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Emily Sentilles
Director, Healthcare Transformation Waiver
Texas Health and Human Services Commission
Mail Code H400
PO Box 13247
Austin, TX 78711

Submitted via email to txhealthcaretransformation@hpsc.state.tx.us

Dear Ms. Sentilles:

Texas Hospital Association (THA) respectfully submits comments regarding the proposed Comprehensive Hospital Increase Reimbursement Program (CHIRP) quality metrics on behalf of our more than 470 member hospitals and health systems, including rural, urban, children's, teaching, and specialty hospitals. CHIRP is comprised of two components, the Uniform Hospital Rate Increase Program (UHRIP) and Average Commercial Incentive Award (ACIA), each with quality metrics that participating hospitals are required to report in all modules for which they are eligible.

Comments presented in this letter are intended to frame general considerations and issues we hope will guide HHSC's modifications to proposed quality metrics. They are not specific to any measure or program component. ***THA's comments on individual measures and program components were submitted via the Microsoft Forms survey on Feb. 2, 2021. Please refer to these responses for measure-specific feedback.***

Issue #1 – Implementation timing

HHSC's proposed implementation timing for CHIRP measures appears extremely ambitious, with a proposed first reporting period occurring Q1 2021 (October) encompassing a measurement period that already began on Jan. 1, 2021. This may put hospitals in a challenging position with respect to IT enhancements, training, and other administrative preparation necessary so data can be captured on required measures. In the case of the first measurement period, any modifications would have to be applied retroactively to data already collected in early 2021.

Our members were less confident in their ability to participate in CHIRP without assurance of a lengthier transition period to build out metrics they are not currently able to capture and report. COVID-19 has also consumed hospital resources that might ordinarily be available to support needed enhancements and could further extend the time needed to ensure these capabilities are in place.

Additionally, members currently participating in DSRIP would appreciate further clarification on how the phase-out of reporting on DSRIP quality metrics will interact with phase-in of reporting on CHIRP quality metrics. If hospitals participating in DSRIP and CHIRP will be required to report on both at once, we hope HHSC will consider options to ease reporting requirements on dual participants in the transition year.

Issue #2 - Volume of measures

Given HHSC's requirement hospitals must report on all measures in each CHIRP module for which they are eligible, THA strongly encourages HHSC to consider reducing the total volume of measures, as the current volume may create barriers to widespread provider participation. At present, the reporting obligations are positioned to be highest on children's hospitals, urban hospitals, and state-owned non-IMD hospitals, who would be accountable to either 23 or 24 different measures assuming they meet minimum volume requirements for module eligibility. Hospitals that do not already have robust data capture and health IT capabilities will be particularly challenged to meet these requirements and may find themselves left out of crucial payment opportunities. HHSC can reduce the odds this occurs by simplifying its quality metrics list and reducing the administrative barrier to entry and continued compliance.

Our members have identified several measures that may be good candidates for deletion or postponement. THA has flagged those measures where applicable in the Microsoft forms survey responses and summarized our members' reasons those measures can be removed from CHIRP at this time.

As mentioned in verbal testimony at HHSC's Jan. 11 public hearing, THA also encourages HHSC to adopt quality measures in which achievement may be tested merely on whether the class or classes meet or do not meet the established requirement. Measures not fitting this criterion may be good candidates for deletion.

Issue #3 - Alignment with measures hospitals are accustomed to reporting

THA advocates for HHSC to make reporting as simple as possible by prioritizing data hospitals have readily available and currently report, using identical specifications. Our hospitals believe no new reporting systems or additional staff should be necessary to manage CHIRP reporting. Hospitals already report extensive quality and data metrics and this focus should be on using existing measures already in place.

While we are grateful HHSC has identified validated measures and named the measure steward in most cases, our members anticipate more refinement may be needed to eliminate any differences between how a hospital must format a measure for reporting to a national database, versus how HHSC may request it. For example, an extremely common refrain we heard from hospitals is they would not be able to stratify quality data into the requested categories of STAR, STAR+PLUS, Other Medicaid, Uninsured, and Other Health Insurance. It is a priority request of many hospitals that these grouping variables be broadened and simplified, in order to avoid expensive and time-consuming system alterations.

Issue #4 – Conditioning hospital payments on factors outside hospital control

Our hospitals determined several proposed measures would potentially condition CHIRP payments on data or outcomes over which hospitals have minimal control. Many of these measures are found in ACIA modules focused on care transitions. Hospitals would prefer their payments be conditioned only on measures they can directly influence. For instance, if a quality measure calls for a patient to be referred to follow-up care upon discharge, there is a presumption outpatient care is available and accessible outside the hospital and that those services are covered by the patient's managed care plan. We note in the Microsoft Forms survey several measures we believe may fall within the scope of a managed care organization, and would advocate not only for those measures to be reported by the MCOs, but also that hospital payments not be tied to those outcomes.

Hospitals are committed to improving quality through care coordination in the areas they operate and value the opportunity to work together with MCOs to achieve smooth care transitions after hospitalizations. However, interim steps may be necessary to bring all parties into alignment on programs, goals, limitations, feasibility, and implementation strategy.

Issue #5 - Clarify HHSC's conditions of recoupment, and any intent to pursue pay-for-performance

HHSC's proposed CHIRP rule indicates a participating hospital's failure to meet the quality reporting conditions of participation exposes them to recoupment of funds an MCO has already paid. Our hospitals seek further guidance from HHSC on what is considered failure to meet any of the quality reporting requirements and steps the agency would take to pursue recoupment or reallocation of CHIRP funds.

We request HHSC allow participating providers to carry forward reporting and payment opportunities, to the extent a participating provider fails to achieve a particular metric at the first reporting opportunity. And as mentioned in verbal testimony at HHSC's Jan. 11 public hearing, we recommend any corresponding hospital-specific payment reductions attributable to the quality measures be as minimal as possible (i.e., 1 or 2 percent).

Further, THA is supportive of HHSC's commitment to evaluate incremental improvement of quality on a statewide basis, rather than individual hospitals. Although none of the CHIRP quality measures are currently proposed as pay-for-performance, should HHSC have long-range plans to move CHIRP toward pay-for-performance, THA recommends further collaboration and discussion with our members prior to advancing such plans.

Conclusion

Overall, we encourage HHSC to prioritize administrative simplicity in its selection of measures, minimize conditions that would impose barriers to hospital participation, and communicate guidance clearly so that Texas hospitals can opt-in to these programs with a full understanding of the necessary requirements. Our members appreciate tremendously the agency's diligent work to secure the recent 1115 waiver extension and communicate basic architecture of its new directed payment programs. We understand the importance of CHIRP's quality component in demonstrating progress toward HHSC's overall quality strategy goals and continuing to improve patient care in Texas. Hospitals are eager to collaborate with HHSC in service of these goals.

Thank you for consideration of these comments. With questions, please contact Anna Stelter at astelter@tha.org.

Kind regards,



Anna Stelter
Senior Director, Policy Analysis
Texas Hospital Association

CC: Victoria Grady, Director of Provider Finance, Texas Health and Human Services Commission