

Category 3 Companion Document

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Key Points about the New Category 3 Framework

- CMS and HHSC have agreed upon an updated framework for DSRIP Category 3. Category 3 represents the outcomes associated with each Category 1 or 2 project and will be important to help demonstrate how the waiver is helping to improve the Texas healthcare delivery system
- **Using the Category 3 selection tool, all DSRIP providers are required to verify or select Category 3 outcome measures for each Category 1 or 2 project in March 2014.**
- All providers should review the revised Category 3 outcome measure options in the Excel spreadsheet to determine which measure(s) on the menu are the best fit for each Category 1 and 2 project.
- Major changes to Category 3 from the original RHP Plan submission:
 - The revised Category 3 menu has many more measures (353 measures including tools) to try to accommodate Texas' diverse range of DSRIP projects. Some outcome ID (IT) #s have changed. "Other" outcomes are no longer an option; related measures have been moved on-menu where possible.
 - Each measure on the menu is designated either as Pay for Performance (P4P) or Pay for Reporting (P4R).
 - There will be standard achievement methodologies for P4P measures (i.e., the % improvement in achievement level to earn Category 3 funds in DY 4 and DY 5).
 - All measures must be reported based on specification requirements, as outlined in the compendium, and also may be found at the links on the measures spreadsheet. For most measures, the denominator used for Category 3 reporting will be broader than those individuals served by the Category 1 or 2 project. However, providers are allowed to tailor the denominator to better match the project target population based on certain factors such as diagnosis, demographic variables and project location.
- Providers will continue to choose either at least 1 standalone measure or 3 non-standalone measures for each Category 1 or 2 project.
- A Category 1 or 2 project may have a mix of P4P and P4R measures.
- P4P measures are the preferred choice. If there is a P4P measure appropriate to the Category 1 or 2 project that the provider can report to the specifications in the compendium, then the provider must select a P4P measure. (See NOTE below about already approved outcomes.)
- P4R measures may be selected when there is no P4P measure appropriate to the Category 1 or 2 project that the provider can report to specifications, but will require prior authorization to be used.
 - If a provider needs to use a P4R measure, the provider also must select an alternate improvement activity to earn a portion of its Category 3 funds allocated to that P4R measure in DY 5.
- NOTE: If a provider wants to keep its originally proposed outcome measure for a project, the measure was approved by CMS in the initial approval process, and it is on the revised Category 3 menu, the provider may keep the measure and the CMS approval constitutes

prior authorization if required. The provider should verify the current IT number of each measure and fill out the required information in the Category 3 selection tool. A standard achievement methodology will apply for these measures rather than what the provider submitted.

- Within limits and based on each provider's current Category 3 funding, the provider will decide what portion of its Category 3 funding to allocate to each Category 1 or 2 project. Once the provider makes that decision, the selection tool will automatically evenly distribute Category 3 valuation associated with a given Category 1 or 2 project across the selected Category 3 measure(s) for the project. The selection tool includes approved Category 1 and 2 4-year projects as well as replacement projects and proposed 3-year projects.
- Any Category 3 milestones the provider previously selected for DY3-5 will no longer be reported on; the number of milestones each year will be prescribed by HHSC.
- In DY 3, there will be two milestones for each outcome measure - providers will be eligible to earn 50% of the funding for each Category 3 measure during April reporting based on a status report and the other 50% during the October reporting period based on establishing or validating the baseline for each measure.
- In DY 4 and DY 5, the number and type of milestones each year (process milestones and achievement milestones) will vary depending on whether a measure is designated as P4P or P4R.
- There will be standard achievement levels for P4P measures in DY 4 and DY 5. In October 2014, providers may request to deviate from the standard achievement levels based on extenuating circumstances to be determined by HHSC and CMS, such as if the intervention population is much smaller than the denominator required in the measure specifications. Since changes to standard achievement levels will require additional approval by CMS, HHSC encourages providers to carefully consider allowable denominator subsets now as a way to appropriately reflect the target population for each project (which will still be broader than the intervention population in almost all cases).
- Category 3 milestones may still be carried forward into the next demonstration year if needed, and partial payment for Category 3 milestones still applies for achievement milestones (in which the provider is earning funds based on improvement in achievement level).

Category 3 Framework

CMS and HHSC have finalized an overarching framework for use of Category 3. Much of this content will be further detailed in subsequent sections of this companion document. This section offers a high level summary of the mechanics of Category 3.

All providers are required to select Category 3 measures from the revised Category 3 menu for their Category 1 and 2 projects. All measures are approved for use and must be reported to the specifications detailed.

The Category 3 menu of measures contains a large proportion of Pay for Performance (P4P) measures that providers may select from to receive incentive payments for demonstrating incremental improvements in the selected outcome. These measures are considered the stronger, more validated measures. If there is a P4P measure appropriate to the Category 1 or 2 project that the provider can report to the specifications in the compendium, then the provider must select a P4P measure.

The Category 3 menu also contains some measures that are designated as Pay for Reporting (P4R). As HHSC worked with CMS to get as many measures on the menu as possible to accommodate the wide variety of Texas DSRIP providers and projects, these P4R measures were approved for inclusion in the menu as “exploratory” measures even though they do not have the strongest rigor of validation or evidence, or may have the potential for adverse selection or care processes. All P4R measures require prior authorization by HHSC and CMS. Providers that need to use a P4R measure will not receive payment for improving its rate, but instead will receive payment for reporting the measure to the associated specifications. Providers may still demonstrate improvement in these measures; however, that improvement will not be the basis for incentive payment. For these reporting only or "exploratory" measures providers must engage in an alternate improvement activity. These activities are detailed in a subsequent section of the companion as Population-Focused Priority measures and Stretch Activities.

Once a provider selects its outcome measures (ITs) for each Category 1 and 2 project, each measure will be assigned a measure ID number specific to that provider (e.g. 123456789.3.200), and each IT will be paid based on a combination of process milestones and achievement milestones. For all Category 3 measures, there will be two process milestones in DY3 (to be further discussed in a subsequent section), and the table below describes how incentive payments for DY 4 and DY 5 will be allocated to both P4P and P4R outcomes. Any Category 3 milestones the provider previously selected DY3-5 will no longer be reported on; the number of milestones each year will be prescribed by HHSC as shown below.

	Pay for Performance (P4P) outcome measures	Pay for Reporting (P4R) outcome measures
DY4	<p>Process Milestone 10 - 50% of DY4 allocation for reporting P4P measure to specifications</p> <p>Achievement Milestone 1 - 50% of DY4 allocation for demonstrating improvement in P4P measure over baseline*</p>	<p>Process Milestone 10 - 100% of DY4 allocation for reporting P4R measure to specifications</p>
DY5	<p>Achievement Milestone 1 - 100% of DY5 allocation for demonstrating improvement in P4P measure over baseline*</p>	<p>Process Milestone 10 - 50% of DY5 allocation for reporting P4R measure to specifications</p> <p><u>Alternate Improvement Activity</u> EITHER Achievement Milestone 2 – 50% of DY5 allocation for demonstrating improvement in a Population Focused Priority Measure OR Process Milestone 11 – 50% of DY5 allocation for reporting as required on a stretch activity**</p>

*Achievement levels associated with improvement to be discussed in subsequent sections

**Discussions of allowable alternate improvement activities to be discussed in subsequent sections.

As with milestones in Category 1 and 2 projects, all of the Category 3 milestones described above are eligible for late achievement or carry forward achievement into the next DY. This includes milestones in DY5, for which a provider may demonstrate achievement in the year after DY5 if carry forward is requested (from October 1, 2016 – September 30, 2017).

In addition, all P4P achievement milestones are eligible for partial payment based on partial achievement of goals in 25% increments. Achievement will be based on the highest quartile achieved. For example, if a provider demonstrates improvement in the selected outcome to 65% of the goal for the demonstration year, it will receive 50% of the incentive payment associated with that milestone. Process milestones are not eligible for partial achievement and need to report on all required elements to be eligible for payment.

Category 3 Outcome Measures

All of the measures included in the Category 3 menu have been approved by CMS. Often the source of these measures is an authoritative agency around outcome measurement (e.g., AHRQ, NCQA, CDC, NQF). Most of these measures have been validated and tested to ensure that the outcomes are measuring what they purport to measure. In some cases, where validated measures did not previously exist, measures were created based on evidence based guidelines and practices. These measures were included in the menu to reflect outcomes pertinent to approved Category 1 and 2 projects. The outcomes are salient to aspects of patient care that reflect better health and satisfaction with services, improved efficiencies in health care delivery and cost savings.

Outcome Domains

All of the Category 3 outcome measures are organized into 15 Outcome Domains (ODs). This organization is a grouping of like outcomes to facilitate measure selection.

- OD-1: Primary Care and Chronic Disease Management
- OD-2: Potentially Preventable Admissions
- OD-3: Potentially Preventable Readmissions (PPRs) – 30-day Readmission Rates
- OD-4: Potentially Preventable Complications, Healthcare Acquired Conditions, and Patient Safety
- OD-5: Cost of Care
- OD-6: Patient Satisfaction
- OD-7: Oral Health
- OD-8: Perinatal Outcomes and Maternal Child Health
- OD-9: Right Care, Right Setting
- OD-10: Quality of Life/Functional Status
- OD-11: Behavioral Health/Substance Abuse Care
- OD-12: Primary Prevention
- OD-13: Palliative Care
- OD-14: Healthcare Workforce
- OD-15: Infectious Disease Management

Measure Components

The components below are included for each measure in the revised Category 3 measures list (spreadsheet) and/or the compendium, which includes further details on how each measure is to be reported.

Improvement Target (IT) reference number: The number designation specific to an individual outcome measure. This reference number is the identifier used in DSRIP projects to indicate a selected outcome.

Measure title: The measure title is a brief statement of the outcome being measured.

Measure type: Pay for Performance (P4P) or Pay for Reporting (P4R). This designation specifies how the measure will be used for the purpose of DSRIP payment. P4P measures are generally more robust and have a larger body of evidence to support their use. P4R measures, also called "exploratory" measures, are still evidence based but are not as strong. This measure designation will be a critical consideration as providers select their outcomes as each of the measure types has distinct requirements for use and payment (which will be further described in subsequent sections). P4P measures are the preferred measures and P4R measures only are to be used if there is not a P4P measure that fits a Category 1 or 2 project that the provider is able to report to specifications.

Prior Authorization (PA) – Whether a measure requires prior authorization for use.

Improvement methodology - For measures where the measures type is designated as Pay for Performance (P4P), the improvement methodology describes how improvement goals will be calculated. P4P measures will be assigned to one of two methodologies that will be used to determine achievement targets for DY4 and DY5. The two methodologies are identified as either Quality Improvement System for Managed Care (QISMC) or Improvement Over Self (IOS). The determination of achievement targets for each of these methodologies will be discussed in greater detail in the subsequent section.

Measure specification type: Measure specifications are included in the menu in three forms: Identical, Modified, or Custom (as designated by HHSC/CMS)

- Identical measures – These measure specifications are included in the Category 3 menu as described by the measure steward.
- Modified measures – These measure specifications have been slightly modified to reflect DSRIP provider focus (e.g. HEDIS measures included, with revisions to language describing population [changed “member” to “patient” for DSRIP]).
- Custom measures – These measures are based on clinical guidelines and/or standard measurement definitions (e.g. prevalence) and were created to accommodate approved DSRIP projects when there was no stronger evidence-based measure available.

Measure source: Specifies the organization that endorses or stewards the measure (e.g. National Committee for Quality Assurance), or the source of clinical guideline or recommendation (e.g. American Congress of Obstetricians and Gynecologists).

Standalone (SA) or Non-Standalone (NSA): This designation is tied to the type of outcome captured by the measure. Process measures are generally regarded as NSA while outcomes that describe clinical outcomes are assigned the SA status.

Setting: Specifies the provider setting in which a measure can be applied. Many measures are specific to the ambulatory or inpatient setting and should only be quantified among individuals in that setting.

Benchmarks (where relevant) - Many of the P4P measures also include references to a high performing (90th percentile) or low performing (25th or 10th percentile) benchmark rates. These benchmark rates are used as guidelines for measure performance and to incorporate into the calculation of DY4 and DY5 achievement targets. This calculation is discussed further in the subsequent section.

Description: A brief summary describing what the measure results mean.

Numerator: Description of eligible cases for the particular measure (e.g.. all patients with an HbA1c > 9.0%). Note: many measures include specific numerator inclusion and exclusion criteria.

Denominator: Describes the total eligible population in which cases (numerator) can be identified (e.g. all adult patients with diabetes). Note: many measures include specific denominator inclusion and exclusion criteria.

Data Source: Specifies information sources in which data specific to the measure can be obtained (e.g. administrative data and electronic health records)

Grouping Patients for Outcomes

Assessing selection of outcomes to measure the impact of a project (or intervention) as it relates to outcomes requires review of multiple levels of patient groupings. For the purpose of Category 3 outcomes, there are three main groups of patients to review.

- **Intervention population** - This is the group of individuals that receives the intervention outlined in the Category 1 or 2 project. In almost all cases (and based on measure specifications), a provider will not report on the intervention level population for the purposes of Category 3 reporting.
- **Target population** - This is the group of individuals that is eligible to receive the intervention (the broader group of individuals the intervention is designed to serve). While Category 3 must be reported to measure specifications, CMS has allowed that providers may narrow the measure denominator based on certain criteria to more closely represent the Category 1 or 2 project's target population (see subsequent information on allowable denominator subsets)
- **Outcome population** - This is the group of patients that meet the criteria for outcome measurement based on the specifications for each measure. This often is a broader population than the project target population.

Allowable Denominator Subsets

As noted previously, all Category 3 outcome measures are required to be reported to the specifications required for the measure as outlined in the menu and the compendium. However, as appropriate to the Category 1 or 2 project, the provider can propose a more narrow denominator (a subset of the outcome population) based on one or more of the following criteria:

- Payer source (Medicaid or Indigent or both),
- Target condition (including co-morbid condition/diagnosis)
- Demographic factors - age, race/ethnicity, and/or gender, or
- Clinic or other location where the Category 1 or 2 project is taking place.

HHSC encourages providers to carefully consider allowable denominator subsets prior to submitting your selection tools as a way to appropriately reflect the target population for each project (which will still be broader than the intervention population in almost all cases).

Understanding types of populations - example: Suppose a performing provider, a multi-provider primary care practice, is implementing a project that would offer a series of diabetes self-management classes (intervention) designed for adult Hispanic patients with diabetes (target population). This provider has selected IT-1.10 - HbA1c control as the associated Category 3 outcome. This outcome requires reporting of A1c control for all adult diabetic patients (outcome population).

Of the 510 adult patients with diabetes that are registered to that practice (*outcome population*), 360 of those adult patients identify as Hispanic and have diabetes (*target population*). 90 of those targeted patients attend the self-management classes (*intervention population*). 150 adult diabetic patients do not meet the criteria of the target population for the intervention because they are not Hispanic. This means that the performing provider captured 25% (90/360) of its target population by the intervention (spread of intervention) and 17.6% of the total adult diabetic population (90/510) (breadth of intervention). 29% of the overall diabetic population (150/510) was not eligible for the intervention based on the target criteria.

Connectedness of these patient groupings

As demonstrated in the example above, changes in the selected outcome for the intervention population will be captured (albeit to a different magnitude) in the target and outcome populations.

For some projects that are implementing system-wide interventions (all patients with certain condition are equally eligible to receive the intervention) the intervention population may be the same as the target and outcome population. In these cases the magnitude of the impact to the outcome population is equal to the magnitude of the impact of the intervention in the outcome being reported.

Using the same example from above to further describe this-

Let's assume that of those 90 patients that received the intervention, 75 of them have an HbA1c level that is in control (<9% by the measure definition). Of the 420 adult patients with diabetes in the outcome population that did not attend the classes, 240 of those patients have an A1c that is in control (< 9%). Among the 420 adult patients that

did not attend the classes, 270 are Hispanic patients of which 155 have an A1c that is in control. Also, there are 45 patients that do not have an A1c level reported during the measurement year. This means that there are a total of 15 (intervention group) + 180 (non-intervention group) are not in control or do not have an A1c level reported for a total of 195 patients.

The measure specifications for IT-1.10 reflect the percentage of adult patients with diabetes (type 1 or 2) whose most recent A1c level was > 9% (poor control). The numerator specifies the number of people with a level > 9%, while the denominator specifies adult patients with diabetes.

Assuming the performing provider does not opt to do a denominator subset (Hispanic adults), the performing provider would report the outcome rate for Category 3 in the following manner (adhering to measure specifications):

Numerator- number of patients whose most recent A1c level >9% (or who did not have an A1C test in the measurement period) = 195 patients not in control

Denominator- 510 adult diabetic patients.

Rate: $195/510 \times 100 = 38.2\%$ of patients with A1c level >9%

However, if we assume that the provider opts to define the denominator to just include the 360 Hispanic adult diabetics served, the performing provider would report the outcome rate for Category 3 in the following manner:

Numerator- number of Hispanic patients whose most recent A1C level >9% (or who did not have an A1c test in the measurement period) = 130 patients not in control

Denominator- 360 adult Hispanic diabetic patients.

Rate: $130/360 \times 100 = 36.1\%$ of Hispanic patients with A1c level >9%

Interpretation: 38.2% of the adult diabetic patients registered to the practice (outcome population) had an A1c > 9% or did not receive a test last year. 61.8% of patients had an A1c level in the last year that was <9%. In addition, of the target population (Hispanic adults), 36.1% had an A1c > 9% or did not receive a test last year, while the other 63.9% had an A1c level that was < 9%. For the intervention population, 16.67% had an A1c > 9% or did not receive a test last year.

The above example demonstrates how in many cases it may be advantageous to the provider to propose an appropriate denominator subset. Since the project's target population is Hispanic adults with diabetes and the intervention appears to have been successful at improving the testing and A1c rates for those served by the project, the A1c control rate for Hispanic adults is better than the A1c control rate for all adult diabetics registered to the practice.

Establishing a Baseline for Each Category 3 Measure

Each DSRIP provider will need to establish a baseline for all Category 3 outcome measures, both P4P and P4R. Baselines also must be established for any selected Population-Focused Priority measures used as an alternative performance activity. The baseline will be specific to the patients served by that provider. Baselines will not be formally reported until October 2014 (or later if needed), but the selection tool allows the provider to do forecasting related to a measure, including for the full outcome population and any possible denominator subsets, to help the provider see how the achievement goals would work based on its estimated baseline information.

The provider's baseline for each measure will determine the achievement goals for the measure in DY4 and DY5. The baseline period should be as recent as possible and will either be a 12-month or 6-month period (unless an exception is approved). Providers should review the measure specifications to help determine the appropriate baseline period. The selection tool contains the following allowable baseline periods:

- 12 months - DY3 (10/1/13 – 9/30/14)
- 6 months (1) DY3 - 10/1/13 – 3/31/14
- 6 months (2) DY3 - 04/1/14 – 9/30/14
- 12 months CY 2013 (1/1/13-12/31/13)
- 12 months - DY2 (10/1/12 – 9/30/13)
- Other: Providers specify/propose an alternative 6 or 12 month time period to be reviewed and approved by HHSC.

If a provider already established a baseline for a measure in DY2, HHSC asks that the provider verify or update the baseline in the October 2014 reporting period using one of the above time periods or another time period in the same time range (such as state fiscal year 2014, which is 9/1/13-8/31/14). Please ensure that the baseline is reported to the measure specifications in the compendium, except for any allowable denominator subsets proposed as appropriate to the Category 1 or 2 target population. If a provider needs to request a baseline period other than those specified above, it should select "other" on the selection tool and explain why a different baseline period is proposed.

Selecting Category 3 Measures for Each Category 1 or 2 Project

DSRIP providers should use the following process to select Category 3 outcome measures for each of their Category 1 and 2 projects.

1. Review the revised Category 3 menu of measures (spreadsheet) to determine the measure(s) that best fit each Category 1 or 2 project.

2. Is there a P4P measure appropriate to your Category 1 or 2 project that you can report to specifications? If yes, select P4P.
3. If the answer to #2 is no, select a P4R measure, which also requires selection of an alternate improvement activity.
4. In selecting an alternate improvement activity, reporting on achievement related to a population-focused priority measure is the preferred activity, if you can report one to specifications. (More on these measures is in subsequent sections.) If you cannot use a population-focused priority measure, then select a stretch activity relevant to the P4R outcome measure selected.

If a provider's originally proposed outcome measure(s) for a project are on the revised menu, and you can report them to specifications, you may keep them, but check the revised menu to see if the IT (outcome ID #) has changed, and fill in the required information on the Category 3 selection tool. All P4P measures, including these measures, will be required to use a standard achievement methodology (either QSMIC or IOS as specified on the menu) rather than the achievement levels the provider originally proposed.

HHSC and CMS will review Category 3 selections to determine 1) whether a P4P measure could have been used if a P4R was selected and 2) in the case of appropriate P4R selections, whether a population-focus priority measure could have been used rather than a stretch activity. HHSC encourages providers to seek technical assistance prior to submitting Category 3 selections if you are uncertain which measure(s) may fit a project.

For the purposes of outcome selection, providers must select measures for each Category 1 or 2 project based on the following requirements.

- Each Category 1 or 2 project must have at least 1 standalone measure or 3 non-standalone measures. This has not changed from the original Category 3 requirements; what has changed is that non-standalone measures may be selected that cross domains as appropriate to the Category 1 or 2 project.
- One or more non-standalone measures also may be combined with at least one standalone measure.

All P4R measures require prior authorization (PA). There also are some P4P measures designated as PA; these were on the original menu but are not considered the strongest measures, so they only may be used by providers that originally proposed them for their projects (grandfathered). They may not be newly selected. For any measure that requires PA – either P4R or P4P – if a provider originally selected the measure for a project and it was approved by CMS in the initial RHP Plan approval letter, that approval constitutes PA for the measure if a provider decides to keep that measure.

When selecting Category 3 outcome measures, providers also should consider the following:

- A Category 1 or 2 project may have a mix of P4P and P4R measures. Each measure is treated separately for reporting and payment purposes.

- If a provider has more than one P4R measure, each P4R measure must have an alternative improvement activity, but if appropriate the same alternative improvement activity may be used for multiple P4R measures.
- If a provider already is a high performer (at or above the high performance level) for an outcome, the provider should select another measure in order to demonstrate improvement. If the provider does not realize it is a high performer until around October 2014 when it prepares to submit baseline information, HHSC will need to work with the provider on next steps.
- Check for duplication between each selected Category 3 measure and improvement milestones for the associated Category 1 or 2 project. If there is duplication or the provider is unsure, HHSC will work with the provider to address. Unless there is overt duplication between the Category 3 measure and Category 1 or 2 improvement milestone, the provider will be able to retain both. Now that the measured population (denominator) for Category 3 is generally broader than the Category 1 or 2 intervention population, this minimizes duplication between the two. If there is duplication and the provider still needs to select the Category 3 measure because it's the best or only measure for the project, the provider will be required to replace the Category 1 or 2 overlapping milestone(s) during the next DY4-5 plan modification opportunity in June/July 2014.
- If a project originally had just one outcome selected related to patient satisfaction and CMS indicated in the initial RHP Plan approval letters that to retain its original valuation the provider needed to either add another Category 3 measure or replace the patient satisfaction measure with another measure, that must be done in March to retain valuation and will be noted under Phase 1 comments in the provider's selection tool.
- Other than for the projects described in the bullet above, it is recommended (but not required) that Category 1 or 2 projects with one outcome either from OD-6 (Patient Satisfaction) or OD-10 (Quality of Life) add another more clinical measure to help show the outcomes of the project. This may not be possible in all cases, and for some projects (such as certain behavioral health-focused projects), quality of life may be the best measure; however, CMS did not consider patient satisfaction and quality of life to be the strongest measures, particularly for hospitals and other providers that have data to report on other measures.

Valuation and Milestones

Valuation

In the initial RHP Plan submission, a Performing Provider had flexibility to assign different values to its Category 3 outcomes and related milestones and outcome improvement targets, as long as total payments met the annual minimum category allocation amounts defined in the PFM Protocol. When provider's re-select or verify their Category 3 measure(s), for administrative purposes, Category 3 valuation for DY3-5 will be determined as follows:

1. HHSC will total up all the funds the provider allocated to Category 3 each DY for DY 3, 4, and 5.

2. HHSC will total up the provider’s approved Category 1 and 2 DSRIP projects.
3. Each provider will decide what percentage of its Category 3 funds will go toward a given Category 1 or 2 project (this percentage must be the same for DY 3-5) with the following floor:
 - i. Divide the total number of approved Category 1 and 2 DSRIP projects into 100. For example, 5 approved Category 1 and 2 DSRIP projects = $100/5 = 20$. If the provider were to divide its Category 3 funds equally across the 5 approved Category 1 or 2 projects, each of those projects would be allocated 20% of its Category 3 funding.
 - ii. A provider must allocate at least 50% of that “average” Category 3 funding to each Category 1 or 2 project. In this example, $50\% * 20\% = 10\%$.
 - iii. Across its five Category 1 or 2 projects, in this example the provider must allocate at least 10% of its Category 3 funds to each Category 1 or 2 project, and in total the percentages allocated across the 5 Category 1 or 2 projects must equal 100%.
 - iv. HHSC may grant exceptions to a provider’s minimum required percentage allocation per Category 1 or 2 project if needed for a provider to retain Category 3 valuation proportional to its Category 1 and 2 valuation. This would occur in cases where the valuation of a provider’s Category 1 and 2 projects varies widely (e.g. one \$7 million project and one \$200,000 project).
4. Once a provider decides the percentage of its funds to allocate to a given Category 1 or 2 project for DY 3-5, based on the number of outcome measures the provider selects for that Category 1 or 2 project, HHSC will allocate an equal amount of Category 3 funds to each outcome measure, and also to each milestone for that measure in a given demonstration year. This calculation will be done automatically in the selection tool.

Example 1 - P4P Measures

A provider allocates to its 1.1 project 30% of its total Category 3 valuation, which equals \$1 million in DY 3, \$2 million in DY 4, and \$4 million in DY5. The provider selects two pay for performance outcome measures associated with its 1.1 project. Funding distribution:

	DY 3	DY 4	DY 5
Cat 3 P4P Measure 1	\$500,000 (50% for status update and 50% for establishing baseline)	\$1 million (50% for reporting to specs and 50% for improving on the measure)	\$2 million (100% for improving on the measure)
Cat 3 P4P Measure 2	\$500,000 (50% for status update and 50% for establishing baseline)	\$1 million (50% for reporting to specs and 50% for improving on the measure)	\$2 million (100% for improving on the measure)

Example 2 - P4R Measures

A provider allocates to its 1.1 project 30% of its total Category 3 valuation, which equals \$1 million in DY 3, \$2 million in DY 4, and \$4 million in DY5. The provider selects two pay for reporting outcome measures associated with its 1.1 project. Funding distribution:

	DY 3	DY 4	DY 5
Cat 3 P4R Measure 1	\$500,000 (50% for status update and 50% for establishing baseline)	\$1 million (100% for reporting to specs)	\$2 million (50% for reporting to specs and 50% for improvement on priority-focused population measure or completion of stretch activity)
Cat 3 P4R Measure 2	\$500,000 (50% for status update and 50% for establishing baseline)	\$1 million (100% for reporting to specs)	\$2 million (50% for reporting to specs and 50% for improvement on priority-focused population measure or completion of stretch activity)

Types of Category 3 Milestones

For DY3-5, the number of Category 3 milestones that a provider will report will be prescribed by HHSC. There will be two milestones for DY3 and either one or two for each measure for DY4 and DY5 depending on whether the selected outcome measure is P4P or P4R. Any Category 3 milestones (including process milestones) that the provider previously selected will go away, but the provider is encouraged to continue activities it had planned to do to support its Category 3 efforts and should include them in its semi-annual qualitative project reporting.

The terms “process milestone” and “achievement milestone” will be used to distinguish between milestones in DY3-5. Process milestones will be those milestones in which a provider is not earning its DSRIP payment based on reaching a goal achievement level, e.g. it will be used for reporting to specifications and stretch activities. Achievement milestones will be used for milestones for P4P measures and Population-Focused Priority measures in which the provider will earn funds based on progress towards a goal achievement level for the measure.

Pay for Performance (P4P) Measures

As referenced above, each of the Category 3 measures will have a designation of measure type. In cases where the measure type is P4P, providers will receive incentive payments for demonstrating improvements in rate performance towards an achievement target. Achievement targets are determined based on a provider's baseline performance in the measure and are calculated by one of the two methodologies described below.

In DY4, providers will receive 50% of their DY4 allocation for each P4P Category 3 measure for reporting the measure to specifications. As this is a process milestone, it is not eligible for partial payment, meaning that achievement on this milestone is all or nothing.

The remaining 50% of the DY4 allocation can be earned through an achievement milestone based on reported performance toward the goal achievement level. Partial payment can be earned for the achievement milestone as specified in the Program Funding and Mechanics Protocol.

- Providers may receive partial payment for making progress towards, but not fully achieving, an outcome improvement target (now "achievement milestone"). The partial payment would equal 25%, 50% or 75% of the achievement value of the outcome improvement target. Based on the progress reported, each outcome improvement target will be categorized as follows to determine the total achievement value percentage:
 - Full achievement (value = 1)
 - At least 75 % achievement (value = .75)
 - At least 50% achievement (value = .5)
 - At least 25% achievement (value = .25)
 - Less than 25% achievement (value = 0)

Both the process milestone and achievement milestone may be carried forward for late achievement in DY5.

In DY5, providers can earn 100% of their DY5 allocation for each Category 3 measure for demonstrating improvement toward the goal achievement level. Partial payment and carry forward for late achievement also apply for the year following DY5 (October 1, 2016 – September 30, 2017).

Quality Improvement System for Managed Care (QISMC): For those P4P measures where the improvement methodology is designated as QISMC, providers will receive incentive payments for closing the gap between their baseline performance and the benchmark rates listed. For DSRIP, we're using a hybrid of this system used for managed care, and the benchmarks are a proxy for performance based on national or state data and may not be an exact match to the population or delivery system for a DSRIP project. **If a provider, at

baseline, is performing above the high performance benchmark they are required to select another measure.**

The achievement level goal for DY4 will be determined as follows:

- IF a provider's reported baseline rate falls below the low performance benchmark (also called minimum performance level or MPL) the DY4 Achievement Target is equal to the rate listed for the MPL.
- IF a provider's reported baseline rate falls above the MPL but below the high performance level (HPL) benchmark, the provider must close the gap between baseline performance and the HPL rate by 10%.

The achievement level goal for DY5 will be determined as follows.

- IF a provider's reported baseline rate falls below the low performance benchmark (also called minimum performance level or MPL) the DY5 Achievement Target is equal to a 10% gap reduction between the MPL and HPL.
- IF a provider's reported baseline rate falls above the MPL but below the high performance level (HPL) benchmark providers must close the gap between baseline performance and the HPL rate by 20%.

Example:

IT-1.10 A1C poor control (>9%)			MPL = 50.7%	HPL = 28.95%
Baseline performance	DY4 Achievement Target (goal)	DY5 Achievement target (goal)	DY4 performance/ payment	DY5 performance/ payment
Scenario 1: 63.4%	50.7% (= MPL)	48.53% = MPL – ([HPL-MPL] X 10%)	53.4%: 78% achievement towards goal- earns 75% of allocation	47.50%: 100% achievement towards goal- earns 100% of allocation
Scenario 2: 36.7%	35.93% (= (baseline - HPL) x 10% improvement over baseline)	35.15% (= (baseline - HPL) x 20% improvement over baseline)	35.50%: 100% achievement towards goal- earns 100% of allocation	35.40%: 84% achievement towards goal- earns 75% of allocation

Improvement over Self (IOS): There are some P4P measures where QSMIC appropriate benchmarks (HPL and MPL) are not available. For these P4P measures, the improvement methodology is designated as “IOS”, or Improvement over self, providers earn incentive payments for demonstrating improvement over baseline performance.

The achievement level goals will be determined as follows:

- DY4 achievement level goal is equal to 5% improvement over the provider’s baseline
- DY5 achievement level goal is equal to 10% improvement over the provider’s baseline

IT-1.9	Depression Management: Depression Remission at 12 months			No benchmark information available
Baseline	DY4 Achievement target (goal)	DY4 performance/payment	DY5 Achievement target (goal)	DY5 performance/payment
40.25%	45.25% (baseline + 5% improvement)	47.5%: 100% achievement towards goal - earns 100% of allocation	50.25% (baseline + 10% improvement)	48.5%: 83% achievement towards goal - earns 75% of allocation.

Pay for Reporting (P4R) Measures

In cases where the selected measure type is P4R, providers will earn incentive payment for successfully reporting the measure to specifications in DY4 and DY5 and engaging in an 'alternate improvement activity' in DY5.

All P4R measures require prior authorization for use. Prior authorization will occur during the initial HHSC review process after providers have submitted their selected measures. This Prior Authorization will determine a) if the measure was a previously selected by the provider and was approved for use (if so, this serves as the authorization) and b) if not previously approved, whether there is a P4P measure that would be an appropriate fit for the project that the provider can report to specifications.

In DY4 providers will earn 100% of the DY4 allocation for each P4R measure for reporting it to specifications. This process milestone can be carried forward but is not eligible for partial payment.

Alternate Improvement Activities: In DY5, providers will earn 50% of the DY5 allocation for reporting the P4R measure to specifications and the remaining 50% for demonstrating improvement in an 'alternate improvement activity'. Providers can find a list of these alternate improvement activities on the waiver website.

For Hospital, Community Mental Health Center, and Academic Health Science Center Physician Group provider types, providers should select an outcome from the Population-Focused Priority measure list. These outcomes do not have to be tied to the associated Category 1 or 2 project and instead represent a larger health priority for the health system. These measures will follow the improvement methodology specified for the outcome measure (QISMC or IOS) as described for P4P measures above - 20% gap reduction between baseline and HPL for QISMC in DY5 or 10% improvement over baseline for IOS in DY5. In DY5 providers will demonstrate goal achievement for this achievement milestone, which is eligible for partial payment.

For Local Health Department providers and for those providers above who cannot identify a measure to report from the Population-focused priority measure list, providers may select from the 'Stretch Activities'. These activities are intended to improve data infrastructure and capacity. In DY5 providers will report completion of the stretch activity. As a process milestone, stretch activities are eligible for carry forward but are not eligible for partial payment.

Category 3 Outcome Review Process

Providers will submit outcome selections through the Provider Selection Tool, no later than March 10th 2014, in order for a provider to begin to earn DY3 Category 3 funds in the April reporting period. If a provider needs more time, the deadline for submission of the selection tool is March 31, 2014 and the provider will be unable to earn any DY3 Category 3 funds in the April reporting period. A provider must choose either the March 10th deadline or March 31st deadline for all of its projects. HHSC will begin review starting with those measures that require prior authorization.

For the prior authorization process HHSC will determine if:

- 1.) The outcome selected is the most appropriate for the project and there is not another outcome that would also be appropriate for the project.
- 2.) If the outcome was previously approved for use by CMS.

HHSC and CMS will use information from providers for review of the prior authorization measure, which will become a part of the official submission of the Category 3 outcome.

After completing the review of the prior authorization measures, HHSC will begin review of all other outcomes. HHSC will be reviewing the associated Category 1 or 2 projects to determine fit of the outcome, provider rationales for selection, use of denominator subsets and selections for Alternate Improvement Activities- Population-Focused Priority measures and Stretch Activities. **When possible providers should select a Population-Focused Priority measure instead of a Stretch Activity.

HHSC will provide feedback to providers or request additional information to inform the review.

Many providers will not have received official approval by the April 2014 reporting period. As such, providers will submit the April Status update based on the outcomes submitted. Providers will receive feedback from HHSC with adequate time to collect and report baseline rates and submit those rates in October reporting.

Category 3 Reporting

DY2 Achievement Carried Forward into DY3

For those providers that carried forward DY2 achievement into DY3, providers must still meet the requirements for achievement.

It is highly recommended that providers in this situation submit a DY2 Category 3 status report in April along with DY3 status report. The submission of this DY2 status report will fulfill requirements for all Category 3 process milestones in DY2. Providers should use Category 3 identifying information preceding the most recent selections - Project IDs and historical IT reference numbers - to complete the DY2 template. The outcomes selected in March 2014 only apply to DYs 3-5.

DY3 Reporting

In **April**, providers that submit their Category 3 measures no later than March 10, 2014, will submit a status update for each Category 3 measure selected during the March 2014 selection process. The template for this April reporting period will be available on the Waiver website. The intention of this status report is to report understanding of the measure specification, denominator populations, planning for the Alternate Improvement Activities and any technical assistance needs. Providers will earn 50% of their DY3 allocation for the Category 3 measure for successful submission of this April Status report. Providers may opt to delay reporting of this process milestone until the October 2014 reporting period or even carry achievement of this process milestone forward into DY4, although this is not recommended if the provider does have technical assistance needs.

In **October**, to earn 50% of their DY3 allocation for Category 3, providers will submit and validate their baseline rates for each of the selected, and by then approved, Category 3 outcome measures. Validation requires a statement from the provider's head quality officer (or other designee as identified by the provider and responsible for data integrity) to certify that baseline rates are collected per the approved measure specifications and reflect an accurate baseline rate for that outcome. HHSC will provide an excel template for this baseline submission. Also in October, providers that submit their Category 3 selections between March 11 and March 31, 2014, may submit a status template to earn the other 50% of their DY3 Category 3 funds.

For those providers whose selected outcome type is Pay For Reporting) (P4R), the provider must establish the baseline rate both for the P4R measure and for any associated Population-Focused Priority Measures. In order to earn the 50% of the DY3 allocation for establishing the baseline, a provider must submit the baseline information for the Category 3 P4R measure. The baseline information for the Population-Focused Priority measure will not be tied to this payment, but must be submitted prior to reporting achievement and may be submitted in October.

For P4P measures, these baseline rates will be used to determine achievement targets (goals) for DY4 and DY5 for each measure. For Population-Focused Priority measures, the baseline rates will be used to determine the achievement goal for DY5.

Requesting exemption from standard achievement setting methodology

During the submission of October baseline rates, providers will be able to request to deviate from the Standard Achievement setting methodology (QISMC or IOS) in extenuating circumstances. This is intended for those Category 1 or 2 projects that are serving a population that is not adequately reflected in the approved Category 3 denominator (full or subset) and feel that standard achievement targets for DY4 and DY5 are not reachable. Policies and requirements for this request are under development with CMS. At a minimum, providers will be required to report the proportion of Category 1 or 2 QPI to Category 3 denominator and a rationale for why the deviation is warranted.

DY4 reporting

As previously discussed, reporting in DY4 will vary depending on the type of outcome selected (P4P or P4R).

Measure and performance type	Milestone type and % fund allocation	Successful Achievement
P4P – QISMC	Process Milestone (PM) - 50% allocation Achievement Milestone (AM) - 50% allocation	PM - accurate reporting of DY4 rate per approved measure specifications. AM - achievement of DY4 goal (MPL achieved or 10% gap reduction between baseline rate and HPL benchmark)
P4P- IOS	Process Milestone (PM) - 50% allocation Achievement Milestone (AM) - 50% allocation	PM - accurate reporting of DY4 rate per approved measure specifications. AM - achievement of DY4 goal (5% improvement over baseline rate)
P4R	Process Milestone (PM) - 100% allocation	PM - accurate reporting of DY4 rate per approved measure specifications.

DY5 reporting

DY5 reporting will vary depending on the type of outcome selected (P4P or P4R) as well as the type of Alternate Improvement Activity selected.

Measure and performance type	Milestone type and % fund allocation	Successful Achievement
P4P - QISMC	Achievement Milestone -	AM- achievement of DY5 goal

	100% allocation	(improvement over MPL goal by a 10% gap reduction between MPL and HPL or 20% gap reduction between baseline rate and HPL benchmark)
P4P – IOS	Achievement Milestone - 100% allocation	AM- achievement of DY5 goal (10% improvement over baseline rate)
P4R	Process Milestone - 50% allocation <u>Alternate Improvement Activity</u> – 50% allocation for Achievement Milestone for Population-Focused Priority Measure improvement OR Process Milestone for Stretch Activity	PM - accurate reporting of DY5 rate per approved measure specifications. AM - for Population-Focused Priority measures- achievement of DY5 goal OR PM- successful reporting of Stretch Activity

Reporting Outcomes as a Component of required Semi-Annual Reporting for Category 1 and 2 projects. Providers are encouraged to track outcomes in their intervention population to demonstrate effectiveness of the Category 1 and 2 projects. As the Category 3 outcomes generally will measure a population broader than the intervention population, providers should include any relevant outcome improvements in the intervention population within the required semi-annual report sections for each of the measures. Providers may wish to address the following questions.

- 1.) What are the baseline and/or DY performance rates in the selected Category 3 outcomes for those individuals that were in the *Category 1 or 2 project (intervention) population*?
- 2.) What are the baseline and/or DY performance rate in the selected Category 3 outcomes for those individuals that were in the *Category 1 or 2 target population*?
- 3.) Describe any differences in the Category 3 denominator populations and the intervention and target populations. What are these differences attributed to (assuming the difference is the effects of the intervention, what in the intervention led to the differences)?
- 4.) Within the intervention population are there differences in effects between sub-groups that can be attributed to intervention activities?

Additional Tools and Resources for Providers

- Webinar from February 4, 2014 – The presentation is on the Waiver website and the recording will be posted as soon as possible. In addition to a summary of the information in this companion document, contains questions and answer session.
- Master measures list - An excel file containing all measures included in Category 3, the associated reference numbers, brief summary of measure specifications and benchmarks (when relevant). This excel document is a condensed version of the Compendium document.
 - As of February 25, 2014, there are some mismatches of outcome IDs between the master measures list posted on the website and an abbreviated master measures list (brief) distributed via Anchors. The brief list matches the outcome IDs in the selection tool, and the list on the website will be updated to match the numbering in the brief list as soon as possible.
- Compendium - This will be published separately from the RHP Planning Protocol (for timing purposes to facilitate outcome selection) but will be an appendix to the RHP Planning Protocol. This document includes detailed measure specifications, performance benchmarks, and measurement periods.
- Tools appendix - Describes guidelines for use - administration, scoring, intended populations of use - of all tools referenced in OD-6 (Patient Satisfaction), OD-10 (Quality of Life) and OD-11 (Behavioral Health Assessment Tools). This will be an appendix to the RHP Planning Protocol.
- Provider selection tool - The template that providers will use to select Category 3 outcomes for all Category 1 or 2 projects. HHSC will also use this tool to conduct reviews of selected outcomes.
- RHP Planning Protocol - This document will contain a description of the Category 3 Framework, a listing of the approved measures, the measure (SA/NSA) types and performance types (P4P/P4R). In addition, Alternate Improvement Activities and target setting methodologies will be described.
- Program Funding and Mechanics (PFM) Protocol – Describes DSRIP financial and programmatic requirements and will be updated to reflect the revised Category 3 framework.
- One pagers - Based on feedback received from the field during the request in January 2014 for comment from providers, HHSC is producing a series of one-pagers to offer additional guidance on specific measurement concepts. Currently under development is guidance around risk adjusting, outcome denominator, and the 3M Methodology for Category 4 rates being produces by the Texas EQRO.
- TA requests
 - Anchors may coordinate technical assistance (TA) requests. HHSC will provide a template for submission of questions and will schedule a time to provide TA via phone to each RHP.
 - Providers also may submit questions in email to the Waiver inbox at TXHealthcareTransformation@hhsc.state.tx.us. Providers are also encouraged to reach out to Anchor entities, provider associations and other

performing providers for assistance with data collection and measure interpretation.

Completing the Category 3 Selection Tool

Providers will indicate their Category 3 outcome selections within the Excel template provided by HHSC. This tool is referred to as the Category 3 Provider Selection Tool and is posted on the Waiver website. This document describes the contents of and how providers should use this selection tool. This is the only mechanism for providers to select and submit Category 3 outcome measures for review and approval.

When providers have completed the Excel workbook for all projects contained within the tool, providers should email this file to DSRIP@Deloitte.com and cc their Anchor. **If a provider plans to report during the April reporting period on the process milestone for the DY3 “Category 3 Status Update,” this workbook must be submitted to the Deloitte email above no later than midnight on March 10th (Monday).** If more time is needed to complete all sections of this workbook, providers may submit the selection tool no later than midnight on March 31st (Monday) to the same Deloitte email address listed above (and cc their Anchor) but will forgo the ability to report on Category 3 for DY 3 during the April Reporting Period. Providers should inform HHSC and their Anchor if they will be submitting March 31st.

Providers must complete all sections of the tool (detailing Category 3 selections and Category 3 valuation for each of the Category 1 or 2 projects) prior to submission. When all the submission requirements have been completed, the Progress Report Tab shows a green “Complete.” **Partially completed workbooks will not be accepted.** (The only exception to this is for those projects with a single measure for OD-5 Cost of Care. In OD-5, measures are considered stand-alone only if the associated project area is 2.5 - Redesign for Cost Containment. The Selection tool defaults the designation of measures from OD-5 as Non-standalone (NSA) so providers will not receive a "Complete" on the Cat 3 Historical Valuation tab for the section labeled Min 1 SA or 3 NSA outcomes. HHSC will manually change these outcomes to Standalone for project in area 2.5 during the review process.)

Providers should fill out all yellow cells (enable macros if needed) to complete the tool. If a provider is copying and pasting information from a different source, they should copy and paste “values.” In the past, some providers copied from another document, which causes problems with the file formatting/formulas.

The Provider Selection Tool is replacing the Category 3 narratives as it contains much of the same content. This template will contain historical information of prior Category 3 valuation, outcomes selected, and IGT entities. The tool will also allow providers to verify, replace or delete prior selections as well as update Category 3 funding allocations and include detail and rationale for each outcome selected. Each provider will use one template, which will contain Category 3 outcomes measures associated with all of the Category 1 or 2 projects - including approved 4-year projects, replacement projects and 3- year projects. For those replacement projects and 3-year projects that have not yet been approved, the Category 3 selections will be contingent on approval of the associated Category 1 or 2 project.

Instructions for using the Selection Tool

Providers should use this section of the companion to fill out the Selection Tool. Providers should also have the most recently approved copy of the Category 1 or 2 project narratives and tables created from Phase 4 revisions, revised Category 3 Master menu, Population Focused Priority Measures and Stretch Activities available to facilitate the selection process.

Navigate to the Waiver website and download/save a copy of the Category 3 provider selection template. (<http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml>). To ensure full file functionality (drop down lists, etc.), please note the following system requirements:

- Do not use a Mac to open the file.
- Use Excel version 2010 or newer. (If this is not possible, providers may email the box and HHSC will provide a tool that will be compatible with Excel versions 2007 or earlier.)

Save this file with the following file naming convention:

Category 3 Selection. TPI. Provider Name. MM.DD.YY

- I) **Create Provider's Category 3 Selection Tool-**
 - a) Open the template. The first tab includes four sections. The first section is a progress tracker for this tab. The fields in this section will turn green and indicate complete as the provider fills out this tab.
 - b) Please check that macros have been enabled by going to **File< Options< Trust Center< Trust Center Settings< Macro Settings<**. You may need to close out of Excel fully and reopen Excel for the formulas to calculate automatically. You may also enter F9 for the workbook to calculate formulas.
 - c) In the second section providers will populate the yellow cells with contact information for the individual submitting this tool. All fields in this section must be populated.
 - d) In the third section, providers will use the drop down list to select RHP as well as provider TPI. This selection of TPI creates the provider-specific content for the subsequent tabs. The TPI included is based on the project IDs and not the updated TPI the provider has submitted for payment purposes.
 - e) The last step for this tab is to click the button in the fourth section to create the Category 1 or 2 Outcome tabs. This step may take a few moments to complete. When the creation of the outcome tabs is complete, the progress indicator at the top of this first tab will turn green and indicate complete. Providers may now move on to the next tab- **Cat 3 Historical Valuation**.

- III) **Review Category 3 Historical Valuation and outcome selections. Indicate which outcome measures will be selected for each of the listed Category 1 or 2 projects.**

- a) Navigate to the second tab called **Category 3 Historical Valuation**. In the first section is a progress tracker specific for this tab which will indicate 'Complete' when provider has populated all of the required cells.
- b) In the second section of this tab- **Provider information**- there are no fields for providers to populate. There is a button in this section that will clear any inputs made by the provider to this tab. If providers clear inputs, providers will have to re-fill out this tab.
- c) The third section of this tab - **Historical Category 3 Allocation Amount**- does not require provider input and is used to demonstrate how the total Category 3 funding as well as the DY3 - DY5 total values were determined. This represents all dollars associated with all Category 3 outcomes for all of the provider's Category 1 and 2 projects. The provider allocated these funds to Category 3 to meet minimum funding requirements when it submitted its projects.
- d) The next section on this tab- **Historical Project and Outcome Data**- includes a listing of outcomes previously selected for each Category 1 or 2 project, any relevant Phase 1 comments and the Category 3 allocation previously associated with the specific Category 3 project. In this section, the provider will need to indicate if it is retaining, selecting new or deleting each of the Category 3 outcomes associated with each Category 1 or 2 project. The provider will indicate this in the yellow cell by using the dropdown list to select 'Retain', 'Select New' or 'Remove.' For the first project this is found in row 72. If the provider opts to select new IT (replacing the outcome measure historically selected) the next rows will include a drop down of the Category 3 Outcome Domains (1-15) as well as IT reference numbers for the Category 3 outcomes in the selected domain. Providers should first select the Outcome Domain and then the IT reference number for the selected measure. Providers should refer to the revised Category 3 menu to assist with outcome selection as some measures have been renumbered during the revisions to Category 3. If an outcome measure has been renumbered, and the provider wishes to continue to use that outcome, the provider must "Select New" and input the revised number for the measure.

****Of note, previously selected outcomes that are no longer on the Category 3 menu (such as "Other") will need to be replaced or deleted. If you retain these outcomes, your subsequent tabs may display with a different outcome, matching by IT reference number of the revised menu, or will display an error.**

- e) Providers also have the option to add up to three additional outcomes beyond the number that was historically selected for each Category 1 or 2 project. Providers must also enter the number of additional outcomes (1-3) under "If Yes, how many?" Providers indicate these in the cells (cell N:59 for the first project). For each Category 1 or 2 project, providers will have to indicate that either 'Yes' additional outcomes are needed or 'No' no additional outcomes needed. These selections will populate the subsequent tabs where providers will include additional detail specific to each of these newly selected outcomes. IF providers opt to add additional outcomes, the tool will automatically assign a Category 3 project ID. Providers will select the Outcome Domain and IT reference number using the drop down lists.

- f) Within each of the Category 1 or 2 projects, providers will see a section confirming that each of the projects has at least one stand-alone or 3 non-standalone outcome measures selected.
- g) Providers must complete the steps above for each outcome in each of the Category 1 and 2 projects listed on this tab. If you go back and change your selected Category 3 or add a new Category 3 to a particular Category 1 or 2 project, the data in the Category 3 tab for that Category 1 or 2 project will be cleared.
- h) Once the provider has populated all of the yellow cells in this tab to indicate whether each outcome will be retained, replaced or deleted and whether additional outcomes will be added, the progress tracker at the top of the page will turn green and state "Complete." The provider may then move onto the next tab.

IV) <Category 1 or 2 project ID> Outcome detail

- a) Based on the selections from the Historical Project and Outcome data, this page will be populated with some of the details around the selected outcome(s).
- b) For each of the Category 3 outcome measures selected the following details will be populated: Outcome domain (1-15), prior authorization required (Yes/No), performance type (P4P or P4R), measure type (SA/NSA), setting (ambulatory, inpatient, both, emergency department), measure description, numerator and denominator. *****These measure specifications are a brief summary and providers can refer to the compendium document for complete information to ensure that they can meet data collection requirements as detailed by the measure specifications for the selected measure(s).**
 - i) **If the performance type of the selected measure is P4R**, the provider will need to complete the section called '**Alternate Improvement Activities for P4R measures**'. Provider will use the series of drop down menus to indicate which type of Alternate activity will be used to fulfill the improvement component for this P4R measure- either Population Focused Priority Measure or Stretch Activity. Once the provider makes this distinction, the provider will be able to choose the specific Population Focused Priority measure or Stretch Activity from the drop down list. ****Providers that are able to report a Population Focused Priority measure should opt to do this instead of selecting a Stretch Activity.** This will be reviewed by HHSC and CMS.
 - ii) **If the performance type of the selected measure is P4P**, a section called **Target Setting Methodology** will be visible. There is no required provider entry in this section; however providers may use it to estimate baseline performance to approximate DY4 and DY5 Achievement targets. Providers may opt to populate these estimated baselines for the full denominator as well as denominator subsets. IF a provider has opted to use a subset, the inclusion of an approximate baseline for full denominator as well as subset denominator may be helpful during the HHSC review process. ****Provider should be aware that benchmarks are continuing to be updated and any baseline estimates providers include in this section do not represent baseline submission.** Rather, this is a tool for providers to see how goals will be calculated.

- c) Moving down, the first required entry for providers in this section is the designation of denominator subsets. Providers must indicate whether or not they are requesting the use of a denominator subset. If yes, a section specific to denominator subsets will be available for providers to populate which subset(s) will be used, include a description of what this subset denominator will capture as well as the rationale for the selection of a subset.

****Important considerations for the use of denominator subsets.**

- 1.) Subsets are intended to allow providers to systematically narrow the full denominator described in the specifications to reflect an intended target population of the associated Category 1 or 2 project.
- 2.) Provider use of a subset must be justified by the Category 1 or 2 project narrative description of the target population.
- 3.) Providers may create a subset on the basis of: Payer (Medicaid, Uninsured or both), Gender, Age, Co-morbid condition, Facility where services are delivered and Race/Ethnicity. While the dropdown box only allows a provider to select one denominator subset, if a provider seeks to narrow the denominator by more than one factor (e.g. gender and age), then the provider should note this in the narrative cell below the dropdown cell that asks for a description of the subset denominator.
- 4.) Denominator subsets must still be applicable to the intention of the measure. For example, a provider may use an age subset for a pediatric based number; however, the ages must still fall within the range referenced by the measure specifications.
- 5.) Providers should be aware that the same benchmarks will be applied to these denominator subsets.
- 6.) HHSC will review all denominator subsets to ensure that the denominator described reflects a target population of the project instead of the intervention population.

- d) Provide rationale for outcomes selected. Providers will need to include a narrative to describe why the outcome selected is an appropriate fit for the project. This rationale will be of great importance during the HHS/CMS review and approval process and replaces the rationale section previously included in the Category 3 project narrative. It is highly recommended the provider address the following questions within this rationale.

- 1.) How does this outcome reflect the impact of the project intervention? Specifically, why is this outcome an appropriate fit for the Category 1 or 2 project?

- 2.) How will changes in the intervention population be reflected in improvements in this outcome? Specifically, how does the selected denominator encompass the intervention population?
- 3.) How is this selected outcome related to any of the other outcomes selected for this associated project?
- 4.) IF the measure type is P4R, how does the selected Alternate Improvement Activity reflect a system priority (for Population Focused Priority measures) or a needed improvement to data infrastructure or capacity (for Stretch Activities)?
- e) Indicate if there is potential overlap between this Category 3 outcome and any of the Category 1 or 2 project milestones. Providers should review the associated Category 1 or 2 project tables from the Phase 4 revisions to identify any potential areas of overlap or duplication. In many cases, overlap may be acceptable. In cases of overt duplication, providers will have the opportunity to make changes to the Category 1 or 2 project milestones during the next plan modification process for DY4 and DY5 (in June/July 2014). HHSC will work with those providers who indicate 'Yes' for potential overlap to ensure that there is no duplication in DY4 and DY5. To be clear, potential overlap will not cause a Category 3 project to be not approved. More, it is a mechanism for HHSC to clearly identify which providers may need additional assistance.
- f) Indicate whether provider will be able to report a baseline rate for this outcome in October 2014. Providers should indicate yes, no or unsure to this question. IF yes, providers should select the baseline measurement period they anticipate using from the drop-down list. Provider may also select 'Other' from this drop down and propose another baseline measurement period, ensuring to include a description of length of measurement period (6 or 12 months) and over what DY or CY.
- g) Include any additional comments to be reviewed by HHSC. If no additional comments you must enter NA in this field.

Providers will need to follow the steps above for each outcome measure selected for an associated Category 1 or 2 project as well as for each of the <Category 1 or 2 project ID> Outcome Detail tabs. When the provider has completed all of the required sections within a given tab, the progress tracker at the top of the tab will turn green and state "Complete".

- V) **Cat 3 Valuation-** This tab contains all of the provider's Category 1 or 2 projects as well as the associated Category 3 outcome measures. Providers will allocate Total Category 3 funds, based on % allocations, to each Category 1 and 2 project.
- a) This tab has defaults for an equal allocation of the total Category 3 Allocation to each of the Category 1 and 2 projects. In the second section (yellow cells) providers may change these percentages ensuring that the following requirements are met.

1.) The minimum amount for % allocation for any given Category 1 or 2 project can be no less than 50% of the default percentage listed. Put another way, each Category 1 or 2 project must have an allocation no less than 50% that the allocation would be if all of the Category 1 and 2 projects have an equal allocation of Category 3 funds.

2.) The percentages across all of the Category 1 or 2 projects must equal 100%.

3.) If the above minimum % by project does not allow a provider to allocate its Category 3 funds proportionally across its Category 1 and 2 projects based on their relative valuation (which may occur in instances where a provider has projects with valuations that differ greatly), the provider should contact HHSC for technical assistance with this tab of the selection tool.

- b) Once the provider has indicated the % allocation for the Category 1 or 2 projects the DY3, 4 and 5 amounts for each of the outcomes associated with that project will be automatically calculated, with an equal distribution of the allocation to each of the outcomes. This will be displayed in the next section on this tab called Project Specific Valuation tracking.
- c) Providers must indicate the number of IGT entities associated with each Category 3 outcome project regardless of whether the number of IGT entities has changed.

Once the providers have met all to the requirement for valuation for all of the Category 1 or 2 projects and have indicated the number of IGT entitles for each of the Category 3 project, the progress tracker at the top of this tab will turn green and indicate 'Complete'.

VI) **Cat 3 IGT data-** This section lists the IGT Entities funding the Category 3 projects and calculates the IGT needed for each of the Category 3 projects broken down by DY. Providers may update the yellow cells as needed. If providers are including a new IGT entity for any of the Category 3 outcomes or have added more outcomes, then they must populate the pink cells with the IGT name, TPI, TIN, affiliation number, and percent IGT allocation for each DY. The percent IGT allocations for each Category 3 outcome must add up to 100%. Any changes made to the IGT information will turn the cell to a light green. The FMAP used to calculate IGT needed are :DY3 - 58.69, DY4 - 58.05, and DY5 - 58.05.

The provider has now completed the process for Category 3 outcome selections. Providers should refer to the last tab - Progress Report - to ensure that all requirements are met for each of the tabs.

******In order to be able to earn a portion of Category 3 DY3 funds in the April 2014 reporting period, providers will submit this completed template for all Category 1 and 2 projects to Deloitte no later than Midnight (CST) on March 10, 2014. Otherwise, the completed template must be submitted to Deloitte not later than Midnight (CST) on March 31st. Submissions**

should be emailed to DSRIP@Deloitte.com with a cc to the Anchor. Email subject lines must follow this format: TPI. Provider Name. Category 3 Selection Tool. Date of submission.

If a provider chooses to delay template submission until the March 31st deadline, the provider should inform HHSC of this fact via email to the waiver mailbox (txhealthcaretransformation@hhsc.state.tx.us) with a cc to the Anchor.