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DY4-5 Category 3 Achievement Results and DY7-8 Measure Bundles

Objective: Category 3 achievement demonstrates how well providers improved quality outcomes in DYs 4-5. DYs 7-8 shifts more value to quality outcome achievement and allows Providers to add on to measures they selected in DYs 3-6. Consequently, evaluating DYs 4-5 *Category 3 pay-for-performance (P4P) achievement can help Providers evaluate risk while selecting measures from the DY7-8 menu.*

Background and Method: An IT number identifies a Category 3 measure listed in HHSC's Category 3 Compendium. For example, IT 1.10 measures the percent of diabetic patients whose HbA1c is less than 9%. Each project's Category 3 measure has an allocated dollar value that is paid if the provider's goal is achieved. Providers can also achieve partial payment if movement is made towards the goal in incremental quartile percentages. Therefore analyzing Category 3 achievement should indicate goal and quality achievement.

In summing each project's Category 3 allocations by IT number, we identified:

- How frequently certain Category 3 outcome measures were selected by unique providers (sometimes an individual provider selected an IT more than once)
- How much money was allocated to achievement by IT number
- How much of the allocation was actually paid per IT number (an indication of quality improvement and goal achievement)
- Whether any Category 3 ITs are in the Category C measure menus

Figure 1. Achievement and DY7-8 connection for the ten Category 3 P4P IT numbers with the greatest DY4 and DY5 allocations in Region 3

Demonstration Years 4-5 Category 3 Selections & Achievement						Demonstration Years 7-8 Category C Selections
ITs	Description	DY4&5 Valuation	# of Unique Providers	DY4% Achieved	DY5 % Achieved*	Measure Bundle and Measure Selections
IT-1.10	Diabetes care: HbA1c poor control (>9.0%)	$33,940,840	10	65%	26%	Hospitals & Physician Practices: A1: Improved Chronic Disease Management: Diabetes Care & K1 Rural Preventative Care LHD & CMHC: L1-115 & M1-115: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
IT-9.4.e	Reduce Emergency Department visits for Behavioral Health/ Substance Abuse	$14,598,576	6	87%	56%	Hospitals & Physician Practices: H2: Behavioral Health and Appropriate Utilization LHD & CMHC: L1-387 & M1-387: Reduce Emergency Department visits for Behavioral Health and Substance Abuse (Reported as two rates)
IT-3.3	Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate	$12,386,517	3	71%	40%	Hospitals & Physician Practices: B1: Care Transitions & Hospital Readmissions** LHD & CMHC: None
IT-10.1.a.v	Pediatric Quality of Life Inventory (PedsQL)	$12,104,572	3	100%	96%	No Corresponding Measure Bundles or Measures
IT-11.26.e.i	Patient Health Questionnaire 9 (PHQ-9)	$11,898,560	4	100%	95%	Hospitals & Physician Practices: C1: Primary Care Prevention - Healthy Texans LHD & CMHC: L1-269 Preventive Care and Screening: Influenza Immunization; None for CMHC
IT-12.6	Influenza Immunization - Ambulatory	$10,491,806	5	100%	97%	
IT-12.4	Pneumonia vaccination status for older adults	$9,683,594	2	97%	3%	Hospitals & Physician Practices: C1: Primary Care Prevention - Healthy Texans; K1: Rural Preventative Care LHD & CMHC: L1-268 Pneumonia vaccination status for older adults; None for CMHC
IT-1.7	Controlling high blood pressure	$8,822,310	5	100%	92%	Hospitals & Physician Practices: A2: Improved Chronic Disease Management: Heart Disease LHD & CMHC: L1-103 & M1-103: Controlling High Blood Pressure (BAT Recommendation to allow follow-up home blood pressure readings recorded in E H R/medical record)
IT-1.13	Diabetes care: Foot exam	$8,776,191	1	100%	100%	Hospitals & Physician Practices: A1: Improved Chronic Disease Management: Diabetes Care; K1: Rural Preventative Care LHD & CMHC: None
IT-3.22	Risk Adjusted All-Cause Readmission	$6,188,215	3	100%	2%	Hospitals & Physician Practices: B1: Care Transitions & Hospital Readmissions LHD & CMHC: None

*These percentages do not include CFs that will be reported in Oct DY6 Reporting

** Does not correspond exactly with IT-3.3

Figure 1. displays ten Category 3 P4P IT numbers with the greatest DY4 and DY5 allocations in Region 3. The far left column in Figure 1 lists the IT numbers and measure descriptions. Moving to the right, the table displays the number of unique providers who selected the measure, the sum of those IT number allocations across the Region, and the percentage of allocated funds achieved in DYs 4 and 5. These columns represent activity that has occurred DYs 3-6 but specifically the outcomes of DYs 4 and 5. The arrows next to the achieved percentages point to corresponding boxes, Category C bundles and measures. The arrows show where the DYs 3-6 Category 3 IT number exists in the DY7-8 bundle or measure, if at all. Using the ten Category 3 P4P IT numbers with the greatest DY4 and DY5 allocations in Region 3, Figure 2 on page 3 displays the percent of DY4 and DY5 allocation that providers achieved thus far and the carry forward values that can still be paid during October DY6 reporting.

See ACHIEVEMENT RESULTS on page 2

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DY4-5 Category 3 Achievement Results and DY7-8 Measure Bundles (continued)

Findings:

Per Figure 1, of the ten Category 3 IT#s with the greatest DY4 and DY5 allocations in Region 3:

- *For Hospitals & Physician Practices*
  - ⇒ Two do not exist in the Category C menu
  - ⇒ Three are in K1: Rural Preventive Care
  - ⇒ Two are in A1: Improved Chronic Disease Management: Diabetes
  - ⇒ Two are in C1: Primary Care Prevention – Healthy Texans
  - ⇒ Two are in B1: Care Transitions & Hospital Readmissions
- *For LHDs & CMHCs*
  - ⇒ Five do not exist in the Category C menu for LHDs
  - ⇒ Seven do not exist for CMHCs
  - ⇒ Both LHDs & CMHCs have include the following measures: L1-115 and M1-115: Comprehensive Diabetes Care: Hemoglobin A1C (HbA1c) Poor Control (>9.0%); L1-387 and M1-387: Reduce Emergency Department visits for Behavioral Health and Substance Abuse (reported as two rates); L1-103 and M1-103: Controlling High Blood Pressure (BAT recommendation to allow follow-up home blood pressure readings recorded in HER/medical record)
  - ⇒ LHDs have two measures: L1-268: Preventative Care and Screening: Influenza Immunizations; L1-268: Pneumonia Vaccination Status for Older Adults

In DYs 4 and 5, IT-1.10 (Diabetes care: HbA1c poor control (>9.0%)) had the largest allocation in Region 3. This IT was also selected the most frequently and by the greatest number of unique providers. Despite this, providers drew down only 65% of DY4 funds. Organizations considering selecting this measure or bundle can assess why the achievement for this Category 3 Measure was relatively low through discussion with providers that report this Category 3 Measure currently. For example, are there technical issues with reporting, patient compliance issues, social determinants, high resource needs, or other challenges? Deciphering the challenges behind achievement can help Providers choose appropriate Measures in DYs7 and 8.

Conversely, IT-9.4.e (Reducing Emergency Department visits for Behavioral Health/Substance Abuse) had the next highest Regional allocation but providers were much more successful in achieving goals for it—the Region achieved 87% of the IT's total valuation in DY4. This may indicate that the goals for this outcome can be reasonably achieved. However, providers should discuss the intervention and population size used to quantify performance in DYs 3-6 to determine if that is accurate.

In addition to looking at achievement, Carry Forward values are just as important to keep in mind when selecting Measure Bundles and Measure for DYs 7 and 8. Figure 2 indicates the DY4 and DY5 achievement during the respective reporting years, DY4 Carry Forward Achievement values, DY4 Loss of Funds, and DY5 Carry Forward value per top valued IT measures listed in Figure 1. Because DY5 Carry Forwards can still be achieved in October reporting, it is too early to know whether providers will meet their Carry Forward goals in DY5. Still, analysis demonstrates that much of IT-1.10 and IT-9.4.e's DY4 and DY5 funds—the top two valued ITs—were Carried Forward to the next DY. Numerous reasons for this may exist, including audit timing problems impacting reporting and inability to improve upon the outcome enough to meet the goal.

See ACHIEVEMENT RESULTS on page 3

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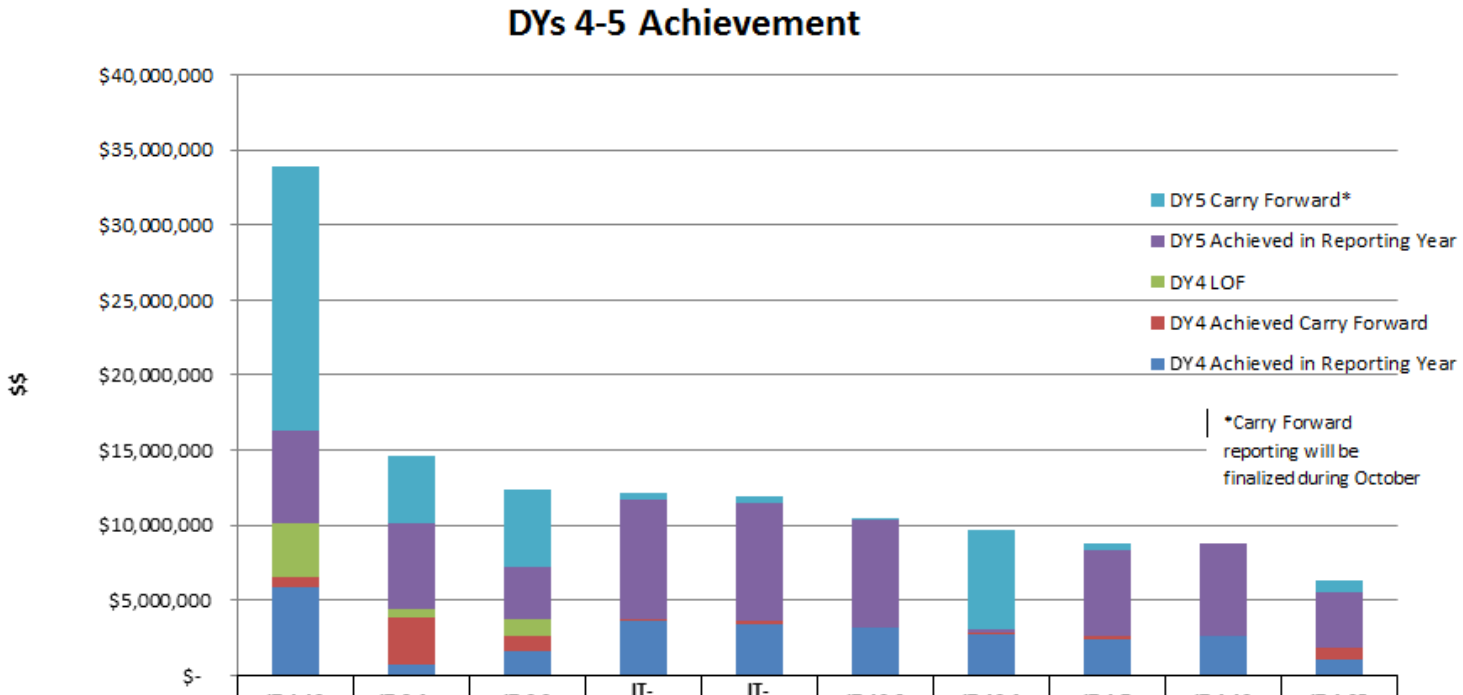
DY4-5 Category 3 Achievement Results and DY7-8 Measure Bundles (continued)

Discussion:

Providers can benefit from collaborating with one another to determine the reasons behind achievement in DYs 4-5 Category 3 outcomes that exist on the DY7-8 menu. Carry Forward results available after October DY6 reporting will provide a better picture on providers' ability to meet the DY5 goals. DY5 required greater improvement from baseline than DY4 goals did and reflect the goal progression anticipated in DY7-8. This fall, the Anchor will share similar analysis about IT numbers that are not in the top ten IT numbers by valuation.

Figure 2. DY5 achievement and Carry Forward for the ten Category 3 IT numbers with the greatest DY4 and DY5 allocations in Region 3



	IT-1.10	IT-9.4.e	IT-3.3	IT-10.1.a.v	IT-11.26.e.i	IT-12.6	IT-12.4	IT-1.7	IT-1.13	IT-1.25
DY5 Carry Forward*	$17,618,71	$4,462,597	$5,141,550	$369,725	$437,636	$184,862	$6,616,108	$480,477	$-	$819,668
DY5 Achieved in Reporting Year	$6,225,886	$5,686,974	$3,489,026	$7,967,014	$7,868,876	$7,098,483	$184,863	$5,676,159	$6,184,763	$3,707,285
DY4 LOF	$3,565,339	$566,182	$1,077,160	$-	$-	$-	$80,079	$-	$-	$-
DY4 Achieved Carry Forward	$653,611	$3,123,095	$1,096,469	$174,717	$198,386	$43,679	$43,679	$304,070	$-	$842,995
DY4 Achieved in Reporting Year	$5,877,288	$759,728	$1,582,312	$3,593,116	$3,393,662	$3,164,781	$2,758,866	$2,361,605	$2,591,428	$1,002,772

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Gearing up for DY7-8: A look at quality outcomes and continued transformation of the DSRIP Program

As shown in Figure 1, HHSC intends to keep a level of continuity between the clinical outcomes of Demonstration Years (DYs) 3-6 and the clinical outcomes of DY7-8. Improving upon the same clinical outcomes across Demonstration Years (DYs) undoubtedly moves the safety net system towards greater transformation and improved clinical health outcomes. Moving into DY7-8, the technical and operational challenges involved in completing transformational efforts are still an ever-present hurdle in the DSRIP program. But, let's take a moment to examine these obstacles and discuss how the Region can maximize its success in the following areas: collaboration on selecting Category C measures, scaling up quality improvement, and assessing where the safety net can be strengthened.

Communication between Providers about Regional performance data can play a key role in the selection of appropriate Category C measures. Providers can study past performance and share best practices that can help them successfully achieve DY7-8 goals. After several years of regular communication, relationships and trust are already in place to allow for increased communication amongst Providers. Silos and fragmentation of delivery of care continue to disappear.

Discussions amongst Providers and regional partners can also assist with understanding how to scale up quality efforts. Under the DY7-8 structure, Providers must improve quality on patients system-wide in order to receive payment. Therefore, understanding how to effect change across a larger platform quickly will be essential to success in the next iteration of the DSRIP program. Talking with Performing Providers about their plans and experiences can help.

Lastly, continuous collaboration and communication amongst Providers is needed in order to understand the safety net under the DY7-8 structure and what partnerships can be made to support services that newly fall outside of the DSRIP program. With standardization, some transformative projects may not fall within a provider's system definition or have an affiliated Category C quality measure. Providers may discontinue those services if they cannot obtain support, leaving holes in the safety net DSRIP initially sought to patch. Through Regional discussion, Providers can determine if and how to patch new holes and strengthen the safety-net system for patients served.

Collaboration and communication are key highlights of DSRIP's success and has helped Providers to overcome obstacles and technical challenges that are inherent in the DSRIP program. Through the provision of opportunities to share experiences, lessons learned, best practices, and successes, Providers are favorably positioned to increase their individual organizational goals and to make an even broader impact on population health. The strength of the safety net largely depends on how well organizations collaborate with each other. To do this, the Region can leverage is sturdy relationships to select appropriate quality initiatives and size them to scale, strengthen the safety-net, overcome common obstacles, and maximize DSRIP successes over the next two years.

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Infographic: The relationship between Category B & C

To the right is an infographic that depicts the relationship between Category B Patient Population by Provider (PPP) and Category C Measure Bundles and Measures. In DY7-8, each Performing Provider is required to report two numbers for Category B: the total number of individuals served by their system, which HHSC refers to as "Total PPP" in the DY7-8 Draft Program Funding and Mechanics Protocol (PFM), and the number of Medicaid and Low-Income or Uninsured (MLIU) individuals served by a Provider's system, which HHSC refers to as "MLIU PPP." For the purposes of this infographic, we have labeled "Total PPP" as "System PPP" to reiterate the concept that "Total PPP" represents the total number of individuals served by a Provider's defined system.

It is important to remember that although privately insured individuals are reported in the "System PPP" for the purposes of Category B reporting, they are not reported in the "MLIU PPP" number. Since the target population for DSRIP is MLIU patients, The MLIU PPP must be maintained or increased each DY within an allowable variation set by HHSC in order for the Provider to receive payment.

For Category C, HHSC is requiring Performing Providers to report three rates for each Category C measure: the Medicaid-only, LIU-only , and all-payer rates. If an individual is not in a Performing Provider's Category B/system definition, they cannot be counted in Category C. However, if a patient is counted in Category B/System PPP, the Category C denominator criteria and setting will stipulate whether they are actually counted in the Category C denominator. Please see the Draft Category C Measure Specifications document to determine which individuals in your System PPP meet the denominator and numerator criteria for each of your Category C measures. In the infographic, the table on the bottom left indicates which individuals meet the Category C measure specification criteria for the numerator and denominator. The boxes to the right of the table illustrate which rates those individuals are reported in based on if they meet the payer type and all of the required numerator and denominator specifications required. Note that some specific exceptions apply to Category C reporting based on Provider characteristics. Please check your PFM, HHSC feedback documents, and Category C Measure Specifications documents to determine if any exclusions apply to your Category C population.

More information on Category B and Category C can be found in the following documents:

- The 8/4/17 version of the DY7-8 PFM,
- The 7/28/17 Draft Measure Bundle Protocol, version 2
- HHSC's 8/4/17 and 5/17/17 Stakeholder Summary Feedback documents.

All documents listed above were used to create this infographic. HHSC has submitted the 8/4/17 Draft PFM and 7/28/17 Draft Measure Bundle Protocol to CMS. **As a reminder all DY7-8 protocol documents are currently drafts and are subject to CMS approval.**