

Texas DSRIP Transition Year Proposal

Demonstration Year 6 (DY6 - October 1, 2016 – September 30, 2017)

The following information is consistent with the extension/renewal request submitted to CMS, unless otherwise specified. The purpose of DY 6 transition year is to lay the groundwork for program improvements in DY7.

HHSC agrees with CMS that the DSRIP program will be strengthened by focusing on key state and regional priorities and incentivizing further collaboration among DSRIP providers and Medicaid health plans. HHSC proposes that the majority of current DSRIP projects be allowed to continue in the extension period while focusing on the Category 3 and Category 4 quality measures to demonstrate state priorities and the outcomes of DSRIP.

- Request DY5 level of DSRIP funding of \$3.1 billion for DY6.
- Continue the majority of the current active Category 1 and 2 projects (some may be required to take a logical next step to further transformation in DY6 and many will do so in DY7 -- for example, a chronic care management project may add additional chronic conditions or a project to expand primary care may take a next step to certify as a medical home.)
 - DY6 project valuation will be equal to DY5 project valuation for most projects. (Some project valuations may be reduced due to low achievement or high value outliers.)
 - Increase focus on Medicaid and Low Income Uninsured (MLIU) percentage of patients served by requiring reporting of this metric through either pay for reporting or pay for performance in the transition year (moving to pay for performance in subsequent years).
 - Consider the requirement for submitting Medicaid IDs, with the ability to send a justification if a provider is not able to submit (e.g., local health departments).
 - Milestones for DY6 would include # of total patients served, # of MLIU patients served, project activities, sustainability planning, outcomes reporting and project level evaluation that is template driven and more standardized. (This is also a way to streamline reporting and reduce administrative burden for providers and the state).
 - Work to further align outcomes reporting with projects to show meaningful improvement, including to better reflect outcomes related to pediatrics and behavioral healthcare in DY7 and beyond.
 - Category 3 outcomes would change from pay for performance to pay for reporting.
 - Assume carryforward for metrics continues to apply.

- Establish a new performance bonus pool (pay for performance) in place of the current Category 4 pay for reporting (*in the extension request, this was discussed as use for unearned funds rather than changing Category 4*).
 - Current pay for reporting for Potentially Preventable Events would change to a regional performance bonus pool using state level data.
 - Set aside 5-10% of valuation per provider for the performance bonus pool (PBP) to reward high performing regions and pay providers in DY6 based on regional agreement on, and selection of, performance measures.
 - HHSC will establish the PBP measures that will be required for all regions, and will develop a list of additional potential PBP measures that a region can select based on the key community needs and DSRIP areas of focus in that region.
 - Measures would be selected in DY6 through Category 4 reporting to lay the groundwork for the PBP pay for performance that would begin in DY7.
 - This strategy is flipping the current Category 3 pay for performance with Category 4 pay for reporting (which is mostly state level data). The advantages of this change would be using state level data for performance rather than provider level data which has been a big challenge for providers.
 - All performing providers would participate in the bonus pool, not just hospitals.

- Lay the groundwork for further quality alignment between DSRIP and Medicaid managed care, including development of a value based payment roadmap in DY6.

- Combining projects
 - For administrative simplification, in January/ February 2015, HHSC will determine which projects are eligible to combine in DY6 to potentially include:
 - Cross-regional CMHC projects
 - Similar projects by the same provider; or
 - Similar projects by different providers within the same health system.
 - HHSC is open to combining additional projects if this is CMS' preference from DY7 onward to further reduce the 1400+ current projects.

Note: Based on lessons learned from current projects and for providers that withdrew a project after the midpoint assessment, allow alternate transformative projects from a narrower menu that would be submitted in DY6 to begin in DY7.

Funds from \$3.1B not currently allocated to projects

The following are the various ways that there could be leftover funds in DY 6. Leftover funds are unused funds based on the \$3.1 billion DY6 request (these funds are not allocated to current projects - currently \$14.5M, could increase). Includes the following:

- Projects under review that HHSC determines need to have their valuation reduced.

- Projects under review that HHSC determines are not eligible to continue.
- Projects that voluntarily withdrew after June 30, 2014 including those that withdraw in summer 2016.

Initial option for partial use of leftover funds

- For providers with a total provider valuation less than \$250,000 per DY, their total provider valuation will be raised to \$250,000 per DY beginning in DY6, so the DY6 project valuation for one or more of their projects will be greater than the DY5 project valuation. This will impact 27 providers.
 - To do this, HHSC will use approximately \$3 million of the current estimated \$14.5 million in remaining funds not allocated to DY5 to a region or withdrawn projects.
 - Providers may opt out of the increased valuation if IGT funds will not be available.

HHSC is exploring other possible one-time uses of leftover funds in DY6, including helping regions and DSRIP participants increase learning collaborative efforts to support regional goals for the shared performance bonus pools, and targeted efforts to strengthen the impact of DSRIP across the state (such as in rural areas and among children's hospitals). HHSC plans to further flesh out these proposals for CMS consideration.