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Services

DSRIP DY7-8

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June 21, 2017**

Overview*



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- Key Changes to the Program Funding and Mechanics (PFM) Protocol
- Overview of Measure Bundle Protocol
 - Category B: System Definition
 - Category C: Selection, Valuation, and Eligible Denominator Populations
- Estimated Timeline
- Questions

* All proposals are contingent on the outcome of CMS negotiations.

Key Changes to PFM Protocol

Based on stakeholder feedback and leadership direction, HHSC made changes to the following:

- RHP Plan Update Submission Timeline
- Category Funding Distribution, including the Private Hospital Participation Regional Incentive
- Costs and Savings Requirement
- Category C Requirements, including the Minimum Point Threshold (MPT)
- Remaining Unused Funds
- Reporting and Carryforward



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RHP Plan Update

- HHSC updated the RHP Plan Update due date from November 30, 2017, to January 31, 2018.
- This allows additional time for Performing Providers to review CY2017 baseline data if they prefer prior to selecting Measure Bundles and no longer overlaps with October DY6 reporting.
- The targeted HHSC approval date remains as March 31, 2018.

Category Funding Distribution



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- HHSC shifted 20 percent of a Performing Provider's total valuation for demonstration year (DY) 7 from Category C to submission of the RHP Plan Update.
- The private hospital participation regional incentive was also increased from a maximum of 10 percent of total valuation in Category D to 15 percent.

| | DY7 | DY8 |
|----------------------------|-----------|-----------|
| RHP Plan Update Submission | 20% | NA |
| Category A | 0% | 0% |
| Category B | 10% | 10% |
| Category C | 55 or 65% | 75 or 85% |
| Category D | 15 or 5% | 15 or 5% |



Costs and Savings

- HHSC limited the Category A - Costs and Savings requirement to Performing Providers with a total valuation of \$1 million or more per DY.
- These Performing Providers must select at least one core activity of the Performing Provider's choice to submit costs and forecasted or generated savings.



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Category C Requirements

- HHSC added optional measures to Measure Bundles rather than requiring all measures within a bundle to be reported.
- Performing Providers have flexibility in distributing valuation among Measure Bundles/Measures as described in the PFM.
- Selected Measure Bundles/Measures must meet minimum denominator size requirements.
- Performing Providers must select at least one "standalone" Measure Bundle or "standalone" measure (3 point measure).
- Delayed and shortened baseline measurement periods may be requested and subject to HHSC approval.



MPT Calculation

- A Performing Provider's MPT is calculated based on:
 - DY7 total valuation
 - Standard point valuation of \$500,000
 - MPT cap of 75 for hospitals and physician practices
 - MPT cap of 40 for community mental health centers (CMHCs) and local health departments (LHDs)
 - Medicaid and uninsured inpatient days and outpatient costs (hospitals only)



Remaining Unused Funds

- Based on HHSC review of stakeholder feedback and leadership direction, the remaining unused funds are allocated to RHPs that did not fully utilize their original regional allocation.
- These RHPs may determine how to allocate the additional funds to new and existing Performing Providers based on the community needs assessment.
 - Each RHP must conduct at least 2 public stakeholder meetings.
 - Each Performing Provider must certify that there is IGT for the additional funding.

| RHP | Additional Regional Allocation per DY |
|--------------|---------------------------------------|
| RHP 1 | \$866,635 |
| RHP 2 | \$2,308,000 |
| RHP 4 | \$522,345 |
| RHP 5 | \$4,797,112 |
| RHP 8 | \$5,739,571 |
| RHP 17 | \$9,284,861 |
| RHP 18 | \$1,318,286 |
| RHP 20 | \$4,062,821 |
| TOTAL | \$28,899,632 |



MLIU PPP Reporting

- Category B - Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP) may be reported in the last reporting period of each DY or the first reporting period of the next DY.
 - For example, DY7 MLIU PPP may be reported in DY7 Round 2 - October 2018 or DY8 Round 1 – April 2019.
- The MLIU PPP requirement is to maintain or increase the number of MLIU individuals. HHSC removed the previous MLIU PPP requirement to maintain the ratio of MLIU individuals to total individuals.



Category C Carryforward

- Carryforward of achievement was added:
 - DY7 goal achievement may be achieved in PY1 or PY2.
 - DY8 goal achievement may be achieved in PY2 or PY3.
 - The carried forward achievement must be reported in the first reporting period after the end of the carried forward measurement period.
 - For measures with a delayed baseline measurement period, DY8 carried forward goal achievement may be reported in DY9.



DY7-8 Reporting

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| | Category A | Category B | Category C | | | | | Category D |
|-------------|----------------------|-----------------|--|--|--|--|---|----------------------|
| | | | P4P Measures | | | | P4R Measures | |
| DY7 Apr | | | DY7 Baseline - CY17 | | | | | DY7 Category D |
| DY7 Oct | DY7 Category A | DY7 MLIU PPP | | | | DY7 Delayed Measurement Period (DMP) Baseline - ends by 9/30/18 | | |
| DY8 Apr | | | | DY7 Goal Achievement - PY1 CY18 | | | DY7 or DY8 DMP Goal Achievement - PY2 ends by 9/30/19 | |
| DY8 Oct | DY8 Category A | DY8 MLIU PPP | | | | | DY8 RY2 Measure | |
| DY9 Apr | | | DY7 Carryforward Goal Achievement - PY2 CY19 | DY8 Goal Achievement - PY2 CY19 | | DY8 DMP Carryforward Goal Achievement - PY3 ends by 9/30/20 | | |
| DY9 Oct | | | | | | | | |
| DY10 Apr | | | | DY8 Carryforward Goal Achievement - PY3 CY20 | | | | |

Overview of Measure Bundle Protocol

- Category A: Core Activities, Alternative Payment Models, Costs & Savings, Collaborative Activities
- **Category B: System Definition***
- **Category C: Measure Bundles***
- Category D: Population-Focused Improvements

*Today's webinar focuses on Categories B&C



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Category A



Category A

Reported during the second reporting period of each DY to be eligible for payment for Categories B-D:

- Core Activities
- Alternative Payment Methodologies (APM)
- Costs and Savings
- Collaborative Activities



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Category B

System Definition

- A participating provider's system definition is intended to reflect the universe of patients served by a performing provider and should incorporate all components of its organization that serve patients.
- There are required and optional components of a performing provider's system definition for each provider type participating in DSRIP.
- The required components are considered essential functions and/or departments of the provider type, what is referred to in the PFM as "base unit."



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System Definition

- Required components must be included in a performing provider's system definition if the organization has that business component.
- Optional components may be added to the system definition and Category B patient count, including contracted partners and "other".
- Providers should consider data availability when defining their system definition.

Draft System Components (Pt 1)



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| | Required* | Optional |
|----------------------------|--|-------------------------------------|
| Hospitals | Inpatient Services | Contracted Specialty Clinics |
| | Emergency Department | Contracted Primary Care Clinics |
| | Owned Outpatient Clinics | School-based Clinics |
| | Maternal Department | Contracted Palliative Care Programs |
| | Homeless Program | Contracted Mobile Health Programs |
| | Urgent Care Clinics | Other |
| | | |
| Physician Practices | Owned or Operated Primary Care Clinics | Contracted Specialty Clinics |
| | Owned or Operated Specialty Care Clinics | Contracted Primary Care Clinics |
| | Owned or Operated Hospital | Contracted Community-based Programs |
| | | Other |

* Required only if the performing provider has the business component.

Draft System Components (Pt 2)



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| | Required* | Optional |
|--|--|---------------------|
| Community Mental Health Centers | State-funded Community Hospital | Home-based services |
| | Community Institution for Mental Disease (IMD) | Contracted Clinic |
| | General Medical Hospital | School-based Clinic |
| | Hospital | Other |
| | Office/Clinic | |
| | State Mental Health Facility | |
| | State Mental Retardation Facility | |
| | | |
| Local Health Department | Clinics | Mobile Outreach |
| | Immunization Locations | Other |

* Required only if the performing provider has the business component.



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Category C

Category C Agenda

- Category C Menu Development
- Category C Selection Requirements
- Category C Valuation Requirements
- Eligible Denominator Population

Parking Lot (items for next time):

- *Measurement Periods*
- *Measure Specifications*
- *Goal Calculation*



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Category C Overview

- Category C builds on pay-for-performance quality measures from Category 3 in DY2-DY6.
- Hospitals and physician practices will select Measure Bundles from the Measure Bundle Menu.
 - Measure Bundles have both required and optional measures.
- CMHCs will select measures from the CMHC Menu.
- LHDs will select measures from the LHD Menu.



Category C & MPT

Measure Selection

- Hospitals and physician practices must select Measure Bundles worth enough points to meet the Minimum Point Threshold (MPT).
- CMHCs and LHDs must select measures worth enough points to meet the MPT.



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Hospital & Physician Practice Bundle Development Process

- Measure Bundles align with common and successful project areas from DY2-6 as determined by the Clinical Champions in developing the Transformational Extension Menu.
- HHSC worked with Bundle Advisory Teams (BATs) consisting of over 100 clinicians from across the state in a 6 week iterative consensus building process to develop the Measure Bundles.
- Measures were taken from existing common Category 3 measures from DY2-6, CMS Consensus and Core Sets, MACRA MIPS QPP measures, and measures submitted by BAT members.
- Most measures from the MCO P4Q Program are included in the Category C Measure Bundle Menu.



CMHC & LHD Menu Development Process

- HHSC worked with the Texas Council of Community Centers, CMHC providers, and LHD providers to develop the list of measures for the CMHC and LHD Menus.
- Where possible, HHSC encourages alignment of measures across the Measure Bundles, CMHC, and LHD Menus.
- *Both CMHCs and LHDs may request in the stakeholder feedback survey to add specific measures from the Measure Bundle Menu to the CMHC or LHD menus as appropriate.*

Measure Overview

- There are 144 measures in the draft menu.
- All measures are P4P unless specified as an innovative measure.
- Some measures are included in multiple bundles.
- Some measures are included in both the Hospital and Physician Practice Measure Bundle Menu and the CMHC or LHD menus.
- Specifications will be updated for DY7/DY8.



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Measure Points

Each measure is assigned a point value based on the following criteria:

| Points | Description |
|----------|--|
| 3 Points | Patient clinical measures for which improvement in the measure represents an improvement in patient health outcomes or utilization patterns. (Most measures that were standalone measures in DY2-6 will be 3-point measures in DY7-8) |
| 2 Points | Cancer screening measures and hospital safety and infection measures |
| 1 Point | Measures of clinical practice, immunization rates, and measures related to quality of life or functional assessment |
| 0 Points | Innovative measure that are pay-for-reporting (P4R) |



Hospital & Physician Practice Measure Bundle Base Point Value

- The base point value of a Measure Bundle is determined by adding the points for the required measures in the Measure Bundle.
- Some bundles are designated a "*High State Priority*" or a "*State Priority*" which results in an increase to the base point value.
 - High State Priority are multiplied by 2.
 - State Priority are multiplied by 1.5.
- State priority bundles align with HHSC Medicaid/CHIP quality strategies.



Hospital & Physician Practice Additional Points

- Certain optional measures in a Measure Bundle, if selected, add points to the Measure Bundle.
 - Measures that add additional points are most optional 3-point measures and measures that align with state priorities.
- Optional measures that add points, if selected, are not impacted by a High State Priority or a State Priority Multiplier.



Hospital & Physician Practice Base Point Value Example

E1 Improved Maternal Care

| ID | Measure | Required | Required Measure Points | Additional Points |
|--------|---|----------|-------------------------|-------------------|
| E1-148 | PC-01 Elective Delivery | N | | |
| E1-150 | PC-02 Cesarean Section | Y | 1 | |
| E1-151 | PC-03 Antenatal Steroids | N | | |
| E1-193 | Contraceptive Care – Postpartum Women Ages 15–44 | N | | +1 |
| E1-232 | Timeliness of Prenatal Care | Y | 1 | |
| E1-235 | Post-Partum Follow-Up and Care Coordination | Y | 3 | |
| E1-300 | Behavioral Health Risk Assessment | Y | 1 | |
| E1-378 | Appropriate Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision – Cesarean section. | N | | |
| TBD | <i>Innovative Measure Under Consideration: Preeclampsia or OB Hemorrhage measure</i> | N | | |

- Bundle points are calculated as sum of required points times 2 for a high state priority ($6 \times 2 = 12$)
- Selecting bundle E1 counts as 12 points towards MPT, or 13 points if selected with optional measure E1-193

Hospital & Physician Practice Measure Bundles (A1 – D4)



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| Bundle ID | Hospital & Physician Practice Measure Bundles | Base Points | Possible Additional Points | Max Possible Points |
|------------------|--|--------------------|-----------------------------------|----------------------------|
| A1 | Improved Chronic Disease Management: Diabetes Care [State Priority (SP)] | 12 | 3 | 15 |
| A2 | Improved Chronic Disease Management: Heart Disease (SP) | 12 | 3 | 15 |
| B1 | Care Transitions & Hospital Readmissions | 6 | - | 6 |
| B2 | Patient Navigation & ED Diversion | 4 | 3 | 7 |
| C1 | Primary Care Prevention - Healthy Texans (SP) | 9 | - | 9 |
| C2 | Primary Care Prevention - Cancer Screening & Follow-Up | 6 | 3 | 9 |
| C3 | Hepatitis C | 5 | - | 5 |
| D1 | Pediatric Primary Care (SP) | 12 | 1 | 13 |
| D3 | Pediatric Hospital Safety | 6 | - | 6 |
| D4 | Pediatric Chronic Disease Management: Asthma (SP) | 11 | 3 | 14 |

Hospital & Physician Practice Measure Bundles (E1 – J1)



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| Bundle ID | Hospital & Physician Practice Measure Bundles | Base Points | Possible Additional Points | Max Possible Points |
|-----------|---|-------------|----------------------------|---------------------|
| E1 | Improved Maternal Care [High State Priority (HSP)] | 12 | 1 | 13 |
| F1 | Improved Access to Adult Dental Care | 6 | - | 6 |
| F2 | Preventive Pediatric Dental | 2 | - | 2 |
| G1 | Palliative Care | 6 | - | 6 |
| H1 | Integration of Behavioral Health in a Primary Care Setting (SP) | 8 | - | 8 |
| H2 | Behavioral Health and Appropriate Utilization (SP) | 9 | 6 | 15 |
| H3 | Chronic Non-Malignant Pain Management (HSP) | 4 | 3 | 7 |
| H4 | Integrated Care for People with Serious Mental Illness (SP) | 3 | - | 3 |
| I1 | Specialty Care | 2 | - | 2 |
| J1 | Hospital Safety | 8 | - | 8 |

Hospital & Physician Practice Minimum Bundle Selection Requirement

- A hospital or physician practice with a total valuation (all categories) of more than \$2,000,000 per DY must either:
 - Select at least one Bundle with at least one required 3 point measure, or
 - Select at least one Bundle with at least one optional 3 point measure selected.



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Hospital & Physician Practice Minimum Bundle Selection 1

- The following can only be selected in addition to a bundle with a required or selected optional 3-point measure:
 - C1: Healthy Texans
 - C3: Hepatitis C
 - D3: Pediatric Hospital Safety
 - F2: Preventive Pediatric Dental
 - G1: Palliative Care
 - H4: Integrated Care of People with Serious Mental Illness
 - I1: Specialty Care
 - J1: Hospital Safety



Hospital & Physician Practice Minimum Bundle Selection Example 1

C1: Primary Care & Prevention – Health Texans

- No required or optional 3-point measures
- Does not meet minimum selection requirement and must be selected along with a Bundle with a 3-point measure.

| ID | Measure | Required | Required Measures Points | Additional Points |
|--------|--|----------|--------------------------|-------------------|
| C1-105 | Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention | Y | 1 | |
| C1-113 | Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing | Y | 1 | |
| C1-147 | Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up | Y | 1 | |
| C1-268 | Pneumonia vaccination status for older adults | Y | 1 | |
| C1-269 | Preventive Care and Screening: Influenza Immunization | Y | 1 | |
| C1-272 | Adults (18+ years) Immunization status | Y | 1 | |
| C1-280 | Chlamydia Screening in Women (CHL) | N | | |
| C1-285 | Advance Care Plan | N | | |
| C1-389 | Human Papillomavirus Vaccine (age 14 -26) | N | | |



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Hospital & Physician Practice Minimum Bundle Selection 2

- The following have a required 3-point measure and count towards minimum bundle selection requirement:
 - A1: Diabetes Care
 - A2: Heart Disease
 - B1: Care Transitions & Hospital Readmissions
 - B2: Patient Navigation & ED Diversion
 - D1: Pediatric Primary Care
 - D4: Pediatric Asthma
 - E1: Improved Maternal Care
 - F1: Adult Dental
 - H1: Integration of BH in a Primary or Specialty Care Setting
 - H2: BH and Appropriate Utilization



Hospital & Physician Practice Minimum Bundle Selection Example 2

A1: Diabetes Care

- Has a required 3-point measure
- Meets minimum bundle selection requirement

| ID | Measure | Required | Required Measures Points | Additional Points |
|--------|---|----------|--------------------------|-------------------|
| A1-111 | Comprehensive Diabetes Care: Eye Exam (retinal) performed | N | | |
| A1-112 | Comprehensive Diabetes Care: Foot Exam | Y | 1 | |
| A1-113 | Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing | N | | |
| A1-115 | Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) | Y | 3 | |
| A1-116 | Comprehensive Diabetes Care: Medical Attention for Nephropathy | N | | |
| A1-207 | Diabetes care: BP control (<140/90mm Hg) | Y | 3 | |
| A1-208 | Comprehensive Diabetes Care LDL-C Screening | Y | 1 | |
| A1-247 | Reduce Emergency Department visits for Diabetes | N | | +3 |
| A1-321 | Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation | N | | |



Hospital & Physician Practice Minimum Bundle Selection 3

- The following have an optional 3-point measure that count towards the minimum bundle selection requirement if the optional 3-point measure is selected:
 - C2: Cancer Screening & Follow Up
 - Must select optional measure C2-274: Mammography follow-up rate
 - H3: Chronic Non-Malignant Pain Management
 - Must select optional measure H3-197: Use of Opioids at High Dosage



Hospital & Physician Practice Minimum Bundle Selection Example 3

C2: Primary Care Prevention: Cancer Screening

- Optional 3-point measure
- Meets minimum bundle selection requirement if optional 3-point measure is selected

| ID | Measure | Required | Required Measures Points | Additional Points |
|--------|--|----------|--------------------------|-------------------|
| C2-106 | Cervical Cancer Screening | Y | 2 | |
| C2-107 | Colorectal Cancer Screening | Y | 2 | |
| C2-162 | Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients | N | | |
| C2-186 | Breast Cancer Screening | Y | 2 | |
| C2-199 | PQRS #439: Age Appropriate Screening Colonoscopy | N | | |
| C2-274 | Mammography follow-up rate | N | | +3 |
| C2-275 | Abnormal Pap test follow-up rate | N | | |

Hospital & Physician Practice Measure Bundles (K1 – K2)



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| Bundle ID | Hospital & Physician Practice Measure Bundles | Base Points | Possible Additional Points | Max Possible Points |
|-----------|---|-------------|----------------------------|---------------------|
| K1 | Rural Preventative Care | 3 | 4 | 7 |
| K2 | Rural Emergency Care | 3 | - | 3 |

- K1 and K2 can only be selected by hospitals with a total valuation (All Categories) at or below \$2,000,000 per DY.
- Hospitals with a total valuation below \$2,000,000 may select bundles in addition to K1 or K2.

Hospital & Physician Practice Minimum Bundle Valuation

- Providers have flexibility in distributing valuation among Measure Bundles.
- Each selected Measure Bundle has a minimum valuation based on the point value of the Measure Bundle and the total point value of all selected Measure Bundles.
- Measure Bundles without a 3-point measure (required or selected) have a maximum valuation.
- Measure Bundles with at least one 3-point measure selected have no maximum valuation.



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Hospital & Physician Practice Bundle Valuation Calculations

Where:

A = Measure Bundle Point Value

B = The sum of all selected Measure Bundles Point Values

C = Category C valuation

Minimum Measure Bundle Valuation:

$$(A/B)/2 * C$$

Maximum Measure Bundle Valuation for
bundles with no 3-point measure selected:

$$(A/B) * C$$



Hospital & Physician Practice Valuation Example (Pt 1)

- Performing Provider: Hospital, with inpatient and outpatient
- Total Valuation per DY: \$20,000,000
- Hospital's MPT: 40 points
($\$20,000,000 / \$500,000$)
- Category C Valuation in DY7: \$11,000,000
(RHP met private hospital participation requirements so Cat D at 15% and Cat C at 55%; $\$20,000,000 \times .55$)

Hospital & Physician Practice Valuation Example (Pt 2)



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| Bundle Selections | Selected Bundle Required Points + Additional Points | Min DY7 Valuation | Max DY7 Valuation | DY7 Selected Valuation |
|---|---|--|---|------------------------|
| A1 Improved Chronic Disease Management: Diabetes Care | 12 | $(12 / 40) / 2$ * \$11,000,000 = \$1,650,000 | NA | \$4,850,000 |
| B1 Care Transitions & Hospital Readmissions | 6 | $(6 / 40) / 2$ * \$11,000,000 = \$825,000 | NA | \$825,000 |
| C1 Primary Care Prevention - Healthy Texans (no 3-point measures) | 9 | $(9 / 40) / 2$ * 11,000,000 = \$1,237,500 | $(9 / 40)$ * \$11,000,000 = \$2,475,000 | \$1,800,000 |
| E1 Improved Maternal Care | 12 + 1 | $(13 / 40) / 2$ * \$11,000,000 = \$1,787,500 | NA | \$3,525,000 |
| Total | 40 points (meets MPT) | | | \$11,000,000 |



Hospital & Physician Practice Bundle Valuation Details

- Measure Bundle valuation as a percentage of a provider's Category C valuation will be consistent across measurement years.
 - EXAMPLE: Bundle A will be 20% of Cat C valuation in DY7 and DY8. Bundle C cannot be 15% of Cat C in DY7 and 30% of Cat C in DY8.
- Each Measure in a Measure Bundle is equally valued, with some exceptions for measures with low volume.



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Hospital & Physician Practice Exceptions for Limited Scope of Practice

- Exceptions to the MPT and bundled selection may be available for providers with a limited scope of practice such as children's hospitals, infectious disease hospitals, and Institutes of Mental Disease.
- Providers with a limited scope of practice may submit an exception request to HHSC prior to RHP plan submission. The submission date for such requests is currently TBD.
- Requests may be subject to review by CMS and if approved may result in a reduced valuation.

CMHC & LHD Measure Selection Requirements

- CMHCs and LHDs will select measures rather than measure bundles.
- CHMCs and LHDs must select at least one 3-point measure.
- Exception for depression response measure: If a CMHC selects more than one of the depression response measures M1-165, M1-181, or M1-286, only 3 points will be counted towards the Performing Provider's MPT.



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CMHC & LHD Measure Valuation

- CMHC and LHD providers have flexibility in distributing valuation among measures.
- All measures have a minimum valuation.
- Measures that are 1-point or 2-point measures have a maximum valuation.



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CMHC & LHD Measure Valuation Calculations

Where:

C = Total Category C valuation

D = Number of Measures Selected

Minimum Measure Valuation:

$$(C/D)/2$$

Maximum measure valuation for 1-point and 2-point measures:

$$(C/D)$$



CMHC & LHD Valuation Example (Pt 1)

- Performing Provider Type: CMHC
- Total Valuation per DY: \$7,500,000
- CMHC's MPT: 15 points
($\$7,500,000 / \$500,000$)
- Category C Valuation in DY7: \$4,125,000
(RHP met private hospital participation requirements so Cat D at 15% and Cat C at 55%; $\$4,125,000 \times .55$)

CMHC & LHD Valuation Example (Pt 2)



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| Measure Selection | Points | Min DY7 Valuation | Max DY7 Valuation | DY7 Example Valuation |
|--|----------------------------|--------------------------------------|------------------------------------|-----------------------|
| M1-165: Depression Remission at 12 Months | 3 | $(\$4,125,000/10)/2$ $=\$206,250$ | N/A | \$450,000 |
| M1-181: Depression Response at 12 Months- Progress Towards Remission | (3)* | | N/A | \$650,000 |
| M1-241: Decrease in MH admissions to criminal justice settings | 3 | | N/A | \$550,000 |
| M1-257: Care Planning for Dual Diagnosis | 1 | | $(\$4,125,000/10)$ $=\$412,500$ | \$300,000 |
| M1-259: Assignment of PCP to Individuals with Schizophrenia | 1 | | | \$250,000 |
| M1-260: Annual Physical Exam for Persons with Mental Illness | 1 | | | \$362,500 |
| M1-265: Housing Assessment for Individuals with Schizophrenia | 1 | | | \$206,250 |
| M1-340: Substance use disorders | 1 | | | \$343,750 |
| M1-342: Time to Initial Evaluation | 1 | | | \$412,500 |
| M1-387: Reduce ED visits for BH and Substance Abuse | 3 | | N/A | \$600,000 |
| TOTAL | 15 points (met MPT) | | | \$4,125,000 |

*M1-181 does not count towards MPT but functions like a 3-point measure for valuation

Eligible Denominator Population



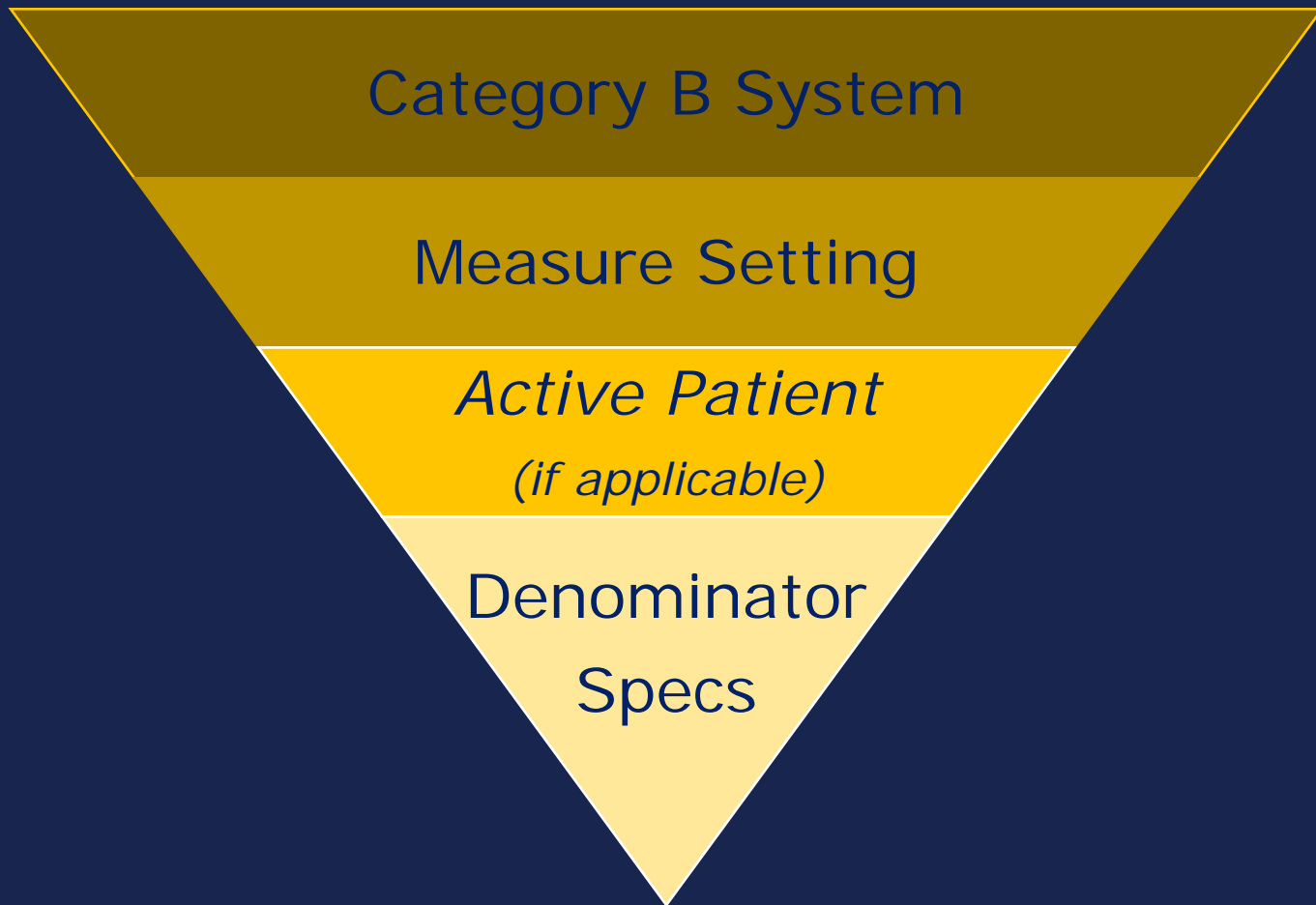
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- The eligible denominator population for each measure will be determined by
 - the measure setting assigned to each measure,
 - active patient definition if applicable,
 - and the denominator specifications.
- Measures within a bundle may have different settings
 - Example: A1: Diabetes Care
 - A1-112 HbA1c Testing, primary care setting
 - A1-247 ED Visits for Diabetes, ED setting

Measure Specific Denominator Population



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Active Patient – Primary Care



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- For measures with a primary care setting
 - Individuals that meet any one of the following criteria:
 - Two visits in the 12-month measurement period
 - One visit in the 12-month measurement period and one visit in the 12 months prior to the measurement period
 - Assigned to a primary care physician

Active Patient – Specialty Care



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- For measures with an outpatient specialty care setting, providers will propose an active patient definition for each specialty included in a measure bundle as part of the RHP Plan Update.
- Some measures will be reported for both primary and specialty care settings as a combined rate.
 - Example: H1-146 Screening for Clinical Depression & Follow-Up Plan may apply to a primary care setting, as well as optional outpatient specialty care settings such as endocrinology and orthopedics.

Denominator Example (Pt 1)



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H1: Integration of BH in a Primary and Specialty Care Setting

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

1. System: The provider's system definition includes primary care clinics and outpatient specialty care clinics
2. Setting: Primary care clinics and outpatient specialty care clinics appropriate for bundle, in this case Endocrinology and Orthopedic
3. Active Patient: In each measurement period, the provider would identify individuals that meet the active patient definition in each setting
4. Denominator Specifications: From those individuals, the denominator would be determined following measure specifications

Denominator Example (Pt 2)



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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 LIU)
- Based on the combined MLIU 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 active patient population will change each year.

Category C Compendium of Measure Specifications

- The following items will be included in the Category C Compendium of Measure Specifications:
 - Settings for each measure
 - Measures identified as QISMC or IOS
 - Benchmarks if QISMC
 - Exceptions to measurement periods for certain measures (example: NQF 0041 Influenza Immunization)
 - Measures that are not eligible for a 6-month baseline
 - Complete draft expected in July/August



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Hospital & Physician Practice Innovative Measures

- During the Measure Bundle development process, some innovative measures were identified for inclusion in the Measure Bundles.
- HHSC is currently working with potential measure stewards for innovative measures in the Bundles D1, H1, and H3.
- HHSC is seeking a measure steward for the proposed innovative measure related to oral cancer screening in Bundle F1: Improved Access to Adult Dental Care.



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Category D



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Category D

Statewide Reporting Measure Bundle

- Population-focused improvements.
- Providers required to report according to type of provider.
- Similar to previous Category 4 with additional measures developed for non-hospital providers.



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Next Steps

Estimated Timeline

- Through July 7, 2017 – Gather stakeholder feedback on the draft Measure Bundle Protocol using the survey posted on the waiver website. HHSC is particularly interested in feedback on Category D measures.
- Late July 2017 – Submit Measure Bundle Protocol to CMS for approval, including any updates to the PFM based on the Measure Bundle Protocol.



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Estimated Timeline (cont.)



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- July/August – release of full draft of Category C Compendium of Measure Specifications
- August 2017 – DY7-8 proposed rules posted for public comment.
- August/September 2017 – Targeted CMS approval of protocols.
- January 31, 2018 – Anchors submit RHP Plan Updates.



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Thank you

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