DRAFT Attachment J
Program Funding and Mechanics Protocol

I. PREFACE --

On December 12, 2011, the Centers for Medicare and Medicaid Services (CMS) approved Texas' request for a new Medicaid demonstration waiver entitled "Texas Healthcare Transformation and Quality Improvement Program" (Project # 11-W-00278/6) in accordance with section 1115 of the Social Security Act. The initial waiver was approved through September 30, 2016 and an initial extension was granted through December 31, 2017. [NOTE: Additional language related to the request for 21 additional months that would extend the waiver through September 30, 2019 will be added pending the status of the CMS decision.] This section of the PFM applies to Demonstration Years (DYs) 7 and 8. Policies of DYs 1 through 6 are provided in the Addendum.

1. Delivery System Reform Incentive Payment Program

Special Terms and Conditions (STC) 46 of the Demonstration authorizes Texas to establish a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program is designed to provide incentive payments to hospitals and other providers for investments in delivery system reforms that increase access to health care, improve the quality of care, and enhance the health of patients and families they serve.

Activities funded by DSRIP shall be based on Regional Healthcare Partnerships (RHPs). Each RHP shall have geographic boundaries and will be coordinated by a public hospital or local governmental entity. The public hospital or local governmental entity shall collaborate with Performing Providers and regional stakeholders to update the RHP Plan that was originally developed in 2012 to accelerate meaningful delivery system reforms that improve patient care for low-income populations. The RHP Plan Updates must be consistent with RHP's mission and quality goals, as well as CMS's triple aims to: improve care for individuals (including access to care, quality of care, and health outcomes); improve health for the population; and lower costs through improvements (without any harm whatsoever to individuals, families, or communities).

RHP Plan Updates for DY7-8 will reflect the evolution of the DSRIP program from project-level reporting to provider core activities supporting outcomes that measure continued transformation of the Texas healthcare system at the provider level. DY7-8 will serve as an opportunity for providers to move further towards sustainability of their transformed systems, including development of alternative payment models to continue services for Medicaid and low-income or uninsured individuals after the waiver ends.

Categories 1-4 in DY2-6 are transitioned to the following Categories in DY7-8:

- **Category A** - Required reporting that includes progress on core activities, alternative payment model arrangements, costs and savings, and collaborative activities as described in paragraph 24.
- **Category B** - Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP)
- **Category C** - Measure Bundles
- **Category D** - Statewide Reporting Measure Bundle, similar to the previous hospital Category 4 reporting expanded to include all Performing Providers.

2. Measure Bundle Protocol and Program Funding and Mechanics Protocol

In accordance with STC 46(a) and 46(d)(ii)(A) & (B), the Measure Bundle Protocol (Attachment TBD) defines the system-level measures that are bundled to align closely with DSRIP project areas from the initial waiver period. The Program Funding and Mechanics Protocol (Attachment J) describes the State review process for RHP Plans, incentive payment methodologies, RHP and State reporting requirements, and penalties for missed milestones.

Following CMS approval of Attachment TBD and Attachment J, each RHP must submit an RHP Plan Update that identifies the selected Measure Bundles for each provider in accordance with these attachments and the STCs.

This version of the Program Funding and Mechanics Protocol is approved as of xxxxx.

3. Organization of "Attachment J: Program Funding and Mechanics Protocol"

Attachment J has been organized into the following sections:

I. Preface
II. DSRIP Eligibility Criteria
III. Key Elements of RHP Plan Updates for DY7-8
IV. Review and Approval Process of RHP Plan Updates for DY7-8
V. Plan Modifications for DY7-8
VI. Performing Provider Requirements for DY7-8
VII. Disbursement of DSRIP Funds for DY7-8
VIII. RHP and State Reporting Requirements
IX. Data Quality Assurance

4. Definitions

a. Core Activities - includes 1) activities tied to DY2-6 projects, which providers are going to continue in DY7-8; and 2) new activities selected by providers to support achievement of the selected Measure Bundles.

b. Demonstration Year (DY) 6 - The initial 15-month period of time, as approved by the Centers for Medicare & Medicaid Services (CMS), for which the waiver is extended beyond the initial demonstration period, or October 1, 2016 - December 31, 2017.

   i. Demonstration Year (DY) 6A - Federal fiscal year (FFY) 2017, or the first 12 months of DY6 (October 1, 2016 - September 30, 2017).
   ii. Demonstration Year (DY) 6B - The last three months of DY6 (October 1, 2017 - December 31, 2017).

c. Demonstration Year (DY) 7 - Federal fiscal year (FFY) 2018, which includes DY6B (October 1, 2017 - September 30, 2018). This is also the reporting year (RY) 1.

d. Demonstration Year (DY) 8 - Federal fiscal year (FFY) 2019 (October 1, 2018 - September 30, 2019). This is also the reporting year (RY) 2.

e. Initial demonstration period - The first five demonstration years (DYs) of the waiver, or December 12, 2011 through September 30, 2016.

f. Measure Bundle - A grouping of measures that share a unified theme, apply to a similar population, and are impacted by similar activities. Each bundle may include process measures and patient clinical outcome measures.

g. Medicaid and Low-income or Uninsured (MLIU)

   i. To qualify as a Medicaid individual for purposes of MLIU Patient Population by Provider (PPP), the individual must be enrolled in Medicaid at the time of at least one DSRIP project encounter during the applicable DY.
   ii. To qualify as a low-income or uninsured individual for purposes of MLIU PPP, the individual must either be below 200 percent of the federal poverty level (FPL) 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 or uninsured at the time of a separate DSRIP project encounter during the applicable DY, that individual is classified as a Medicaid individual for purposes of MLIU PPP.

h. Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP) - The number of MLIU individuals served, as well as the ratio of MLIU individuals to total individuals served, by the Performing Provider during an applicable DY.

i. Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP) Goal - The number of MLIU individuals that a Performing Provider must serve, as well as the ratio of MLIU individuals to total individuals that a Performing Provider must serve, in accordance with paragraph 22, during an applicable DY. The goals are based on: 1) the average of the number of MLIU individuals served in DY5 and the number of MLIU individuals served in DY6; and 2) the average of the ratio of MLIU individuals served to total individuals served in DY5 and the ratio of MLIU individuals served to total individuals served in DY6.

j. Uncompensated Care (UC) Only Hospital – A hospital eligible to be a Performing Provider that is not a Performing Provider but receives UC payments.

II. DSRIP ELIGIBILITY CRITERIA

5. RHP Regions

a. <u>RHP Composition</u>

Texas has approved 20 Regional Healthcare Partnerships (RHPs) whose members may participate in the DSRIP program. The approved RHPs share the following characteristics:

- The RHPs are based on distinct geographic boundaries that generally reflect patient flow patterns for the region;
- The RHPs have identified local funding sources to help finance the non-federal share of DSRIP payments for Performing Providers; and
- The RHPs have identified an Anchoring Entity to help coordinate RHP activities.

The approved RHPs include the following counties:

1) RHP 1: Anderson, Bowie, Camp, Cass, Cherokee, Delta, Fannin, Franklin, Freestone, Gregg, Harrison, Henderson, Hopkins, Houston, Hunt, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Trinity, Upshur, Van Zandt, Wood
2) RHP 2: Angelina, Brazoria, Galveston, Hardin, Jasper, Jefferson, Liberty, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, Tyler
3) RHP 3: Austin, Calhoun, Chambers, Colorado, Fort Bend, Harris, Matagorda, Waller, Wharton
4) RHP 4: Aransas, Bee, Brooks, DeWitt, Duval, Goliad, Gonzales, Jackson, Jim Wells, Karnes, Kenedy, Kleberg, Lavaca, Live Oak, Nueces, Refugio, San Patricio, Victoria
5) RHP 5: Cameron, Hidalgo, Starr, Willacy
6) RHP 6: Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Kendall, Kerr, Kinney, La Salle, McMullen, Medina, Real, Uvalde, Val Verde, Wilson, Zavala
7) RHP 7: Bastrop, Caldwell, Fayette, Hays, Lee, Travis
8) RHP 8: Bell, Blanco, Burnet, Lampasas, Llano, Milam, Mills, San Saba, Williamson
9) RHP 9: Dallas, Denton, Kaufman
10) RHP 10: Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, Tarrant, Wise
11) RHP 11: Brown, Callahan, Comanche, Eastland, Fisher, Haskell, Jones, Knox, Mitchell, Nolan, Palo Pinto, Shackelford, Stephens, Stonewall, Taylor
12) RHP 12: Armstrong, Bailey, Borden, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Cottle, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Floyd, Gaines, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, Kent, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley 0, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Scurry, Sherman, Swisher, Terry, Wheeler, Yoakum
13) RHP 13: Coke, Coleman, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Pecos, Reagan, Runnels, Schleicher, Sterling, Sutton, Terrell, Tom Green
14) RHP 14: Andrews, Brewster, Crane, Culberson, Ector, Glasscock, Howard, Jeff Davis, Loving, Martin, Midland, Presidio, Reeves, Upton, Ward, Winkler
15) RHP 15: El Paso, Hudspeth

16) RHP 16: Bosque, Coryell, Falls, Hamilton, Hill, Limestone, McLennan
17) RHP 17: Brazos, Burleson, Grimes, Leon, Madison, Montgomery, Robertson, Walker, Washington
18) RHP 18: Collin, Grayson, Rockwall
19) RHP 19: Archer, Baylor, Clay, Cooke, Foard, Hardeman, Jack, Montague, Throckmorton, Wichita, Wilbarger, Young
20) RHP 20: Jim Hogg, Maverick, Webb, Zapata

b. RHP Tier Definition

i. Tier 1 RHP
An RHP that contains more than 15 percent share of the statewide population under 200 percent of the federal poverty level (FPL) as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS).

ii. Tier 2 RHP
An RHP that contains at least 7 percent and less than 15 percent share of the statewide population under 200 percent FPL as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS).

iii. Tier 3 RHP
An RHP that contains at least 3 percent and less than 7 percent share of the statewide population under 200 percent FPL as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS).

iv. Tier 4 RHP
An RHP is classified in Tier 4 if one of the following three criteria are met: (1) the RHP contains less than 3 percent share of the statewide population under 200 percent FPL as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS); (2) the RHP does not have a public hospital; or (3) the RHP has public hospitals that provide less than 1 percent of the region's uncompensated care.

6. RHP Anchoring Entity

The Texas Health and Human Services Commission (HHSC) delegates to the Anchoring Entity the responsibility of coordination with the RHP participants in the RHP Plan Update for that region. Each RHP shall have one Anchoring Entity that coordinates the RHP Plan Update for that region. In RHPs that have a public hospital, a public hospital shall serve as the Anchoring Entity. In RHPs without a public hospital, the following entities may serve as Anchoring Entities: (1) a hospital district; (2) a hospital authority; (3) a county; or (4) a State university with a health science center or medical school. RHP Anchoring Entities shall be responsible for coordinating RHP activities and assisting HHSC perform key oversight and reporting responsibilities.

Anchoring Entities' activities shall include:

- Coordinating the community needs assessment update for the region;
- Engaging stakeholders in the region, including the public;

- Coordinating the RHP Plan Update that best meets community needs in collaboration with RHP participants;
- Ensuring that the RHP Plan Update is consistent with Attachment TBD, Attachment J, and all other State/waiver requirements;
- Facilitating RHP Plan Update compliance with the RHP Plan Checklist;
- Transmitting the RHP Plan Update to HHSC on behalf of the RHP;
- Ongoing monitoring and annual reporting (as required in paragraphs 33 and 36) on status of activities and performance of Performing Providers in the region; and
- Ongoing communication with HHSC on behalf of the RHP.

7. IGT Entities

Intergovernmental transfer (IGT) Entities are entities that fund the non-federal share of DSRIP payments for an RHP. They include Anchoring Entities, government-owned Performing Providers, community mental health centers (CMHCs), local health departments, academic health science centers, and other government entities such as counties.

An IGT Entity may fund DSRIP, Uncompensated Care (UC), or both DSRIP and UC as long as requirements described herein are met and the IGT funding source comports with federal requirements outlined in STC 55.

IGT Entities may fund DSRIP outside of their RHP. Such funding must be documented in the RHP Plan Update for the RHP in which the Performing Provider is physically located.

8. Performing Providers

"Performing Providers" are providers that are responsible for: 1) implementing core activities supporting the goals of Measure Bundles in an RHP Plan; and 2) measuring, reporting, and improving performance on Measure Bundles in an RHP Plan, among other reporting requirements outlined in this protocol. All Performing Providers must have a current Medicaid provider identification number. Performing Providers that complete milestones and measures as specified in Attachment TBD, “Measure Bundle Protocol” are the only entities that are eligible to receive DSRIP incentive payments in DYs 7-8. Performing Providers will primarily be hospitals, but CMHCs, local health departments, physician practice plans affiliated with an academic health science center, and other types of providers approved by the State and CMS may also receive DSRIP payments. Physician practices plans not affiliated with an academic health science center may also be eligible as Performing Providers.

A Performing Provider may only participate in the RHP Plan where it is physically located except that physician practice plans affiliated with an academic health science center, major cancer hospitals, or children’s hospitals may perform activities outside of the region where the Performing Provider’s institution is physically located.

9. DSRIP Requirements for Uncompensated Care (UC) Only Hospitals

a. A UC only hospital must participate in an annual learning collaborative and report on mandatory Category 4 reporting domains identified in Attachment TBD, “Measure Bundle Protocol."

III. KEY ELEMENTS OF RHP PLAN UPDATES FOR DY7-8

10. RHP Plan Updates for DY7-8

Each RHP Anchoring Entity must submit an RHP Plan Update for DY7-8 using a State-approved template that identifies the participants, objectives, Measure Bundles, milestones, and associated DSRIP values adopted from Attachment TBD, "Measure Bundle," and meets all requirements pursuant to the STCs and described herein.

The RHP Plan Updates shall include the following sections:

1. RHP Organization including collaborating organizations
2. Community Needs Assessment
3. Stakeholder Engagement
4. MLIU Patient Population by Provider (PPP) baselines
5. Measure Bundles for each Performing Provider - including narrative descriptions of the transition from DY2-6 projects to the selected Measure Bundles and planned activities for DY7-8, which could include activities tied to DY2-6 projects, as well as new activities supporting achievement of the selected Measure Bundles.
6. DSRIP valuation amounts
7. Signed certifications from the leadership of Performing Providers

IV. REVIEW AND APPROVAL PROCESS OF RHP PLAN UPDATES FOR DY7-8

11. HHSC Review and Approval Process

a. <u>Submission of RHP Plan Updates</u>
By November 30, 2017, or 30 days after the approval of Attachment TBD, "Measure Bundle Protocol," and Attachment J, "Program Funding and Mechanics Protocol" (whichever is later), each RHP Anchoring Entity will submit the completed RHP Plan Update for DY7-8 for HHSC review.

b. <u>Anchoring Entity Review of RHP Plan Updates</u>
To support HHSC's review process, the RHP Anchoring Entity shall perform an initial review of each Performing Provider's submission for the RHP Plan Update for DY7-8 to ensure compliance with elements described in 11.c. below prior to submitting the RHP Plan Update to HHSC.

c. <u>HHSC Review of RHP Plan Updates</u>

i. HHSC shall review and assess each RHP Plan Update according to the following criteria:
   1. The RHP Plan Update is in the prescribed format.
   2. The RHP Plan Update contains and completes all required elements described herein and is consistent with the STCs.
   3. The RHP Plan Update conforms to the requirements for MLIU Patient Population by Provider (PPP), Measure Bundles, and statewide Measure Bundles as described herein, as well as in Attachment TBD, "Measure Bundle Protocol."
   4. The amount and distribution of funding is in accordance with Section VI "Performing Provider Requirements for DY7-8" and Section VII "Disbursement of DSRIP Funds for DY7-8" of this protocol.
   5. The RHP Plan Update is consistent with the overall goals of the DSRIP program and the objectives of the Medicaid program.

ii. By January 31, 2018, or 60 days following the due date for submission of the RHP Plan Updates, HHSC will complete its review of each RHP Plan Update and will notify the RHP Anchoring Entity in writing of any questions, concerns, or problems identified.

iii. The RHP Anchoring Entity shall respond in writing to any notification by HHSC of questions, concerns, and problems by the date specified in the aforementioned notification.

iv. By March 31, 2018, or 120 days following the due date for submission of the RHP Plan Updates, HHSC will approve or disapprove each RHP Plan Update.

V. PLAN MODIFICATIONS FOR DY7-8

Consistent with the recognized need to provide RHPs with flexibility to modify their RHP Plan Updates over time and take into account evidence and learning from their own experience over time, as well as for unforeseen circumstances or other good cause, an RHP may request prospective changes to its RHP Plan Update through a plan modification process.

12. Plan Modification Process

An RHP may request modifications to an RHP Plan under the following circumstances:

a. <u>Deleting or Terminating a Measure Bundle</u>
An RHP may request to delete or terminate a Measure Bundle from its RHP plan and forgo replacing it if the RHP continues to meet the minimum Measure Bundle requirements outlined in Section VI “Performing Provider Requirements for DY7-8” and the loss of the Measure Bundle does not jeopardize or dilute the remaining delivery system reforms pursued in the plan. An RHP may not redistribute incentive funding from the deleted Measure Bundle to other existing Measure Bundles; the affected Performing Provider and RHP shall forfeit DSRIP allocation associated with the deleted Measure Bundle.

b. <u>Modifying Measure Bundles or MLIU Patient Population by Provider (PPP)</u>
RHPs may submit requests to HHSC to modify elements of measures bundles or MLIU PPP prospectively with good cause. Changes to Measure Bundle selection must be requested by

February 28th, 2018. Other requests must be submitted to HHSC 90 days prior to the next reporting period according to the standardized timeline and other parameters specified by the State.

c. Plan Modification Review and Approval Process
Plan modifications must be submitted in writing to HHSC; HHSC shall take action on the plan modification request and notify providers in writing of any questions or concerns identified. If the requested changes are approved by HHSC, HHSC will notify the providers. Substantial changes in measures bundles or MLIU PPP will be subject to a secondary review and ongoing compliance monitoring by the independent assessor. If the independent assessor disagrees with HHSC's assessment to approve a plan modification, CMS will have an opportunity to review the plan modification and request a re-review by HHSC.

VI. PERFORMING PROVIDER REQUIREMENTS FOR DY7-8

13. DY7-8 Pool Allocation

The DSRIP pool allocation for DY7-8 is $3.1 billion per DY. The $775 million allocated to DY6B is combined with the $2.325 billion agreed to for DY7.

14. Performing Provider Valuation

a. A Performing Provider's total valuation for DY7 and DY8 is equal to its total valuation for DY6A with the following exceptions:

   i. If HHSC determined that a DSRIP project was ineligible to continue in DY6A, then the Performing Provider affected by such a determination may use the funds associated with the DSRIP project beginning in DY7; or
   ii. If a Performing Provider withdrew a DSRIP project between June 30, 2014 and June 30, 2016, then the Performing Provider may use the funds associated with the DSRIP project beginning in DY7.

b. Performing Providers' valuation must comport with the following funding distribution in DY7-8.

DSRIP Funding Distribution

	DY 7	**DY 8**
Category A - required reporting	0%	0%
Category B - MLIU PPP	10%	10%
Category C- Measure Bundles	80 or 85%	80 or 85%
Category D - Statewide Reporting Measure Bundle	5 or 10%	5 or 10%

*If private hospital participation minimums are met as described in paragraph 23, then Performing Providers may increase the Statewide Reporting Measure Bundle funding distribution to 10%.

15. Category B - Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP)

a. Each Performing Provider is required to report the total number of individuals served by their system, as well as the number of MLIU individuals served by their system, each DY to be eligible for 10 percent of the Performing Provider's total valuation.

b. Each Performing Provider is required to submit the baseline total number of individuals served by their system, as well as the baseline number of MLIU individuals served by their system, in the RHP Plan Update.

c. The baseline total number of individuals served and the baseline number of MLIU individuals served must be based on the average of the DY5 and DY6 total number of individuals served and MLIU individuals served. The reported baselines will be subject to compliance monitoring.

d. The number of MLIU individuals served and the ratio of MLIU individuals served to total individuals served must be maintained each DY with an allowable variation. The allowable variation is to be determined by HHSC once providers have submitted their baselines and will be based on provider size and types.

e. The numbers of MLIU individuals served and total individuals served must be reported in the first round of reporting following the end of the DY being reported.

16. Measure Bundle Requirements for Hospitals and Physician Practices

a. The Measure Bundles for hospitals and physician practices may include the following and are described in Attachment TBD, "Measure Bundle Protocol" Category C.

   i. Improved Chronic Disease Management: Diabetes Care
   ii. Improved Chronic Disease Management: Heart Disease
   iii. Primary Care & Prevention - Healthy Texans
   iv. Primary Care & Prevention - Cancer Screening
   v. Pediatric Primary Care
   vi. Improved Maternal/Perinatal Care
   vii. Improved Access to Adult Dental Care
   viii. Palliative Care
   ix. Care Transitions
   x. Integration of Behavioral Health in a Primary Care Setting
   xi. Behavioral Health and Appropriate Utilization
   xii. Access to Specialty Care
   xiii. Chronic Non-Malignant Pain Management
   xiv. Hospital Safety

b. Each Measure Bundle includes process measures and patient clinical outcome measures.

   i. Each measure within a bundle will be pay-for-performance (P4P) or pay-for-reporting (P4R).
   ii. All measures in a bundle must be reported.

c. Each Measure Bundle is assigned a point value as described in Attachment TBD, "Measure Bundle Protocol".

d. Each hospital and physician practice is assigned a minimum point threshold for Measure Bundle selection.

e. Each hospital and physician practice must select Measure Bundles worth enough points to meet its minimum point threshold in order to maintain its valuation.

   i. If a hospital or physician practice selects fewer Measure Bundles than its minimum point threshold, its total valuation will be lowered proportionately.

f. Each Measure Bundle is valued based on the hospital or physician practice's total valuation for "Measure Bundles" proportionally distributed among the selected Measure Bundles based on the point values for each Measure Bundle.

   Example:

   A hospital has a minimum point threshold of 20 points and a "Measure Bundles" valuation of $1 million. The hospital selects Bundle A worth 15 points and Bundle B worth 5 points. Bundle A is valued at $750,000 (15/20 * $1 million). Bundle B is valued at $250,000 (5/20 * $1 million).

g. Each measure within a Measure Bundle is valued equally.

h. A standard point valuation is defined by the State to calculate minimum point thresholds.

i. Minimum Point Thresholds for Hospitals

   i. The minimum point threshold for a hospital is based on the following factors:
      1. The hospital's DY7 valuation.
      2. The hospital's DY6 valuation as a percentage of the DY6 valuations for all hospitals.
      3. The minimum point threshold cap as determined by the State.
      4. The hospital's size and its role in serving Medicaid and uninsured individuals, which may be measured by:

A. The hospital's outpatient Medicaid and uninsured charges as a percentage of all hospitals' Medicaid and uninsured outpatient charges as reported in the Texas Hospital Uncompensated Care Tool (TXHUC) for FFY2016.
B. The hospital's Medicaid and uninsured inpatient days as a percentage of all hospitals' Medicaid and uninsured inpatient days as reported in the Texas Hospital Uncompensated Care Tool (TXHUC) for FFY2016.
C. The hospital's FFY 2016 Disproportionate Share Hospital (DSH) and UC Pool payments as a percentage of the FFY 2016 DSH and UC Pool payments to all hospitals.

Example of how the minimum point threshold for a hospital may be determined:

First, the hospital's Statewide Hospital Factor is determined as follows:

Statewide Hospital Factor =

.25(The hospital's outpatient Medicaid and uninsured charges as a percentage of all hospitals' Medicaid and uninsured outpatient charges as reported in the Texas Hospital Uncompensated Care Tool (TXHUC) for FFY2016) +
.25(The hospital's Medicaid and uninsured inpatient days as a percentage of all hospitals' Medicaid and uninsured inpatient days as reported in the Texas Hospital Uncompensated Care Tool (TXHUC) for FFY2016) +
.50(The hospital's FFY 2016 Disproportionate Share Hospital (DSH) and UC Pool payments as a percentage of the FFY 2016 DSH and UC Pool payments to all hospitals)

Second, the hospital's Statewide Ratio is determined as follows:

Statewide Ratio =
DY6 Valuation as a % of the DY6 valuations for all hospitals/ Statewide Hospital Factor

- If Statewide Ratio ≥ 2:
  Minimum Point Threshold = the lesser of: 1) DY7 Valuation/ Standard Point Valuation ($200,000) x Statewide Ratio/ 2; or 2) Minimum Point Threshold Cap (100 points)
- If Statewide Ratio < 2:
  Minimum Point Threshold = the lesser of: 1) DY7 Valuation/ Standard Point Valuation ($200,000); or 2) Minimum Point Threshold Cap (100 points)

ii. The minimum point threshold for a hospital that does not have data for the factors under paragraph 24.i.i.4. will be determined by HHSC.

j. Minimum Point Thresholds for Physician Practices

i. The minimum point threshold for a physician practice Performing Provider is based on the following factors:
   1. The physician practice's DY7 valuation.
   2. The physician practice's DY6 valuation as a percentage of the DY6 valuations for all physician practices.
   3. The minimum point threshold cap as determined by the State.
   4. The physician practice's size and its role in serving Medicaid and uninsured individuals, which may be measured by:
      A. The physician practice's outpatient Medicaid and uninsured charges as a percentage of all physician practices' Medicaid and uninsured outpatient charges as reported in the Texas Hospital Uncompensated Care Tool (TXHUC) for FFY2016.
      B. The physician practice's Medicaid and uninsured inpatient days as a percentage of all physician practices' Medicaid and uninsured inpatient days as reported in the Texas Hospital Uncompensated Care Tool (TXHUC) for FFY2016.
      C. The physician practice's FFY 2016 Disproportionate Share Hospital (DSH) and UC Pool payments as a percentage of the FFY 2016 DSH and UC Pool payments to all physician practices.

Example of how the minimum point threshold for a physician practice may be determined:

First, the physician practice's Statewide Hospital Factor is determined as follows:

Statewide Physician Practice Factor =

.25(The physician practice's outpatient Medicaid and uninsured charges as a percentage of all physician practices' Medicaid and uninsured outpatient charges as reported in the Texas Hospital Uncompensated Care Tool (TXHUC) for FFY2016) +
.25(The physician practice's Medicaid and uninsured inpatient days as a percentage of all physician practices' Medicaid and uninsured inpatient days as reported in the Texas Hospital Uncompensated Care Tool (TXHUC) for FFY2016) +
.50(The physician practice's FFY 2016 Disproportionate Share Hospital (DSH) and UC Pool payments as a percentage of the FFY 2016 DSH and UC Pool payments to all physician practices)

Second, the physician practice's Statewide Ratio is determined as follows:

Statewide Ratio =
DY6 Valuation as a % of the DY6 valuations for all physician practices/
Statewide Hospital Factor

- If Statewide Ratio ≥ 2:
  Minimum Point Threshold = the lesser of: 1) DY7 Valuation/ Standard Point Valuation ($200,000) x Statewide Ratio/ 2; or 2) Minimum Point Threshold Cap (100 points)
- If Statewide Ratio < 2:
  Minimum Point Threshold = the lesser of: 1) DY7 Valuation/ Standard Point Valuation ($200,000); or 2) Minimum Point Threshold Cap (100 points)

ii. The minimum point threshold for a physician practice that does not have data for the factors under 16.j.i.3. will be determined by HHSC.

17. Measure Bundle Requirements for Community Mental Health Centers (CMHCs)

a. Each CMHC is required to select a combination of measures to create one or more Measure Bundles as described in Attachment TBD, "Measure Bundle Protocol" Category C.

b. Each measure is assigned a point value by the State.

c. Each measure within a Measure Bundle is valued equally.

18. Measure Bundle Requirements for Local Health Departments (LHDs)

a. Each LHD is required to select a combination of measures to create one or more Measure Bundles as described in Attachment TBD, "Measure Bundle Protocol" Category C.

b. Each measure is assigned a point value by the State.

c. Each measure within a Measure Bundle is valued equally.

19. Measurement Periods for P4P Measures

a. The baseline period is Calendar Year 2017 (January 1, 2017 - December 31, 2017).

b. Performance Year (PY) 1 is Calendar Year 2018 (January 1, 2018 - December 31, 2018).

c. PY2 is Calendar Year 2019 (January 1, 2019 - December 31, 2019).

d. Exceptions to P4P measure measurement periods may be indicated in the Measure Bundle Protocol for measures where a calendar year measurement period would impact the continuity of data reported (example: NQF 0041 Influenza Immunization, where the measure steward specifies a denominator inclusion period of visits between October 1 and March 31st to align with the flu season).

20. Measure Milestones

a. The milestone structure and valuation for DY7-8 is as follows:

	P4R Measure	P4P Measure
DY7	100% Reporting Year (RY) 1 reporting milestone	25% baseline reporting milestone
		25% PY1 reporting milestone
		50% PY1 goal achievement milestone
DY8	100% RY2 reporting milestone	25% PY2 reporting milestone
		75% PY2 goal achievement milestone

b. A baseline must be reported and approved to report PY1. Approval is for reporting purposes only. PY1 may be reported in the reporting period following baseline review.

   i. Providers must adhere to measure specifications and maintain a record of any variances that were approved by HHSC prior to reporting baseline.
   ii. Approval of a reported baseline does not constitute approval to report outside measure specifications. If at any point HHSC or a Compliance Monitor identifies that a provider is reporting a measure outside measure specification, reporting and goal achievement milestone payment may be withheld or recouped while the provider works to bring reporting into compliance with specifications.

c. Reporting and goal achievement for a performance year must be reported in the same reporting period.

21. Measure Denominator Population

a. Each measure's denominator population must include all individuals served by the provider system during a given measurement period.

b. Facility, co-morbid condition, age, gender, and race/ethnicity subsets are not allowed.

c. For P4P measures, each Performing Provider is paid for achievement of the MLIU rate.

   i. Providers may request at the time of measure selection to be paid for achievement on the all-payer, Medicaid only, or LIU only rate with justification, such as data limitations or small volume.

d. For P4P and P4R measures, each Performing Provider is required to report the rate for each of the following payer types to be eligible for payment of the reporting milestone for the measure: All-Payer, Medicaid, and LIU.

   i. Providers may request at the time of measure selection to be exempt from reporting the rate for Medicaid or LIU due to data limitations.

22. Methodology for Setting P4P Measure Goals

Goals are set as an improvement over the baseline. Each measure will be designated in the Measure Bundle Protocol as either Quality Improvement System for Managed Care (QISMC) or Improvement over Self (IOS). QISMC measures will have a defined High Performance Level (HPL) and Minimum Performance Level (MPL) based on state or national benchmarks.

		DY7/PY1	**DY8/PY2**
QISMC	Baseline below MPL	MPL	10% gap closure between the MPL and HPL
	Baseline Between MPL and HPL	The greater absolute value of improvement between: 10% Gap Closure towards HPL, or baseline plus (minus) 5% of the difference between the HPL and MPL, not to exceed the HPL	The greater absolute value of improvement between: 20% Gap Closure towards HPL, or baseline plus (minus) 10% of the difference between the HPL and MPL, not to exceed the HPL.
	Baseline above HPL*	HPL	HPL
IOS		5% Gap Closure	10% Gap Closure
*measures with a baseline above the HPL are not eligible for partial achievement.			

23. Category D - Statewide Reporting Measure Bundle

a. Each Performing Provider is required to report on the Statewide Reporting Measure Bundle according to the type of Performing Provider as described in Attachment TBD, “Measure Bundle Protocol”.

b. Category D is valued at 5 percent of a Performing Provider's total valuation. Category D may be increased to 10 percent of a Performing Providers' total valuation if the requirements under paragraph 23.c. are met.

c. A region must maintain the following private hospital participation at submission of the RHP Plan DY7-8 update. A 3 percent decrease may be allowed in each region and considered maintenance.

Private Hospital Participation

RHP	Private Hospital Valuation	Minimum Private Hospital Valuation in each DY
1	$38,856,709	$37,691,007
2	$12,933,175	$12,545,180
3	$133,630,962	$129,622,034
4	$52,527,267	$50,951,449
5	$116,996,712	$113,486,810
6	$67,998,588	$65,958,631
7	$84,513,275	$81,977,876
8	$9,607,121	$9,318,907
9	$114,588,283	$111,150,635
10	$52,415,564	$50,843,097
11	$21,345,261	$20,704,903
12	$40,896,051	$39,669,169
13	$14,111,711	$13,688,360
14	$13,799,933	$13,385,935
15	$39,491,671	$38,306,921
16	$6,915,842	$6,708,367
17	$12,637,136	$12,258,022
18	$13,270,499	$12,872,384
19	$5,832,483	$5,657,509
20	$15,636,426	$15,167,333
TOTAL	**$868,004,670**	**$841,964,530**

d. Each Category D measure is valued equally within a bundle.

VII. DISBURSEMENT OF DSRIP FUNDS FOR DY7-8

24. Category A - Eligibility for DY7-8 Payments

Each Performing Provider is required to complete the following as a basis to be eligible for payment of Categories B-D.

a. Core Activities
Each Performing Provider must report on progress and updates to core activities indicated in the RHP Plan Update during the second reporting period of each DY.

b. Alternative Payment Methodology
Each Performing Provider must report on any progress toward or implementation of Alternative Payment Model (APM) arrangements with Medicaid managed care organizations (MCOs) or other payors during the second reporting period of each DY.

c. Costs and Savings
Each Performing Provider must submit costs of the core activities and forecasted/generated savings in a template approved by HHSC or a comparable template during the second reporting period of each DY.

d. Collaborative Activities
Each Performing Provider is required to attend at least one learning collaborative, stakeholder forum, or other stakeholder meeting each DY and report on participation during the second reporting period of each DY.

25. Basis for Payment of Category B - MLIU PPP

The number of MLIU individuals served and the ratio of MLIU individuals served to total population served by the Participating Provider must be maintained each DY with an allowable variation from the baseline as described in paragraph 15.d. to be eligible for payment of the MLIU PPP milestone. The milestone payment will be split evenly between achievement of the numeric value of MLIU individuals and the ratio of MLIU individuals to total individuals served in the system. The allowable variation below the maintenance goal (baseline) will be determined by HHSC and is to be based on the size and type of provider. If a provider is unable to maintain the number or the ratio within the allowable variation, then the payment associated with the number or ratio will be reduced. Payments will be made at 100%, 90%, 75%, 50% or 0% of the portion of the milestone value (whether the MLIU numeric goal or the MLIU percentage goal), based on the allowable variation.

26. Basis for Payment of Category C - Measure Bundles

a. Reporting Milestones
A Performing Provider must fully achieve reporting milestones to qualify for a DSRIP payment related to these milestones.

b. Achievement Milestones
Partial payment is available in quartiles for partial achievement measured over baseline in PY1 and PY2. QISMC measures with a baseline above the HPL are not eligible for partial achievement.

i. Each measure has an associated achievement milestone that is assigned an achievement value based on the performer's achievement of the measure's goal as follows:

- If 100 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 1.0;
- If at least 75 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.75;
- If at least 50 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.5;

- If at least 25 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.25; or
- If less than 25 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.

ii. The percent of the goal achieved for DY7-8 milestones is determined as follows:

- DY7 partial achievement = (PY1 Achieved - Baseline)/(PY1 Goal - Baseline)
- DY8 partial achievement = (PY2 Achieved - Baseline)/(PY2 Goal - Baseline)

27. Basis for Payment of Category D - Statewide Reporting Measure Bundle

The amount of the incentive funding paid to a Performing Provider will be based on the amount of progress made in successfully reporting all measures included in a reporting domain. A Performing Provider must complete reporting on all Category D measures included in a reporting domain prior to requesting incentive payments.

28. Carry-forward Policy

If a Performing Provider does not report a measure in a Measure Bundle that was specified in its RHP Plan Update for completion in a particular demonstration year, the available incentive funding associated with the milestone will be carried forward until the end of the following demonstration year during which the Performing Provider may report the measure and receive full payment. Incentive funding that is carried forward still remains associated with the original demonstration year for all accounting purposes (including calculation of the annual DSRIP payment limits). Carrying forward reporting does not change baseline or performance measurement periods.

Carried forward DSRIP funding is subject to all Medicaid claiming requirements and may be paid no later than two years after the end of a demonstration year in which it was to have been completed (e.g., for DY 7, which ends September 30, 2018, payments may be made no later than September 30, 2020). Although authority for DSRIP funding expires September 30, 2019, DSRIP payment may be claimed after this point, subject to the carry-forward provisions in this section.

The carry-forward policy does not apply to Category B - MLIU PPP or Category D -Statewide Reporting Measure Bundle.

29. Penalties for Missed Milestones

If a Performing Provider does not report the measures during the 12-month carry-forward period or the reporting year with respect to MLIU PPP and Category D, funding for the incentive payment shall be forfeited by the provider.

30. Remaining DY7-8 DSRIP Funds - TBD

VIII. RHP AND STATE REPORTING REQUIREMENTS

31. RHP Reporting in DYs 7-8

Two times per year, Performing Providers seeking payment under the DSRIP program shall submit reports to HHSC demonstrating progress achieved during the reporting period. The reports shall be submitted using the standardized reporting form approved by HHSC. IGT Entities will review the submission of the reported performance. Based on the reports, HHSC will calculate the incentive payments for the progress achieved in accordance with Section VII "Disbursement of DSRIP Funds for DY7-8". The Performing Provider shall have available for review by Texas or CMS, upon request, all supporting data and back-up documentation. These reports will be due as indicated below after the end of each reporting period:

- Reporting period of October 1 through March 31: the reporting and request for payment is due April 30.
- Reporting period of April 1 through September 30: the reporting and request for payment is due October 31.

These reports will serve as the basis for authorizing incentive payments to Performing Providers in an RHP for achievement of DSRIP milestones. HHSC shall have 30 days to review and approve or request additional information regarding the data reported for each milestone. If additional information is requested, the Performing Provider shall respond to the request within 15 days and HHSC shall have an additional 15 days to review, approve, or deny the request for payment, based on the data provided. HHSC shall schedule the payment transaction for each RHP Performing Provider within 30 days following HHSC approval of the Performing Provider's RHP report.

32. Intergovernmental Transfer Process

HHSC will calculate the nonfederal share amount to be transferred by an IGT Entity in order to draw the federal funding for the incentive payments related to the milestone achievement that is reported by the Performing Provider in accordance with paragraph 31 and approved by the IGT Entity and the State. Within 14 days after notification by HHSC of the identified nonfederal share amount, the IGT Entity will make an intergovernmental transfer of funds. The State will draw the federal funding and pay both the nonfederal and federal shares of the incentive payment to the Performing Provider. If the IGT is made within the appropriate 14-day timeframe, the incentive payment will be disbursed within 30 days. The total computable incentive payment must remain with the Performing Provider.

At the time that HHSC requests IGT funding for DSRIP incentive payments, the state may also require the IGT Entity to transfer additional funds to provide a portion of the non-federal share of the state's administrative costs related to waiver monitoring activities, as permitted under the state plan.

33. RHP Annual Year End Report

Each RHP Anchoring Entity shall submit an annual report by December 15 following the end of Demonstration Years 7-8. The annual report shall be prepared and submitted using the standardized reporting form approved by HHSC. The report will include information provided in the interim reports previously submitted for the Demonstration Year. Additionally, the RHP will provide a narrative description of the progress made, lessons learned, challenges faced, stakeholder engagement, and other pertinent findings.

34. Texas Reporting to CMS

a. Quarterly and Annual Reporting
DSRIP will be a component of the State's quarterly operational reports and annual reports related to the Demonstration. These reports will include:

iii. All DSRIP payments made to Performing Providers that occurred in the quarter as required in the quarterly payment report pursuant to STC 53(b);
iv. Expenditure projections reflecting the expected pace of future disbursements for each RHP and Performing Providers;
v. A summary assessment of each RHP's DSRIP activities during the given period including progress on milestones; and
vi. Evaluation activities and interim findings for the evaluation design pursuant to STC 73.

b. Claiming Federal Financial Participation
Texas will claim federal financial participation (FFP) for DSRIP incentive payments on the CMS 64.9 waiver form. FFP will be available only for DSRIP payments made in accordance with all pertinent STCs and Attachment TBD, "Measure Bundle Protocol" and Attachment J, "Program Funding and Mechanics Protocol."

IX. DATA QUALITY ASSURANCE

35. Data validation and alignment with managed care

Data and metrics that form the basis of incentive payments in DSRIP should have a high degree of accuracy and validity. The state must require that each Performing Provider certify that data received to demonstrate DSRIP achievement is accurate and complete. Data accuracy and validity also will be subject to review by the independent assessor.

Consistent with the requirements of STC 28, the state will update its comprehensive quality strategy and include in its annual report to CMS opportunities to better standardize quality measurement between DSRIP and the state's Medicaid managed care programs in order to reduce administrative burden and ensure greater validity and reliability for performance measures.

36. Compliance Monitoring of DSRIP Projects

All RHP plans are subject to potential audits, including review by the independent assessor. Upon request, Performing Providers must have available for review by the independent assessor, HHSC, and CMS, all supporting data and back-up documentation demonstrating performance as described under an RHP plan for DSRIP payments.

Failure of a Performing Provider to provide supporting documentation of milestone achievement to the independent assessor or HHSC within the defined period of time may result in recoupment of DSRIP payments.

HHSC may recoup funding for a milestones when a provider's documentation does not support the information reported.

ADDENDUM - DY1-6 REQUIREMENTS

I. PREFACE

On December 12, 2011, the Centers for Medicare and Medicaid Services (CMS) approved the Texas request for a new Medicaid demonstration waiver entitled "Texas Healthcare Transformation and Quality Improvement Program" (Project # 11-W-00278/6) in accordance with section 1115 of the Social Security Act. The new waiver was approved through September 30, 2016.

1. Delivery System Reform Incentive Payment Program

Special Terms and Conditions (STC) 45 of the Demonstration authorizes Texas to establish a Delivery System Reform Incentive Payment (DSRIP) program. Initiatives under the DSRIP program are designed to provide incentive payments to hospitals and other providers for investments in delivery system reforms that increase access to health care, improve the quality of care, and enhance the health of patients and families they serve.

The program of activity funded by the DSRIP shall be based on Regional Healthcare Partnerships (RHPs). Each RHP shall have geographic boundaries and will be coordinated by a public hospital or local governmental entity with the authority to make intergovernmental transfers. The public hospital or local governmental entity shall collaborate with hospitals and other potential providers to develop an RHP Plan that will accelerate meaningful delivery system reforms that improve patient care for low-income populations. The RHP Plans must be consistent with regional shared mission and quality goals of the RHP and CMS's triple aims to improve care for individuals (including access to care, quality of care, and health outcomes); improve health for the population; and lower costs through improvements (without any harm whatsoever to individuals, families, or communities).

2. RHP Planning Protocol and Program Funding and Mechanics Protocol

In accordance with STC 45(a) and 45(d)(ii)(A) & (B), the RHP Planning Protocol (Attachment I) defines the specific initiatives that will align with the following four categories: (1) Infrastructure Development; (2) Program Innovation and Redesign; (3) Quality Improvements; and (4) Population-focused Improvements. The Program Funding and Mechanics Protocol (Attachment J) describes the State and CMS review process for RHP Plans, incentive payment methodologies, RHP and State reporting requirements, and penalties for missed milestones.

Following CMS approval of Attachment I and Attachment J, each RHP must submit an RHP Plan that identifies the projects, outcomes, population-focused objectives, and specific milestones and metrics in accordance with these attachments and STCs.

This version of the Program Funding and Mechanics Protocol is approved as of May 22, 2014.

3. Organization of "Attachment J: Program Funding and Mechanics Protocol"

4.

Attachment J has been organized into the following sections:

X. Preface
XI. DSRIP Eligibility Criteria
XII. Key Elements of Proposed RHP Plans
XIII. State and Federal Review Process of RHP Plans
XIV. RHP and State Reporting Requirements
XV. Disbursement of DSRIP Funds
XVI. Plan Modifications
XVII. Carry-forward and Penalties for Missed Milestones

II. DSRIP ELIGIBILITY CRITERIA

5. RHP Regions

Texas has approved 20 Regional Healthcare Partnerships whose members may participate in the DSRIP program. The approved RHPs share the following characteristics:

- The RHPs are based on distinct geographic boundaries that generally reflect patient flow patterns for the region;
- The RHPs have identified local funding sources to help finance the non-federal share of DSRIP payments for Performing Providers; and
- The RHPs have identified an Anchoring Entity to help coordinate RHP activities.

The approved RHPs include the following counties:

1. RHP 1: Anderson, Bowie, Camp, Cass, Cherokee, Delta, Fannin, Franklin, Freestone, Gregg, Harrison, Henderson, Hopkins, Houston, Hunt, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Trinity, Upshur, Van Zandt, Wood

2. RHP 2: Angelina, Brazoria, Galveston, Hardin, Jasper, Jefferson, Liberty, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, Tyler

3. RHP 3: Austin, Calhoun, Chambers, Colorado, Fort Bend, Harris, Matagorda, Waller, Wharton

4. RHP 4: Aransas, Bee, Brooks, DeWitt, Duval, Goliad, Gonzales, Jackson, Jim Wells, Karnes, Kenedy, Kleberg, Lavaca, Live Oak, Nueces, Refugio, San Patricio, Victoria

5. RHP 5: Cameron, Hidalgo, Starr, Willacy

6. RHP 6: Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Kendall, Kerr, Kinney, La Salle, McMullen, Medina, Real, Uvalde, Val Verde, Wilson, Zavala

7. RHP 7: Bastrop, Caldwell, Fayette, Hays, Lee, Travis

8. RHP 8: Bell, Blanco, Burnet, Lampasas, Llano, Milam, Mills, San Saba, Williamson

9. RHP 9: Dallas, Denton, Kaufman

10. RHP 10: Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, Tarrant, Wise

11. RHP 11: Brown, Callahan, Comanche, Eastland, Fisher, Haskell, Jones, Knox, Mitchell, Nolan, Palo Pinto, Shackelford, Stephens, Stonewall, Taylor

12. RHP 12: Armstrong, Bailey, Borden, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Cottle, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Floyd, Gaines, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, Kent, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley 0, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Scurry, Sherman, Swisher, Terry, Wheeler, Yoakum

13. RHP 13: Coke, Coleman, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Pecos, Reagan, Runnels, Schleicher, Sterling, Sutton, Terrell, Tom Green

14. RHP 14: Andrews, Brewster, Crane, Culberson, Ector, Glasscock, Howard, Jeff Davis, Loving, Martin, Midland, Presidio, Reeves, Upton, Ward, Winkler

15. RHP 15: El Paso, Hudspeth

16. RHP 16: Bosque, Coryell, Falls, Hamilton, Hill, Limestone, McLennan

17. RHP 17: Brazos, Burleson, Grimes, Leon, Madison, Montgomery, Robertson, Walker, Washington

18. RHP 18: Collin, Grayson, Rockwall

19. RHP 19: Archer, Baylor, Clay, Cooke, Foard, Hardeman, Jack, Montague, Throckmorton, Wichita, Wilbarger, Young

20. RHP 20: Jim Hogg, Maverick, Webb, Zapata

6. RHP Anchoring Entity

The Texas Health and Human Services Commission (HHSC) delegates to the Anchoring Entity the responsibility of coordination with the RHP participants in development of the RHP Plan for that region. Each RHP shall have one Anchoring Entity that coordinates the development of the RHP Plan for that region. In RHPs that have a public hospital, a public hospital shall serve as

the Anchoring Entity. In regions without a public hospital, the following entities may serve as anchors: (1) a hospital district; (2) a hospital authority; (3) a county; or (4) a State university with a health science center or medical school. RHP Anchoring Entities shall be responsible for coordinating RHP activities and assisting HHSC perform key oversight and reporting responsibilities.

Anchoring Entities activities shall include:

- Coordinating the development of a community needs assessment for the region;
- Engaging stakeholders in the region, including the public;
- Coordinating the development the 5-year RHP Plan that best meets community needs in collaboration with RHP participants;
- Ensuring that the RHP Plan is consistent with Attachment I, Attachment J, and all other State/waiver requirements;
- Facilitating RHP Plan compliance with the RHP Plan Checklist;
- Transmitting the RHP Plan and any associated plan amendments to HHSC on behalf of the RHP;
- Ongoing monitoring and annual reporting (as required in paragraphs 16 and 24) on status of projects and performance of Performing Providers in the region; and
- Ongoing communication with HHSC on behalf of the RHP.

7. IGT Entities

Intergovernmental transfer (IGT) Entities are entities that fund the non-federal share of DSRIP payments for an RHP. They include Anchoring Entities, government-owned Performing Providers, community mental health centers (CMHCs), local health departments, academic health science centers, and other government entities such as counties.

An IGT Entity may fund DSRIP, Uncompensated Care (UC), or both DSRIP and UC as long as regional requirements are met, as described in Section VI "Disbursement of DSRIP Funds" and the IGT funding source comports with federal requirements outlined in paragraph 55 of the waiver's special terms and conditions.

IGT Entities may fund DSRIP projects outside of their RHP Region. Such a DSRIP project must be documented in the RHP Plan where the Performing Provider implementing the DSRIP project is physically located, with a few exceptions described in 7 below.

8. Performing Providers

Providers that are responsible for performing a project in an RHP Plan are called "Performing Providers." All Performing Providers must have a current Medicaid provider identification number. Performing Providers that complete RHP project milestones and measures as specified in Attachment I, "RHP Planning Protocol" are the only entities that are eligible to receive DSRIP incentive payments in DYs 2-5. Performing Providers will primarily be hospitals, but CMHCs, local health departments, physician practice plans affiliated with an academic health science center, and other types of providers approved by the State and CMS may also receive DSRIP

payments. Physician practices plans not affiliated with an academic health science center may also be eligible as Performing Providers under the "Pass 2" methodology as described in paragraph 29.d.

A Performing Provider may only participate in the RHP Plan where it is physically located except that physician practice plans affiliated with an academic health science center, major cancer hospitals, or children's hospitals may perform projects outside of the region where the Performing Provider's institution is physically located if it receives an allocation from that region in accordance with the process described in paragraph 29. In these cases, the project must be included in the RHP Plan where the DSRIP project is implemented. All related DSRIP payments for the project(s) are counted against the allocation of that RHP Plan as specified in Section VI "Disbursement of DSRIP Funds".

9. DSRIP and Uncompensated Care Pool

a. <u>UC Pool Description</u>
STC 44 establishes an Uncompensated Care Pool to help defray uncompensated care costs provided to Medicaid eligibles or to individuals who have no source of third party coverage, for services provided by hospitals or other selected providers.

b. <u>DSRIP Requirements for UC Pool Program Participants</u>
Hospitals that receive payments from the Uncompensated Care Pool shall participate in the RHP and be required to report on a subset of Category 4 measures from Attachment I, "RHP Planning Protocol". The subset of Category 4 measures fall into 3 domains: (1) Potentially Preventable Admissions (PPAs); (2) Potentially Preventable Readmissions (PPRs) and (3) Potentially Preventable Complications (PPCs). Category 4 reporting shall begin in DY 3 for the PPA and PPR domains, and in DY 4 for the PPC domain and continue through DY 5. Hospitals that only participate in UC shall not be eligible to receive DSRIP funding for required Category 4 reporting. If a hospital fails to report on all required Category 4 measures by the last quarter of the applicable Demonstration Year, the hospital shall forfeit one fourth of its total UC payments for that DY. A hospital may request from HHSC a 6-month extension from the end of the DY to report any outstanding Category 4 measures. The fourth-quarter UC payment will be made upon completion of the outstanding required Category 4 measure reports within the 6-month period. A hospital may receive only one 6-month extension to complete Category 4 reporting for each demonstration year. This requirement shall apply to all UC participating hospitals, including hospital Performing Providers that are fully participating in DSRIP. Hospitals that meet the criteria described in paragraph 11.f below are exempt from this requirement.

UC hospital participants shall also participate in learning collaboratives conducted annually during DYs 3-5 to share learning, experiences, and best practices acquired from the DSRIP program across the State.

III. KEY ELEMENTS OF PROPOSED RHP PLANS

10. RHP Plans

Each RHP must submit an RHP Plan using a State-approved template that identifies the projects, objectives, and specific milestones, metrics, measures, and associated DSRIP values adopted from Attachment I, "RHP Planning Protocol" and meet all requirements pursuant to STCs 45 and 46. The project and DSRIP payments are documented in the RHP Plan where the Performing Provider of the DSRIP project is physically located. An exception applies to projects performed by physician practice plans affiliated with an academic health science center, major cancer hospitals, or children's hospitals in locations outside of the RHP region where these Performing Providers are physically located (as discussed in paragraph 7 above). In these cases, the project must be documented in the RHP Plan where the DSRIP project is implemented.

11. Organization of RHP Plan

a. Executive Summary
The Executive Summary shall provide a summary of the RHP Plan, a summary of the RHP's vision of delivery system transformation, a description of the RHP's patient population, a description of the health system, and a table of the projects being funded including project titles, brief descriptions of the projects, and the five-year goals. The Executive Summary shall also include a description of key challenges facing the RHP and how the five-year RHP Plan realizes the RHP's vision.

b. Description of RHP Organization
The RHP Plan shall describe how the RHP is organized and include information on RHP participants including the Anchoring Entity, IGT Entities, Performing Providers, and other stakeholders.

c. Community Needs Assessment
The RHP Plan shall include a community needs assessment for the five-year period that has the following elements for the region:

i. Demographic information (e.g., race/ethnicity, income, education, employment, etc.)
ii. Insurance coverage (e.g., commercial, Medicaid, Medicare, uncompensated care);
iii. Description of the region's current health care infrastructure and environment (e.g., number/types of providers, services, systems, and costs; Health Professional Shortage Area [HPSA]);
iv. Description of any initiatives in which providers in the RHP are participating that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives underway in the RHP region.
v. Description of changes in the above areas, i. – iv., expected to occur during the waiver period of federal fiscal years 2012-16.
vi. Key health challenges specific to the region supported by data (e.g., high diabetes rates, access issues, high emergency department [ED] utilization, etc.)

The RHP's community needs assessment should guide, and be reflected in, the RHP Plan and selection of projects. The community needs assessment may be compiled from existing data sources.

d. Stakeholder Engagement
The RHP Plan shall include a description of the processes used to engage and reach out to the following stakeholders regarding the DSRIP program:

i. Hospitals and other providers in the region.
ii. Public stakeholders and consumers, including processes used to solicit public input into RHP Plan development and opportunities for public discussion and review prior to plan submission.
iii. A plan for ongoing engagement with public stakeholders.
iv. At a minimum, a description of public meetings that were held in different areas of the RHP Region, the public posting of the RHP Plan, and the process for submitting public comment on the RHP Plan.

e. RHP Plan Development
The RHP Plan shall describe the regional approach for addressing the community needs and goals, process for evaluating and selecting projects, and identification of Pass 1 and Pass 2 projects. The RHP Plan shall also include as an appendix a list of projects that were considered but not selected.

12. Number of Projects and Measures

a. General Requirements for Categories 1-4
Pursuant to Attachment I, RHP Planning Protocol, an RHP Plan must meet the following requirements:

i. RHPs must select a minimum number of projects from Categories 1 and 2. The number of minimum projects will differ for RHPs depending on their Tier classification (defined below). An RHP's Tier classification is displayed in Table 1 of Section VI "Disbursement of DSRIP Funds";

ii. Both hospital-based and non-hospital Performing Providers must establish outcomes in Category 3 that tie back to their Category 1 and 2 projects; and

iii. Hospital-based Performing Providers must report on the population-focused improvement measures across five domains identified in Category 4.

Certain hospital Performing Providers defined in 11.f below shall be exempt from selected requirements.

c. RHP Tier Definition

37. Tier 1 RHP
An RHP that contains more than 15 percent share of the statewide population under 200 percent of the federal poverty level (FPL) as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS).

38. Tier 2 RHP

An RHP that contains at least 7 percent and less than 15 percent share of the statewide population under 200 percent FPL as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS).

39. Tier 3 RHP
An RHP that contains at least 3 percent and less than 7 percent share of the statewide population under 200 percent FPL as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS).

40. Tier 4 RHP
An RHP is classified in Tier 4 if one of the following three criteria are met: (1) the RHP contains less than 3 percent share of the statewide population under 200 percent FPL as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS); (2) the RHP does not have a public hospital; or (3) the RHP has public hospitals that provide less than 1 percent of the region's uncompensated care.

c. Categories 1 and 2 Projects

i. Tier 1 RHP
A Tier 1 RHP must select a minimum of 20 projects from Categories 1 and 2 combined, with at least 10 of the 20 projects selected from Category 2, in accordance with Attachment I, "RHP Planning Protocol", which lists the acceptable projects, milestones, metrics, and data sources.

ii. Tier 2 RHP
A Tier 2 RHP must select a minimum of 12 projects from Categories 1 and 2 combined, with at least 6 of the 12 projects selected from Category 2, in accordance with Attachment I, "RHP Planning Protocol", which lists the acceptable projects, milestones, metrics, and data sources.

iii. Tier 3 RHP
A Tier 3 RHP must select a minimum of 8 projects from Categories 1 and 2 combined, with at least 4 of the 8 projects selected from Category 2, in accordance with Attachment I, "RHP Planning Protocol, which lists the acceptable projects, milestones, metrics, and data sources.

iv. Tier 4 RHP
A Tier 4 RHP must select a minimum of 4 projects from Categories 1 and 2 combined, with at least 2 of the 4 projects selected from Category 2, in accordance with Attachment I, "RHP Planning Protocol", which lists the acceptable projects, milestones, metrics, and data sources.

v. Performing Provider Participation in Categories 1 and 2

1. A Performing Provider in an RHP Plan must, at a minimum, participate in a project(s) from either Category 1 or Category 2, and if it chooses to, may participate in projects from both Categories;
2. The RHP Plan must explain how incentive payments to Performing Providers that perform a similar DSRIP project are not duplicative. For example, if two Performing Providers offer diabetes disease management, they must describe how the projects are serving different patients; and

3. The RHP Plan must explain how incentive payments do not duplicate funding for activities of federal initiatives funded by the U.S. Department of Health and Human Services.

d. Category 3: Outcome Reporting and Improvements

i. For each of its Category 1 and 2 projects, every Performing Provider must have one or more related Category 3 outcomes. The outcomes shall assess the results of care experienced by patients, including patients' clinical events, patients' recovery and health status, patients' experiences in the health system, and efficiency/cost. A single Category 3 outcome may tie back to more than one project in Categories 1 or 2 implemented by the Performing Provider. All Category 3 outcomes must be reported to specifications as outlined in the RHP Planning Protocol (and the compendium, which contains specifications for each outcome).

ii. Performing Providers shall report on outcome improvement over baseline in DY 4 and DY 5. In DYs 2 and 3, Performing Providers may undertake actions/steps to establish baselines and prepare for outcome reporting in DYs 4 and 5. These preparatory activities will be reflected as process milestones in the RHP Plan.

a. A hospital Performing Provider shall identify the outcome(s) it has selected for its Category 1 and 2 projects in the RHP Plan. Such baselines must be established for no later than DY 3.
b. A non-hospital Performing Provider may defer identifying outcomes for its Category 1 and 2 projects until a date defined by HHSC, at which point new, approved outcomes shall be added to the RHP Planning Protocol and incorporated into the RHP Plan. A non-hospital Performing Provider must complete establishment of baselines for its selected outcomes for no later than DY 3.
c. Each Performing Provider shall have the opportunity during DY 3, based on the revised RHP Planning Protocol and Category 3 framework, to modify the outcome(s) previously selected for its Category 1 and 2 projects, in a manner specified by HHSC.
d. If the provider's baseline (DY 3) performance on a Category 3 measure exceeds their DY 5 target, the provider must either increase the DY 5 target to exceed their baseline performance or add an alternate improvement activity, as described in the RHP Planning Protocol.

e. Category 4 "Pay for Reporting" Measures

Pursuant to STC 45(d)(ii)(A), all hospital-based Performing Providers in all RHPs must report on all common Category 4 measures. A Performing Provider may also choose to report on additional optional measures. In accordance with this requirement, beginning in DY 3 (FFY 14) and DY 4 (FFY 15) hospital-based Performing Providers in all RHPs must include reporting of all common domains, pursuant to Attachment I, "RHP Planning Protocol". Hospitals defined under paragraph 11.f are exempt from reporting Category 4 measures. If an exempted hospital elects to report Category 4, then it shall report on all

common Category 4 measures and be held to the same requirements as all other Performing Providers participating in Category 4. If a hospital-based Performing Provider's population for a given measure is not sufficiently large to produce statistically valid data, the hospital shall not be required to report the data for that particular Category 4 measure. HHSC will collect all Category 4 data for each hospital. Where limited by Texas statutory requirements pertaining to the confidentiality of individual hospital data for some of the Category 4 measures, HHSC will summarize certain data related to Category 4 for CMS at the RHP level rather than at the individual provider level.

f. Hospital Exemption
DSRIP hospitals that meet the criteria below and as approved by the State are exempt from implementing Category 4 reporting in paragraph 11.e of this section.

Definition:
A hospital is not a state-owned hospital or a hospital that is managed or directly or indirectly owned by an individual, association, partnership, corporation, or other legal entity that owns or manages one or more other hospitals and:

(1) is located in a county that has a population estimated by the United States Bureau of the Census to be not more than 35,000 as of July 1 of the most recent year for which county population estimates have been published; or

(2) is located in a county that has a population of more than 35,000, but that does not have more than 100 licensed hospital beds and is not located in an area that is delineated as an urbanized area by the United States Bureau of the Census.

13. Organization of DSRIP Projects

a. Categories 1-4 Descriptions
The RHP five-year plan will include sections on each of the 4 categories as specified in the RHP Planning Protocol. They include:

i. Category 1 Infrastructure Development lays the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.
ii. Category 2 Program Innovation and Redesign includes the piloting, testing, and replicating of innovative care models.
iii. Category 3 Quality Improvements includes outcome reporting and improvements in care that can be achieved within four years.
iv. Category 4 Population Focused Improvements is the reporting of measures that demonstrate the impact of delivery system reform investments under the waiver.

b. Categories 1-2 Requirements
For each project selected from Category 1 and 2, RHP Plans must include a narrative that includes the following subsections:

i. Identifying Information
Identification of the DSRIP Category, name of the project, project element, and RHP Performing Provider name and Texas Provider Identifier (TPI) involved with the project. Each project shall be implemented by one Performing Provider only.

ii. Project Goal
The goal(s) for the project, which describes the challenges or issues of the Performing Provider and brief description of the major delivery system solution identified to address those challenges by implementing the particular project; the starting point of the Performing Provider related to the project and based on that, the 5-year expected outcome for the Performing Provider and the patients.

iii. Rationale
As part of this subsection, each Performing Provider will provide the reasons for selecting the project, milestones, and metrics based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point with available baseline data, as well as a description of how the project represents a new initiative for the Performing Provider or significantly enhances an existing initiative, including any initiatives that may have related activities that are funded by the U.S. Department of Health and Human Services.

iii. Relationship to Other Projects and Measures
A description of how this project supports, reinforces, enables, and is related to other Category 1 and 2 projects, Category 3 outcomes, and Category 4 population-focused improvement measures within the RHP Plan

iv. Milestones and Metrics Table
For each project, RHP Plans shall include milestones and metrics adopted in accordance with Attachment I, "RHP Planning Protocol." In a table format, the RHP Plan will indicate by demonstration year when project milestones will be achieved and indicate the data source that will be used to document and verify achievement.

1. For each project from Category 1 and 2, the Performing Provider must include at least 1 milestone based on a Process Milestone and at least 1 milestone based on an Improvement Milestone over the 4-year period in accordance with Attachment I, "RHP Planning Protocol."
2. For each project from Category 1 and 2, the Performing Provider must include at least 1 milestone that reflects the quantifiable patient impact (number of additional individuals served or encounters provided) of the project in DY 5. The 3-year projects, which are referenced in paragraph 18, also must contain a quantifiable patient impact milestone in DY 4. For certain projects, as specified by CMS and HHSC, these milestones also must include the quantifiable patient impact specific to the Medicaid and low-income uninsured populations.
3. For each milestone, the estimated DSRIP funding must be identified as the maximum amount that can be received for achieving the milestone. For each year, the estimated available non-federal share must be included and the source (IGT Entity) of non-federal share identified.

c. Category 3 Requirements
This focus area involves outcomes associated with Categories 1 and 2 projects. All Performing Providers (both hospital and non-hospital providers) shall select outcomes that tie back to their projects in Categories 1 and 2. RHP Plans must include:

i. Identifying Information
Identification of the Category 3 outcome and RHP Performing Provider name and Texas Provider Identifier that is reporting the outcome.

ii. Narrative Description
In the associated Category 1 or 2 project, a brief narrative description of each Category 3 outcome selected for the project.

iii. Category 3 Selection Information
A summary of Category 3 outcome selection information for all DSRIP providers in an RHP shall be included as an attachment to the plan.

1. For each outcome, in DY 2 the RHP Plan may include process milestones described in 11.d.ii above that support the development of the outcome. For October 2013 DY 2 reporting, HHSC and CMS allowed a status update to meet the requirements for DY 2 Category 3 process milestones given that CMS and HHSC had not finalized the revised Category 3 framework and outcomes options as of the end of DY 2.
2. For each outcome, the RHP Plan will include two process milestones for each outcome in DY 3 – one for providing a status update on a template specified by HHSC once Category 3 outcomes are re-selected in DY 3, and one for establishing or verifying the provider's baseline for the outcome upon which improvement will be measured.
3. In DY 4 and DY 5 each outcome will have one or two milestones depending on whether the outcome is designated as a pay for performance (P4P) outcome or pay for reporting (P4R) outcome in the RHP Planning Protocol. These milestones may be process or achievement milestones depending on the specific outcome measure. See paragraph 32 and the RHP Planning Protocol for further details.
4. For each milestone, the estimated DSRIP funding must be identified as the maximum amount for achieving the milestone. For each year, the estimated non-federal share must be included and the source (IGT Entity) of non-federal share identified.

d. Category 4 Requirements
This focus area involves population-focused improvements associated with Categories 1 and 2 projects and Category 3 outcomes. Each hospital-based Performing Provider shall report on all common measures pursuant to Attachment I, "RHP Planning Protocol". RHP Plans must include:

i. Identifying information
Identification of the DSRIP Category 4 measures and RHP Performing Provider name and Texas Provider Identifier (TPI) that is reporting the measure.

ii. Narrative description

A narrative description of the Category 4 measures.

iii. Table Presentation
In a table format, the RHP Plan will include, starting in demonstration year 3:

1. List of Category 4 measures the Performing Provider will report on by domain;
2. For each measure, the estimated DSRIP funding must be identified as the maximum amount that can be received for reporting on the measure. For each year, the estimated available non-federal share must be included and the source of non-federal share identified.

e. Project Valuation
The RHP Plan shall contain a narrative that describes the overall regional and individual project approach for valuing each project and rationale, including an explanation why a similar project selected by two Performing Providers might have different valuations (e.g., due to project size, provider size, project scope, populations served, community benefit, cost avoidance, and addressing priority community needs). Project valuations must comply with requirements prescribed in Section VI "Disbursement of DSRIP Funds".

In addition, the value of a four-year Category 1 or Category 2 project may not exceed the greater of 10 percent of the Performing Provider's Pass 1 allocation (described in paragraph 29.c) or $20 million in total over DYs 2-5. For projects that represent collaboration across more than one Performing Provider as described in paragraph 29.c.iii and iv., the total maximum value may not exceed the greater of the sum of 10 percent of each Performing Provider's Pass 1 allocation for each Performing Provider that is collaborating in the project or $20 million in total over DYs 2-5. The value of a three-year project may not exceed $20 million in total for Categories 1-3 for DYs 3-5.

IV. STATE AND FEDERAL REVIEW PROCESS OF RHP PLANS

14. Review Process

HHSC will review all 5-year RHP Plan proposals prior to submission to CMS for final approval according to the schedule below.

The HHSC and CMS review process for 5-year RHP Plan proposals shall include the following schedule:

15. HHSC Review and Approval Process

a. Pre-Submission Review of RHP Plans
To support HHSC's review process, the RHP Anchoring Entity shall perform an initial review of the RHP Plan to ensure compliance with elements described in b. below and with the RHP Plan Checklist, prior to submitting the plan to HHSC.

b. HHSC Review of Plans

i. Between September 1, 2012 and December 31, 2012, each RHP identified in paragraph 4 will submit a 5-year RHP Plan to HHSC for review. HHSC shall review and assess each plan according to the following criteria using the RHP Plan Checklist:
   - The plan is in the format and contains all required elements described herein and is consistent with special terms and conditions, including STCs 45(a), 45(b), 45(c), and 45(d)(iii).
   - The plan conforms to the requirements for Categories 1, 2, 3, and 4, as described in Section III "Key Elements of Proposed RHP Plans", Attachment I, "RHP Planning Protocol", and "RHP Plan Checklist."
   - Category 1 and 2 projects clearly identify goals, milestones, metrics, and expected results, including quantifiable patient impact appropriate to the project option. Category 3 clearly identifies the outcomes to be reported. Category 4 clearly identifies the population-focused health improvement measures to be reported.
   - The amount and distribution of funding is in accordance with the stipulations of STC 46 and Section VI "Disbursement of DSRIP Funds" of this protocol.
   - The plan and all of the projects within are consistent with the overall goals of the DSRIP program and the objectives of the Medicaid program.

ii. Within 30 days of initial, complete RHP Plan submission, HHSC will complete its initial review of each timely submitted RHP Plan proposal using the RHP Plan Checklist and based on the Program Funding and Mechanics Protocol and RHP Planning Protocol and will notify the RHP Anchoring Entity in writing of any questions or concerns identified.

iii. The Anchoring Entity shall respond in writing to any notification by HHSC of questions or concerns. The RHP's responses must be received by the date specified in the aforementioned notification. The RHP Anchoring Entity's initial response may consist of a request for additional time to address HHSC's comments provided that the RHP's revised plan addresses HHSC's comments and is submitted to HHSC within 15 days of the notification.

c. <u>HHSC Approval of Plans</u>
HHSC will take action on each timely submitted RHP Plan, will approve each plan that it deems meets the criteria outlined in Attachment I, "RHP Planning Protocol", Attachment J, "Program and Funding Protocol", and "RHP Plan Checklist" and submit approved plans to CMS for final consideration. HHSC may approve a plan for submission to CMS that requires technical corrections when there is substantial compliance with the above criteria and HHSC notifies CMS of the priority technical corrections that need to be made.

16. CMS Review Process for initial RHP plan submissions

CMS will review an RHP's 5-year RHP Plan upon receipt of the plan as approved by HHSC. Plans reviewed and approved by HHSC will result in a decision by CMS within 45 days of receipt of an HHSC-approved plan. Plan(s) must meet all criteria outlined in paragraph 14.b.i above.

CMS will review RHP plans in a phased process that will allow providers to begin working on their DSRIP projects in DY 2 and 3 ("Initial Approval") while the issues in subparagraph c. of this paragraph are resolved in order to allow providers to continue working on their DSRIP projects in DY 4 and 5 ("Full Approval").

a. CMS Initial Approval

Within 45 days of receipt of the State-approved RHP Plan and RHP Plan Checklist from HHSC, CMS will complete its overall review of the RHP Plan and will either:

- Approve the plan; or
- Notify HHSC and the Anchoring Entity if initial approval will not be granted for all of, or a component of, the RHP Plan. For example, CMS may approve a project in the plan but not approve the project valuation if it does not comport with Section VI "Disbursement of DSRIP Funds". Notice to the State will be in writing and will include any questions, concerns, or issues identified in the application.

Receipt of initial approval constitutes recognition that the requirements of paragraph 29.a-d were met at the time of the full RHP Plan submission as of December 31, 2012.

An RHP may revise a plan for any components of the plan identified by CMS as not approvable. After the revisions are determined to be acceptable by HHSC, HHSC shall submit the revisions to CMS and CMS shall initially approve or deny the revisions (in whole or in part) in writing to HHSC by May 1, 2013 or within 15 days of receipt of the revisions, whichever is later.

If a provider submits an alternative project for review during the plan revision process, HHSC and CMS shall review the project in accordance with the timeline for new RHP Plan submissions (e.g. CMS has 45 days for initial review and 15 days for review of revisions).

With initial approval, if a project does not require priority technical corrections, the project is eligible to earn DY 2 and DY 3 payments. If a project requires priority technical corrections, the project is eligible to earn DY 2 payments with initial approval but the necessary priority technical corrections must be approved in order to be eligible to earn DY 3 payments. Initially approved projects must also meet the requirements of paragraphs 30 and 31 in order to receive DSRIP payments.

b. Priority Technical Corrections

HHSC or CMS may require an RHP to submit priority technical corrections to an RHP Plan that receives initial approval. Possible priority technical corrections include:

- Hospital provider Category 3 outcome does not meet criteria for one standalone or three non-standalone measures.
- Provider did not include at least one process milestone and one improvement milestone.

- Category 3 outcome duplicates an improvement milestone.
- All project components, if required, were not included in the narrative or milestones.
- Project lacks clearly defined milestones and metrics, including the lack of a quantifiable patient impact milestone for DYs 4 and 5, as required by paragraph 14.b.i.
- Any other priority technical correction CMS specifies for a project in the RHP Plan initial approval letter.
- Any other priority technical correction identified by HHSC, including any identified by HHSC subsequent to the RHP Plan initial approval letter, that is needed to clarify a Category 1 or 2 project or Category 3 outcome in order to make payment, such as clearly defined milestones and metrics.

These changes must be submitted to HHSC for review by no later than October 1, 2013 or such later date as specified by HHSC or CMS. HHSC, in collaboration with CMS, will work with the provider to refine the submitted priority technical corrections as needed for approval no later than March 31, 2014. DSRIP payment for a project for DY 3 may be withheld until the necessary priority technical corrections are approved (and all other requirements for DSRIP payment described in paragraphs 30 and 31 are met).

c. CMS Full Approval

CMS may require an RHP to submit additional revisions to the plan to receive full approval, as specified in the RHP Plan initial approval letter. Full approval is necessary for a project to be eligible for DY 4 and 5 DSRIP funding, except that ii. of this subparagraph only applies to DY 4 and 5 DSRIP funding for Category 3. HHSC will review all revisions submitted prior to CMS review and final consideration, consistent with the process for review of plan modifications, described in paragraph 32.d. Fully approved projects must also meet the requirements of paragraph 30 and 31 in order to receive DSRIP payments.

In addition to any project-specific revisions requested in the RHP Plan initial approval letter, all RHPs will be required to submit the following revisions, as applicable, in order to receive full approval for the plan.

i. Valuation that is consistent with project impact

Using an objective methodology developed with HHSC, CMS will determine whether the information submitted on each project's impact sufficiently justifies each project's value for DYs 4 and 5. Any outlier project values identified by HHSC or CMS will be reviewed by the state's independent assessor as part of the mid-point assessment. The assessor will make recommendations to HHSC, and if HHSC's decision differs from the recommendations, HHSC will consult CMS to establish the DY4-5 project value. Projects that receive valuation approval for DYs 4 and 5 through this process may still be subject to a DY 4 and 5 modification during the mid-point assessment, including adjustments to metrics or valuation, if the performance of the project substantially deviates from what was approved.

ii. Category 3 framework for DY 4 and 5

Recognizing the complexity of setting Category 3 outcome targets, CMS and HHSC will jointly develop a standard target setting methodology for Category 3 outcomes no later than February 28, 2014 that will apply prospectively to Category 3 achievement milestones for DYs 4 and 5 for all projects. This methodology will recognize the demonstration's focus on the Medicaid/uninsured populations and the differing baselines for different providers and will use appropriate benchmarks (where applicable) to set targets for meaningful improvement. The methodology also will recognize the innovative nature of certain projects, as well as data limitations and data sharing issues for certain types of performing providers, including non-hospital providers.

Providers will be required to use this standard methodology to set their Category 3 achievement targets in DYs 4 and 5 unless they provide a compelling justification to use a different target that is approved by HHSC based on statistically justifiable inconsistencies with the target setting benchmark used, including differences in the relative size of the Category 1 or 2 project and reporting specifications of the measure. If providers have already submitted Category 3 improvement targets for DYs 4 and 5 to CMS in the initial approval process, they should replace their previous targets with new targets based on the standard target setting methodology. Providers will have the opportunity by October 2014 to request to use an achievement target other than the standard methodology. The independent assessor will provide recommendations to HHSC in cases where providers request to use a different target. HHSC will need to approve the use of a different target that is not based on the standard target setting methodology.

Category 3 process or achievement milestone information for DYs 4 and 5 must be submitted to be eligible for payment of Category 3 outcome measures for DYs 4 and 5 (in addition to all requirements for DSRIP payment described in paragraphs 30 and 31). HHSC will work with RHPs to submit Category 3 outcomes once the standard target setting methodology is developed and to refine outcomes as needed in October 2014.

17. Post-approval Public Engagement and Ongoing Monitoring

After receiving initial CMS approval of an RHP Plan, the RHP shall conduct a post-award implementation forum with stakeholders, including those described in paragraph 10.d, in order to promote shared learning and continued alignment with community goals. The feedback from these post-award forums shall be summarized in HHSC's annual demonstration report and should help inform the development of more robust quality improvement infrastructure for the region that can support the learning collaborative plan for each region, as described below and in the appendix to the RHP Planning Protocol.

On each RHP's website, the RHP Anchoring Entity will publicly post a copy of the most recently approved RHP plan as well as any pending plan modifications that have been submitted to HHSC for review. The RHP websites will also provide for an opportunity for public comment.

In order to monitor the implementation of DSRIP activities and support shared learning, RHPs shall submit semi-annual progress reports to HHSC and CMS in a standardized format jointly agreed upon by HHSC and CMS. If semi-annual reports are not submitted on time or do not meet the requirements of the reporting, future DSRIP payments may be withheld until the complete report is submitted (and all other requirements for DSRIP payment described in paragraphs 30 and 31 are met). HHSC shall provide overall programmatic reporting in the demonstration's quarterly and annual reports for all RHPs combined.

18. Learning Collaborative Plans

Recognizing the importance of learning collaboratives in supporting continuous quality improvement, RHPs will submit learning collaborative plans by October 1, 2013, to reflect opportunities and requirements for shared learning among the approved DSRIP projects in the region. Specifically, there should be a coherent discussion of providers' participation in a learning collaborative that is strongly associated with their projects and demonstrates a commitment to collaborative learning that is designed to accelerate progress and mid-course correction to achieve the goals of the projects and to make significant improvement in the Category 3 outcome measures and the Category 4 population health reporting measures.

Tier 4 RHPs may submit, for HHSC and CMS review, a request not to conduct their own regional learning collaborative if they have a compelling justification, such as if they do not have the administrative capacity to do so. They also must submit their plan to actively participate in the statewide learning collaborative referenced in paragraph 8.b and any plans to participate in other RHPs' learning collaboratives, which is strongly encouraged.

19. Review and Approval Process for Three-Year DSRIP Projects

By December 2013, using DY 3-5 DSRIP funds not yet allocated to DSRIP projects, each RHP may submit additional proposed three-year DSRIP projects for HHSC and CMS review and approval. Based on the criteria established in paragraph 14, HHSC will work with the RHPs and the Performing Provider of each proposed three-year project to get the projects ready for CMS submission. HHSC will take action on each project that it deems meets the criteria outlined in the "RHP Plan Checklist" and submit approved plans to CMS for initial consideration during a 45-day CMS review process.

If a three-year project submitted by HHSC is not initially approved by CMS prior to May 31, 2014 during CMS's 45-day review, then HHSC rather than CMS will notify RHPs of subsequent approvals as appropriate. Provider will have a one-time opportunity to revise projects that were not initially approved by CMS by a date specified by HHSC. HHSC, and the independent assessor will review these projects to ensure compliance with the "RHP Plan Checklist." HHSC will notify CMS of the HHSC approved projects, and provide CMS an opportunity for secondary review within 30 days, if requested by CMS.

20. Mid-Point Assessment

By the end of 2014, an independent assessor (also known as the compliance monitor) will work with HHSC to conduct a transparent mid-point assessment of all RHPs using CMS-approved criteria. This review will provide an opportunity to modify projects and/or metrics in consideration of learning and new evidence. The independent assessor will review certain projects identified by HHSC, CMS or the entity based on information provided for all projects in semi-annual reports for the following elements:

- Compliance with the approved RHP plan, including the elements described in the project narrative.
- Compliance with the required core components described in the RHP Planning Protocol, including continuous quality improvement activities.
- Non-duplication of Federal funds.
- The clarity of the improvement milestones for DYs 4 and 5 and their connection with actual project activities and meaningful, quantifiable patient impact. A clear improvement milestone should be supported by a coherent and comprehensive project description that clearly describes the relationship between the goals, the interventions and the measures of progress and outcome.
- The benefit of the project to the Medicaid and uninsured population and to the health outcomes of all patients served by the project (examples include number of readmissions, potentially preventable admissions, or adverse events that will be prevented by the project in DY 4 and DY 5).
- The opportunity to continue to improve the project by applying any lessons learned or best practices that can increase the likelihood of the project advancing the triple aim.

Based on the recommendations by the independent assessor, HHSC or CMS may require prospective plan modifications that would be effective for DYs 4 and 5, including adjustments to project metrics or valuation, if the performance of the project has substantially deviated from what was approved Based on additional DSRIP compliance monitoring conducted by the independent assessor after the mid-point assessment is completed, HHSC or CMS also may require prospective plan modifications to be effective for DY 5.

HHSC will submit to CMS, on or before September 1, 2013, draft review criteria, a description of its approach to review, and a draft DSRIP Plan Checklist that will reflect the approved criteria and will be used in the assessment. CMS will provide comments within 60 days of HHSC's submission. CMS and HHSC will work collaboratively to refine the criteria, approach, and DSRIP Plan Checklist. HHSC will apply these criteria to ensure that DSRIP projects are thoroughly and consistently reviewed. Where possible, HHSC will notify providers in advance of the mid-point assessment if providers need to make changes in order to comply with the approved review criteria.

HHSC will review all modifications resulting from the mid-point, consistent with the process for review of plan modifications, described in paragraph 32.d. Future DSRIP payment for a provider may be withheld until the necessary changes as identified by the mid-point assessment are

submitted (and all other requirements for DSRIP payment described in paragraphs 30 and 31 are met).

21. Revisions to the RHP Planning Protocol

If the CMS review process of RHP Plans results in the modification of any component of an RHP's plan, including but not limited to projects, milestones, measures, metrics, or data sources, that was not originally include in the RHP Planning Protocol, Texas may revise the RHP Planning Protocol accordingly. CMS will review and approve these proposed revisions within 30 days of submission by HHSC, provided that the RHP Planning Protocol revisions are in accordance with the final approved RHP Plan(s) prompting the revision(s) and all applicable STC requirements. Such revisions to the RHP Planning Protocol do not require a waiver amendment.

V. RHP AND STATE REPORTING REQUIREMENTS

22. RHP Reporting for Payment in DY 1

a. RHP Plan Submission
Submission of a State-approved RHP Plan to CMS shall serve as the basis for the full DY 1 presumptive payment to that RHP's Performing Providers and Anchoring Entity as prescribed by Section VI "Disbursement of DSRIP Funds".

b. RHP Plans Not Approved by CMS on or after May 1, 2013
All Performing Providers and Anchoring Entities in an RHP whose RHP Plan is not approved in full by CMS shall be at risk for recoupment of their entire DY 1 incentive payment related to plan submission. Within 10 business days of CMS written denial of an RHP Plan, the State shall recoup the DY 1 payment from all eligible entities in the affected RHP and promptly return the associated FFP to CMS. If an RHP deletes a project without a replacement to obtain CMS approval of the RHP Plan, the State shall recoup the DY 1 payment from the entities that received funding for that project and promptly return the associated FFP to CMS.

23. RHP Reporting for Payment in DYs 2-5

Two times per year, Performing Providers seeking payment under the DSRIP program shall submit reports to HHSC demonstrating progress on each of their projects as measured by category-specific milestones and metrics achieved during the reporting period. The reports shall be submitted using the standardized reporting form approved by HHSC. IGT Entities will review the submission of the reported performance. Based on the reports, HHSC will calculate the incentive payments for the progress achieved in accordance with Section VI "Disbursement of DSRIP Funds". The Performing Provider shall have available for review by Texas or CMS, upon request, all supporting data and back-up documentation. These reports will be due as indicated below after the end of each reporting period:

- Reporting period of October 1 through March 31: the reporting and request for payment is due April 30.

- Reporting period of April 1 through September 30: the reporting and request for payment is due October 31.

These reports will serve as the basis for authorizing incentive payments to Performing Providers in an RHP for achievement of DSRIP milestones. HHSC and CMS concurrently shall have 30 days to review and approve or request additional information regarding the data reported for each milestone/metric and measure. If additional information is requested, the Performing Provider shall respond to the request within 15 days and both HHSC and CMS shall have an additional 15 days to review, approve, or deny the request for payment, based on the data provided. HHSC shall schedule the payment transaction for each RHP Performing Provider within 30 days following CMS and HHSC approval of the Performing Provider's RHP report.

HHSC and CMS may determine that a subset of not less than half of the projects and metrics will be reviewed during the 30 days after the reporting period. In such instances, HHSC and CMS will designate those projects and metrics that are not reviewed within 30 days as "provisionally approved." Such "provisionally approved" projects and metrics will be reviewed in full by HHSC prior to the next reporting due date. HHSC will report back to CMS which projects were reviewed by the end of the initial 30 day review period and which projects will be reviewed prior to the next reporting cycle due date. When all reports have been reviewed, HHSC will submit to CMS a report with the results of completed reviews and assurance that all reviews have been completed. CMS will review projects and metrics judiciously as it deems necessary.

For metrics that are "provisionally approved" the Performing Provider will receive full DSRIP payment. After review of any "provisionally approved" item, additional information regarding the data reported for each milestone/metric will be requested if necessary. If the initial supporting documentation, and any additional information, does not form a sufficient basis for actual metric achievement, HHSC will recoup the associated overpayments from the Performing Provider. If the Performing Provider does not comply with the recoupment, the overpayment amount will be deducted from future Medicaid payments. HHSC will notify CMS of any cases where the initial supporting documentation and additional information does not form a sufficient basis for metric achievement and the outcome of recouping the payments or withholding future payments.

24. Intergovernmental Transfer Process

HHSC will calculate the nonfederal share amount to be transferred by an IGT Entity in order to draw the federal funding for the incentive payments related to the milestone achievement that is reported by the Performing Provider in accordance with paragraph 22 and approved by the IGT Entity and the State. Within 14 days after notification by HHSC of the identified nonfederal share amount, the IGT Entity will make an intergovernmental transfer of funds. The State will draw the federal funding and pay both the nonfederal and federal shares of the incentive payment to the Performing Provider. If the IGT is made within the appropriate 14-day timeframe, the incentive payment will be disbursed within 30 days. The total computable incentive payment must remain with the Performing Provider.

At the time that HHSC requests IGT funding for DSRIP incentive payments, the state may also require the IGT Entity to transfer additional funds to provide a portion of the non-federal share of

the state's administrative costs related to waiver monitoring activities, as permitted under the state plan.

25. RHP Annual Year End Report

Each RHP Anchoring Entity shall submit an annual report by December 15 following the end of Demonstration Years 2-5. The annual report shall be prepared and submitted using the standardized reporting form approved by HHSC. The report will include information provided in the interim reports previously submitted for the Demonstration Year, including data on the progress made for all metrics. Additionally, the RHP will provide a narrative description of the progress made, lessons learned, challenges faced, and other pertinent findings.

26. Texas Reporting to CMS

b. Quarterly and Annual Reporting
DSRIP will be a component of the State's quarterly operational reports and annual reports related to the Demonstration. These reports will include:

vii. All DSRIP payments made to Performing Providers that occurred in the quarter as required in the quarterly payment report pursuant to STC 43(b);
viii. Expenditure projections reflecting the expected pace of future disbursements for each RHP and Performing Providers;
ix. A summary assessment of each RHP's DSRIP activities during the given period including progress on milestones; and
x. Evaluation activities and interim findings for the evaluation design pursuant to STC 68.

c. Claiming Federal Financial Participation
Texas will claim federal financial participation (FFP) for DSRIP incentive payments on the CMS 64.9 waiver form. FFP will be available only for DSRIP payments made in accordance with all pertinent STCs and Attachment I, "RHP Planning Protocol" and Attachment J, "Program Funding and Mechanics Protocol". All RHP Plans are subject to potential audits, including review by the independent assessor during the mid-point assessment and ongoing compliance monitoring. The Performing Providers shall have available for review by HHSC and CMS, upon request, all supporting data and back-up documentation evidencing performance as described under an RHP Plan for DSRIP incentive payments. Failure of the Performing Provider to maintain adequate documentation or inaccurate reporting of data may result in recoupment of DSRIP payments, including based on findings of the independent assessor.

VI. DISBURSEMENT OF DSRIP FUNDS

27. DSRIP Allocation Methodology to RHPs in DYs 1-5

a. Initial DSRIP Allocation
For Demonstration Years 1-5, DSRIP funding amounts identified in Table 6 of Waiver STC 46 shall be allocated to RHPs according to a formula that takes into account the RHP's role

in the safety net system. RHPs that shoulder a larger burden of Medicaid care and serve a larger share of low-income populations shall be allocated a higher share of DSRIP funds. The goal of this approach is to ensure that delivery system reforms under DSRIP have the greatest impact on Medicaid and low-income populations. The following variables were selected as proxies for measuring an RHP's participation in Medicaid and serving low-income populations:

i. Percent of State population with income below 200% FPL residing in the RHP Region (Source: U.S. Census Bureau: 2006-2010 American Community Survey for Texas). An RHP's percentage was calculated by dividing the number of low-income individuals with income below 200% FPL in the RHP Region by the total number of low-income individuals in the State with income below 200% FPL.
ii. Percent of Texas Medicaid acute care payments in SFY 2011 made in the RHP Region (including fee for service, MCO, vendor drug, and PCCM payments). An RHP's percentage was calculated by dividing SFY 2011 Medicaid acute care payments in the RHP Region by total SFY 2011 State Medicaid acute care payments.
iii. Percent of total SFY 2011 Medicaid supplemental payments (former Upper Payment Limit [UPL] program) made to providers in the RHP. An RHP's percentage was calculated by dividing SFY 2011 Medicaid supplemental payments by total SFY 2011 State Medicaid supplemental payments.

The RHP's percentages for the three variables are weighted equally, and then the individual RHP's percentages are averaged to come up with the RHP's DSRIP Funding Allocation Percentage for each demonstration years 1-5.

An RHP's DSRIP Funding Allocation Percentage shall be multiplied by the statewide DSRIP funding amounts in DYs 1-5 identified in Table 6 of STC 46. The product result of this calculation yields the DSRIP funding allocation amount for an RHP, which is reflected in Table 1 below. This table also displays the Tier Level of an RHP as defined in paragraph 11, Section III "Key Elements of Proposed RHP Plans".

Table 1: DSRIP Allocation (All Funds)

RHP	Tier	Funding Allocation %	DY 1	DY 2	DY 3	DY 4	DY 5	Total
1	3	4.00%	19,978,502	91,901,110	106,525,374	113,957,376	123,866,713	456,229,075
2	3	3.78%	18,880,393	86,849,806	100,670,253	107,693,759	117,058,434	431,152,643
3	1	20.22%	101,101,113	465,065,121	539,071,136	576,680,750	626,826,902	2,308,745,022
4	3	4.23%	21,162,653	97,348,206	112,839,268	120,711,775	131,208,451	483,270,354
5	4	7.02%	35,114,687	161,527,561	187,231,512	200,294,176	217,711,061	801,878,997
6	2	10.15%	50,733,669	233,374,879	270,511,925	289,384,850	314,548,750	1,158,554,074
7	3	6.04%	30,176,126	138,810,179	160,899,104	172,124,622	187,091,981	689,102,012
8	4	1.66%	8,275,517	38,067,378	44,125,056	47,203,548	51,308,205	188,979,704
9	2	14.29%	71,434,099	328,596,853	380,886,614	407,460,098	442,891,411	1,631,269,075
10	2	9.74%	48,707,230	224,053,259	259,706,952	277,826,042	301,984,828	1,112,278,311
11	4	1.16%	5,822,871	26,785,208	31,047,550	33,213,658	36,101,803	132,971,091
12	3	3.56%	17,777,700	81,777,422	94,790,698	101,404,003	110,221,742	405,971,566
13	4	0.67%	3,353,261	15,425,003	17,879,590	19,127,003	20,790,221	76,575,078
14	4	2.29%	11,426,916	52,563,813	60,928,316	65,179,128	70,846,879	260,945,051
15	3	4.41%	22,037,042	101,370,394	117,501,509	125,699,288	136,629,661	503,237,895
16	4	1.30%	6,511,903	29,954,753	34,721,466	37,143,894	40,373,798	148,705,813
17	4	1.89%	9,474,480	43,582,608	50,517,928	54,042,434	58,741,777	216,359,227
18	4	1.22%	6,095,208	28,037,958	32,499,651	34,767,068	37,790,292	139,190,178
19	4	0.95%	4,727,871	21,748,205	25,209,007	26,967,774	29,312,798	107,965,655
20	4	1.44%	7,208,757	33,160,283	38,437,093	41,118,751	44,694,294	164,619,177
		100%	**500,000,000**	**2,300,000,000**	**2,666,000,000**	**2,852,000,000**	**3,100,000,000**	**11,418,000,000**

b. One-time Re-Assessment of DSRIP Allocation to RHPs in DY 3
During DY 3, HHSC shall re-assess DSRIP allocation amounts to RHPs. In the event that the total amount of DSRIP funds included in an RHP Plan for DYs 3-5 is less than the total amount available to the RHP in Table 1, HHSC shall redistribute uncommitted amounts that an RHP does not propose to use for new three year projects for DYs 3-5. The uncommitted amounts shall be redistributed to RHPs according to a DSRIP funding allocation methodology agreed to by HHSC and CMS. The redistributed funds may be used by RHPs to fund new three year projects beginning in DY 3 that are approved according to the process described in paragraph18.

28. Benchmark Payment Variation between UC and DSRIP

UC payments will be based on each provider's reported UC costs on the UC application and reduced proportionately if the total statewide UC cap is exceeded for a given demonstration year. However, to ensure a robust and meaningful DSRIP program, RHPs are strongly encouraged to submit RHP Plans that in total fund DSRIP projects at no less than the percentages listed in Table 2 below. Table 2 shows the statewide waiver funding allocation schedule for DSRIP and UC described in Table 6 of STC 46.

Table 2: Waiver Funding Allocation between UC Program and DSRIP Programs

	DY 2	DY 3	DY 4	DY 5	Total
% UC	63%	57%	54%	50%	60%
% DSRIP	37%	43%	46%	50%	40%

29. DY 1 RHP DSRIP Allocation Formula

a. Eligible Entities
Anchoring Entities and Performing Providers that begin participation in DSRIP in DY 2 and that have a current Medicaid provider identification number are eligible to receive a DY 1 DSRIP payment according to the requirements in this section. An entity that serves both roles in an RHP is eligible to receive a DY 1 payment under each of the categories described below.

b. Anchoring Entities
The Anchoring Entity of an RHP shall be allocated 20 percent of the total DY 1 RHP DSRIP funding amount.

c. Performing Providers
Remaining DY 1 RHP DSRIP funding (less the Anchoring Entity DY 1 DSRIP) shall be allocated to Performing Providers based on an allocation formula. The allocation formula divides an RHP Plan's estimated dollar value of a Performing Provider's DSRIP projects in Categories 1-4 over the DYs 2-5 period by the total value of the RHP's DSRIP projects over the DYs 2-5 period. The resulting percentage is then multiplied by the RHP's remaining DY 1 DSRIP amount to determine the DY 1 DSRIP payment for the Performing Provider.

Example:

- An RHP's DY1 DSRIP Allocation is $25 million.
- 20 percent or $5 million is allocated to the Anchoring Entity.
- The remaining amount, $20 million, shall be distributed to Performing Providers according to the following formula:
    1. An RHP Plan reports a total DSRIP valuation of projects in DYs 2-5 equal to $500 million across 10 Performing Providers.
    2. Performing Provider "A's" DSRIP valuation for projects over the 4-year period in the RHP is $100 million, or 20 percent of the total DSRIP valuation.
    3. Based on the formula, Performing Provider "A" would be eligible to receive $4 million or 20 percent of the remaining $20 million DY 1 DSRIP payment amount.

30. DYs 2-5 RHP DSRIP Allocation Formula

a. Eligibility for DSRIP
Performing Providers described in Section II "DSRIP Eligibility Criteria" are eligible to receive RHP DSRIP payments in Demonstration Years 2-5. Each Performing Provider will be individually responsible for progress towards and achievement of its milestone bundles in all categories as defined in the RHP's approved RHP Plan. As outlined in Section V "RHP and State Reporting Requirements", Performing Providers will be eligible to receive DSRIP incentive payments related to achievement of their milestone bundles upon submission and approval of the required reports for payment.

b. "Two-Pass" Process for Allocating DSRIP Funds
DSRIP funding shall be allocated to Performing Providers using a two-stage process. The first stage or "Pass 1" sets an initial allocation to each potential provider who would be eligible to participate in DSRIP as described in paragraph 26.c.i.-ii. The purpose of this step is to encourage broad participation in DSRIP within an RHP. Under Pass 1, the RHP must identify and fund its minimum required number of projects. In addition, in order to access Pass 2 funds, RHPs in each Tier must meet DSRIP participation requirements for major safety net hospitals (described below in paragraph 29.c.v.2) and meet a threshold for DSRIP participation by non-profit and other private hospitals (described below in paragraph 29.c.v.3).

Recognizing that not all potentially eligible Performing Providers will participate in DSRIP, Pass 2 of the DSRIP allocation process permits RHPs to reallocate unused DSRIP funds for new projects in Categories 1, 2, and 3. DSRIP projects funded in the plan must support the RHP's overall goals and be consistent with its community needs assessment. HHSC shall ensure in the RHP Plan submission requirements that the "two-pass" process has been followed.

c. Initial DSRIP Allocation ("Pass 1" Allocation)

i. Hospital Providers
Potentially eligible hospital Performing Providers in an RHP that participated in either the Disproportionate Share Hospital (DSH) program during FFY 2012 or the

former Upper Payment Limit (UPL) program during FFY 2011 shall be allocated 75 percent of the RHP's annual DSRIP funds. Of this amount, each hospital shall be assigned a potential DSRIP allocation based on a provider's size and role in serving Medicaid and uninsured patients, as measured by three variables:

1. The hospital's percent share of Medicaid acute care payments in SFY 2011 made to all potentially eligible hospitals in the RHP (including fee for service, MCO, and PCCM payments);
2. The hospital's percent share of total SFY 2011 Medicaid supplemental payments made to all potentially eligible hospital providers in the RHP (former UPL program); and
3. The hospital's percent share of uncompensated care in the RHP. A hospital's uncompensated care is measured by its FFY 2012 Hospital Specific Limit (HSL). For hospitals that do not have a FFY 2012 Hospital Specific Limit, uncompensated care shall be measured by that hospital's charity care costs reported in the 2010 Annual Hospital Survey trended to 2012 by an annual trend rate of approximately 2 percent (4 percent total trend over the two-year period).

The individual hospital's percent share of Medicaid acute care payments shall be weighted 25 percent, percent share of Medicaid supplemental payments shall be weighted 25 percent, and percent share of uncompensated care shall be weighted 50 percent to determine the Hospital DSRIP Funding Allocation Percentage. The Hospital DSRIP Funding Allocation shall be multiplied by the annual RHP DSRIP amount allocated to hospitals in the RHP to come up with the Pass 1 allocation amount for each hospital.

ii. <u>Non-Hospital Providers</u>

Potentially eligible non-hospital Performing Providers in an RHP are allocated a total of 25 percent of the RHP's annual DSRIP funds, to be distributed as follows:

1. Community Mental Health Centers (CMHCs) initially shall be allocated a total of 10 percent of the RHP's annual DSRIP funds;
2. Physician Practices affiliated with an Academic Health Science Center initially shall be allocated a total of 10 percent of the RHP's annual DSRIP funds. Such physician practices outside an RHP as referenced in paragraph 7 may access the 10 percent upon request of the RHP; and
3. Local Health Departments initially shall be allocated a total of 5 percent of the RHP's annual DSRIP funds.

If an RHP does not include one or more of the non-hospital providers listed above, the Pass 1 allocations will be redistributed in "Pass 2" as described in paragraph 29.d.

iii. <u>Option for Smaller Hospitals in Tiers 1 and 2 to Collaborate in Pass 1</u>

1. Hospitals in RHPs categorized in Tiers 1 or 2 whose DSRIP allocation in Pass 1 in DY 2 is less than $2 million are encouraged to work within their RHP to

combine their individual DSRIP allocations to implement a robust DSRIP project(s) that will be valuable to the RHP as determined by the RHP Plan and community needs assessment. A single Performing Provider must implement each DSRIP project.

2. Such hospitals can combine their individual DSRIP allocations if there is a signed agreement between the affected parties submitted with the RHP Plan stating that the transaction is entered into freely and that it benefits regional transformation. No hospital is required to combine its individual DSRIP allocation.

iv. Option for Performing Providers in Tiers 3 and 4 to Collaborate in Pass 1

1. Performing Providers in RHPs categorized in Tiers 3 or 4 may combine their individual DSRIP allocations within their RHP to implement a robust DSRIP project(s) considered valuable to the RHP as determined by the RHP Plan and community needs assessment. A single Performing Provider must implement each DSRIP project.
2. Such Performing Providers can combine their individual DSRIP allocations if there is a signed agreement between the affected parties submitted with the RHP Plan stating that the transaction is entered into freely and that it benefits regional transformation. No Performing Provider is required to combine its individual DSRIP allocation.

v. Requirements in Pass 1

1. Minimum Projects
   RHP Plans must identify the minimum number of Category 1 and 2 projects the RHP is required to implement according to its Tier Level as outlined in Section III "Key Elements of Proposed RHP Plans" and must show that Performing Providers will meet the funding allocation requirements in each Category as described in paragraph 29.e. If an RHP Plan does not meet these criteria in Pass 1, the RHP Plan will not be approved.

2. DSRIP Participation Target for Major Safety Net Hospitals
   An RHP Plan must meet DSRIP participation requirements for major safety net hospitals in order to be eligible to participate in "Pass 2" and to receive any redistributed DSRIP funds in DY 3 (as described in paragraph 26.b). In order to ensure broad participation of safety net hospitals in DSRIP, each RHP will have a minimum number of safety net hospitals participate in DSRIP as Performing Providers. The participation target varies by RHP Tier Level and is presented in Table 3 below.

   For the purposes of this requirement, a hospital is defined as a major safety net hospital if it meets either of these two criteria:
   a. Criteria 1

The hospital participated in the Disproportionate Share Hospital (DSH) program in FFY2012 and

i. The hospital received at least 15 percent of the region's total Medicaid revenue (fee-for-service, managed care, primary care case management [PCCM]) in FFY2011 for Pass 1 hospitals or;
ii. has a trended 2012 hospital specific limit (HSL) that represents at least 15 percent of the region's total HSL,

or

b. Criteria 2
The hospital has a Pass 1 DSRIP allocation for DY 2-5 of greater than $60 million as defined in paragraph 29.c.i above.

Table 3: Major Safety Net Hospital DSRIP Participation Target by RHP Tier Level

RHP Tier	Number of Major Safety Net Hospitals in each RHP that must Participate in DSRIP*	Estimated Number of Safety Net Hospitals Participating in DSRIP
Tier 1	At least 5	5
Tier 2	At least 4	11
Tier 3	At least 2	12
Tier 4	At least 1	10
Total		38

*If there are fewer major safety net hospitals in an RHP than specified for its Tier level, then the RHP Plan must include all the major safety net hospitals as defined above in that RHP as Performing Providers for DSRIP.

3. Broad Hospital Participation Target
An RHP Plan must meet the broad hospital participation target in order to be eligible to participate in "Pass 2" and to receive any redistributed DSRIP funds in DY 3 (as described in paragraph 26.b). RHPs shall have minimum representation of non-profit and other private hospitals in their RHP plans. An RHP Plan must include projects with values equal to at least a minimum percentage of DSRIP Annual Allocation Amounts assigned to non-profit and other private hospitals as defined in paragraph 29.c.i above. The minimum percentage varies by RHP Tier Level and is presented in Table 4 below.

Table 4: Non-Profit and Other Private Hospital DSRIP Target by RHP Tier Level

RHP Tier	Percent of Total Pass 1 Assigned DSRIP Annual Amounts Aggregated Across all Non-Profit and Other Private Hospitals included in RHP Plan
Tier 1	At least 30%
Tier 2	At least 30%
Tier 3	At least 15%

Tier 4	At least 5%

d. Re-allocation of Unused DSRIP Amounts for New Projects ("Pass 2")
After requirements of Pass 1 are met, as specified in paragraph 29.c.iv, if there are DSRIP allocation amounts that remain unused by potential Performing Providers, the RHP may redirect the unused amounts to fund additional projects by hospital providers and non-hospital providers that support the overall goals and community needs assessment of the RHP. HHSC also strongly encourages broad geographic representation across the region. In "Pass 2", the RHP shall identify the new projects and outcomes from Categories 1-3, the Performing Providers who shall implement the project, and the DSRIP funding amount assigned to the projects and measures.

In addition to the eligible providers identified in paragraph 29, physician practices that are not affiliated with academic science health centers may participate in Categories 1, 2, and 3 DSRIP projects in Pass 2. Hospitals that did not participate in the DSH program in FFY 2012 or the UPL program in FFY 2011 may also participate in DSRIP in Pass 2.

i. Pass 2 - Performing Providers that did not participate in Pass 1:
Potentially eligible Performing Providers in an RHP that did not participate in Pass 1 shall be allocated a total of 25 percent of the RHP's unused Pass 1 DSRIP funds. The Anchor will calculate the following for Pass 2 using the total unused DSRIP from Pass 1 allocations:

1. Hospital Performing Providers that did not participate in the DSH program in FFY 2012 or the UPL program in FFY 2011 shall be allocated a total of 15 percent of the RHP's unused Pass 1 DSRIP funds. Each hospital shall be allocated a proportion of the 15 percent divided by the number of new hospital Performing Providers.
2. Physician practices not affiliated with academic health science centers shall be allocated 10 percent of the RHP's unused Pass 1 DSRIP funds. Each physician practice shall be allocated a proportion of the 10 percent divided by the number of interested physician practices.

ii. Pass 2 - Performing Providers that participated in Pass 1:
Performing Providers in an RHP that participated in Pass 1 shall be allocated a total of 75 percent of the RHP's unused Pass 1 DSRIP funds. The Anchor will calculate the following for Pass 2 using Pass 1 DSRIP project information:

1. Each individual Performing Provider's percent of the total Pass 1 funding for DSRIP projects in Pass 1 in DYs 2-5.
2. The Performing Provider's percent as calculated in 1. above is multiplied by the 75 percent of the RHP's unused Pass 1 DSRIP funds to determine the allocation of DSRIP to each Performing Provider in the RHP for Pass 2.

3. Performing Providers may implement new DSRIP projects that complement the projects from Pass 1 and address outstanding community needs.
4. One Performing Provider must implement each DSRIP project.

iii. Collaboration among Performing Providers in Pass 2
Within each RHP, Performing Providers may combine their individual Pass 2 DSRIP allocations to fund a DSRIP project that is a priority for the RHP if there is a signed agreement between the affected parties submitted with the RHP Plan stating that the transaction is entered into freely and that it benefits regional transformation. No Performing Provider is required to combine its individual DSRIP allocation.

iv. If there are unused funds after Pass 2, the Anchoring Entity may collaborate with RHP Performing Providers to determine which additional DSRIP projects to include in the RHP Plan.

e. Project Valuation
RHP Plans shall include a narrative that describes the approach used for valuing projects and rationale to support the approach. At a minimum, Performing Providers shall ensure that upon initial submission of the RHP Plan and individual three-year projects, project values comport with the following funding distribution across Categories 1-4 in DYs 2-5. Projects valued at the maximum levels described in paragraph 12.e are expected to support meaningful, large-scale delivery system transformation and must provide sufficient justification of the project value in the RHP Plan.

In addition, if an IGT entity does not elect to transfer additional IGT funds to provide a portion of the nonfederal share of the administrative costs related to waiver monitoring activities, as described in paragraph 23, the state may lower a provider's valuation. The state may lower the valuation by an amount necessary to equal the associated IGT entity's share of the expected funds for waiver monitoring activities described in paragraph 23.

Hospital Performing Providers: DSRIP Category Funding Distribution

	DY 2	**DY 3**	**DY 4**	**DY 5**
Category 1 & 2	No more than 85%	No more than 80%	No more than 75%	No more than 57%
Category 3	At least 10%	At least 10%	At least 15%	At least 33%
Category 4*	5%	10 - 15%	10 - 15%	10 - 15%

*Hospital providers defined in paragraph 11.f, Section III "Key Elements of Proposed RHP Plans" that elect not to report Category 4 measures shall allocate Category 4 funding to Categories 1 & 2 or 3.

Non-Hospital Performing Providers: DSRIP Category Funding Distribution

	DY 2	**DY 3**	**DY 4**	**DY 5**
Category 1 & 2	95% to 100%	No more than 90%	No more than 90%	No more than 80%

Category 3*	0% to 5%	At least 10%	At least 10%	At least 20%

*Non-hospital Performing Providers are expected to allocate funds for Category 3 in the RHP Plan submission and may submit plan modifications in DY 2 with specific Category 3 outcomes to be eligible for the funding in DYs 3-5.

f. Milestone Valuation
With respect to Categories 1, 2, and 4, milestones for a project within a demonstration year shall be valued equally. For Category 3, milestones for a project within a demonstration year from DY 3-5 shall be valued equally (within the limits for pay for reporting and pay for performance and other parameters described in paragraph 32 below).

31. Payment Based on Achievement of Milestone Bundles in Categories 1, 2, and 4

a. Definition
With respect to Categories 1-2, a milestone bundle is the compilation of milestones and related metrics associated with a project in a given year. A milestone may have more than one annual metric associated with it. Two or more metrics associated with a milestone shall be assigned equal weighted value for the purpose of calculating incentive payments. With respect to Category 4, a milestone bundle is the compilation of reporting measures within a Category 4 domain. A Category 4 reporting measure within a domain shall be considered a milestone for the purpose of this section and all measures within a domain shall be weighted equally for the purpose of calculating incentive payments.

b. Basis for Calculating Incentive Payment for Categories 1-2
Incentive payments are calculated separately for each project in Categories 1 and 2.The amount of the incentive funding paid to a Performing Provider will be based on the amount of progress made within each specific milestone bundle. For each milestone within the bundle, the Performing Provider will include in the RHP semi-annual report the progress made in completing each metric associated with the milestone. A Performing Provider must fully achieve a Category 1 or 2 metric to include it in the incentive payment calculation.

Based on the progress reported, each milestone will be categorized as follows to determine the total achievement value for the milestone bundle:

- Full achievement (achievement value = 1)
- At least 75 percent achievement (achievement value = .75)
- At least 50 percent achievement (achievement value = .5)
- At least 25 percent achievement (achievement value = .25)
- Less than 25 percent achievement (achievement value = 0)

The achievement values for each milestone in the bundle will be summed together to determine the total achievement value for the milestone bundle. The Performing Provider is then eligible to receive an amount of incentive funding for that milestone bundle determined by multiplying the total amount of funding related to that bundle by the result of dividing the reported achievement value by the total possible achievement value. If a Performing Provider has previously reported progress in a bundle and received partial funding, only the additional

amount it is eligible for will be disbursed. HHSC may determine milestones that qualify for partial achievement. (See example below of disbursement calculation).

Example of disbursement calculation:

A Category 1 Project in DY 2 is valued at $30 million and has 5 milestones, which make up the Milestone Bundle. Under the payment formula, the 5 milestones represent a maximum achievement value of 5.

The hospital Performing Provider reports the following progress at 6 months:

Milestone 1: 100 percent achievement (achievement value = 1)

- Metric 1: Fully achieved
- Metric 2: Fully achieved

Milestone 2: 66.7% percent achievement (Achievement value = .5)

- Metric 1: Fully achieved
- Metric 2: Fully achieved
- Metric 3: Not Achieved

Milestone 3: 0 percent achievement (Achievement value = 0)
Metric 1: Not Achieved

Milestone 4: 50 percent achievement (Achievement value = .5)

- Metric 1: Fully Achieved
- Metric 2: Not Achieved

Milestone 5: 40 percent achievement (Achievement value = .25)

- Metric 1: Fully achieved
- Metric 2: Fully Achieved
- Metric 3: Not Achieved
- Metric 4: Not Achieved
- Metric 5: Not Achieved

Total achievement value at 6 months = 2.25
Disbursement at 6 months = $30M x (2.25/5) = $13.5 million

By the end of the Demonstration Year, the hospital Performing Provider successfully completes all of the remaining metrics for the project. The hospital is eligible to receive the balance of incentive payments related to the project:

Disbursement at 12 months is $30 million - $13.5 million = $16.5 million.

c. Basis for Calculating Incentive Payment for Category 4

i. DY 2 Incentive Payments
In DY 2, a hospital Performing Provider participating in Category 4 reporting shall be eligible to receive an incentive payment equal to 5 percent of its total allocation amount in DY 2 upon submission to HHSC of a status report that describes the

system changes the hospital is putting in place to prepare to successfully report Category 4 measures in DYs 3-5.

ii. DYs 3-5 Incentive Payments
The amount of the incentive funding paid to a hospital Performing Provider will be based on the amount of progress made in successfully reporting all measures included in a domain. A hospital must complete reporting on **all** Category 4 measures included in a domain prior to requesting incentive payments. Hospitals shall report progress on completing measure reporting in the semi-annual reports.

Example of disbursement calculation:

A Category 4 Domain includes 5 reporting measures. The hospital Performing Provider completes reports on two measures by March 31 (or by the 6th month of the DY). The hospital reports this achievement in the first semi-annual report; however, an incentive payment is not made because 3 other measures in the domain remaining outstanding. By the 12th month of the DY, the hospital has successfully reported on the remaining 3 measures. At that point, the hospital may request and receive a full incentive payment for the entire domain of measures. If a hospital fails to report on a single measure in a domain, it will forfeit the entire payment for the domain in question.

32. Basis for Payment in Category 3

a. Valuation of Category 3 Outcomes
In February 2014, CMS and HHSC agreed to a revised Category 3 framework, including a revised list of Category 3 outcome options and a standard target setting methodology to be used to measure outcome improvement in DY 4 and DY 5.

The revised RHP Planning Protocol classifies Category 3 outcomes either as pay for performance (P4P) or pay for reporting (P4R). The number and type of milestones for each outcome in DY4 and DY 5 depends on whether the outcome is P4P or P4R, and in DY 5 Performing Providers with P4R measures also are required to report on a population-focused priority measure or stretch activity. See the RHP Planning Protocol for further details on the revisions to Category 3.

In the initial RHP Plan submission, a Performing Provider had flexibility to assign different values to its Category 3 outcomes and related milestones, as long as total payments met the annual category allocation amounts defined in 29.e above and the valuations were sufficiently justified.

Based on the updated Category 3 outcomes and framework in the RHP Planning Protocol, in March 2014 providers will re-select or verify their Category 3 outcome(s) for each Category 1 or 2 project. Category 3 valuation for DY 3-5 will be determined as follows:

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

ii. HHSC will total the provider's Category 1 and 2 DSRIP projects, including both approved four-year projects and proposed three-year projects.

iii. 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. When determining the percentage of Category 3 funds related to each Category 1 or 2 project, a Performing Provider must allocate a minimum percentage to each Category 1 or 2 project. The minimum percentage is calculated as follows:

1. Divide the total number of Category 1 and 2 DSRIP projects into 100. This is the average percentage of total Category 3 funding that would relate to each Category 1 or 2 project.
2. Multiply the average percentage from 1 above by 25%.
3. The product in 2 above is the minimum percentage of Category 3 funds that can be allocated to a Category 3 outcome related to a Category 1 or 2 project.
4. 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).

Example of Category 3 Valuation Allocation Methodology with 5 Category 1 and 2 Projects

	DY 3	DY4	DY5
Project 1.1	30%	30%	30%
Project 1.2	25%	25%	25%
Project 1.3	35%	35%	35%
Project 2.1	5%	5%	5%
Project 2.2	5%	5%	5%

iv. 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, and also to each milestone for that outcome in a given demonstration year.

v. If one or more of a Performing Provider's proposed three-year DSRIP projects do not get approved, HHSC will adjust the Category 3 valuations of its projects based on the above methodology.

vi. The Category 3 funding breakdown in DY 3-5 is as follows:

	P4P Category 3 Outcomes	**P4R Category 3 Outcomes (need prior authorization)**
DY3	50 percent status report / 50 percent establish baseline (both process milestones)	50 percent status report / 50 percent establish baseline (both process milestones)

DY 4	50 percent P4R (process milestone) / 50 percent P4P (achievement milestone)	100 percent P4R on outcome (process milestone)
DY 5	100 percent P4P (achievement milestone)	50 percent P4R on outcome (process milestone) 50 percent P4P on population-focused priority measure (achievement milestone) or stretch activity (process milestone)

Example 1 - P4P Outcomes

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 outcomes associated with its 1.1 project. Funding distribution:

	DY 3	DY 4	DY 5
P4P Outcome 1	$500,000 (50% for status update and 50% for establishing baseline)	$1 million (50% for reporting to specifications and 50% for improving on the outcome)	$2 million (100% for improving on the outcome)
P4P Outcome 2	$500,000 (50% for status update and 50% for establishing baseline)	$1 million (50% for reporting to specifications and 50% for improving on the outcome)	$2 million (100% for improving on the outcome)

Example 2 - P4R Outcomes

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 outcomes associated with its 1.1 project. Funding distribution:

	DY 3	DY 4	DY 5
P4R Outcome 1	$500,000 (50% for status update and 50% for establishing baseline)	$1 million (100% for reporting to specifications)	$2 million (50% for reporting to specifications and 50% for improvement on population health measure or stretch activity)

P4R Outcome 2	$500,000 (50% for status update and 50% for establishing baseline)	$1 million (100% for reporting to specifications)	$2 million (50% for reporting to specifications and 50% for improvement on population health measure or stretch activity)

b. Process Milestones/Metrics
A Performing Provider must fully achieve metrics associated with the process milestones to qualify for a DSRIP payment related to these milestones.

c. Achievement Milestones
Performing Providers may receive partial payment for making progress towards, but not fully achieving, an achievement milestone. The partial payment would equal 25 percent, 50 percent, or 75 percent of the achievement value of that milestone. Based on the progress reported, each achievement milestone will be categorized as follows to determine the total achievement value percentage:

- Full achievement (achievement value = 1)
- At least 75 percent achievement (achievement value = .75)
- At least 50 percent achievement (achievement value = .5)
- At least 25 percent achievement (achievement value = .25)
- Less than 25 percent achievement (achievement value = 0)

Example of disbursement calculation:

A hospital Performing Provider has set an achievement target that would decrease potentially preventable readmissions for a target population with a chronic condition by 5 percent in DY 4 and by 10 percent in DY 5.

In DY 4, the Performing Provider achieved a 2.5 percent reduction in PPR, short of its goal. Under the partial payment policy, the provider would be reimbursed 50 percent of the incentive payment associated with this achievement milestone because it achieved 50 percent of the target. The Performing provider may earn the remaining DY 4 incentive payment for the achievement milestone in the following year (DY 5) under the carry-forward policy outlined in Section VIII: "Carry-forward and Penalties for Missed Milestones."

VII. PLAN MODIFICATIONS

Consistent with the recognized need to provide RHPs with flexibility to modify their plans over time and take into account evidence and learning from their own experience over time, as well as

for unforeseen circumstances or other good cause, an RHP may request prospective changes to its RHP Plan through a plan modification process.

33. Plan Modification Process

An RHP may request modifications to an RHP Plan under the following circumstances:

ii. Adding New Projects for Demonstration Year 3
An RHP may amend its plan to include new projects financed by either new or existing IGT Entities that are implemented by either existing and/or new Performing Providers. These projects shall be 3 years in duration, beginning in Demonstration Year 3. Projects added for DY 3 may be selected from Categories 1, 2, or 3 of Attachment I, "RHP Planning Protocol" and are subject to all requirements described herein and in the STCs. Newly added hospital Performing Providers shall be required to report Category 4 measures according to Section III "Key Elements of Proposed RHP Plans". HHSC and CMS will review three year projects according to the process described in paragraph 18.

iii. Deleting or Terminating an Existing Project
An RHP may request to delete or terminate a project from its RHP plan and forgo replacing it if the RHP continues to meet the minimum project number requirements outlined in Section III "Key Elements of Proposed RHP Plans" and the loss of the project does not jeopardize or dilute the remaining delivery system reforms pursued in the plan. An RHP may not redistribute incentive funding from the deleted project to other existing projects; unless the project is replaced in accordance with subparagraph a. above, the affected Performing Provider and RHP shall forfeit DSRIP allocation associated with the deleted project. The forfeited DSRIP allocation may be available for redistribution to RHPs in accordance with Section VI "Disbursement of DSRIP Funds".

If a project is terminated prior to the mid-point assessment, HHSC will recoup prior DSRIP payments for that project and return the associated federal share of the payments to CMS.

A Performing Provider will receive some period of time after the mid-point assessment to determine if a DSRIP project will continue for the remainder of the demonstration. Specifically, if the Performing Provider withdraws after the mid-point assessment but before DY 4 payments are made, no prior DSRIP payments will be recouped.

If a DSRIP project is terminated after the post mid-point assessment consideration period, then HHSC will recoup all DSRIP payments made after the mid-point assessment and return the associated federal share of the payments to CMS.

iv. Modifying Existing Projects
RHPs may submit requests to HHSC to modify elements of an existing project prospectively, including changes to milestones and metrics with good cause. Such requests must be submitted to HHSC 90 days prior to when the changes go into effect according to the standardized timeline agreed to by the state and CMS. Performing

providers have opportunities to submit plan modification requests in December 2013 (for DY 3-5) and July 2014 (for DY 4-5). The final opportunity to submit plan modification requests for DY 4 will align with the timing of the mid-point assessment. There will be a final opportunity during DY 4 to submit plan modification requests for DY 5 only for Category 3 changes and for three-year projects.

v. Plan Modification Review and Approval Process
Plan modifications must be submitted in writing to HHSC; HHSC shall take action on the plan modification request using a CMS-approved approach, criteria, and checklist. HHSC will notify providers in writing of any questions or concerns identified. Once the projects are determined by HHSC to meet the CMS-approved criteria, the plan modifications will be approved and HHSC will notify CMS. Substantial reductions in project scope (such as reductions to quantifiable patient impact, as well as significant changes in the hiring of staff and completion of core components) will be subject to a secondary review and ongoing compliance monitoring by the independent assessor. If the independent assessor disagrees with HHSC's assessment to approve a plan modification, CMS will have an opportunity to review the plan modification and request a re-review by HHSC.

VIII. CARRY-FORWARD AND PENALTIES FOR MISSED MILESTONES

34. Carry-forward Policy

If a Performing Provider does not fully achieve a milestone bundle in Categories 1 or 2, or a Category 3 process milestone or achievement milestone that was specified in its RHP Plan for completion in a particular demonstration year, it will be able to carry forward the available incentive funding associated with the milestone until the end of the following demonstration year during which the Performing Provider may complete the milestone and receive full payment. Incentive funding that is carried forward still remains associated with the original demonstration year for all accounting purposes (including calculation of the annual DSRIP payment limits). Carried forward DSRIP funding is subject to all Medicaid claiming requirements and may be paid no later than two years after the end of a demonstration year in which it was to have been completed (e.g., for DY 2, which ends September 30, 2013, payments may be made no later than September 30, 2015). Although authority for DSRIP funding expires September 30, 2016, DSRIP payment may be claimed after this point, subject to the carry-forward provisions in this section. To effectuate carry-forward policy, a Performing Provider shall provide narrative description on the status of the missed milestones and outline the provider's plan to achieve the missed milestones by the end of the of the following demonstration year.

35. Penalties for Missed Milestones

If a Performing Provider does not complete the missed milestone bundle or measure during the 12-month carry-forward period or the reporting year with respect to Category 4, funding for the incentive payment shall be forfeited and no longer available for use in the DSRIP program.

IX. DATA QUALITY ASSURANCE

36. Data validation and alignment with managed care

Data and metrics that form the basis of incentive payments in DSRIP should have a high degree of accuracy and validity. The state must require that each Performing Provider certify that data received to demonstrate DSRIP achievement is accurate and complete. Data accuracy and validity also will be subject to review by the independent assessor.

Consistent with the requirements of STC 27, the state will update its comprehensive quality strategy and include in its annual report to CMS opportunities to better standardize quality measurement between DSRIP and the state's Medicaid managed care programs in order to reduce administrative burden and ensure greater validity and reliability for performance measures.

X. TRANSITION YEAR (DY6)

37. Definitions

a. Demonstration Year (DY) 6 - The initial 15-month period of time, as approved by the Centers for Medicare & Medicaid Services (CMS), for which the waiver is extended beyond the initial demonstration period, or October 1, 2016 - December 31, 2017.

   i. Demonstration Year (DY) 6A - Federal fiscal year (FFY) 2017, or the first 12 months of DY6 (October 1, 2016 - September 30, 2017).
   ii. Demonstration Year (DY) 6B - The last three months of DY6 (October 1, 2017 - December 31, 2017).

b. Extension period - The entire period of time, as approved by the Centers for Medicare & Medicaid Services (CMS), for which the waiver is extended beyond the initial demonstration period.

c. Initial demonstration period - The first five demonstration years (DYs) of the waiver, or December 12, 2011 through September 30, 2016.

d. Medicaid and Low-income or Uninsured (MLIU) – MLIU is changed from Medicaid/ Low-income uninsured in the initial demonstration period to Medicaid and low-income or uninsured in the applicable DY.

   i. To qualify as a Medicaid individual for purposes of MLIU Quantifiable Patient Impact (QPI), the individual must be enrolled in Medicaid at the time of at least one DSRIP project encounter during the applicable DY.
   ii. To qualify as a low-income or uninsured individual for purposes of MLIU QPI, the individual must either be below 200 percent of the federal poverty level (FPL) 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 or uninsured at the time of a separate DSRIP project encounter during the applicable DY, that individual is classified as a Medicaid individual for purposes of MLIU QPI.

e. Medicaid and Low-income or Uninsured (MLIU) Quantifiable Patient Impact (QPI) – The number of MLIU individuals served, or encounters provided to MLIU individuals, in accordance with paragraph 41(a)(iii), during an applicable DY that are attributable to the DSRIP project.

f. Medicaid and Low-income or Uninsured (MLIU) Quantifiable Patient Impact (QPI) Goal – The number of MLIU individuals that a Performing Provider intends to serve, or the number of MLIU encounters that a Performing Provider intends to provide, in accordance with paragraph 41(a)(iii), during an applicable DY that are attributable to the DSRIP project.

g. Quantifiable Patient Impact (QPI) Grouping – The category of the QPI measurement. The category may be either individuals served or encounters provided.

h. 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 during the 12-month period preceding the implementation of the DSRIP project. There is a pre-DSRIP baseline for total QPI and a pre-DSRIP baseline for MLIU QPI. For a DSRIP project that is a new intervention, both the pre-DSRIP baseline for total QPI and the pre-DSRIP baseline for MLIU QPI are zero.

i. Total Quantifiable Patient Impact (QPI) – The total number of individuals served or encounters provided, in accordance with paragraph 41(a)(ii), during an applicable DY that are attributable to the DSRIP project.

j. Total Quantifiable Patient Impact (QPI) Goal – The total number of individuals that a Performing Provider intends to serve, or the total number of encounters that a Performing Provider intends to provide, in accordance with paragraph 41(a)(ii), during an applicable DY that are attributable to the DSRIP project.

k. Uncompensated Care (UC) Only Hospital – A hospital eligible to be a Performing Provider that is not a Performing Provider but receives UC payments.

38. DY6 DSRIP Pool Allocation

a. The DSRIP pool allocation for DY6 is $3.875 billion.

i. $3.1 billion of the DSRIP pool allocation for DY6 is allocated to DY6A.
ii. $775 million of the DSRIP pool allocation for DY6 is allocated to DY6B.

b. The $775 million allocated to DY6B will be combined with any DSRIP pool funds agreed to for DY7.

c. Performing Providers' values must comport with the following funding distributions across Categories 1-4 in DY6A.

Hospital Performing Providers: DSRIP Category Funding Distribution*

	DY 2	DY 3	DY 4	DY 5	DY 6A
Category 1 & 2	No more than 85%	No more than 80%	No more than 75%	No more than 57%	No more than 57%
Category 3	At least 10%	At least 10%	At least 15%	At least 33%	At least 33%
Category 4	5%	10 - 15%	10 - 15%	10 - 15%	No more than 10%

*Hospital Performing Providers defined in paragraph 11.f, Section III "Key Elements of Proposed RHP Plans" that elected not to report Category 4 measures during the initial demonstration period allocated Category 4 funding to Categories 1 & 2 or 3. Consequently, the percentage of these Performing Providers' funding that is allocated to Categories 1 & 2 may exceed the maximum threshold of 57 percent to up to 67 percent. Also, if the Performing Provider met the 57 percent threshold at the time of initial RHP plan submission, but later exceeded it due to HHSC and CMS approval of a three-year project or withdrawal of Category 4 Reporting Domain 6, Categories 1 & 2 may be allocated no more than 62 percent of the DSRIP funds allocated to the Performing Provider.

Non-Hospital Performing Providers: DSRIP Category Funding Distribution

	DY 2	DY 3	DY 4	DY 5	DY 6A
Category 1 & 2	95% to 100%	No more than 90%	No more than 90%	No more than 80%	No more than 80%
Category 3	0% to 5%	At least 10%	At least 10%	At least 20%	At least 20%

39. Current DSRIP Projects Eligible to Continue

a. A Performing Provider's total value for DY6A is equal to its total value for DY5 with the following exceptions:

   i. HHSC notified a Performing Provider in January 2016 that a DSRIP project's value may be reduced if the DSRIP project fails to complete DSRIP project or metric goals by the end of DY5; or
   ii. Performing Providers with a total value less than $250,000 for DY5 may increase their total value to up to $250,000 per each subsequent DY beginning in DY6. The increase in value is contingent on funds availability as described in paragraph 44. Categories 1-4 will each be increased proportionately. However, any funds in excess of the 10 percent maximum for Category 4 will be allocated to Category 3. A Performing Provider may need to increase a DSRIP project's MLIU QPI goal for DY6A and beyond in order to obtain the increased value. Performing Providers eligible for this option must make this choice by a date to be determined by HHSC.

b. For each DSRIP project that HHSC determines is eligible to continue, the Performing Provider must indicate to HHSC, by a date to be determined by HHSC, whether it chooses to: 1) discontinue the DSRIP project in DY6; or 2) continue the DSRIP project in DY6.

   i. If a Performing Provider indicates to HHSC, by a date to be determined by HHSC, that it chooses to discontinue the DSRIP project in DY6, the Performing Provider may not propose any new DSRIP projects for the entirety of the extension period with funds associated with the discontinued DSRIP project.
   ii. If a Performing Provider indicates to HHSC, by a date to be determined by HHSC, that it chooses to continue the DSRIP project in DY6, the Performing Provider must indicate to HHSC, by a date to be determined by HHSC, whether it chooses to: 1) continue the DSRIP project for the remainder of the extension period; or 2) replace the DSRIP project with a new DSRIP project to commence no sooner than the beginning of DY6B.

c. If a DSRIP project is withdrawn prior to the second payment period for DY7, HHSC will recoup all prior extension period DSRIP payments associated with the DSRIP project.

d. If a DSRIP project is withdrawn after the second payment period for DY7, but before the first reporting period for DY8, no prior extension period DSRIP payments associated with the DSRIP project will be recouped due to withdrawal.

e. If a DSRIP project is withdrawn after the first reporting period for DY8, any DSRIP payments made after that period will be recouped.

f. The DY5 intergovernmental transfer (IGT) process, payment calculations, and monitoring IGT are maintained in the extension period. IGT entities from DY5 will continue to provide

funding for the extension period unless a Performing Provider submits changes during a reporting period. No new certifications (RHP Plan Section VI) are required for continuing RHP participants.

g. If a Performing Provider participated in Category 4 in DY5, the Performing Provider will continue to participate in Category 4 in DY6A. The Performing Provider's Category 4 value for DY6A will be equal to the Performing Provider's Category 4 value for DY5, unless the Performing Provider's DY5 Category 4 value is greater than 10 percent of the Performing Provider's total DY5 value. In this case, the Performing Provider's DY6A Category 4 value will be reduced to 10 percent of the Performing Provider's total DY5 value, and the funds above the 10 percent threshold will be allocated to Category 3 in DY6A.

40. Current DSRIP Projects Ineligible to Continue

a. If HHSC determines that a DSRIP project is ineligible to continue in its current form, that DSRIP project may not participate in the extension period. A Performing Provider affected by such a determination will have the opportunity to use the funds associated with the DSRIP project beginning in DY6B, subject to DY6B-DY10 requirements.

41. Requirements for Continuing DSRIP Projects

a. <u>Category 1 and 2 Requirements for DY6A</u>

i. Each DSRIP project must have the following four milestones in DY6A:
   A. A total QPI milestone valued at 25% of each DSRIP project's Category 1 or 2 value;
   B. A MLIU QPI milestone valued at 25% of each DSRIP project's Category 1 or 2 value;
   C. A core component reporting milestone valued at 25% of each DSRIP project’s Category 1 or 2 value; and
   D. A sustainability planning milestone valued at 25% of each DSRIP project’s Category 1 or 2 value.

ii. *Total QPI Milestone*
   A. HHSC will convert each total QPI metric to a total QPI milestone with standardized language in DY6A. However, if a DSRIP project has multiple QPI metrics in DY5, that project may be exempted from this conversion, based on criteria determined by HHSC and CMS.
   B. The DY6A total QPI goal is equal to the DY5 total QPI goal. However, certain DSRIP projects are eligible for an adjustment to the DSRIP project's DY6A total QPI goal as identified by HHSC.
   C. DSRIP projects must retain the same QPI grouping from the initial demonstration period in DY6A for total QPI.
   D. DSRIP projects must retain the same pre-DSRIP baseline from the initial demonstration period in DY6A for total QPI. If multiple metrics are

combined to form one total QPI milestone, the pre-DSRIP baselines will also be combined.

E. DSRIP projects may carry forward total QPI milestones from DY6A to DY6B and DY7.

iii. *MLIU QPI Milestone*

A. Beginning in DY6A, there is a standardized MLIU QPI milestone.

B. For DSRIP projects that have an MLIU QPI requirement in DY5:

1. The DY6A MLIU QPI goal is equal to the DY5 MLIU QPI goal. If, based on HHSC's determination pursuant to paragraph 41(a)(ii)(B), the DY6A total QPI goal is changed, the DY6A MLIU QPI goal will also be changed in proportion to the DY6A total QPI goal.
2. If the DSRIP project has an MLIU QPI metric in DY5, it retains the same pre-DSRIP baseline for MLIU QPI in DY6A used in the initial demonstration period.
3. If the DSRIP project does not have an MLIU QPI metric in DY5, the pre-DSRIP baseline for MLIU QPI in DY6A is equal to the pre-DSRIP baseline for total QPI multiplied by the earliest MLIU percentage goal on record with HHSC. 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 DY6A would be 100, and the pre-DSRIP baseline for MLIU QPI in DY6A 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**
DY6A Total QPI milestone	Serve 50 additional patients in the expanded clinic (individuals).	220	50	NA
DY6A MLIU QPI milestone	Serve 45 MLIU patients (individuals).	220*.**80**=176	NA	**45**

C. For DSRIP projects that do not have an MLIU QPI requirement in DY5:
   1. The DY6A 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. If, based on HHSC's determination pursuant to paragraph 41(a)(ii)(B), the DY6A total QPI goal is changed, the DY6A MLIU QPI goal will also be changed in proportion to the DY6A total QPI goal.
   2. The pre-DSRIP baseline for MLIU QPI in DY6A is equal to the pre-DSRIP baseline for total QPI in DY6A multiplied by the earliest MLIU percentage goal on record with HHSC. For example, if a project's pre-DSRIP baseline for total QPI in DY6A is 100 individuals, and the DY3 MLIU percentage target was 20%, the pre-DSRIP baseline for total QPI in DY6A would be 100, and the pre-DSRIP baseline for MLIU QPI in DY6A would be 20.
   3. Although all DSRIP projects must have a DY6A MLIU QPI goal, DSRIP projects under paragraph 41(a)(iii)(C), with the exception of projects subject to paragraph 41(a)(iii)(C)(4), has a DY6A MLIU QPI milestone that is pay-for-reporting (P4R). This means that the Performing Provider is eligible to receive payment for the project's

DY6A MLIU QPI milestone by reporting their actual DY6A MLIU QPI achievement, regardless of whether they achieved the DY6A MLIU QPI goal.

4. HHSC may determine that some of these DSRIP projects must have an DY6A MLIU QPI milestone that is P4P, meaning that the Performing Provider must demonstrate achievement of the project's DY6A MLIU QPI goal in order to receive payment for the DY6A MLIU QPI milestone. These DSRIP projects include the following:
    a) All Project Area 1.9 DSRIP projects, as described by the RHP Planning Protocol;
    b) DSRIP projects that did not achieve the estimated MLIU percentage in DY3, DY4, or DY5, and that caused them to have a higher than expected value per MLIU individual/ encounter;
    c) DSRIP projects for which HHSC notified the Performing Provider that the project was eligible to continue with changes, but the project's MLIU QPI milestone must be P4P; and
    d) DSRIP projects that included an MLIU goal in their QPI metric Baseline/Goal statement of their own choosing or that were required to address MLIU to receive CMS initial DSRIP project approval.

D. Certain DSRIP projects are eligible for an adjustment to the DSRIP project's DY6 MLIU QPI goal. These DSRIP projects include:
    1. A DSRIP project that HHSC identifies as underperforming on MLIU estimates in the initial demonstration period;
    2. A DSRIP project that is reporting on individuals or encounters that meet the MLIU definition for the initial demonstration period, but will not meet the MLIU definition for the extension period; and
    3. Any other DSRIP project that HHSC determines has a strong justification for an adjustment.

E. Performing Providers of a DSRIP project described in paragraph 41(a)(iii)(D) may, by a date to be determined by HHSC, request an adjustment to the DSRIP project's DY6A MLIU QPI goal.

F. In DY6A, DSRIP projects must retain the same total QPI grouping from the initial demonstration period for MLIU QPI.

G. DSRIP projects may carry forward MLIU QPI milestones from DY6A to DY6B and DY7.

H. To be eligible for the MLIU QPI milestone payment, beginning in DY6A, Performing Providers must report for each DSRIP project the MLIU individuals served or MLIU encounters provided at the individual or encounter level as opposed to the percentage of total QPI.
    1. There are limited exceptions to this requirement. Performing Providers may request an exception to this requirement by a date to be determined by HHSC. DSRIP projects eligible for an exception include:

a) A DSRIP project for which the Performing Provider did not assess the DSRIP project participants' health insurance coverage or financial status prior to September 30, 2015, and instead used a proxy to estimate the MLIU population served in their October DY4 QPI Reporting Template, and:
   1) Utilizes an intervention site that is a school, non-medical social service office (i.e., shelter), or community health fair;
   2) Is in Project Area 1.6 (Enhance Urgent Medical Advice), 2.6 (Implement Evidence-based Health Promotion), or 2.7 (Implement Evidence-based Disease Prevention Programs) as described by the RHP Planning Protocol; or
   3) The Performing Provider is a Local Health Department that does not bill Medicaid for the types of services provided through the DSRIP project; or

b) Any other DSRIP project that HHSC determines has a strong justification for an exception.

iv. *Non-QPI Milestones*

A. DSRIP projects must include the following non-QPI milestones in DY6A:
   1. Core component reporting, which may include continuous quality improvement (CQI); and
   2. Sustainability planning, which may include:
      a) Activities toward furthering the exchange of health information, integration into managed care, or collaboration with other community partners; and/ or
      b) A project-level evaluation.

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

B. DSRIP projects may report on DY6A non-QPI milestones only during the second reporting period of DY6A, and may not carry forward non-QPI milestones from DY6A to DY6B or DY7.

b. <u>Category 3 Requirements for DY6A</u>

i. The Category 3 outcome values for DY6A are equal to the Category 3 outcome values for DY5.
   A. However, if a Performing Provider's Category 4 value is greater than 10 percent of the Performing Provider's total value, the funds in excess of the 10 percent will be redistributed to Category 3 outcomes proportionately.

ii. If a Category 3 outcome is designated as pay-for-performance (P4P) in DY5, 100 percent of the Category 3 outcome's value in DY6A is P4P.

iii. If a Category 3 outcome is designated as pay-for-reporting (P4R) or maintenance (outcomes designated as maintenance were high performing at baseline with no reasonable room for improvement and have been approved to use a milestone

structure that includes an alternate improvement activity) with a population focused priority measure (PFPM) in DY5, 100 percent of the Category 3 outcome's value in DY6A is P4P of the PFPM.

iv. If a Category 3 outcome is designated as P4R with an associated stretch activity in DY5, the Performing Provider must choose one of the following options by a date determined by HHSC in a form determined by HHSC:

A. The Performing Provider may maintain the Category 3 outcome designated as P4R from DY5 and select a new stretch activity that does not duplicate the DY5 stretch activity.

1. If the Performing Provider chooses this option, the Performing Provider must select a stretch activity from the following:

a) Program evaluation (Alternate approaches to program and outcome linkages).

b) New participation in Health Information Exchange (HIE), or improvement of existing HIE structure.

c) Cost analysis and value-based purchasing planning.

2. If the Performing Provider chooses this option, 50 percent of the Category 3 outcome's value is P4R of the Category 3 outcome, and 50 percent is for completion of the stretch activity.

B. The Performing Provider may select a PFPM to replace the Category 3 outcome designated as P4R. If a Performing Provider chooses this option, 100 percent of the Category 3 outcome's value is P4P of the newly selected PFPM.

v. If a Category 3 outcome is designated as maintenance with an associated stretch activity in DY5, 100 percent of the Category 3 outcome's value in DY6A is for statistically significant maintenance of the approved baseline rate.

vi. For Category 3 P4P outcomes, DY6A goals will be set as an improvement over the baseline approved in DYs 3-5 to be achieved in performance year (PY) 3, or PY4 if not fully achieved in PY3. PY3 is the 12-month period immediately following the PY2 approved for use in DYs 3-5, or Performing Providers may request, by a date to be determined by HHSC, to use DY6A as PY3. PY4 is the 12-month period immediately following the selected PY3.

A. For Category 3 outcomes designated as Quality Improvement System for Managed Care (QISMC) with a baseline between the High Performance Level (HPL) and Minimum Performance Level (MPL), PY3 goals will be set as a 25 percent gap closure towards the HPL used for goal setting in DYs 3-5, or with a minimum improvement floor for outcomes with a baseline close to the HPL. For outcomes with a baseline below the MPL, PY3 goals will be a 15% gap closure between the MPL and the HPL.

B. For outcomes designated as improvement over self (IOS) in DY5, DY6A goals will be set as a 12.5 percent gap closure towards perfect over baseline.

C. HHSC will develop an alternate DY6A goal-setting methodology for outcomes designated as IOS - Survey.

vii. Partial payment for DY6A will be measured over the PY1 goal. For outcomes approved to use a baseline established in DY4, partial payment will be measured over the PY1 equivalent goal, which is a 5 percent IOS or 10 percent QISMC gap closure.

Percent of Goal Achieved for Category 3 P4P Outcomes			
PY	Milestone	Positive Direction (higher rates indicate improvement)	Negative Direction (lower rates indicate improvement)
PY3	DY6A AM-3.x	(PY3 achieved - PY1 goal or equivalent)/(PY3 goal - PY1 goal or equivalent)	(PY1 goal or equivalent - PY3 achieved)/(PY1 goal or equivalent - PY3 goal)
PY4	Carryforward of DY6A AM-3.x	(PY4 achieved - PY1 goal or equivalent)/(PY3 goal - PY1 goal or equivalent)	(PY1 goal or equivalent - PY4)/(PY1 goal or equivalent - PY3 goal)

viii. Performing Providers may carry forward Category 3 milestones from DY6A to DY6B and DY7.

c. Category 4 Requirements for DY6

i. Requirements for Category 4 in DY6A are the same as the requirements for Category 4 Reporting Domains (RDs) 1-5 in DY5.
ii. If a Performing Provider's Category 4 value is greater than 10 percent of the Performing Provider's total value, the funds in excess of the 10 percent will be redistributed to Category 3.
iii. The optional RD6 will be removed in DY6A as it was required to value Category 4 at the 15 percent maximum in DYs 3-5.

42. Requirements for Combining Certain DSRIP Projects

a. Certain DSRIP projects may be eligible to combine in DY6A based on Performing Provider requests to combine. These DSRIP projects must:

i. Be eligible to continue into the extension period;
ii. Not exceed a DY6A value of $5 million when combined; and
iii. Be one of the following:
   A. Cross-regional community mental health center DSRIP projects;
   B. Similar DSRIP projects by the same Performing Provider; or
   C. Similar DSRIP projects by different Performing Providers within the same health system.

b. HHSC will combine these DSRIP 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.

43. DSRIP Requirements for Uncompensated Care (UC) Only Hospitals

a. A UC only hospital must participate in an annual learning collaborative and report on mandatory Category 4 domains.

44. Remaining DSRIP Funds

a. The funds in the DSRIP pool not allocated to DSRIP projects for DY6A will be reallocated.

i. Funds are reallocated to increase Performing Providers' total value to up to $250,000 per each subsequent DY beginning in DY6A, as described in paragraph 39(a)(ii).

ii. The Anchoring Entity of an RHP is allocated the greater of the regional DSRIP Funding Allocation Percentage as defined in paragraph 27(a) multiplied by $20 million or the following minimum allocations:

A. A Tier 1 RHP Anchoring Entity has no minimum DY6A allocation.
B. A Tier 2 RHP Anchoring Entity has no minimum DY6A allocation.
C. A Tier 3 RHP Anchoring Entity has a minimum DY6A allocation of $1,250,000.
D. A Tier 4 RHP Anchoring Entity has a minimum DY6A allocation of $625,000. A Tier 4 RHP's minimum DY6A allocation may be increased to $800,000 if the Anchoring Entity meets the requirements described in paragraph 45(a)(i).

DY6A Anchoring Entity Allocation (All Funds)

RHP	Tier	Funding Allocation %	DY6A Anchoring Entity Allocation	DY6A Anchoring Entity Allocation with Regional Learning Collaboratives
1	3	4.00%	$1,250,000	$1,250,000
2	3	3.78%	$1,250,000	$1,250,000
3	1	20.22%	$4,044,045	$4,044,045
4	3	4.23%	$1,250,000	$1,250,000
5	4	7.02%	$1,404,587	$1,404,587
6	2	10.15%	$2,029,347	$2,029,347
7	3	6.04%	$1,250,000	$1,250,000
8	4	1.66%	$625,000	$800,000
9	2	14.29%	$2,857,364	$2,857,364
10	2	9.74%	$1,948,289	$1,948,289
11	4	1.16%	$625,000	$800,000
12	3	3.56%	$1,250,000	$1,250,000
13	4	0.67%	$625,000	$800,000
14	4	2.29%	$625,000	$800,000

15	3	4.41%	$1,250,000	$1,250,000
16	4	1.30%	$625,000	$800,000
17	4	1.89%	$625,000	$800,000
18	4	1.22%	$625,000	$800,000
19	4	0.95%	$625,000	$800,000
20	4	1.44%	$625,000	$800,000
		100.00%	**$25,408,632**	**$26,983,632**

iii. The DY6A Anchoring Entity allocation is in lieu of the anchor administrative payment.

45. Anchoring Entity Requirements

a. To receive its DY6A Anchoring Entity allocation, an Anchoring Entity must:

i. Submit a DY6A learning collaborative plan at the beginning of DY6 if it is the Anchoring Entity of a Tier 1, 2, or 3 region or it is the Anchoring Entity of a Tier 4 region that wishes to receive the enhanced allocation.
   A. The DY6A learning collaborative plan, at a minimum, must include an annual regional learning collaborative. The learning collaborative must include a focus on DSRIP integration into Medicaid managed care, value-based purchasing, alternative payment models, or sustainability strategies for low-income uninsured. The Anchoring Entity could meet also meet this requirement through a work groups that would be in addition to the annual learning collaborative.
   B. Two or more regions may work together to submit a cross-regional DY6A learning collaborative plan.
   C. HHSC will develop a template that includes the required activities specified in paragraph 45(a)(i)(A). Anchoring Entities will complete each element in the template and HHSC will follow up if the template questions are incomplete.

ii. Extension Stakeholder Engagement Forum: Once CMS and HHSC agree on the longer term extension, the Anchoring Entity will conduct an extension stakeholder engagement forum to promote collaboration in the next phase of the waiver and community goals. The feedback from this forum should be used to inform the learning collaborative plan for DY6B and beyond. The Anchoring Entity will post a copy of the updated RHP Plan on the RHP's website prior to the forum.

iii. Submit the following information in June 2017, or by another date specified by HHSC:
   A. The region's community needs assessment that was submitted with the original RHP plan in 2012 that has been updated as appropriate to reflect major changes, including changes to the priority needs;
   B. A description of the process used to update the region's community needs assessment, including the process used to obtain stakeholder feedback; and

C. The RHP plan that was submitted in 2012 that has been updated for DY6B onward. This updated RHP plan will include next steps for DSRIP projects as agreed upon by HHSC and CMS that would occur beginning in DY6B.

iv. Submit documentation during October 2017 that demonstrates that the Anchoring Entity implemented the DY6A learning collaborative plan and conducted an extension stakeholder engagement forum.

46. Compliance Monitoring of DSRIP Projects

a. All RHP plans are subject to potential audits, including review by the independent assessor. Upon request, Performing Providers must have available for review by the independent assessor, HHSC, and CMS, all supporting data and back-up documentation demonstrating performance as described under an RHP plan for DSRIP payments.

   Failure of a Performing Provider to provide supporting documentation of metric or milestone achievement may result in recoupment of DSRIP payments.