

Texas DSRIP Category 3 Framework

- 1. CMS will approve additional measures for the Category 3 menu, with the specifications most recently worked out with the state**
 - a. Most measures will be approved for Pay for Performance (P4P), including some measures that don't have a QISMC benchmark. Some P4P measures will require prior authorization (these are measures that were on the original Category 3 menu, but are not considered the strongest P4P measures).
 - b. A handful of measures will be approved as "Exploratory measures," for P4R (with prior authorization).
 - c. Measures must be used according to CMS specifications using appropriate denominators that are not limited to the number of people enrolled in a project.
 - i. Appropriate to the project, the denominator can be a subset of all patients served based on criteria such as payer source (i.e. Medicaid/indigent), target condition, age, race/ethnicity, gender, or clinic.
 - ii. Providers must clearly specify their measure denominator in their revised DSRIP plans.
 - iii. The state's independent mid-point assessor will verify that providers are conforming to measure specifications (by sampling and/or focusing on specific high risk measures).

- 2. All providers will be required to select Category 3 measures for their Category 1 & 2 projects**
 - a. Measures must be selected before the end of March 2014 in order for providers to receive the first half of their Category 3 payment for DY 3 in the April 2014 reporting period.
 - b. Providers will need to continue to either choose 1 standalone measure or 3 non-standalone measures. CMS will allow a bundle of non-standalone measures across domains if needed for a project to find appropriate measures.
 - c. Providers may select P4R measures only if a P4P measure is not available and a P4R "exploratory measure" is more appropriate for the project (e.g. Hospital provider without internal capacity to collect risk adjusted admission or readmission rates (PPA/PPRs), local health departments doing prevalence measures and behavioral health providers targeting the seriously mentally ill with no appropriate P4P measures).
 - d. The state and CMS must prior authorize the use of P4R measures and certain P4P measures, which will occur after they are proposed in March. (If a provider has a P4P measure that requires prior authorization that already was approved by CMS in the initial review letters, this will meet the prior authorization requirement.) This also will be reviewed by the independent contractor doing the mid-point assessment by sampling and/or focusing on specific high risk measures.
 - There may be categories of P4R measures that don't require prior authorization (such as measures for local health departments).

3. Providers doing P4R measures will need to engage in additional activities.

- a. For providers who couldn't identify an appropriate P4P measure and are doing P4R exploratory measures, providers will need to engage in additional stretch activities (Attachment 1) or improve on population-focused priority measures (Attachment 2) to earn full Category 3 DSRIP payment.
 - i. Providers who are able to report measures from the population-focused priority measures per the specifications should opt to engage in this activity.
 - ii. If a provider is not able to identify a measure it can report from the population-focused priority measure list it may opt to implement a stretch activity.

4. Providers doing P4P measures will receive 50 percent of Category 3 funding in DY 4 for reporting to specifications

- a. For these providers, 50 percent of DY 4 Category 3 funding and 100 percent of DY 5 Category 3 funding will be for P4P.
 - b. Providers will continue to be eligible for partial achievement and a 1 year carry forward, including for DY 5.
- ➔ CMS expects P4P providers to follow the QISMC improvement target method (Attachment 3) for DY 4 and 5 (or a 5%/ 10% improvement over baseline in DY 4/ 5 for providers doing measures without benchmarks). However, the state has requested an opportunity to adjust the percent of the gap needed to be closed for providers where the target population is smaller than the expanded denominator that CMS is requesting providers to use or for extenuating circumstances, such as if the project population differs greatly from the broader denominator. Baselines will be reported with the 2nd DY 3 Reporting opportunity in October 2014. The provider will have an opportunity to propose an alternate improvement target method in October based on certain parameters the state and CMS will jointly develop.

The table below illustrates the proposed allocation of funding in Category 3 for DY 4 and 5:

	P4P projects	P4R projects (Expected to be a limited number; need prior auth)
DY 4	50 percent P4R/ 50 percent P4P	100 percent P4R on measure
DY 5	100 percent P4P*	50 percent P4R on measure 50 percent P4P on Population- focused priority measure or stretch activity

*HHSC continues to negotiate with CMS for some percentage of P4R for DY 5.