

Transition Year Proposal
DY6 (October 1, 2016 – September 30, 2017)
SUBJECT TO CMS APPROVAL

XIII. TRANSITION YEAR (DY6)

37. Definitions

- a. Total Quantifiable Patient Impact (QPI) – The number of individuals served, or encounters provided, in a given demonstration year (DY) through the DSRIP project.
- b. Quantifiable Patient Impact (QPI) Grouping – The category of the QPI measurement. The category may be either individuals served or encounters provided through the DSRIP project.
- c. Pre-DSRIP Baseline - The service volume prior to the implementation of a DSRIP project, as measured by the number of individuals served or encounters provided in the 12-month period preceding implementation of the DSRIP project. For projects with a new intervention, the pre-DSRIP baseline is zero. There is a pre-DSRIP baseline for total QPI and a pre-DSRIP baseline for MLIU QPI.
- d. Medicaid and Low-income and/ or Uninsured (MLIU) – MLIU is changed from Medicaid/ Low-income uninsured in the initial demonstration period to Medicaid and Low-income and/ or uninsured in the applicable DY. [Note that this is a new definition. To qualify as LIU in the initial demonstration period, an individual must be both low-income and uninsured. To qualify as LIU in the waiver extension period, an individual can be low-income and/or uninsured; in other words, they only have to be one or the other (low-income or uninsured) not both.]
 - i. To qualify as a Medicaid individual for purposes of MLIU, the individual must be enrolled in Medicaid (including an individual enrolled in both Medicaid and Medicare [i.e., dual eligible]) at the time of at least one DSRIP project encounter during the applicable DY.
 - ii. To qualify as a low-income and/ or uninsured individual for purposes of MLIU, the individual must either be below 200% FPL and/or must not have health insurance at the time of at least one DSRIP project encounter during the applicable DY.
 - iii. If an individual was enrolled in Medicaid at the time of one DSRIP project encounter during the applicable DY, and was low-income and/ or uninsured at the time of a separate DSRIP project encounter during the applicable DY, that individual shall be classified as Medicaid.
- e. Medicaid and Low-income and/ or Uninsured (MLIU) Quantifiable Patient Impact (QPI) – The number of Medicaid and Low-income and/or Uninsured individuals served or encounters provided through the project.

- f. Medicaid and Low-income and/ or Uninsured (MLIU) Quantifiable Patient Impact (QPI) Goal – The number of MLIU individuals that a performing provider aims to serve, or the number of MLIU encounters that a performing provider aims to provide, during the applicable DY, in accordance with paragraph 40(a)(iii). For those projects with a MLIU QPI requirement, the goal must be achieved to be eligible for payment.
- g. Initial Demonstration Period - December 12, 2011 through September 30, 2016 (i.e., DY1 through DY5).

38. Current Projects Eligible to Continue

- a. DY6 project valuation is equal to DY5 project valuation for most projects with the following exceptions:
 - i. HHSC determines that a project valuation needs to be reduced based on that project's failure to complete metric goals by the end of DY5.
 - ii. Performing providers with a total valuation less than \$250,000 in DY5 may increase their total valuation to up to \$250,000 for each subsequent DY across Categories 1-4 beginning in DY6. Categories 1-4 are each increased proportionately if a performing provider chooses this option. To fund these increases, HHSC will use approximately \$3 million of the current remaining funds not allocated to continuing projects.
- b. Performing providers must, for all of their current projects, indicate to HHSC by Summer 2016, on a form to be determined by HHSC, whether they wish to: 1) discontinue a project in DY6-10; or 2) continue or propose to replace a project in DY6-10. Performing providers that select Option #2 must indicate to HHSC by early 2017 whether they wish to continue a project or replace a project for DY7-10, subject to DY7-10 requirements. If, after selecting Option #2, a performing provider decides to neither continue nor replace a project, HHSC will recoup any DY6 payments that the performing provider received for that project.
- c. The DY5 intergovernmental transfer (IGT) process, payment calculations, and monitoring IGT are maintained in DY6. IGT entities from DY5 will continue for DY6 funding unless a performing provider submits changes during the reporting period. No new certifications (RHP Plan Section VI) are required for continuing RHP participants.
- d. Regional learning collaborative requirements are unchanged in DY6.

39. Current Projects Determined Not Eligible to Continue

- a. A project that meets the criteria below will be reviewed by HHSC, and may be determined ineligible to continue:
 - i. Scored a 4 or 5 in the midpoint assessment;
 - ii. Has a DY5 valuation over \$5 million;

- iii. Was flagged by HHSC staff during reporting review or change request review and/ or did not report achievement of any milestones/ metrics during April DY4 or October DY4 reporting.
- b. If HHSC determines that a project described in 39a can continue, that project will continue in accordance with paragraph 38.
- c. If HHSC determines that a project described in 39a cannot continue, that project may not participate in DY6. A performing provider affected by such a determination may be eligible to submit replacement projects to begin in DY7.

40. Requirements for Continuing Projects

a. Category 1 and 2 Requirements for DY6

- i. Each Category 1 or 2 project must have the following four milestones in DY6:
 - A. Total QPI - valued at 25% of each project's valuation.
 - B. MLIU QPI - valued at 25% of each project's valuation.
 - C. Core component reporting - valued at 25% of each project's valuation.
 - D. Sustainability planning - valued at 25% of each project's valuation.

ii. *Total QPI Milestone*

- A. HHSC will convert each total QPI metric to a total QPI milestone with standardized language in DY6. However, certain projects may be exempted from this conversion if they have multiple QPI metrics in DY5, based on criteria to be determined by HHSC.
- B. The DY6 total QPI goal is equal to the DY5 total QPI goal. However, certain projects may be exempted from this goal setting rule based on DY4 and DY5 achievement levels, to be determined by HHSC.
- C. Projects retain the same QPI Grouping from the initial demonstration period in DY6.
- D. Projects retain the same pre-DSRIP baseline for total QPI from the initial demonstration period in DY6.
- E. Projects may carry forward total QPI from DY6 to DY7.

iii. *MLIU QPI Milestone*

- A. There is a standardized MLIU QPI milestone in DY6.
- B. For projects that have an MLIU QPI requirement in DY5 [mostly 3-year projects under Project Area 1.9]:

1. The DY6 MLIU QPI goal is equal to the DY5 MLIU QPI goal.
2. If the project has an MLIU QPI metric in DY5, it retains the same pre-DSRIP baseline for MLIU QPI in DY6 that was utilized in the initial demonstration period.
3. If the project does not have an MLIU QPI metric in DY5, the pre-DSRIP baseline for MLIU QPI in DY6 is equal to the pre-DSRIP baseline for total QPI multiplied by the earliest MLIU percentage goal on record. [For example, if a project's pre-DSRIP baseline for total QPI is 100 individuals, and the DY3 MLIU percentage target was 20%, the pre-DSRIP baseline for total QPI in DY6 would be 100, and the pre-DSRIP baseline for MLIU QPI would be 20].
4. The MLIU QPI milestone must be pay-for-performance (P4P).

Example:

	Goal	Pre-DSRIP baseline	QPI Numeric Goal	MLIU Numeric Goal
DY3 QPI milestone and MLIU % goal (first year of QPI)	Serve 40 additional patients in the expanded clinic (individuals) in DY3. 80% Medicaid/Low Income Uninsured	220	40	While there was no MLIU goal for payment purposes, $40 * .80 = 32$
DY5 QPI milestone and MLIU % goal	Serve 50 additional patients in the expanded clinic (individuals) in DY5. 90% Medicaid/Low Income Uninsured	220	50	While there was no MLIU goal for payment purposes, $50 * .90 = 45$
DY6 Total QPI milestone	Serve 50 additional patients in the expanded clinic (individuals).	220	50	NA
DY6 MLIU milestone	Serve 45 MLIU patients (individuals).	$220 * .80 = 176$	NA	45 ←

C. For projects that do not have an MLIU QPI requirement in DY5:

1. The DY6 MLIU QPI goal is equal to the DY5 MLIU percentage goal multiplied by the DY5 total QPI goal, or as indicated in the DY5 goal language.
2. The pre-DSRIP baseline for MLIU QPI is equal to the pre-DSRIP baseline for total QPI multiplied by the earliest MLIU percentage goal

on record. [For example, if a project's pre-DSRIP baseline for total QPI is 100 individuals, and the DY3 MLIU percentage target was 20%, the pre-DSRIP baseline for total QPI in DY6 would be 100, and the pre-DSRIP baseline for MLIU QPI would be 20].

3. Although all projects must have a DY6 MLIU QPI goal, with the exception of projects under paragraph 40(a)(iii)(C)(4), projects will be paid for reporting their MLIU QPI milestone itself in DY6, regardless of their actual achievement of the goal. [For those projects under this paragraph, this goal will be a target, but the performing provider will not have to meet the goal in DY6 in order to receive DY6 payment; the performing provider will only be required to report on their DY6 level of MLIU. However, HHSC anticipates converting all MLIU milestones to pay-for-performance in DY7, so performing providers should prepare to achieve their goal in subsequent years in order to be eligible for milestone payment].
4. Some projects must demonstrate achievement of their MLIU QPI goal on a P4P basis. These projects include the following:
 - a. All Project Area 1.9 projects.
 - b. Projects that did not achieve the estimated MLIU percentage in DY3, DY4, or DY5, and that failure caused them to be very highly valued per MLIU individual/ encounter relative to all other projects.
 - c. Projects for which HHSC notified the performing provider that they were eligible to continue with changes but are required to report on MLIU as P4P.
 - d. Projects that included an MLIU goal in their QPI metric Baseline/Goal statement (an embedded goal) of their own choosing or that were required to address MLIU to receive CMS initial project approval.

D. A limited number of projects meeting certain HHSC criteria may, in Summer 2016, request an adjustment to their DY6 MLIU QPI goal, on a form to be determined by HHSC. These criteria include:

1. Projects that are underperforming on MLIU; and/or
2. Projects that are reporting on clients that meet the MLIU definition for the initial demonstration period, but will not meet the MLIU definition for the Waiver extension period (see updated MLIU definition in paragraph 37). [For example, an individual who was served by the DSRIP project initially and was uninsured but over the course of the project has been able to purchase insurance on the exchange and is above 200% FPL.]

E. Projects must retain the same QPI Grouping from the initial demonstration period in DY6 for MLIU QPI.

- F. Projects may carry forward MLIU QPI from DY6 to DY7.
- G. To be eligible for the MLIU milestone payment, beginning in DY6, performing providers must report Medicaid IDs for the Medicaid-enrolled individuals they serve. There are limited exceptions to this requirement to be determined by HHSC on a case-by-case basis. [Examples of potential exemptions include projects conducting health fairs, projects providing school-based services, etc.). Performing providers will have an opportunity to request an exception to this requirement in a form to be determined by HHSC by Summer 2016].
- H. In DY6, performing providers will not only report the MLIU percentages achieved. Similar to total QPI reporting for the initial demonstration period, when reporting on MLIU QPI in DY6, performing providers must report encounter/individual data specific to the Medicaid and LIU patients. [The template will provide checkbox options to identify eligible categories of patients that are included in the LIU category (CHIP, local indigent care participants, free/reduced lunch children, etc.)]

iv. *Non-QPI Milestones*

- A. Non-QPI Category 1 and 2 DY5 milestones/metrics may be carried forward to DY6, but will otherwise be discontinued in DY6.
- B. Projects must include the following non-QPI milestones in DY6:
 - 1. Core component reporting, including continuous quality improvement (CQI).
 - 2. Sustainability planning, including health information exchange (HIE), integration into managed care, and other community partnerships.

Performing providers must report on their activities for these milestones in order to be eligible for milestone payment.

- C. Projects may not carry forward non-QPI milestones from DY6 to DY7.

b. Category 3 Requirements

- i. For each Category 1 or 2 project, the respective Category 3 outcome values for DY5 are summed then, for DY6:
 - A. 50% of the Category 3 valuation is pay-for-reporting (P4R) for continuing to report the Category 3 outcomes reported in DY5, including population focused priority measures.
 - B. 50% of the Category 3 valuation is P4R for completing and submitting a Category 1 or 2 project-level evaluation in DY6.

- ii. Performing providers may carry forward Category 3 milestones from DY6 to DY7.

c. Performance Bonus Pool Requirements

- i. 5-10% of DY6 valuation per performing provider is set aside for the performance bonus pool (PBP) to reward high performing regions and pay performing providers based on regional agreement on, and selection of, performance measures as follows:
 - A. For performing providers with less than \$500,000 in total Category 1-4 DY5 funding, 5% of their DY6 funding is set aside for the region's PBP measure selection in DY6.
 - B. For performing providers with \$500,000 or more in total Category 1-4 DY5 funding, 10% of their DY6 funding is set aside for the PBP measure selection in DY6.
 - C. For performing providers who had not participated in Category 4, the 5% or 10% is taken from their Category 3 funding.
 - D. For hospitals who participated in Category 4, the 5% or 10% is equal to their DY5 Category 4 funding. If the hospital's Category 4 funding is higher than the required PBP funding, the additional funding remains in Category 4 for DY6 (e.g., if their Category 4 funding is 15% of their total valuation, all 15% will go to the region's selection of performance measures) but will be accounted for in DY7 onward with Category 1-4 rebalancing. If the hospital's DY5 Category 4 funding is lower than the required PBP funding, the remainder is made up by taking from Category 3 funding proportionately.
- ii. HHSC will establish the PBP measures 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.
- iii. Prior to a region selecting PBP measures, the region must redo/ update the community needs assessment. Anchors will need to solicit feedback from all performing providers and document process used for feedback. Anchors will need to provide rationale for their RHP's measure selections. The PBP measures will be included in the RHP Planning Protocol.
- iv. Payments for the PBP may only be made once the anchor reports on behalf of the entire region in October DY6. [Either all the performing providers in a region or none of the performing providers in a region will receive payment based on the anchor's submission of the region's selected measures.]
- v. Carry forward for the PBP does not apply.

41. Combining Certain Projects

- a. HHSC will determine which projects are eligible to combine in DY6. These projects must be eligible to continue, remain within overall valuation limits as specified in paragraph 13(e.) and will include:

- i. Cross-regional community mental health center projects;
 - ii. Similar projects by the same performing provider; or
 - iii. Similar projects by different performing providers within the same health system.
- b. HHSC will combine these projects' total QPI metrics, MLIU QPI metrics, and MLIU QPI goals, as well as their pre-DSRIP baselines, into:
 - i. One total QPI milestone and goal;
 - ii. One MLIU QPI milestone and goal; and
 - iii. One pre-DSRIP baseline for each.

42. Uncompensated Care (UC)-Only Hospital Requirements

[TBD]

43. Leftover Funds

[TBD]