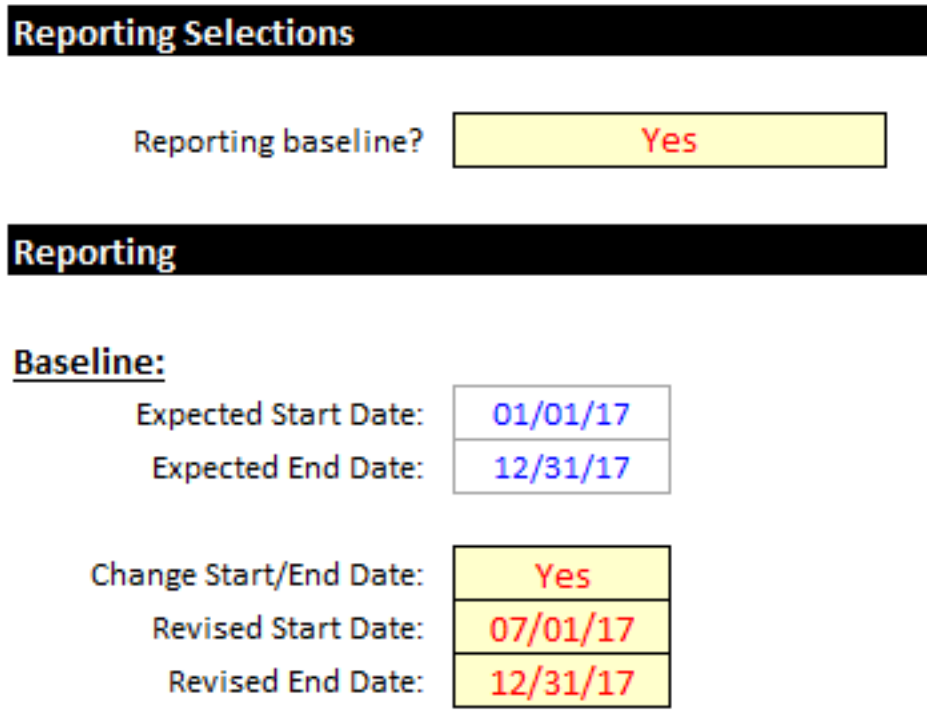
Reporting Section: Reporting by Payer Types

- Based on a measure's approved payer types, providers will enter numerator and denominator information into the template by payer types: All Payer, Medicaid, or LIU (Low Income Uninsured)
- The template will calculate numerators and denominators for the combined MLIU payer type, where applicable, based upon the provider's Medicaid and LIU entries. (See example below.)

	Rate 1 of 2				Rate 2 of 2			
	Achievement	Reporting			Achievement	Reporting		
	MLIU	All Payer	Medicaid	LIU	MLIU	All Payer	Medicaid	LIU
Numerator:	122	325	62	60				
Denominator:	200	500	100	100				
Baseline Rate:	0.6100	0.6500	0.6200	0.6000				

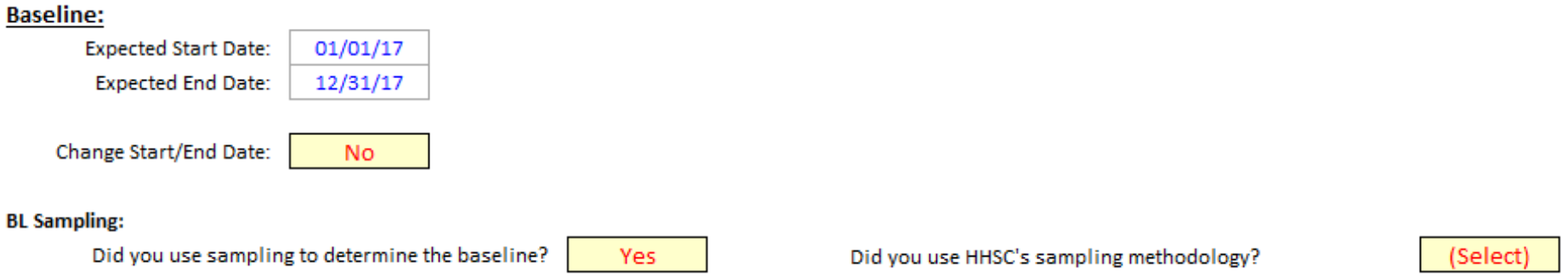
Reporting Section: Baseline Measurement Period

- Providers will have an opportunity to revise the start and end date for the baseline measurement period.
- If the revised baseline measurement period is less than 12 months (shortened), or if the end date is after 12/31/2017 (delayed), and the provider was not approved for a shortened or delayed baseline through the RHP Plan Update, justification for the change will be required in the Qualitative Questions section.



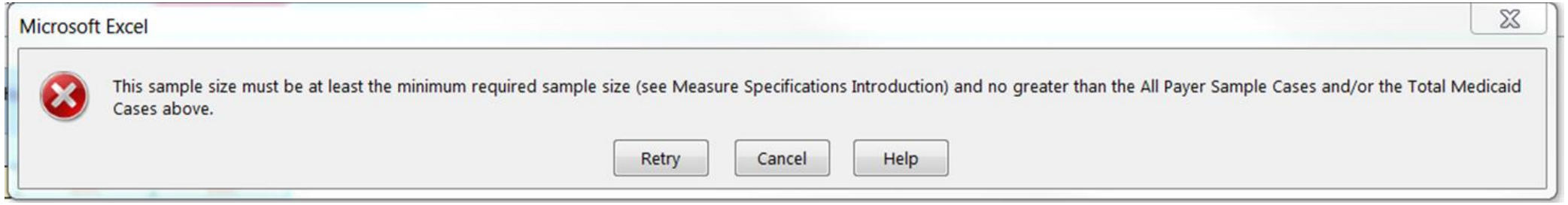
Reporting Section: Baseline Sampling

- Providers will indicate if sampling was used to determine baseline.
  - If sampling was not used, the provider must answer a question in the Qualitative Questions section regarding plans to sample in future reporting years, and, if sampling, how the reporting methodology will differ.
  - Providers that used sampling to determine baseline will need to indicate if HHSC's sampling methodology was used. Providers may follow the sampling methodology provided by a measure's steward if available, or HHSC's methodology. Additionally, providers will need to answer a question in the Qualitative Questions section regarding the method for determining the random sample.



Reporting Section: BL Sampling Subsection

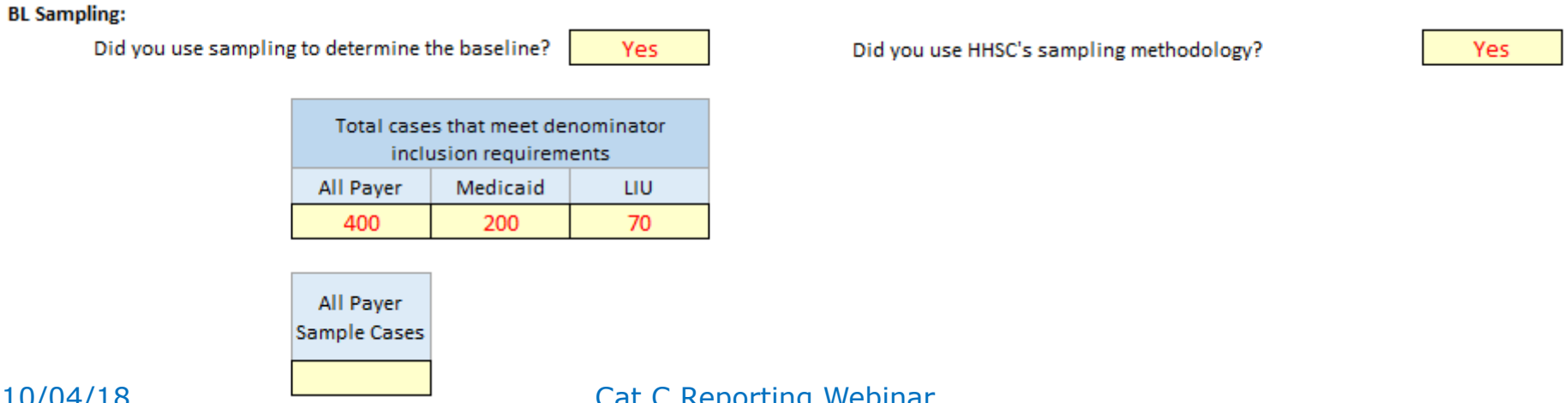
- If sampling, providers will need to enter information into the BL Sampling subsection before seeing the baseline and goal calculation table.
- Providers using HHSC's sampling methodology to determine the baseline will receive an error message if values entered in the BL Sampling subsection do not conform to the sampling requirements outlined in the Introduction section of the Category C Measure Specifications.



- The entries required in the Cat C template mirror the information requested in the Sample Volume Calculator tab of the Category C Goal Calculator. HHSC strongly recommends that providers utilize the goal calculator before conducting their samples to avoid not meeting required sample sizes.

Reporting Section: All Payer Sample

- When sampling, providers will enter the total cases that meet denominator inclusion requirements for each payer type.
- They will then enter the number of cases included in the All Payer sample
  - If the denominator is less than or equal to 380 but greater than 75, the sample must include at least 76 cases.
  - If the denominator is greater than 380, the sample must not be less than 20% of all cases; however, providers may cap the total sample size at 411 cases.



Reporting Section: Separate Medicaid LIU Sample

- After entering the All Payer sample size, the provider will indicate whether a separate Medicaid or LIU sample was conducted.
- A separate sample is required in cases where the expected number of Medicaid or LIU cases in the All Payer sample is less than 76. In these cases, the template will default to Yes.

Total cases that meet denominator inclusion requirements		
All Payer	Medicaid	LIU
400	200	70

All Payer Sample Cases
200

Conducted Separate Medicaid Sample?
(Select)

Conducted Separate LIU Sample?	Cases in Separate LIU Sample
Yes	

Separate LIU sample is required

Reporting Section: Medicaid/ LIU Sample

- If a separate sample was not conducted, the number of Medicaid or LIU cases in the All Payer sample should be entered.
- If a separate Medicaid sample or LIU sample was conducted, the number of cases in the separate sample should be entered.

Total cases that meet denominator inclusion requirements		
All Payer	Medicaid	LIU
400	200	70

All Payer Sample Cases
200

Conducted Separate Medicaid Sample?	Medicaid Cases in All Payer Sample
No	98

Conducted Separate LIU Sample?	Cases in Separate LIU Sample
Yes	70

Separate LIU sample is required

Reporting Section: Numerators & Denominators

- All providers reporting baselines will be required to enter the numerator from the sample (for providers using sampling) or the numerator and denominator (for providers not using sampling) in the BL Rate & Goals subsection.
- Please note that provider could receive error messages in this subsection for issues such as:
  - The Medicaid numerator plus the LIU numerator exceeding the All Payer numerator.
  - The Medicaid denominator plus the LIU denominator exceeding the All Payer denominator.

Table if sample WAS conducted

BL Rate & Goals:

	Rate 1 of 1			
	Achievement	Reporting		
	MLIU	All Payer	Medicaid	LIU
Numerator from Sample:				
Projected Numerator:				
Denominator:	270	400	200	70
Baseline Rate:				
DY7 Goal:				
DY8 Goal:				

Table if sample was NOT conducted

BL Rate & Goals:

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

Reporting Section: Baseline Rate and Goals

- When the numerator from sample is reported, the projected numerator, denominator, and baseline rate will populate along with the achievement for DY7 and DY8 Performance Year goals.
  - For DSRIP reporting purposes, providers will report all eligible cases as the denominator, and the numerator for a measure that uses sampling will be determined by multiplying the denominator by the sampled rate.
- When the numerator and denominator are reported for measures that do not use sampling, the baseline rate will populate along with the achievement for DY7 and DY8 Performance Year goals.
- PY goals are calculated based on the numerator and the outcome, and goal type (e.g., IOS or QISMIC).

Table if sample WAS conducted

BL Rate & Goals:

	Rate 1 of 1			
	Achievement	Reporting		
	MLIU	All Payer	Medicaid	LIU
Numerator from Sample:	127	155	74	53
Projected Numerator:	204.1	310.0	151.0	53.0
Denominator:	270	400	200	70
Baseline Rate:	0.7560	0.7750	0.7551	0.7571
DY7 Goal:	0.7644			
DY8 Goal:	0.7898			

Table if sample was NOT conducted

BL Rate & Goals:

	Rate 1 of 1			
	Achievement	Reporting		
	MLIU	All Payer	Medicaid	LIU
Numerator:	204	310	151	53
Denominator:	270	400	200	70
Baseline Rate:	0.7556	0.7750	0.7550	0.7571
DY7 Goal:	0.7588			
DY8 Goal:	0.7684			

Reporting Subsection: Baseline Data Sources

- The Baseline Data Sources subsection requires providers to select the data sources used to determine the baseline by clicking a checkbox.
- This subsection should be completed based on the data used to report the numerator and denominator or the numerator from sample values as entered above in the BL Rate & Goals subsection.
- All data sources that have a checkbox selected will require a description of the data source.

Baseline Data Sources: Please select all data sources used to report the numerator and denominator entered above and provide a brief description.

Claims/Billing Data:	☑	Describe:	
E.H.R.:	☑	Describe:	
Data exchange agreement not part of HIE:	☐		
H.I.E.:	☐		
Patient Registry:	☐		
Manual Chart Review:	☐		
Other:	☐		

Qualitative Questions

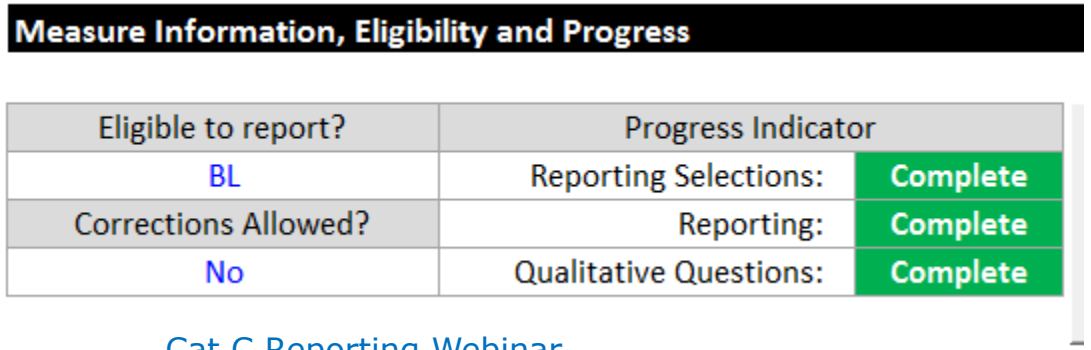
- The questions displayed in the Qualitative Questions section vary depending on the provider's entries in other sections of the template. Providers may be required to provide information on the following:
  - REQUIRED - Whether the provider is reporting an approximate baseline
  - REQUIRED - A description of the numerator and denominator and how they were calculated
  - Conditional - A description of the need to report a shortened baseline
  - Conditional - A description of the need to report a delayed baseline
  - Conditional - A description of the method used for determining the random sample. Whether sampling will be used in future reporting years, and, if so, a description of how the reporting methodology will differ from the baseline
  - Conditional - A description of why the baseline rate is low (NEW)
  - Conditional - A description of why there is no volume for one or more payer type (NEW)
- An optional, additional-comments field is also provided. Please note that this should be the only other field that can be completed on the measure-specific tab for providers who are not eligible to report baseline and for providers opting not to report or correct a baseline.

Description of Numerator and Denominator

- All providers reporting or correcting a baseline must complete the two qualitative questions related to baseline numerator and denominator and how it was calculated.
  - The responses to these questions should summarize the methodology used to calculate the baseline numerator and denominator as reported in the BL Rate & Goals subsection of the Reporting section.
  - A good response will outline the steps used in determining the baseline rate including the inclusions and exclusions, the data sources used in applying the specifications and target population.
  - 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 measure.

Progress Indicator

- Once all required data entry cells are complete, the Progress Indicator column in the table at the top of the tab should read "Complete" for all rows.
- Please note that the Progress Indicator column will read "Complete" once fields in the three sections (Reporting Selections, Reporting and Qualitative Questions). The number of sections on each measure-specific tab will vary based on whether the measure's baseline is being reported.
- When all Progress Indicators read "Complete" on each measure-specific tab, the provider should proceed to the Reporting Summary tab.



Measure Information, Eligibility and Progress

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

Reporting Summary Tab

- The Reporting Summary tab includes a Measure Reporting Summary section that displays Cat C baseline numerators, denominators, and rates for each measure.
- Completed measure-specific tabs show green and incomplete tabs show red in the column to the left of the Measure ID.

Measure Reporting Summary

Selection Details				Achievement (Goal/% Achieved)			Reporting			
				Payer Type	Rate 1		Payer Type	Rate 1		
Measure ID	Title	Year	Reported		AM-7.1	AM-8.1		Num	Denom	Rate
C1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	BL	Summer DY7	MLIU	0.7651	0.7811	All Payer	310.0	400	0.7750
							Medicaid	151.0	200	0.7550
							LIU	53.0	70	0.7571
		PY1	Not Reported				All Payer			
							Medicaid			
							LIU			
		PY2	Not Reported				All Payer			
							Medicaid			
							LIU			
		PY3	Not Reported				All Payer			
							Medicaid			
							LIU			
C1-268	Pneumonia vaccination status for older adults	BL	Summer DY7	MLIU			All Payer			
							Medicaid			
							LIU			
		PY1	Not Reported				All Payer			
							Medicaid			
							LIU			
		PY2	Not Reported				All Payer			
							Medicaid			
							LIU			
		PY3	Not Reported				All Payer			
							Medicaid			
							LIU			

Reporting Summary Tab

- The Progress Indicator section at the top of the Reporting Summary tab will also show "Complete" once all measure-specific tabs are complete.

- In order for the Certification row to show "Complete", the provider must complete the Certification section of the Reporting Summary tab.

Reporting Summary Tab: Certification

- The Certification section requires the provider to check the box next to the statement "I certify that the rates reported on this template have been reviewed for accuracy and are representative of the approved outcomes" and enter the name and title of the certifier, along with the date.
- The Certifier should be the Chief Quality Officer or executive responsible for validating accuracy of Category C reporting.

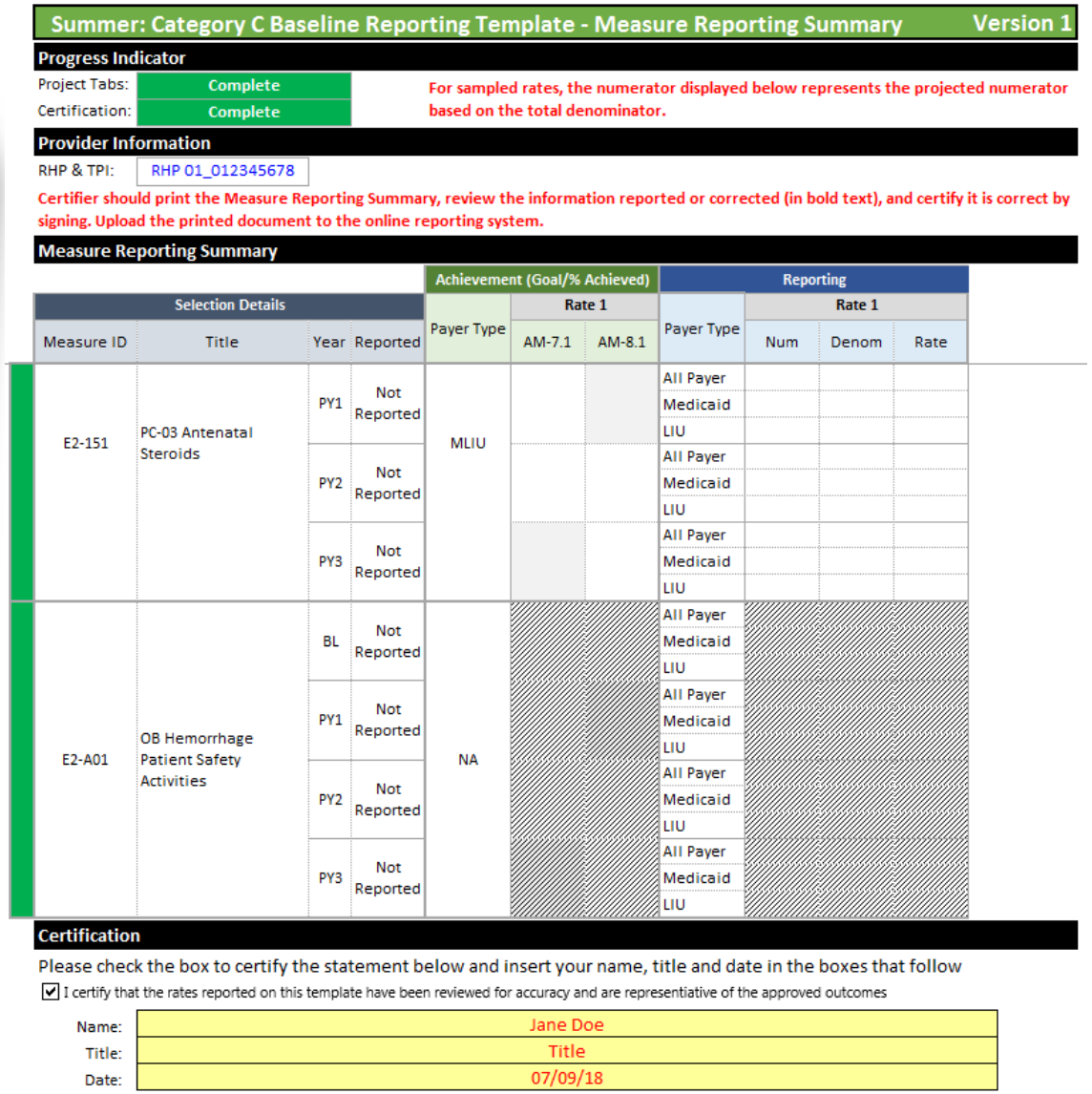
Certification

Please check the box to certify the statement below and insert your name, title and date in the boxes that follow

☐ I certify that the rates reported on this template have been reviewed for accuracy and are representative of the approved outcomes

Name:	
Title:	
Date:	

Reporting Summary Tab: Certification



Summer: Category C Baseline Reporting Template - Measure Reporting Summary Version 1

Progress Indicator

Project Tabs: Complete
Certification: Complete

For sampled rates, the numerator displayed below represents the projected numerator based on the total denominator.

Provider Information

RHP & TPI: RHP 01_012345678

Certifier should print the Measure Reporting Summary, review the information reported or corrected (in bold text), and certify it is correct by signing. Upload the printed document to the online reporting system.

Measure Reporting Summary

Selection Details				Achievement (Goal/% Achieved)			Reporting			
					Rate 1			Rate 1		
Measure ID	Title	Year	Reported	Payer Type	AM-7.1	AM-8.1	Payer Type	Num	Denom	Rate
E2-151	PC-03 Antenatal Steroids	PY1	Not Reported	MLIU			All Payer			
							Medicaid			
							LIU			
		PY2	Not Reported				All Payer			
							Medicaid			
							LIU			
		PY3	Not Reported				All Payer			
							Medicaid			
							LIU			
E2-A01	OB Hemorrhage Patient Safety Activities	BL	Not Reported	NA			All Payer			
							Medicaid			
							LIU			
		PY1	Not Reported				All Payer			
							Medicaid			
							LIU			
		PY2	Not Reported				All Payer			
							Medicaid			
							LIU			
		PY3	Not Reported				All Payer			
							Medicaid			
							LIU			

Certification

Please check the box to certify the statement below and insert your name, title and date in the boxes that follow

☑ I certify that the rates reported on this template have been reviewed for accuracy and are representiative of the approved outcomes

Name: Jane Doe
Title: Title
Date: 07/09/18

- When the Certification section is complete, the Progress Indicator on the Reporting Summary tab will read "Complete" for both rows.
- Providers are required to perform an extra step to certify the accuracy of reported baselines. The Certifier should print the Reporting Summary tab, sign this print-off, and scan the signed Reporting Summary tab.
- Provider has now completed the Cat C Reporting Template and upload the template and signed PDF of the Reporting Summary tab to the online reporting system bulletin board.

Part 5: Category C Modification Requests

TEXAS Health and Human Services

Category C Modification Requests

- The deadline has passed for most modification requests.
- Only delayed baselines may be requested at this time.
- Significant baseline measurement period changes must be requested by submitting a modification request form prior to submitting a baseline.
- Measures that request a significant measurement period change in the reporting template without prior approval from HHSC will result in an NMI.

Modification Requests – Baseline Measurement Period Changes

Significant baseline measurement period changes:

- Significant changes include requesting **further delays** of an approved baseline measurement period (for example, requesting to change a standard baseline to a delayed, requesting further delays of a baseline already approved for a delay.)
- Should be requested in the Modification Request Form
- Requires a detailed rationale in line with RHP Plan Update requirements.
- Submit to HHSC prior to October 23rd for review prior to DY7 R2 reporting.

Minor baseline measurement period changes:

- Minor changes include allowable changes to the length of the baseline measurement period (from 12 months to six months with the same ending date), moving a delayed baseline measurement period back (for example, a baseline approved to end 09/30/2018 requesting a change to an end date of 03/30/2018 or 12/31/2017)
- Should be requested in the Category C reporting template when baseline is reported.

Part 6: Baseline Reporting Payment and HHSC Baseline Review

RM-1 Approval

- HHSC will review reported baselines for both approval of payment for milestone RM-1 (similar to other DSRIP milestones) and baseline acceptance.
- RM-1 will receiving one of the following determinations:
  - Approved
  - Needs More Information
  - Not Approved (after NMI period only)
  - Did not report
- What could result in an NMI:
  - Not submitting a template
  - Not reporting a baseline for a measure that must report a baseline in October DY7 R2
  - Not reporting required payer types without adequate justification (adequate justification example: system does not include individuals with Medicaid coverage that meet the measure specifications)
  - Requesting a significant baseline measurement period change in the template without prior approval

Baseline Review

- HHSC will review reported baselines for acceptance or TA needed. Baselines will receive one of the following determinations:
  - Accepted – HHSC did not identify any issues with the reported baseline and qualitative information and measure is approved to report performance
  - Flagged for TA – HHSC identified one or more issues with the reported baseline that require a resolution before baseline can be reported.
  - Not Accepted – the reported baseline does not meet the minimum baseline reporting requirements (for example, did not report all required payer types, or requested a significant measurement period change without prior approval). Measure that are "Not Accepted" will receive an NMI determination so that issues can be resolved in the NMI period.

Baseline Review TA Flags

- Common issues identified during TA include:
  - Insignificant denominator volume for achievement payer type
  - Low Baseline indicating a possible issue with reporting to specifications or data access resulting in a baseline that is not an accurate reflection of baseline clinical practice
  - Specifications issues
  - Sampling issues
  - All-payer volume may not include all-payer types

RM-1 Approval for Early Baseline Reporting

- Baselines that were accepted or flagged for TA during the early baseline reporting period will be approved for RM-1 automatically in DY7 R2.
  - Submitting a correction through the reporting template will not impact approval of payment of RM-1.
- Baseline that were not accepted during the early baseline reporting period will be required to report again in the October DY7 reporting template to determine payment of RM-1.

Early Baseline Review TA Progress

- Most measures that were flagged for TA after early baseline reporting have been contacted by HHSC with initial questions for providers.
  - A few outstanding providers will be contacted this week.
- Providers are encouraged to respond in a timely manner. HHSC is currently reviewing provider responses and will begin resolving TA Flags shortly.
- Depending on provider response times, HHSC aims to complete all baseline TA issues during the month of October.
- As reminder, providers do not need permission from HHSC to submit correction through the October DY7 reporting template.

RM-1 Approval and DY7 R2 Baseline Review

- HHSC will review baselines for approval of RM-1 and for baseline acceptance. Providers will receive separate determinations for RM-1 and their baseline review status.
- Baselines that are accepted or flagged for TA will be approved for payment of RM-1.
- Baselines that are not accepted will receive an NMI determination so that providers can resolve issues during the NMI reporting period.

Baseline Review Process for October DY7

- HHSC will review all reported baselines during November.
- Providers will receive notification of RM-1 approval in December along with general payment notifications.
- HHSC intends to provide notification of baseline review also in December, but may need a few additional days after milestone approval notifications to send baseline review notifications.
- HHSC will begin baseline TA in January.

Category C NMI Reporting

- A separate template will be made available for the NMI reporting period.
  - The NMI template will be identical in structure to the template for the primary Category C Reporting Period, but with updated reporting eligibility based on review results.
- Only measures that receive an "NMI" determination following the primary reporting period will be eligible to report during the NMI period.
  - Category C Measures with a baseline ending on or before 03/31/18 will receive an NMI if no baseline is reported during the primary reporting period.
- No measures will be eligible to submit corrections through the NMI reporting template.

Part 7:
Category C Specifications

Category C Specifications Components

- Specifications Introduction Part 1
  - Definition of preventive visit and ambulatory visit
  - Sampling Guidance
  - Payer-type guidance
- Target Population
- Measure specifications
  - Measure Source

Part 8:
Category C Resources

Category C Resources

Available on the Online Reporting System Bulletin Board:

Reporting – October DY7
- October DY7 Reporting Companion

Category C Resources
- Category C Goal Calculator (includes sampling calculator & guidance)
- Category C Summary Workbook

Category C Specifications
- Category C Specifications
  - Part 1: Introduction (ALL PROVIDERS)
  - Part 2: Hospital & Physician Practices
  - Part 3: LHD Measures
  - Part 4: CMHC Measures
- Category C Specifications FAQ

Compliance Monitoring Resources
- MSLC Data Support Guide
- MSLC Data Support Guide FAQ
- MSLC Risk-Adjusting Guidance & Template
- MSLC Presentation and Examples

Questions

TEXAS Health and Human Services

Thank you

Mailbox:
TXHealthcareTransformation@hhsc.state.tx.us

Website:

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