DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

John Scott
Interim Director
Healthcare Transformation Waiver
Medicaid and CHIP Services Department
P.O. Box 13247
Texas Health and Human Services Commission
Austin, TX 78711

Dear Mr. Scott:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved technical corrections to both Protocols J (Program Funding and Mechanics Protocol) and R (Measure Bundles Protocol) for Texas' section 1115(a) demonstration project, entitled "Texas Healthcare Transformation and Quality Improvement Program" (Project Number 11-W-00278/6). These technical corrections update Regional Healthcare Partnership (RHP) private hospital participation amounts, clarify the Quality Improvement System for Managed Care (QISMC) goals, and clarify the OB Hemorrhage Safety Bundle collaborative.

Your project officer is Mr. Eli Greenfield, who may be reached at (410) 786-6157 and through e-mail at Eli.Greenfield@cms.hhs.gov. Communications regarding program matters and official correspondence concerning the demonstration should be submitted to Mr. Greenfield at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Sincerely,

[redacted]

Angela D. Garner
Director
Division of System Reform Demonstrations

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 ("Demonstration") entitled “Texas Healthcare Transformation and Quality Improvement Program” (Project # 11-W-00278/6) in accordance with section 1115 of the Social Security Act. This waiver authorized the establishment of the Delivery System Reform Incentive Payment (DSRIP) program. The initial waiver was approved through September 30, 2016, and an initial extension was granted through December 31, 2017. An additional 5 year extension was granted on December 21, 2017. This section of the DSRIP Program Funding and Mechanics Protocol applies to demonstration years (DY) 7 and 8. Policies for DY 1 through 6 are provided in the Addendum.

1. Delivery System Reform Incentive Payment (DSRIP) Program

Special Terms and Conditions (STC) 34 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 Performing 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 Anchoring Entity). The Anchoring Entity shall collaborate with Performing Providers and other stakeholders in the RHP on the RHP Plan Update (an update of the RHP Plan that was originally developed in 2012 to accelerate meaningful delivery system reforms that improve patient care for low-income populations in the RHP). The RHP Plan Update must be consistent with the 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 Performing Provider-level outcomes that measure continued transformation of the Texas healthcare system. DY7-8 will serve as an opportunity for Performing Providers to move further towards sustainability of their transformed systems, including development of Alternative Payment Models (APMs) to continue services for Medicaid and low-income or uninsured (MLIU) individuals after the waiver ends.

To that end, Performing Providers will define the system they will utilize in DY7-8 for Category B and Category C measurements in the RHP Plan Updates. As DSRIP shifts from project-level reporting to system-level reporting, HHSC wants to ensure that providers maintain a focus on serving the target population: MLIU patients. Because DSRIP reporting will no longer be project-specific, HHSC is requesting that providers demonstrate that they are maintaining a certain level of service to the MLIU target population. In addition, HHSC does not want providers to stop serving the MLIU population in an effort to enhance achievement on Category

C measures. The Category B system definition and Patient Population by Provider (PPP) is meant to define the universe of patients that will be served by a Performing Provider; Category C measure denominators will naturally be limited by settings of services or measure specifications.

A Performing Provider's system definition should capture all aspects of the Performing Provider's patient services. There are required and optional components of a Performing Provider's system definition for each Performing Provider type. The required components must be included in a Performing Provider's system definition if the Performing Provider's organization has that business component. Optional components are less common among a provider type, but with the exception of contracted providers, should be included if they are a prominent component of a Performing Provider's system of care. Performing Providers may also add contracted partners to their system definition. Please refer to the Measure Bundle Protocol for the optional and required components of system definition. Performing Providers will define their system in the RHP Plan Update.

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 (APM) arrangements, costs and savings, and collaborative activities as described in paragraph 15.
- **Category B** - Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP)
- **Category C** - Measure Bundles and Measures
- **Category D** - Statewide Reporting Measure Bundle, similar to hospital Category 4 reporting during the initial demonstration period and DY6, expanded to include all Performing Providers.

2. Measure Bundle Protocol and Program Funding and Mechanics Protocol

In accordance with STC 34, the Measure Bundle Protocol (Attachment R) defines the Performing Provider system-level measures that are bundled to align closely with transformative DSRIP project areas from the Initial Demonstration Period and includes an appendix for measure specifications. The Program Funding and Mechanics Protocol (Attachment J) describes the State review process for RHP Plans and RHP Plan Updates, incentive payment methodologies, RHP and State reporting requirements, and penalties for missed milestones.

Following CMS approval of Attachment R and Attachment J, each RHP must submit an RHP Plan Update that identifies the selected Measure Bundles and measures for each Performing Provider for DY7-8 in accordance with these attachments and the STCs.

This version of the Program Funding and Mechanics Protocol is approved as of January 2018.

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

4. Definitions

a. Core Activity - An activity implemented by a Performing Provider to achieve the Performing Provider's Category C measure goals. A Core Activity may include an activity implemented by a Performing Provider as part of a DY2-6 DSRIP project that the Performing Provider continues in DY7-8, or a new activity implemented by a Performing Provider in DY7-8.

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 reporting year (RY) 1.

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

e. Initial Demonstration Period - The first five demonstration years (DY) 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. Measure Bundles are selected by hospitals and physician practices. Each Measure Bundle may include required measures and optional measures that may be selected by hospitals and physician practices in addition to the required 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 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 encounter during the applicable DY.

iii. If an individual was enrolled in Medicaid at the time of one encounter during the applicable DY, and was low-income or uninsured at the time of a separate 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 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 in accordance with paragraph 16, during an applicable DY. The goal is based on the average of the number of MLIU individuals served in DY5 and the number of MLIU individuals served in DY6.

j. Performance Year (PY) - The measurement period used for achievement of a Category C measure. Each performance year corresponds to a calendar year. PY1 is CY 2018, PY2 is CY 2019, and PY3 is CY 2020.

k. System - A Performing Provider's patient care landscape, as defined by the Performing Provider. The system should include all required components, if the Performing Provider has that business component. The system definition may also include optional components, including contracted providers. The system may not be limited by patient type, payer or diagnosis.

l. Total Patient Population by Provider (PPP) - The total number of individuals served by the Performing Provider during an applicable DY. The Total PPP shall include all individuals provided a service during the applicable DY within the Performing Provider's defined system. The Total PPP is the possible universe of patients that could be measured for purposes of Category C measures.

m. 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 on the RHP Plan Update for that RHP. 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 in performing key oversight and reporting responsibilities.

Anchoring Entities' activities shall include:

- Coordinating the community needs assessment update for the RHP;
- Engaging stakeholders in the RHP, including the public and through the learning collaborative plan (as required in paragraph 36);
- 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 R, Attachment J, and all other State/waiver requirements;

- Facilitating RHP Plan Update compliance with the RHP Plan Update Checklist;
- Transmitting the RHP Plan Update to HHSC on behalf of the RHP;
- Ongoing monitoring and annual reporting (as required in paragraphs 35 and 39) on status of activities and performance of Performing Providers in the RHP; 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 (LHDs), 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 60.

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 to achieve the Category C measure goals in an RHP Plan Update; and 2) measuring, reporting, and improving performance on the Category C measure goals in an RHP Plan Update, 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 R, “Measure Bundle Protocol” are the only entities that are eligible to receive DSRIP incentive payments in DY7-8. Performing Providers will primarily be hospitals, but CMHCs, LHDs, and physician practices may also receive DSRIP payments.

A Performing Provider may only participate in the RHP Plan Update for the RHP where it is physically located except that physician practices affiliated with an academic health science center, major cancer hospitals, or children’s hospitals may perform DSRIP outside of the RHP where the Performing Provider’s institution is physically located. Performing Providers participating in multiple RHPs may be assigned to a single "home" RHP.

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

a. A UC only hospital must participate annually in a regional learning collaborative and/or smaller, targeted learning collaborative or stakeholder meeting and report on mandatory Category D measures identified in Attachment R, “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 its RHP for DY7-8 using a State-approved template that identifies the participants, objectives, Measure Bundles, measures, milestones, and associated DSRIP values adopted from Attachment R, "Measure Bundle Protocol," and meets all requirements pursuant to the STCs and described herein.

The RHP Plan Updates shall include the following sections:

A. RHP Organization including collaborating organizations
B. Community Needs Assessment
C. Stakeholder Engagement
D. The Performing Provider's system definition
E. Category A reporting including: 1) the Performing Provider's description of the transition of its DY2-6 projects to its selected Category C Measure Bundles or measures; and 2) the Performing Provider's Core Activities for DY7-8
F. Category B MLIU Patient Population by Provider (PPP) baselines
G. Category C Measure Bundles and measures for each Performing Provider
H. Category D Statewide Reporting Measure Bundles for each Performing Provider
I. DSRIP valuation amounts
J. Signed certifications from the leadership of Performing Providers and their affiliated IGT Entities

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

11. HHSC Review and Approval Process

a. Submission of RHP Plan Updates
By January 31, 2018, or 90 days after the approval of Attachment R, "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. Anchoring Entity Review of RHP Plan Updates
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. HHSC Review of RHP Plan Updates
   i. HHSC shall review and assess each RHP Plan Update according to the following criteria:
      A. The RHP Plan Update is in the prescribed format.

B. The RHP Plan Update contains and completes all required elements described herein and is consistent with the STCs.
C. The RHP Plan Update conforms to the requirements for Category A Required reporting, Category B MLIU Patient Population by Provider (PPP), Category C Measure Bundles and measures, and Category D Statewide Reporting Measure Bundles as described herein, as well as in Attachment R, "Measure Bundle Protocol."
D. 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.
E. The RHP Plan Update is consistent with the overall goals of the DSRIP program and the objectives of the Medicaid program.

ii. By February 28, 2018, or 30 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 60 days following the due date for submission of the RHP Plan Updates, HHSC will approve or disapprove each RHP Plan Update.

V. RHP PLAN UPDATE 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, a Performing Provider may request prospective changes to the RHP Plan Update for the RHP(s) in which it participates through an RHP Plan Update modification process.

12. RHP Plan Update Modification Process

A Performing Provider may request to modify the RHP Plan Update for the RHP(s) in which it participates under the following circumstances:

a. Requests to Modify a Performing Provider's System Definition
A Performing Provider may submit a request to HHSC to change its system definition with good cause. The Performing Provider must submit the request to HHSC no later than 90 days prior to the first day of the semi-annual reporting period. HHSC will evaluate how the change to the Performing Provider's system definition impacts Category B and/or Category C.

b. Requests to Modify MLIU Patient Population by Provider (PPP)
A Performing Provider may submit a request to HHSC to change its MLIU PPP baseline and goals with good cause. Good cause may include:

i. A significant change to the Performing Provider's system definition as approved under paragraph 12.a.;
ii. An error in the data uncovered subsequent to baseline reporting;
iii. A significant policy change at the state or federal level that redefines eligibility for Medicaid or other eligibility-based programs that would be captured in the MLIU population; or
iv. A significant shift in the demographic served by the Performing Provider.

The Performing Provider must submit the request to HHSC no later than 90 days prior to the first day of the semi-annual reporting period.

c. Requests to Modify Category C Measures

i. Category C Measure Payer Types for Reporting Milestones
A Performing Provider may submit a request to HHSC to be exempted from reporting its performance on the Medicaid-only payer type and/or the LIU-only payer type for a measure's reporting milestone with good cause, such as data limitations or low volume. The Performing Provider must submit the request to HHSC prior to reporting a baseline for the measure and first day of the second reporting period of DY7.

ii. Category C P4P Measure Payer Type for Goal Achievement Milestones
A Performing Provider may submit a request to HHSC to change the payer a measure's goal achievement milestone is based with good cause, such as a small denominator or data limitations. The Performing Provider must submit the request to HHSC prior to reporting a baseline for the measure and no later than 30 days prior to the first day of the second reporting period of DY7.

iii. Category C Optional Measures for Hospitals and Physician Practices
A hospital or physician practice may submit a request to HHSC to delete an optional measure from a selected Category C Measure Bundle. The hospital or physician practice must submit the request to HHSC prior to reporting a baseline for the measure and no later than 30 days prior to the first day of the second reporting period of DY7. Optional measures that add point(s) to a Category C Measure Bundle may only be deleted if a hospital's or physician practice's MPT is still met without the deleted optional measure's point(s). The funds associated with the deleted optional measure will be reallocated to the remaining measures in the Measure Bundle such that the remaining measures' valuations are equal.

iv. Category C Measures for CMHCs and LHDs
A CMHC or LHD may submit a request to HHSC to replace a selected Category C measure with one or more other Category C measures with point values greater than or equal to the point value of the measure being replaced. This request is based on good cause, such as a low volume or data limitations. The CMHC or LHD must submit the request to HHSC prior to reporting a baseline for the measure and no later than 30 days prior to the first day of the second reporting period of DY7.

d. Submission, Review, and Approval Process
A Performing Provider must submit an RHP Plan Update modification request in writing to HHSC. HHSC will review the RHP Plan Update modification request and notify the

Performing Provider in writing of any questions or concerns identified. HHSC will then notify the Performing Provider in writing of its decision on the RHP Plan Update modification request. Substantial changes to system definitions, Category C Measure Bundles or measures, or Category B MLIU PPP, may be subject to a secondary review and ongoing compliance monitoring by the independent assessor.

VI. PERFORMING PROVIDER REQUIREMENTS FOR DY7-8

13. DY7-11 Pool Allocation

a. The DSRIP pool allocation for DY7-11 comports with STC 49.

DSRIP Pool Allocation According to Demonstration Year (total computable)

DY7	DY8	DY9	DY10	DY11
3,100,000,000	3,100,000,000	2,910,000,000	2,490,000,000	0

b. No later than March 31, 2019, HHSC will submit an updated PFM Protocol to CMS that includes DSRIP requirements for DY9-10.

c. CMS will aim to approve the updated PFM protocol no later than 45 days after its submission.

d. No later than July 31, 2019, HHSC will submit an updated Measure Bundle Protocol to CMS that includes revised measures and changes to innovative measures for DY9-10.

e. CMS and Texas will collaborate together and aim to approve the updated Measure Bundle Protocol within 60 days after its submission.

14. Performing Provider Valuation

a. A Performing Provider's total valuation for each demonstration year of 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, 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, the Performing Provider may use the funds associated with the DSRIP project beginning in DY7.
   iii. Performing Providers beginning DSRIP participation in DY7 with a total valuation less than $250,000 for DY7 may increase their total valuation to up to $250,000 per each subsequent DY beginning in DY7. Performing Providers eligible for this option must make this choice in the RHP Plan Update.

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

DSRIP Funding Distribution

	DY7	DY8
RHP Plan Update Submission	20%	NA
Category A - required reporting	0%	0%
Category B - MLIU PPP	10%	10%
Category C- Measure Bundles and Measures	55 or 65%	75 or 85%
Category D - Statewide Reporting Measure Bundle	15 or 5%	15 or 5%

*If an RHP's private hospital participation minimums are met, as described in paragraph 23, then Performing Providers in the RHP may increase the Statewide Reporting Measure Bundle funding distribution to 15%.

15. Category A - Eligibility for DY7-8 Payments

Each Performing Provider is required to complete the following for Category A to be eligible for payment of Categories B-D.

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

b. Alternative Payment Models
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 payers during the second reporting period of each DY.

c. Costs and Savings
Performing Providers who have a total valuation of one million dollars or more per DY are required to submit the costs of at least one Core Activity of choice and the forecasted or generated savings of that Core Activity. Performing Providers must submit this information in a template approved by HHSC or a comparable template. Performing Providers should include costs and savings specific to their organization and other contracted providers if that information is available. A progress update must be submitted during the second reporting period of DY7 and a final report of costs and savings must be submitted during the second reporting period of DY8.

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.

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

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

   For purposes of PPP, an individual is a patient receiving a face-to-face or virtual encounter (a service, billable or not) that is the equivalent of a service that would be provided within the physical confines of the defined system. This could include home-visits or other venue-based services that are documented. The service should be billable or charted. Providers are not allowed to count phone calls, text messages, or undocumented encounters.

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. To calculate the MLIU PPP baseline, the Performing Provider will include in their RHP Plan Update the Total PPP in DY5 and DY6 and the MLIU PPP in DY5 and DY6. HHSC will calculate the average of the DYs and set the MLIU PPP maintenance goal. These are new baselines and are not tied to the QPI reported during DY3-6. The reported baselines will be subject to compliance monitoring.

d. The performing provider is required to report the total number of MLIU individuals served each DY. The number of MLIU individuals served must be maintained or increased each DY with an allowable variation. The allowable variation from the goal will not be more than 5% below the 100% goal and is meant to account for natural fluctuation that may occur from one year to the next in the number of patients seeking services at a provider. The allowable variation is to be determined by HHSC once Performing Providers have submitted their baselines, and calculation of allowable variance will consider Performing Provider size, type, and the MLIU percentage of Total PPP served in the baseline years. The Performing Provider is also required to report the Total PPP numeric value. The Performing Provider is not required to maintain the ratio of MLIU PPP to Total PPP from the baseline year to earn a Category B payment, but must provide an explanation for any changes in the ratio.

e. The numbers of MLIU individuals served and total individuals served may be reported in the second reporting period of the DY being reported. Performing Providers may request to carry-forward reporting of MLIU PPP until the first round of reporting following the end of the DY being reported if they need additional time to compile or clean up data. If MLIU PPP reporting is not submitted on time or does not meet the requirements of the reporting, future DSRIP payments may be withheld until the complete report is submitted.

17. Category C - Measure Bundle Requirements for Hospitals and Physician Practices

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

i. Chronic Disease Management: Diabetes Care
ii. Chronic Disease Management: Heart Disease
iii. Care Transitions & Hospital Readmissions
iv. Patient Navigation & Emergency Department Diversion
v. Primary Care Prevention - Healthy Texans
vi. Primary Care Prevention - Cancer Screening
vii. Hepatitis C
viii. Pediatric Primary Care
ix. Pediatric Hospital Safety
x. Pediatric Chronic Disease Management: Asthma
xi. Pediatric Chronic Disease Management: Diabetes
xii. Improved Maternal Care
xiii. Maternal Safety
xiv. Improved Access to Adult Dental Care
xv. Preventive Pediatric Dental
xvi. Palliative Care
xvii. Integration of Behavioral Health in a Primary or Specialty Care Setting
xviii. Behavioral Health and Appropriate Utilization
xix. Chronic Non-Malignant Pain Management
xx. Integrated Care for People with Serious Mental Illness
xxi. Specialty Care
xxii. Hospital Safety
xxiii. Rural Preventive Care
xxiv. Rural Emergency Care

b. Each hospital and physician practice must determine a DSRIP attributed population to apply to its selected Measure Bundles as described in Attachment R, "Measure Bundle Protocol".

c. Each Measure Bundle includes required measures and may include optional measures.

d. Each measure within a Measure Bundle will be pay-for-performance (P4P) or pay-for-reporting (P4R).

e. Each Measure Bundle and measure is assigned a point value as described in Attachment R, "Measure Bundle Protocol."

f. Each hospital and physician practice is assigned a Minimum Point Threshold (MPT) for Measure Bundle selection.

g. Each hospital and physician practice must select Measure Bundles worth enough points to meet its MPT in order to maintain its valuation for DY7 and DY8.

    i. If a hospital or physician practice does not select Measure Bundles worth enough points to meet its MPT, its total DY7 valuation will be reduced proportionately across

its RHP Plan Update funds and Categories B-D based on the number of Measure Bundle points selected, and its total DY8 valuation will be reduced proportionately across its Categories B-D based on the number of Measure Bundle points selected.

Example: A hospital's DY7 valuation is $5 million and its MPT is 50. The RHP's private participation requirements are met, so if it were to select Measure Bundles worth 50 points, its DY7 valuation would be allocated as follows: $1 million for the RHP Plan Update (20%); $500,000 for Category B (10%); $2.75 million for Category C (55%); and $750,000 for Category D (15%).

However, the hospital selects Measure Bundles worth only 40 points, so its DY7 valuation is decreased to $4 million and is allocated as follows: $800,000 for the RHP Plan Update (20%), $400,000 for Category B (10%), $2.2 million for Category C (55%), and $600,000 for Category D (15%).

h. Each hospital or physician practice with a valuation greater than $2,500,000 per DY must: 1) select at least one Measure Bundle with at least one required 3 point measure; or 2) select at least one Measure Bundle with at least one optional 3 point measure, and select an optional 3 point measure in that Measure Bundle. The 3 point measure must have significant volume to meet the requirement.

i. Certain Measure Bundles may include population based clinical outcomes that are required as P4P or P4R based on the measure and a provider's MPT as described in Attachment R, "Measure Bundle Protocol."

j. Each hospital or physician practice with an MPT of 75 must select at least one Measure Bundle with at least one population based clinical outcome as specified in Attachment R, "Measure Bundle Protocol."

k. Only hospitals with a valuation equal to or less than $2,500,000 per DY may select the rural Measure Bundles as identified in Attachment R, "Measure Bundle Protocol."

    i. If a rural Measure Bundle is selected, then certain Measure Bundles and duplicate measures may not be selected as specified in Attachment R, "Measure Bundle Protocol."

l. A hospital or physician practice may only select a Measure Bundle for which the hospital's or physician practice's MLIU denominator for the baseline measurement period for at least half of the required measures in the Measure Bundle has significant volume as defined in Attachment R, "Measure Bundle Protocol," unless an exception is granted by HHSC to use an all-payer, Medicaid-only, or LIU-only denominator with significant volume for one or more required measures.

m. A hospital or physician practice may only select an optional measure in a selected Measure Bundle for which the hospital or physician practice's MLIU denominator for the baseline

measurement period has significant volume as defined in Attachment R, "Measure Bundle Protocol," unless an exception is granted by HHSC to use an all-payer, Medicaid-only, or LIU-only denominator with significant volume.

n. Each hospital or physician practice must indicate required measures with an MLIU denominator with less than significant volume in the RHP Plan Update. HHSC may identify measures with less than significant volume during reporting review and adjust valuation as described in paragraph 17.p.

o. Each hospital and physician practice may allocate its Category C valuation among its selected Measure Bundles as it wishes, so long as: 1) no single Measure Bundle is allocated a percentage of the Category C valuation that is less than seventy-five percent of its point value as a percentage of all the selected Measure Bundles' point values; 2) no Measure Bundle without any required or selected optional 3 point measures is allocated a higher percentage of the hospital's or physician's Category C allocation than the Measure Bundle's point value as a percentage of all its selected Measure Bundles' point values; and 3) no Measure Bundle with at least one required or selected optional 3 point measure is allocated a higher percentage of the hospital's or physician practice's Category C allocation than the Measure Bundle's point value multiplied by 1.25 as a percentage of all its selected Measure Bundles' point values.

   The minimum Measure Bundle valuation is calculated using the following formula:
   (Measure Bundle point value/ all selected Measure Bundles' point values) * .75 * Category C valuation

   The maximum Measure Bundle valuation for a Measure Bundle without any required or selected optional 3-point measures is calculated using the following formula:
   (Measure Bundle point value/ all selected Measure Bundles' point values) * Category C valuation

   The maximum Measure Bundle valuation for a Measure Bundle with at least one required or selected optional 3 point measure is calculated using the following formula:
   (Measure Bundle point value/ all selected Measure Bundles' point values) * 1.25 * Category C valuation

   Example:
   - A hospital has selected four Measure Bundles. Measure Bundle A is worth 4 points, Measure Bundles B-C are each worth 10 points, and Measure Bundle D is worth 6 points, for a total of 30 selected points.
   - Measure Bundle A has no required or selected optional 3-point measures. Measure Bundles B-D have required 3 point measures.
   - The hospital or physician practice may not allocate to Measure Bundle A less than 10% [(4/ 30) * .75] of its Category C valuation, Measure Bundles B-C less than 25% [(10/ 30) * .75] of its Category C valuation, and Measure Bundle D less than 15% [(6/ 30) * .75] of its Category C valuation.

- The hospital or physician practice may not allocate to Measure Bundle A more than 13.33% (4/30) of its Category C valuation, Measure Bundle B-C more than 41.67% [(10/30)* 1.25] of its Category C valuation, and Measure Bundle D more than 25.00% [(6/30)* 1.25] of its Category C valuation.

For valuation changes greater than one percent of a Measure Bundle's point value as a percentage of all the selected Measure Bundles' point values, a justification is required addressing amount of improvement required, level of effort required for improvement, and population impacted. HHSC will review and approve or deny these changes in the RHP Plan Update.

p. The valuation for each measure in a Measure Bundle selected by the hospital or physician practice is determined by dividing the Measure Bundle valuation by the number of measures in the Measure Bundle, so that the measures' valuations are equal with the exception of Measure Bundles with innovative measures. Innovative measures are 50 percent of the value of a measure that is not an innovative measure.
    i. The valuation for each innovative measure in a Measure Bundle with innovative measures is determined by dividing the Measure Bundle valuation by the number of measures in the Measure Bundle subtracted by .5 for each innovative measure and divided by 2. The valuation for the remaining measures in a Measure Bundle with innovative measures is determined by dividing the Measure Bundle valuation by the number of measures in the Measure Bundle subtracted by .5.
    ii. If a hospital or physician practice selects a Measure Bundle with a required measure with an MLIU denominator with no volume as defined in Attachment R, "Measure Bundle Protocol", the measure is removed from the Measure Bundle, and its valuation for the DY is redistributed equally among the remaining measures in the Measure Bundle with significant volume as defined in Attachment R, "Measure Bundle Protocol". This measure valuation also applies to population based clinical outcomes that are approved with no numerator volume.
    iii. If a hospital or physician practice selects a Measure Bundle with a required measure with an MLIU denominator with insignificant volume as defined in Attachment R, "Measure Bundle Protocol", the valuation for the measure's baseline reporting milestone and reporting milestones is maintained, unless an exception is granted by HHSC to use an all-payer, Medicaid-only, or LIU-only denominator with significant volume. The valuation for the measure's goal achievement milestone for the DY is redistributed equally among the goal achievement milestones for the remaining measures in the Measure Bundle with significant volume as defined in Attachment R, "Measure Bundle Protocol." This measure valuation also applies to population based clinical outcomes that are approved to be reported as pay-for-reporting.

q. The standard point valuation (or value per point) is $500,000.

r. Minimum Point Thresholds for Hospitals

    i. A hospital's MPT is based on the following factors:

A. The hospital's DY7 valuation.
B. The hospital's DY7 valuation as a percentage of the DY7 valuations for all hospitals.
C. The hospital MPT cap of 75.
D. The hospital's size and its role in serving Medicaid and uninsured individuals, which is measured by:
   I. 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 FFY 2016 weighted at .64.
   II. The hospital's outpatient Medicaid and uninsured costs as a percentage of all hospitals' Medicaid and uninsured outpatient costs as reported in the TXHUC for FFY 2016 weighted at .36.

ii. A hospital's MPT is calculated as follows:

A. First, the hospital's Statewide Hospital Factor (SHF) is determined as follows:

Statewide Hospital Factor (SHF) =
.64 multiplied by (the hospital's Medicaid and uninsured inpatient days divided by all hospitals' Medicaid and uninsured inpatient days) plus
.36 multiplied by (the hospital's outpatient Medicaid and uninsured costs divided by all hospitals' Medicaid and uninsured outpatient costs)

B. Second, the hospital's Statewide Hospital Ratio (SHR) is determined as follows:

Statewide Hospital Ratio (SHR) =
(DY7 valuation divided by all hospitals' DY7 valuations) divided by SHF

C. Third, the hospital's MPT is determined as follows:

- If SHR ≤ 3:
  MPT = the lesser of:
  a) DY7 valuation divided by standard point valuation ($500,000); or
  b) MPT cap (75 points)
- If SHR > 3 but ≤ 10:
  MPT = the lesser of:
  a) (DY7 valuation divided by standard point valuation [$500,000]) multiplied by (SHR divided by 3); or
  b) MPT cap (75 points)
- If SHR > 10 and DY7 valuation ≤ $15 million:
  MPT = the lesser of:
  a) (DY7 valuation divided by standard point valuation [$500,000]) multiplied by (SHR divided by 3); or

b) 40 points

- If SHR > 10 and DY7 valuation > $15 million:
  MPT = the lesser of:
  a) (DY7 valuation divided by standard point valuation [$500,000]) multiplied by (SHR divided by 3); or
  b) MPT cap (75 points)

iii. If a hospital does not have data for the factors under paragraph 17.q.i.D, is a specialty hospital with a limited scope of practice, or has system overlap with a physician practice Performing Provider, its MPT will be determined using an alternate methodology to be determined by HHSC.

s. Minimum Point Thresholds for Physician Practices

i. A physician practice's MPT is the lesser of:
   A. DY7 valuation divided by standard point valuation ($500,000); or
   B. MPT cap (75 points)

ii. If a physician practice is a specialty physician practice with a limited scope of practice, its MPT will be determined using an alternate methodology to be determined by HHSC.

18. Category C - Measure Selection Requirements for Community Mental Health Centers (CMHCs) and Local Health Departments (LHDs)

a. The Category C measures for CMHCs and LHDs are described in Attachment R, "Measure Bundle Protocol".

b. Each CMHC and LHD must determine a DSRIP attributed population to apply to its selected measures as described in Attachment R, “Measure Bundle Protocol”.

c. Each measure is assigned a point value as described in Attachment R, “Measure Bundle Protocol”.

d. Each CMHC and LHD is assigned a Minimum Point Threshold (MPT) for selection of measures.

e. Each CMHC and LHD must select a measure or a combination of measures worth enough points to meet its MPT in order to maintain its valuation for DY7 and DY8.

i. If a CMHC or an LHD does not select measures worth enough points to meet its MPT, its total DY7 valuation will be reduced proportionately across its RHP Plan Update funds and Categories B-D based on the number of measure points selected,

and its total DY8 valuation will be reduced proportionately across its Categories B-D based on the number of measure points selected.

f. A CMHC or LHD must select and report on at least two unique measures.

g. Each CMHC or LHD with a valuation of more than $2,500,000 per DY must select at least one 3 point measure.

h. An LHD may select P4P measures that the LHD reported for Category 3 in DY6 to meet their MPT as described in Attachment R, “Measure Bundle Protocol.”

i. A CMHC or LHD may only select a measure for which the CMHC’s or LHD’s MLIU denominator for the baseline measurement period has significant volume as defined in Attachment R, "Measure Bundle Protocol", unless an exception is granted by HHSC to use an all-payer, Medicaid-only, or LIU-only denominator with significant volume.

j. All measures selected by a CMHC or LHD are valued equally; however, a CMHC or an LHD may allocate its Category C valuation among its selected measures as long as: 1) no single measure is allocated a valuation that is less than 75 percent of its initial measure valuation ((total Category C valuation/number of measures selected) /2); 2) no single 1-point or 2-point measure is allocated a valuation that exceeds its initial measure valuation (total valuation/number of measures selected); and 3) no single 3-point or 4-point measure is allocated a valuation that exceeds its initial measure valuation (total valuation/number of measures) multiplied by 1.25.

Example:
- A CMHC selected four measures.
- Measures A and B are 3-point measures. Measures C and D are 1-point measures.
- The total Category C valuation for the CMHC is $400,000 with each measure initially valued at $100,000 ($400,000 /4).
- The CMHC may not allocate to Measures A-D less than $75,000 ($100,000 * .75).
- The CMHC may not allocate to Measures A-B more than $125,000 ($100,000 * 1.25) and Measures C and D more than $100,000 ($400,000 /4).

For valuation changes greater than one percent of initial measure valuation, a justification is required addressing amount of improvement required, level of effort required for improvement, and population impacted. HHSC will review and approve or deny these changes in the RHP Plan Update.

k. The standard point valuation (or value per point) is $500,000.

l. Minimum Point Thresholds for CMHCs and LHDs

i. A CMHC's MPT is the lesser of:

A. DY7 valuation/ standard point valuation ($500,000); or
B. The CMHC MPT cap of 40.

ii. An LHD's MPT is the lesser of:
A. DY7 valuation/ standard point valuation ($500,000); or
B. The LHD MPT cap of 20.

19. Category C - Measurement Periods for P4P Measures

a. The baseline measurement period is calendar year (CY) 2017 (January 1, 2017 - December 31, 2017).
   i. A measure may be eligible for a shorter baseline measurement period consisting of no fewer than six months if it: 1) has a denominator or eligible cases greater than or equal to 30 for the requested baseline measurement period; and 2) would not be compromised by a shorter baseline measurement period. Examples of measures that would be compromised by a shorter baseline measurement period include blood pressure control (for which the denominator is individuals diagnosed with hypertension in the first six months of the measurement period), outcomes sensitive to flu season or other seasonal variation, and numerators with a low frequency of probability of occurrence. A Performing Provider may request HHSC approval to use a shorter baseline measurement period for an eligible measure in the RHP Plan Update submission.
   ii. A P4P measure may be eligible for a delayed baseline measurement period that ends no later than September 30, 2018. In cases where a provider has no or insufficient volume to establish a baseline that ends by December 31st, 2017, a Performing Provider may request HHSC approval to use a delayed baseline measurement period for a measure. If HHSC approves the Performing Provider's request, the Performance Year (PY) measurement periods do not change. The measure's goal achievement will begin with PY2. A Performing Provider must report PY1 and PY2 for a measure with a delayed baseline measurement period.
   iii. For LHD P4P measures that were reported in Category 3 in DY6 and selected for DY7-8, the baseline measurement period is DY6 (October 1, 2016 - September 30, 2017).

b. PY1 is CY 2018 (January 1, 2018 - December 31, 2018).

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

d. PY3 is CY 2020 (January 1, 2020 - December 31, 2020).

e. Exceptions to measurement periods may be indicated in Attachment R, "Measure Bundle Protocol" for P4P measures for which a CY 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 31 to align with the flu season).

20. Category C - Measure Milestones

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

	Innovative Measure (P4R) or Quality Improvement Collaborative Activity	**P4P Measure**
DY7	100% Reporting Year (RY) 1 reporting milestone	25% baseline reporting milestone
		25% PY1 reporting milestone
		50% DY7 goal achievement milestone
DY8	100% RY2 reporting milestone	25% PY2 reporting milestone
		75% DY8 goal achievement milestone

b. A Performing Provider must report a baseline for a measure, and HHSC must approve the reported baseline for reporting purposes, before a Performing Provider can report PY1 (or PY2 for measures with a delayed baseline measurement period).

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

c. Performing Providers must report the reporting and goal achievement milestones for a P4P measure for a given PY during the same reporting period with some exceptions for measures with a delayed measurement period.

d. Some measures have multiple parts as outlined in Attachment R, "Measure Bundle Protocol."
   i. A measure with multiple parts has one baseline reporting milestone, one PY reporting milestone for each DY, and multiple goal achievement milestones for each DY.
   ii. The valuation for each measure part's goal achievement milestone is determined by dividing the measure's total goal achievement milestone valuation by the number of measure parts, so that each measure part's goal achievement milestone is valued equally.

iii. All measure parts for a given baseline or achievement for a PY must be reported in the same reporting period.
iv. Each measure part's goal achievement milestone will be measured independently to determine percent of goal achieved as defined in paragraph 27.

21. Category C - Measure Denominator Population

a. Each Category C measure's eligible denominator population must include all individuals served by the Performing Provider system during a given measurement period that are included in the Measure Bundle target population as defined in Attachment R "Measure Bundle Protocol."

b. Performing Providers may not select Performing Provider specific facility, co-morbid condition, age, gender, and race/ethnicity subsets not otherwise specified in Attachment R "Measure Bundle Protocol."

c. In order to be eligible for payment for a measure's reporting milestone, the Performing Provider must report its performance on the all-payer, Medicaid-only, and LIU-only payer types.

    i. A Performing Provider may request in the RHP Plan Update submission to be exempted from reporting its performance on the Medicaid-only payer type or the LIU-only payer type for a measure's reporting milestone with good cause, such as data limitations.
    ii. A Performing Provider may also submit an RHP Plan Update modification request to HHSC to be exempted from reporting its performance on the Medicaid-only payer type or the LIU-only payer type for a measure's reporting milestone with good cause, such as data limitations, prior to reporting a baseline for the measure and no later than the first day of the second reporting period of DY7.

d. Payment for a P4P measure's goal achievement milestone is based on the Performing Provider's performance on the MLIU payer type.

    i. A Performing Provider may request in the RHP Plan Update submission that payment for a P4P measure's goal achievement milestone be based on the Performing Provider's performance on the all-payer, Medicaid-only, or LIU-only payer type with good cause, such as a small denominator or data limitations.
    ii. A Performing Provider may also submit an RHP Plan Update modification request to HHSC to change the payer type on which payment for a measure's goal achievement milestone is based with good cause, such as a small denominator or data limitations; the Performing Provider must submit the request to HHSC prior to reporting a baseline for the measure and no later than 30 days prior to the first day of the second reporting period of DY7.

22. Category C - Methodology for Setting P4P Measure Goals

a. Category C P4P measure goals are set as an improvement over the baseline. Each P4P measure will be designated in Attachment R, "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	**DY8**
QISMC	Baseline below MPL	MPL	10% gap closure between the MPL and HPL
	Baseline equal to or greater than the MPL and lower than the HPL	The greater absolute value of improvement between: 5% gap closure towards HPL, or baseline plus (minus) 2% of the difference between the HPL and MPL	The greater absolute value of improvement between: 20% gap closure towards HPL, or baseline plus (minus) 8% of the difference between the HPL and MPL
	Baseline equal to or greater than the HPL	The lesser absolute value of improvement of baseline plus (minus) 2% of the difference between the HPL and MPL or the IOS goal	The lesser absolute value of improvement of baseline plus (minus) 8% of the difference between the HPL and MPL or the IOS goal
IOS		2.5% gap closure	10% gap closure

b. In cases where a Performing Provider has significant denominator volume and no measureable numerator because required numerator inclusions and exclusions are not tracked during the baseline measurement period, a Performing Provider may request in the RHP Plan Update to use a baseline numerator of 0 for certain measures designated as process measures and QISMC. Measures that are eligible for a numerator of 0 are indicated in Attachment R, "Measure Bundle Protocol."

   i. If a provider is approved by HHSC to report a baseline numerator of 0, the goal for the DY7 goal achievement milestone will be equal to the 75th percentile as indicated in Attachment R, "Measure Bundle Protocol" and the goal for the DY8 goal achievement milestone will be equal to a 10% gap closure between the 75th percentile and the HPL. Measures approved to report with a numerator of 0 will have standard baseline and PY measurement periods as described in paragraph 19.

23. Category D - Statewide Reporting Measure Bundle

a. Each Performing Provider is required to report on the Statewide Reporting Measure Bundle specific to the type of Performing Provider (hospital, physician practice, CMHC, or LHD) as described in Attachment R, "Measure Bundle Protocol."

b. Category D is valued at 5 percent of a Performing Provider's total valuation. Category D may be increased to 15 percent of a Performing Provider's total valuation if the requirements under paragraph 23.c. are met.

c. An RHP must maintain the following total private hospital valuation amounts at submission of the RHP Plan Update for DY7-8. A 3 percent decrease may be allowed in each RHP 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	$64,989,767	$63,040,074
5	$108,996,712	$105,726,810
6	$68,777,524	$66,714,199
7	$84,513,275	$81,977,876
8	$9,607,121	$9,318,907
9	$120,556,063	$116,939,381
10	$50,540,564	$49,024,347
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	$8,476,165	$8,221,880
17	$12,637,136	$12,258,022
18	$5,311,040	$5,151,709
19	$5,832,483	$5,657,509
20	$11,173,926	$10,838,708
TOTAL	$870,343,929	$844,233,611

d. Each measure within the Category D Statewide Reporting Measure Bundle is valued equally.

VII. DISBURSEMENT OF DSRIP FUNDS FOR DY7-8

24. RHP Plan Update Submission for Payment in DY 7

Submission of a State-approved RHP Plan Update shall serve as the basis for payment of 20 percent of a Performing Provider's DY7 total valuation.

25. Category A - Eligibility for DY7-8 Payments

Each Performing Provider is required to complete Category A to be eligible for payment of Categories B-D.

a. Category A must be reported in the second reporting period of each demonstration year to be eligible for payment of Categories B-D of the applicable demonstration year.

b. If Category A is not reported in the second reporting period of each demonstration year, then previous payments for the RHP Plan Update submission and Categories B-D for the applicable demonstration year may be recouped and prospective payments including those in the second reporting period may be withheld until Category A is completed.

26. Basis for Payment of Category B - MLIU PPP

The number of MLIU individuals served by the Performing Provider must be maintained or increased each DY with an allowable variation below the baseline, as described in paragraph 16.d. to be eligible for payment of the MLIU PPP milestone. The allowable variation below the maintenance goal (baseline) will be determined by HHSC and is to be based on the size and type of Performing Provider and will also account for the baseline MLIU percentage of Total PPP.

If a Performing Provider is unable to maintain the MLIU PPP number within the allowable variation, then the payment associated with the number will be reduced. Partial payment will be tiered in the following manner: 100% valuation for achievement at 100% of goal (with allowable variation); 90% of valuation for achievement of 90% to 99% (or 100% less allowable variation as the upper limit with no allowable variation at the lower limit); 75% of valuation for achievement of 75% - 89% of goal (no allowable variation); or 50% of valuation for achievement of 50% - 74% of goal (no allowable variation). A Performing Provider will not earn any payment for maintaining less than 50% of its MLIU patient population.

27. Basis for Payment of Category C - Measure Bundles and Measures

a. P4P and P4R Measure Reporting Milestones
A Performing Provider must fully achieve reporting milestones to qualify for a DSRIP payment related to these milestones.

b. P4P Measure Goal Achievement Milestones
Partial payment for P4P measure goal achievement milestones is available in quartiles for partial achievement measured over baseline in PY1, PY2, and PY3. P4P measures with a baseline above the HPL are not eligible for partial achievement.

i. Each P4P measure has an associated goal achievement milestone that is assigned an achievement value based on the Performing Provider'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:

- Measures with a positive directionality where higher scores indicate improvement in measure:
  - DY7 achievement = (PY1 Achieved - Baseline)/(DY7 Goal - Baseline)
  - Carryforward of DY7 achievement = (PY2 Achieved - Baseline)/(DY7 Goal - Baseline)
  - DY8 achievement = (PY2 Achieved - Baseline)/(DY8 Goal - Baseline)
  - Carryforward of DY8 achievement = (PY3 Achieved - Baseline)/(DY8 Goal - Baseline)
- Measures with a negative directionality where lower scores indicate improvement in a measure:
  - DY7 achievement = (Baseline - PY1 Achieved)/(Baseline - DY7 Goal)
  - Carryforward of DY7 achievement = (Baseline - PY2 Achieved)/(Baseline - DY7 Goal)
  - DY8 achievement = (Baseline - PY2 Achieved)/(Baseline - DY8 Goal)
  - Carryforward of DY8 achievement = (Baseline - PY3 Achieved)/(Baseline - DY8 Goal)

28. 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 measures included in the Statewide Reporting Measure Bundle specific to the type of Performing Provider. A Performing Provider must complete reporting on a Category D measure to be eligible for Category D payment.

29. Carry-forward Policy

Carry forward is allowed for Category B and C. Carry forward is not allowed for Category A or D.

If a Performing Provider is unable to report a Category B MLIU PPP and Total PPP in the second reporting period of the achievement DY, the Performing Provider may request to carry forward reporting of the Category B milestone to the first reporting round of the following DY. The measurement period will not change.

If a Performing Provider does not report a baseline or performance year in the first reporting period after the end of the measurement period, the Performing Provider may request to carry forward reporting of the associated Category C milestone to the next reporting round. For measures with a delayed baseline measurement period, a Performing Provider may request to carry forward reporting of the baseline until the first reporting period of DY8. Carrying forward reporting does not change baseline or performance measurement periods.

Performing Providers may carry forward achievement of the Category C goal achievement milestones so that the DY7 goal achievement milestone can be achieved in PY1 or PY2, and the DY8 goal achievement milestone can be achieved in PY2 or PY3. For measures with a delayed baseline measurement period, DY7 goal achievement can only be achieved in PY2, and the DY8 goal achievement milestone can be achieved in PY2 or PY3. The carried forward achievement must be reported in the first reporting period after the end of the carried forward measurement period.

Incentive funding that is carried forward still remains associated with the original DY 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 DY in which it was to have been completed (e.g., for DY7, 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.

30. Penalties for Missed Milestones

If a Performing Provider does not report the milestones during the carry-forward period or the reporting year with respect to Category D - Statewide Reporting Measure Bundle, funding for the incentive payment shall be forfeited by the Performing Provider.

31. Remaining DY7-8 DSRIP Funds

a. Available DY7-8 DSRIP Funds
The funds remaining from each demonstration year for DY7 and DY8 is based on the difference between the available pool allocation as described in paragraph 13 and all Performing Providers' valuation as described in paragraph 14.a.

b. Regional Allocation
The remaining DY7-8 DSRIP funds are allocated to RHPs that did not fully utilize their original regional DY5 allocation based on the regional DY6 valuation and the valuation

available to the region according to paragraph 14.a, excluding regional changes due to DY6 combined projects and DY7 assignment of "home" regions.

Regional Allocation of Additional DSRIP Funds from Remaining DY7-8 DSRIP Funds

RHP	Additional Regional Allocation per DY
RHP 1	$866,635
RHP 2	$2,308,000
RHP 3	$0
RHP 4	$522,345
RHP 5	$4,797,112
RHP 6	$0
RHP 7	$0
RHP 8	$5,739,571
RHP 9	$0
RHP 10	$0
RHP 11	$0
RHP 12	$0
RHP 13	$0
RHP 14	$0
RHP 15	$0
RHP 16	$0
RHP 17	$9,284,861
RHP 18	$1,318,286
RHP 19	$0
RHP 20	$4,062,821
TOTAL	**$28,899,632**

c. Allocation Requirements

The RHP may determine how to allocate the additional DY7-8 DSRIP funds among Performing Providers based on the community needs assessment. New Performing Providers that did not participate in DSRIP in DY2-6 and are an eligible Performing Provider type may be allocated funds to begin participation in DY7-8.

i. Each RHP must conduct at least two public stakeholder meetings to determine the uses for the additional funding.
ii. Each Performing Provider must certify that there is a source of IGT for the additional funding.
iii. The RHP Plan Update must include a description of the process to determine the uses for the additional funding and indicate the interested Performing Providers that were or were not allocated additional funding.

iv. Existing and new Performing Providers allocated additional funds must follow all DSRIP requirements.

32. Withdrawal of a Performing Provider

If a Performing Provider withdraws from DSRIP during the RHP Plan Update submission or in DY7 or DY8, then the funding may not be transferred to other Performing Providers or to the RHP.

VIII. RHP AND STATE REPORTING REQUIREMENTS

33. RHP Reporting in DY7-8

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 HHSC 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.

34. 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 33 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.

35. RHP Annual Year End Report

Each RHP Anchoring Entity shall submit an annual report by December 15 following the end of each demonstration year during DY7-8. 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 DY. Additionally, the RHP will provide a narrative description of the progress made, lessons learned, challenges faced, stakeholder engagement, and other pertinent findings.

36. Learning Collaborative Plans

Recognizing the importance of learning collaboratives in supporting continuous quality improvement, RHPs will submit learning collaborative plans with the RHP Plan Update, to reflect opportunities and requirements for shared learning among the DSRIP Performing Providers in the region. The DY7-8 learning collaborative plan may include an annual regional learning collaborative and/or smaller, targeted learning collaboratives or stakeholder meetings. Two or more regions may work together to submit a cross-regional DY7-8 learning collaborative plan. HHSC will develop a template for submission of RHP learning collaborative plans.

37. 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 42(c);
iv. Expenditure projections reflecting the expected pace of future disbursements for each RHP and Performing Providers; and
v. A summary assessment of each RHP's DSRIP activities during the given period including progress on milestones.

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 R, "Measure Bundle Protocol" and Attachment J, "Program Funding and Mechanics Protocol."

IX. DATA QUALITY ASSURANCE

38. Data validation and alignment with managed care

Data and milestones 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.

39. Compliance Monitoring of DSRIP

All RHP Plan Updates 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 of a milestone as described under an RHP Plan Update for DSRIP payments.

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

HHSC may recoup payments for milestones when a Performing 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:

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. DSRIP Requirements for UC Pool Program Participants

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

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.

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. HHSC Approval of Plans

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

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:

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

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 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 201l 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. Non-Hospital Providers

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. Option for Smaller Hospitals in Tiers 1 and 2 to Collaborate in Pass 1

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:

a. 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.

b. 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.

c. 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.

d. 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. Category 1 and 2 Requirements for DY6A

   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. Category 3 Requirements for DY6A

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.

Texas DSRIP

Measure Bundle Protocol

[Document subtitle]

Contents

Introduction

The Delivery System Reform Incentive Payment (DSRIP) program is designed to provide incentive payments to Texas hospitals, physician practices, community mental health centers and local health departments 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. This Measure Bundle Protocol for the DSRIP program is effective for Demonstration Years (DYs) 7-8 beginning October 1, 2017 [contingent on negotiations with the Centers for Medicare and Medicaid Services].

The DY7-8 Measure Bundle Protocol reflects the evolution of the DSRIP program from project-level reporting to provider-level outcome reporting to measure the continued transformation of the Texas healthcare system. In DY7-8, DSRIP Performing Providers will report on required reporting categories at their provider system level.

Category A

Required reporting for Category A in DY 7-8 includes progress on Core Activities, Alternative Payment Model (APM) arrangements, costs and savings, and collaborative activities. The Category A requirements were developed to serve as an opportunity for Performing Providers to move further towards sustainability of their transformed systems, including development of APMs to continue services for Medicaid and low-income or uninsured (MLIU) individuals after DSRIP ends. The listing of Core Activities in the Measure Bundle Protocol reflects those project areas that have been determined to be the most transformational and will support continuation of the work begun by Performing Providers during the first years of DSRIP. These Core Activities will be continued or implemented by a Performing Provider to support achievement of its Category C measure goals.

Category B

As DSRIP shifts from project-level reporting to system-level reporting, HHSC wants to ensure that providers maintain a focus on serving the DSRIP target population: MLIU individuals. To that end, Category B will require each Performing Provider to report the total number of individuals and the number of MLIU individuals served by its system during each DY. The Measure Bundle Protocol sets out parameters for a Performing Provider to define its "system" to reflect the Performing Provider's current care landscape that is striving to advance the Triple Aim: improving the patient experience of care; improving the health of populations; and reducing the per capita cost of health care.

Category C

For Category C, targeted measure bundles have been developed for hospitals and physician practices, and lists of measures are available for community mental health centers and local health departments. Measure Bundles consist of measures that share a unified theme, apply to a similar population, and are impacted by similar activities. Bundling measures for DY7-8 allows for ease in measure selection and approval, increases standardization of measures across the state for hospitals and physician practices with similar activities, facilitates the use of regional networks to identify best practices and share innovative ideas, and continues to build on the foundation set in the initial waiver period while providing additional opportunities for transforming the healthcare system and bending the cost curve.

The menu of available Measure Bundles for hospitals and physician practices and measures for community mental health centers and local health departments were built with measures from common

DY2-6 Category 3 pay-for-performance (P4P) measures; new P4P measures added from authoritative sources, with a preference for measures endorsed by the National Quality Forum; and innovative measures as needed, which will be pay-for-reporting (P4R) for DY7-8 and function as a measure testing process.

Measure Development Process

HHSC formed a DSRIP Clinical Champions stakeholder group in 2015 to provide clinical expertise for development of DSRIP processes. The Clinical Champions consist of clinical, health quality, and operational professionals in Texas. In 2015, the Clinical Champions reviewed provider-submitted Transformational Impact Summaries—brief, structured project descriptions and evaluations—and identified DSRIP projects' high impact practices. HHSC used these high impact practices to inform the initial selection of the Category C Measure Bundle topics. The Clinical Champions also helped HHSC refine the DSRIP project menu to include only the most transformational project areas.

In 2017, Texas HHSC began a new process with the Clinical Champions to seek their input on the meaningfulness, improvability and clinical appropriateness of proposed measures to include in the Hospital and Physician Practice Measure Bundles, as well as any identified gaps in measurement. HHSC implemented a multi-round process with the Clinical Champions to choose the draft measures for each of the Category C Measure Bundles. The process entailed three rounds of anonymous voting by Measure Bundle topic subgroups—termed Bundle Advisory Teams—via online surveys. Each round was followed by an advisory team conference call to discuss the survey results.

HHSC assigned Clinical Champions to 11 Bundle Advisory Teams based on their areas of clinical expertise and interest. Additionally, some Clinical Champions with operational expertise were assigned to a Technical Advisory Team, which provided feedback to the Bundle Advisory Teams and HHSC about the feasibility of implementing suggested quality measures in a variety of settings.

The Bundle Advisory Teams rated each potential measure using a 5-point Likert scale, based on the measure's importance according to the member's clinical judgement. During the second and third survey rounds, participants reviewed the anonymous results of previous rounds, including both numerical ratings for each measure and qualitative comments submitted on the surveys and during conference calls. Each round resulted in the exclusion of measures with limited support. Additionally, Bundle Advisory Team members had the opportunity to suggest new and innovative measures, and those were included in the last round of voting.

Community Mental Health Centers and the Texas Council of Community Centers provided recommendations for measures related to behavioral health, and Local Health Departments were engaged in the development of measures for those Performing Providers.

Points were assigned to measures as outlined in the Measure Bundle Protocol.

HHSC will submit an updated Measure Bundle Protocol for DY9-10 to CMS (including a review of innovative measures tested in DY7 and DY8 for possible inclusion as P4P in the DY9-10 menu) no later than July 31, 2019.

Category D

For DY7-8, the Category D Statewide Reporting Measure Bundles have replaced the former Category 4 reporting on population-focused measures. While Category 4 was only for hospitals, all provider types

will be able to report on Category D in DY7-8. The Statewide Reporting Measure Bundles align with the MLIU population, are identified as high priority given the health care needs and issues of the patient population served, and are viewed as valid health care indicators to inform and identify areas for improvement in population health within the health care system. These bundles refine the hospital measures from the former Category 4 and add measures for physician practices, community mental health centers and local health departments. The emphasis of Category D is on the reporting of population health measures to gain information on and understanding of the health status of key populations and to build the capacity for reporting on a comprehensive set of population health metrics.

Category A

Each performing provider is required to report on the following for Category A:

- Core Activities;
- Alternative Payment Models (APMs);
- Costs and Savings; and
- Collaborative Activities.

Category A is designed to support DSRIP sustainability through providers' reporting on progress on the four key areas outlined above. Performing providers will design the structure of their next step initiatives based on the foundation of quality improvements from DY2-6 projects. This approach will offer providers the flexibility to choose the elements for these four key areas with the goal to continue improvement in health care access and coordination. Category A reporting is required for all providers; its structure allows the flexibility for continuous quality improvement for the pay-for-performance in quality measurement in Category C.

Core Activities

With the transition from project-level to provider-level reporting, performing providers will no longer report on projects; instead they will report on achievement of the goals for the Category C measures they select. To understand what enables performing providers to achieve these goals, performing providers report the Core Activities they implement to achieve these goals.

As defined in the PFM, a Core Activity is an activity implemented by a performing provider to achieve its Category C measure goals. A Core Activity can be an activity implemented by a performing provider as part of a DY2-6 DSRIP project that the performing provider chooses to continue in DY7-8, or it can be a new activity that the performing provider is implementing in DY7-8.

Core Activities included in this Protocol are connected to the Transformational Extension Menu (TEM) that HHSC and Clinical Champions developed in 2015-2016. HHSC and Clinical Champions identified in the TEM the most transformative initiatives from the initial waiver period, many of which are based on effective models that can be implemented by providers in the transition from project-level reporting to provider-level quality-based reporting. In addition to activities learned through Texas DSRIP, providers can also propose activities from other national quality initiatives such as the MACRA Merit-based Incentive Payment System (MIPS).

There are certain activities that performing providers can incorporate in any Core Activity as a sub-activity if it contributes to improving quality of care; such as technology improvements (e.g., Electronic Medical Records or Health Information Exchange connectivity) and continuous quality improvement (CQI), but the technological advances activities or the CQI should not be the only activity that performing providers choose to report on.

Core Activities Selection and Reporting

A performing provider needs to select and report on at least one Core Activity that supports the achievement of its Category C measure goals for the selected Measure Bundle(s) or measures. There is no maximum number of Core Activities that the performing provider may select.

Performing providers can select Core Activities from the list created by HHSC and they can include their own Core Activity by using the *Other* option and providing a description. In addition to reporting on Core Activities supporting Category C measures, a performing provider may include a Core Activity tied to the mission of the performing provider's organization, even if the activity does not have a strong connection to the selected measures. Selection of a Core Activity not tied to the measure bundles or measures cannot be the only selection, but can be chosen as an additional core activity that the provider is reporting.

Requirement of at least one Core Activity was designed to increase the flexibility for performing providers and to lessen the reporting commitment by the providers. It is reasonable to assume that some performing providers will have just one main activity and requiring them to report on many initiatives would not benefit the performing provider or state and federal entities. However, providers with many initiatives can benefit from sharing what activities they are implementing. If some performing providers are successful at achieving the goals for the measures they are working on, understanding the main drivers for this success is beneficial to the state and federal government as well as other performing providers who are working on similar quality initiatives. In addition, sharing information on Core Activities can lead to further collaboration among providers within and across the regions.

Performing providers will indicate which DY2-6 projects will have Core Activities that continue in DY7-8 in the RHP Plan Update and which projects have been completed. The RHP Plan Update template will allow providers to select Core Activities that will continue from DY2-6 projects and new Core Activities that will be implemented.

For example, a performing provider that expanded its primary care clinic in DSRIP DY2-6 could indicate to HHSC whether they plan to continue that expansion in DY7-8 (e.g., space expansion, increase in hours that clinic is in operation, or additional staffing). The same provider may decide to select *Provision of coordinated services for patents under Patent Centered Medical Home (PCMH) model* as a Core Activity that will assist the provider in achieving the goals for Improved Chronic Disease Management: Diabetes Care measure bundle.

As another example, a provider who increased access to different types of specialty during DY2-6 and may decide to maintain the same level of specialty staff only in some areas but provide telemedicine services to other areas of specialty. This provider may select *Use telehealth to deliver specialty services* as a Core Activity.

In general, performing providers can select Core Activities from various groupings as long as it reflects what the provider is carrying out. Performing providers working on quality initiatives in the area of behavioral health are not limited to areas directly related to behavioral health Core Activities and can select items of other areas.

During the second reporting period of each DY, providers will report on all Core Activities selected, both continuing and those that are newly added. If adjustments are needed, performing providers can revise their strategies used in achieving Category C goals and update their selection of Core Activities at any time without HHSC approval. During the second reporting period of each DY, performing providers will provide a description of any newly selected Core Activity and the reason for selecting it along with reporting progress on previously selected Core Activities. If a provider has more than one Core Activity in the initial selection, and the provider needs to delete one of these activities due to the changes, they are not required to choose a replacement activity to report on. Providers may also add new core

activities and discontinue those that are not showing results. It is recommended that providers use continuous quality improvement to monitor their progress. Reporting for Core Activities will be done via a template developed by HHSC or entered directly into the DSRIP Online Reporting System.

Menu of Core Activities

Access to Primary Care Services

- Increase in utilization of mobile clinics
- Increase in capacity and access to services by utilizing Community Health Workers (CHWs)/promotoras, health coaches, peer specialists and other alternative clinical staff working in primary care
- Expanded Practice Access (e.g., increased hours, telemedicine, etc.)
- Establishment of care coordination and active referral management that integrates information from referrals into the plan of care
- Provision of screening and follow up services
- Provision of vaccinations to target population
- Integrated physical and behavioral health care services
- Use telemedicine/telehealth to deliver specialty services
- Provision of services to individuals that address social determinants of health.
- Other

Access to Specialty Care Services

- Improvement in access to specialty care services with the concentration on underserved areas, so providers can continue to increase access to specialty care in the areas with limited access to services.
- Use telemedicine/telehealth to deliver specialty services.
- Implementation of remote patient monitoring programs for diagnosis and/or management of care.
- Provision of services to individuals that address social determinants of health.
- Other

Expansion or Enhancement of Oral Health Services

- Utilization of targeted dental intervention for vulnerable and underserved population in alternate setting (e.g., mobile clinics, teledentistry, FQHC, etc.)
- Expanded use of existing dental clinics for underserved population
- Expansion of school based sealant and/or fluoride varnish initiatives to otherwise unserved school-aged children by enhancing dental workforce capacity through partnerships with dental and dental hygiene schools, local health departments (LHDs), federally qualified health centers (FQHCs), and/or local dental providers.
- Other

Maternal and Infant Health Care

- Implementation of evidence-based strategies to reduce low birth weight and preterm birth (Evidence-based strategies include Nurse Family Partnership, Centering Pregnancy, IMPLICIT: Interventions to Minimize Preterm and Low birth weight Infants through Continuous Improvement Techniques among others)
- Develop and implement standard protocols for the leading causes of preventable death and complications for mothers and infants (Early Elective Delivery, Hemorrhage, Preeclampsia, and Supporting Vaginal Birth and Reducing Primary Cesareans)
- Use telemedicine/telehealth to deliver specialty services.
- Provision of services to individuals that address social determinants of health.
- Other

Patient Centered Medical Home

- Provision of coordinated services for patients under Patent Centered Medical Home (PCMH) model, which incorporates empanelment of patients to physicians, and management or chronic conditions and preventive care
- Integration of care management and coordination for high-risk patients based on the best practices (AHRQ PCMH framework, Risk Stratified Care Management- High Risk, Rising Risk and Low Risk designations, ACP PCMH model Safety Net Medical Home Initiative- Change Concepts for Practice Transformation, etc.)
- Enhancement in data exchange between hospitals and affiliated medical home sites.
- Utilization of care teams that are tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; etc.
- Provision of services to individuals that address social determinants of health.
- Other

Expansion of Patient Care Navigation and Transition Services

- Provision of navigation services to targeted patients (e.g., patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, the uninsured, those with low health literacy, frequent visitors to the ED, and others)
- Enhancement in coordination between primary care, urgent care, and Emergency Departments to increase communication and improve care transitions for patients
- Identification of frequent ED users and use of care navigators as part of a preventable ED reduction program, which includes a connection of ED patients to primary and preventive care.
- Implementation of a care transition and/or a discharge planning program and post discharge support program. This could include a development of a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers.
- Utilization of a comprehensive, multidisciplinary intervention to address the needs of high-risk patients.
- Expansion of access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions.

- Provision of services to individuals that address social determinants of health.
- Other

Prevention and Wellness

- Self-management programs and wellness programs using evidence-based designs (e.g., Stanford Small-Group Self-Management Programs for people with arthritis, diabetes, HIV, cancer, chronic pain, and other chronic diseases; SAMHSA's Whole Health Action Management among others)
- Implementation of strategies to reduce tobacco use (Example of evidence based models: 5R's (Relevance, Risks, Rewards, Roadblocks, Repetition) for patients not ready to quit; Ottawa Model; Freedom From Smoking Curriculum- American Lung Association among others)
- Implementation of evidence-based strategies to reduce and prevent obesity in children and adolescents (e.g., Technology Supported Multi Component Coaching or Counseling Interventions to Reduce Weight and Maintain Weight Loss; Coordinated Approach to Child Health - CATCH; and SPARK among others)
- Implementation of evidence-based strategies to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions
- Utilization of whole health peer support, which could include conducting health risk assessments, setting SMART goals, providing educational and supportive services to targeted individuals with specific disorders (e.g., hypertension, diabetes, and health risks such as obesity, tobacco use, and physical inactivity)
- Use of community health workers to improve prevention efforts
- Implementation of evidence based strategies to reduce sexually transmitted diseases.
- Implementation of interventions focusing on social determinants of health that can lead to improvement in well-being of an individual.
- Other

Chronic Care Management

- Utilization of evidence-based care management models for patients identified as having high-risk health care needs and/or individuals with complex needs (e.g., Primary care–integrated complex care management (CCM), Complex Patient Care Model Redesign- enhanced multidisciplinary care teams, The Transitional Care Model, etc.)
- Utilization of care management and/or chronic care management services, including education in chronic disease self-management
- Management of targeted patient populations; e.g., chronic disease patient populations that are at high risk for developing complications, co-morbidities, and/or utilizing acute and emergency care services
- Implementation of a medication management program that serves patients across the continuum of care
- Utilization of pharmacist-led chronic disease medication management services in collaboration with primary care and other health care providers
- Utilization of enhanced patient portal that provides up to date information related to relevant chronic disease health or blood pressure control, and allows patients to enter health information and/or enables bidirectional communication about medication changes and adherence.

- Use telemedicine/telehealth to deliver specialty services.
- Education and alternatives designed to curb prescriptions of narcotic drugs to patients.
- Provision of services to individuals that address social determinants of health.
- Other

Availability of Appropriate Levels of Behavioral Health Care Services

- Utilization of mobile clinics that can provide access to BH care in very remote, inaccessible, or impoverished areas of Texas
- Utilization of telehealth/telemedicine in delivering behavioral services
- Increasing access to services by utilizing staff with the following qualifications: Wellness and Health Navigation: Bachelors level professional with experience in mental health and/or wellness initiatives or a peer specialist who has successfully completed the DSHS certification program for peer specialists
- Provision of care aligned with Certified Community Behavioral Health Clinic (CCBHC) model
- Utilization of Care Management function that integrates primary and behavioral health needs of individuals
- Provision of services to individuals that address social determinants of health and/or family support services.
- Other

Substance Use Disorder

- Provision of Medication Assisted Treatment
- Education of primary care practitioners on preventive treatment option
- Utilization of telehealth/telemedicine in delivering behavioral health services
- Utilization of Prescription Drug Monitoring program (can include targeted communications campaign)
- Supported employment services for individuals in recovery
- Office-based additional treatment for uninsured individuals
- Peer recovery support
- Provision of services to individuals that address social determinants of health including housing navigation services.
- Utilization of telehealth/telemedicine in delivering behavioral services

Behavioral Health Crisis Stabilization Services

- Provision of crisis stabilization services based on the best practices (e.g., Critical Time Intervention, Critical Intervention Team, START model).
- Implementation of community-based crisis stabilization alternatives that meet the behavioral health needs of the patients.
- Implement models supporting recovery of individuals with behavioral health needs.
- Provision of services to individuals that address social determinants of health.
- Other

Palliative Care

- Provision of coordinated palliative care to address patients with end-of-life decisions and care needs.
- Provision of palliative care services in outpatient setting.
- Transitioning of palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility and management of patients' needs.
- Provision of services to individuals that address social determinants of health.
- Utilization of services assisting individuals with pain management.
- Other

Other

If a Core Activity is not on this list, a provider can include a Core Activity and provide a description. As stated previously, providers may not add activities such as continuous quality improvement or a technology improvement as a stand-alone Core Activity. HHSC reserves the right to determine the appropriateness of "other" Core Activities chosen by a provider.

Alternative Payment Models (APMs)

Based on numerous studies and research articles related to categories of healthcare spending and opportunities for increased efficiencies, there is a widespread trend towards linking health care payments to measures of quality and/or efficiency (aka "value"). Texas Medicaid and CHIP programs are following this trend and have developed a Value-Based Purchasing Roadmap. Through its managed care contracting model, HHSC is making progress on a multiyear transformation of provider reimbursement models that have been historically volume based (i.e., fee-for-service) toward models that are structured to reward patient access, care coordination and/or integration, and improved healthcare outcomes and efficiency.

Because the initial DSRIP program has been a very effective incubator for testing how alternative, value based payment models can support patient centered care and clinical innovation, HHSC continues to work closely with MCOs and DSRIP providers on ways to incorporate promising clinical models as VBP arrangements in the Medicaid MCO provision of care. Performing providers will report on progress in building the capacity to participate in a VBP model with MCOs through better utilization of Health Information Technologies and better measurement processes.

Costs and Savings

Based on the requirement included in the PFM, performing providers will submit information related to the costs of at least one Core Activity of their choice and the forecasted or generated savings of that Core Activity. Along with other required information, providers will submit a short narrative including Core Activity chosen, methodology and assumptions made for the analysis. Information related to costs and savings will be submitted in a template approved by HHSC or a comparable template. Performing Providers may use the *Return on Investment Forecasting Calculator for Quality Initiatives* by the Center for Health Care Strategies, Inc., or a comparable template that includes a description of the Core Activity, duration of the initiative, target population, costs, utilization changes and/or savings.

Performing providers will include costs and savings specific to their organization and other contracted providers if that information is available. If selected by the provider Core Activity is broad in scope,

provider can concentrate its analysis on a component of this Core Activity and provide an explanation for such selection during the reporting. A progress update will be submitted to HHSC during the second reporting period of DY7 and a final report of costs and savings will be submitted during the second reporting period of DY8. This information is key to assist performing providers to work with Medicaid Managed Care Organizations and other health care payers for sustainability.

Collaborative Activities

To continue to foster growth of collaboration within and among regions, all performing providers are 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. Lessons learned from these meetings should be relevant at the provider level or applicable to some of the provider Core Activities. Providers will report on collaborative activities in the template prescribed by HHSC.

Category B

System Definition

DSRIP is shifting from project-based reporting to system-level reporting and a focus on system-wide changes and quality outcomes for DY7-8. As such, each performing provider will be required to define its system in the RHP Plan Update for its RHP.

In the broadest sense, the system is defined by the location(s) where patients are served by the performing provider and the types of services patients are receiving. The system definition will provide a broad structure in which performing providers work to improve care and transform the way healthcare is delivered in the state of Texas. While DSRIP will maintain its overall emphasis of improving care and access for the Medicaid and low-income or uninsured (MLIU) population in Texas, DSRIP reporting will no longer be limited by project-specific interventions or project-defined target populations.

A performing provider's system definition should capture all aspects of the performing provider's patient services. The Patient Population by Provider (PPP) (reported in Category B) is intended to reflect the universe of patients served by the performing provider's system, and therefore, the performing provider's system definition should incorporate all aspects of its organization that serve patients. The system definition may not exclude certain populations (with the exception of incarcerated populations served by hospital systems under contract with a government entity). The system definition should include all of a performing provider's service arenas that will be measured in its Category C measures, but may not be limited to those populations or locations if other services are provided by the performing provider.

Systems may be limited by geographic location. For example, a participating provider that operates one hospital in one RHP and another hospital in a separate RHP will have two systems if the separate hospitals were each DSRIP participating providers in DY2-6, though they are technically owned by the same company. System is not exclusively defined by ownership. Alternatively, the system may cross geographic locations. For example, a performing provider that operates a variety of clinics in one RHP and multiple clinics in another RHP may be one system. DSRIP participating providers with the same ownership may not combine two currently separate DSRIP providers into one system for DY7-8, unless this has been previously approved. A performing provider's delineation of system should consider data systems and the extent to which the various components are coordinating to improve health of the patients served.

There are required and optional components of a performing provider's system definition for each performing provider type. The required components are elements of a system that, through discussion with stakeholders and the technical advisory team, should be included as a performing provider's "base unit"; it has been determined that these components are essential functions and/or departments of the provider type. Therefore, the required components must be included in a performing provider's system definition if the performing provider's organization has that business component. A performing provider may then include optional components in its system definition and patient count, including contracted partners for certain services. Unless otherwise granted permission from HHSC, a performing provider should not count within its system definition or patient population another DSRIP performing provider's **required** components. There may be overlap in system definition for contracted partners; for example,

System A that contracts with FQHC A and System B that contracts with FQHC A may both count the FQHC A as part of their system definition.

As indicated in the PFM, performing providers may add contracted entities to their system definition. Certain options will be specified by HHSC, but performing providers will also have the option to add an "other" category. Performing providers will be required to explain any "other" optional component of the system definition. Inclusion of the population served in the optional components may be disallowed by HHSC. Performing providers should include optional components in their system definition only if the performing provider will have access to all data necessary for reporting. Performing providers should be mindful of data arrangements when contracting with entities that they intend to include in their system definition.

Required and Optional System Components

The following table displays the required and optional components of the system definition by performing provider type.

	Required*	**Optional**
Hospitals	Inpatient Services	Contracted Specialty Clinics
	Emergency Department	Contracted Primary Care Clinics
	Owned or Operated Outpatient Clinics	School-based Clinics
	Maternal Department	Contracted Palliative Care Programs
	Owned or Operated Urgent Care Clinics	Contracted Mobile Health Programs
		Other
Physician Practices	Owned or Operated Primary Care Clinics	Contracted Specialty Clinics
	Owned or Operated Specialty Care Clinics	Contracted Primary Care Clinics
	Owned or Operated Hospital	Contracted Community-based Programs
	Owned or Operated Urgent Care Clinics	Other
Community Mental Health Centers	Home-based services	Hospital
	Office/Clinic	Contracted Clinic

		School-based Clinic
		Contracted Inpatient Beds
		State-funded Community Hospital
		Community Institution for Mental Disease (IMD)
		General Medical Hospital
		State Mental Health Facility
		State Mental Retardation Facility
		Other
Local Health Departments	Clinics	Mobile Outreach
	Immunization Locations	Other

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

Once the performing provider has defined its system and the definition has been approved by HHSC, the provider will focus its reporting measure denominators in Category C. Denominators for Category C will be naturally limited by the setting of services or the measure specifications.

Category C

Each performing provider must select Category C Measure Bundles or measures from the following menus included in this section based on provider type: 1) the Hospital and Physician Practice Measure Bundle Menu; 2) the Local Health Department Measure Menu; or 3) the Community Mental Health Center Measure Menu. These menus include the number of points that each Measure Bundle or measure is worth.

Each performing provider is assigned a minimum point threshold (MPT) for Measure Bundle or measure selection as described in the Program Funding and Mechanics Protocol (PFM). Each performing provider must select Measure Bundles or measures worth enough points to meet its MPT in order to maintain its valuation for DY7 and DY8.

1. Measure Points

a. Each measure is assigned a point value based on the following classifications:
    i. Clinical Outcome: Patient clinical measures for which improvement in the measure represents an improvement in patient health outcomes or utilization patterns are valued at 3 points.
    ii. Population Based Clinical Outcome (PBCO): Clinical Outcomes that measures ED utilization or admissions for selected conditions for all individuals in the target population of a Measure Bundle are valued at 4 points.
    iii. Cancer Screening: Cancer screening measures are valued at 2 points
    iv. Hospital Safety: hospital safety and infection measures are valued at 2 points.
    v. Process Measure: measures of clinical practice are valued at 1 point.
    vi. Immunization: immunization rates are valued at 1 point.
    vii. Quality of Life: measures related to quality of life or functional assessment are valued at 1 point.
    viii. Innovative Measure: Innovative measures are pay-for-reporting (P4R) and valued at 0 points.
    ix. Quality Improvement Collaborative Activity: participation in quality improvement activities is valued at 0 points.

b. Measure classification is specified for each measure in Appendix A Category C Specifications Document.

c. All measures are designated as Pay-for-Performance (P4P) except for Innovative Measures and Quality Improvement Collaborative Activities which are Pay-for-Reporting (P4R) in DY7 and DY8. Measures that are P4R are noted in Measure Bundles for Hospital & Physician Practices section.

2. Hospital and Physician Practice Measure Bundle Points & Selection Requirements

a. The base point value of a Measure Bundle is equal to the sum of the points for the required measures in the Measure Bundle. The base point value of a Measure Bundle designated as High State Priority is then multiplied by 2, and the base point value of a Measure Bundle designated as State Priority is then multiplied by 1.5.

i. High State Priority Measure Bundles (sum of the required measures' points multiplied by 2)
    1. E1: Improved Maternal Care
    2. E2: Maternal Safety
    3. H3: Chronic Non-Malignant Pain Management
ii. State Priority Measure Bundles (sum of the required measures' points multiplied by 1.5)
    1. A1: Chronic Disease Management: Diabetes
    2. A2: Chronic Disease Management: Heart Disease
    3. C1: Healthy Texans
    4. D1: Pediatric Primary Care
    5. D4: Pediatric Chronic Disease Management: Asthma
    6. D5: Pediatric Chronic Disease Management: Diabetes
    7. H1: Behavioral Health in a Primary Care Setting
    8. H2: Behavioral Health & Appropriate Utilization
    9. H4: Integrated Care for People with Serious Mental Illness

b. Optional measures in a Measure Bundle, if selected, add points to the Measure Bundle.
    i. Optional measures that add points, if selected, are not impacted by a high state priority or a state priority multiplier.

    EXAMPLE: Measure Bundle A1 - Chronic Disease Management: Diabetes is a State Priority Measure Bundle with required measures equaling 7 points and a multiplier of 1.5 for a base point value of 11 points. If a hospital selects Measure Bundle A1 and selects measures A1-500 Diabetes Composite and A1-508 Rate of ED Visits for Diabetes as P4P (A1-500 and A1-508 Population Based Clinical Outcomes worth an additional four points each and are required as P4P for providers with an MPT of 75, and optional as P4P for providers with an MPT less than 75), 8 points will be added to the Measure Bundle for a total of 19 points towards the hospital's MPT.

c. Limitations on Hospital and Physician Practice Measure Bundle Selections and Optional Measure Selections
    i. Measure Bundles K1 Rural Preventive Care and K2 Rural Emergency Care can only be selected by hospitals with a valuation less than or equal to $2,500,000 per DY. Providers that select measure bundle K1 cannot also select measure bundles A1, A2, B1, C1, D1, E1, or H1. Measure K2-285 cannot be selected if measure bundle K1 is selected.
    ii. Each hospital or physician practice with an MPT of 75 must select at least one Measure Bundle with a Population Based Clinical Outcome.
    iii. For Measure Bundles A1, A2, B1, C1, D1, and H2, Population-based clinical outcomes are required for providers with an MPT of 75 and optional as P4P with 4 additional points for providers with an MPT below 75. Providers that do not opt to select a PBCO as P4P but have a measurable numerator greater than 0 are required to

report the PBCO as P4R following the requirements for a measure with insignificant volume.

iv. For Measure Bundles D4 and D5, the Population-based clinical outcome is a required measure for any provider that selects that Measure Bundle as the PBCO in each bundle is essential to the Measure Bundle objective.

v. Each hospital or physician practice with a valuation of more than $2,500,000 per DY must either: 1) select at least one Measure Bundle with at least one required 3 point clinical outcome measure; or 2) select at least one Measure Bundle with at least one optional 3 point clinical outcome measure selected. Three point clinical measures must have significant volume and be P4P to qualify as the required 3 point measure.

vi. If bundles D3 Pediatric Hospital Safety and J1 Hospital Safety are both selected, the points of each bundle will be reduced by 50%.

3. Community Mental Health Center and Local Health Department Measure Points & Selection Requirements

a. Certain measures designated as a state priority, if selected, add an additional point.

b. CMHCs and LHDs must select and report on at least two unique measures.

c. Each CMHC or LHD with a valuation of more than $2,500,000 per DY must select at least one 3 point clinical outcome measure.

d. If a CMHC selects more than one of the depression response measures M1-165, M1-181, or M1-286, only 4 points will be counted towards the Performing Provider's MPT.

4. Minimum Volume Definitions & Requirements

a. Minimum Volume Definitions

i. *Significant volume* is defined, for most outcome measures, as an MLIU denominator for the measurement period that is greater than or equal to 30, unless an exception has been granted by HHSC to use an all-payer denominator as defined in the PFM.

ii. *Insignificant volume* is defined, for most outcome measures, as an MLIU denominator for the measurement period that is less than 30, but greater than 0, unless an exception has been granted by HHSC to use an all-payer denominator.

iii. *No volume* is defined as an MLIU denominator for the measurement period that is 0. For a PBCO, no volume is defined as a numerator for the 12 month measurement period that is 0.

b. Hospital and Physician Practice Minimum Volume Requirements

i. A hospital or physician practice may only select a Measure Bundle for which the hospital's or physician practice's MLIU denominator for the baseline measurement period for at least half of the required measures in the Measure Bundle has *significant volume*.

ii. A hospital or physician practice may only select an optional measure in a selected Measure Bundle for which the hospital or physician practice's MLIU denominator for the baseline measurement period has *significant volume*.

iii. **Insignificant Volume:** If a hospital or physician practice selects a Measure Bundle with a required measure for which the hospital or physician practice has *insignificant volume*, the valuations of the measure's reporting milestones will remain the same, but the valuations of the measure's achievement milestones will be redistributed proportionally among the achievement milestones for the other measures in the Measure Bundle with *significant volume*.

EXAMPLE: A physician practice selects a Measure Bundle with four required measures, selects one optional measure in the Measure Bundle, and has *insignificant volume* for one required measure. The selected Measure Bundle is assigned a valuation of $1,000,000. The milestone valuations for DY7 and DY8 are as follows:

Measure	Volume	DY7 Measure Bundle Valuation: $1,000,000			DY8 Measure Bundle Valuation: $1,000,000	
		DY7 Baseline Milestone ($250,000)	DY7 PY1 Reporting Milestone ($250,000)	DY7 Achievement Milestone ($500,000)	DY8 PY2 Reporting Milestone ($250,000)	DY8 Achievement Milestone ($750,000)
1 (required)	Significant	$62,500	$62,500	$166,667	$62,500	$250,000
2 (required)	Significant	$62,500	$62,500	$166,667	$62,500	$250,000
3 (required)	Insignificant	$62,500	$62,500	-	$62,500	-
4 (optional)	Significant	$62,500	$62,500	$166,667	$62,500	$250,000

1. If a hospital or physician practice has *insignificant volume* for the baseline measurement period for a required measure in a selected Measure Bundle at the time of RHP Plan Update submission, the hospital or physician practice will notify HHSC in the RHP Plan Update that it has *insignificant volume* for the measure.
2. If a hospital or physician practice reports the baseline or performance for a required measure in a selected Measure Bundle with *insignificant volume* for the measurement period, the measure's achievement milestone valuation may be redistributed as described in this subsection.

iv. **No Volume:** Required measures with *no volume* because the hospital or physician practice does not serve the population measured will be removed from the Measure Bundle and the valuations of the associated reporting and achievement milestones will be redistributed proportionally among the remaining measures in the Measure Bundle.

EXAMPLE: A physician practice selects a Measure Bundle with four required measures, selects one optional measure in the Measure Bundle, and has *no volume* for one required measure. The selected Measure Bundle is assigned a valuation of $1,000,000. The valuations for DY7 and DY8 are as follows:

Measure	Volume	DY7 Measure Bundle Valuation: $1,000,000			DY8 Measure Bundle Valuation: $1,000,000	
		DY7 Baseline Milestone ($250,000)	DY7 PY1 Reporting Milestone ($250,000)	DY7 Achievement Milestone ($500,000)	DY8 PY2 Reporting Milestone ($250,000)	DY8 Achievement Milestone ($750,000)
1 (required)	Significant	$83,333	$83,333	$166,667	$83,333	$250,000
2 (required)	Significant	$83,333	$83,333	$166,667	$83,333	$250,000
3 (required)	None	-	-	-	-	-
4 (optional)	Significant	$83,333	$83,333	$166,667	$83,333	$250,000

1. If a hospital or physician practice has *no volume* for the baseline measurement period for a required measure in a selected Measure Bundle at the time of RHP Plan Update submission, the hospital or physician practice will notify HHSC in the RHP Plan Update that it has *no volume* for the measure.
2. If a hospital or physician practice reports the baseline or performance for a required measure in a selected Measure Bundle with *no volume* for the measurement period, the measure's reporting and achievement milestone valuation may be redistributed as described in this subsection.

c. CMHC and LHD Minimum Volume Requirements

i. A CMHC or LHD may only select measures for which it has *significant volume*.

5. Eligible Denominator Population

All measure bundles will be based on the DSRIP attributed population defined below. Each measure bundle has a target population (or pool of people) for which the provider system is accountable for improvement under the DSRIP incentive arrangements. The target population identifies all individuals in the DSRIP attributed population for each provider system, which then serves as the starting point for all the measures within the measure bundle, and includes all individuals that would fall into the measure specifications for the included measure.

When reporting data for measures in a measure bundle, the eligible denominator population for each measure will be determined by the following process:

Step 1: Determine the DSRIP attributed population using the prescribed attribution methodology defined below.

Step 2: Determine the individuals from step one that are included in the measure bundle or measure target population

Step 3: Determine the individuals from the measure bundle target population that meet the measure specific denominator inclusion criteria.

Step 4: Determine payer type for individuals or encounters in the denominator following standardized specifications to determine the all payer, Medicaid, and uninsured rate for each

measure.

Step 1: Determine the DSRIP attributed population using the prescribed retroactive attribution methodology defined below based on the provider type indicated in the RHP Plan Submission:

1. For Hospital organizations and Physician Practices, the DSRIP attributed population includes individuals from the DSRIP system defined in Category B that meet at least one of the criteria below. Individuals do not need to meet all or multiple criteria to be included.
    a. Medicaid beneficiary attributed to the Performing Provider during the measurement period as determined by assignment to a primary care provider (PCP), medical home, or clinic in the performing providers DSRIP defined system OR
    b. Individuals enrolled in a local coverage program (for example, a county-based indigent care program) assigned to a PCP, medical home, or clinic in the performing providers DSRIP defined system OR
    c. One preventive service provided during the measurement period (Includes value sets of visit type codes for annual wellness visit, preventive care services - initial office visit, preventive care services - established office visit, preventive care individual counseling) OR
    d. One ambulatory encounter during the measurement year and one ambulatory encounter during the year prior to the measurement year OR
    e. Two ambulatory encounters during the measurement year OR
    f. Other populations managed with chronic disease in specialty care clinics in the performing providers DSRIP defined system
    g. One emergency department visit during the measurement year OR
    h. One admission for inpatient or observation status during the measurement year OR
    i. One prenatal or postnatal visit during the measurement year OR
    j. One delivery during the measurement year OR
    k. One dental encounter during the measurement year OR
    l. Enrolled in a palliative care or hospice program during the measurement year OR
    m. Other populations not included above that should be included in a measure bundle target population included in the RHP plan submission and approved by HHSC (for example, individuals enrolled in community based education programs)

2. For Community Mental Health Centers the DSRIP attributed population includes:
    a. All individuals from the DSRIP system defined in Category B that meet one of the following criteria during the measurement period:
        i. One encounter with the performing providers system during the measurement year and one encounter during the year prior to the measurement year OR
        ii. Two encounters with the performing providers system during the measurement year OR
        iii. Other populations defined by the CMHC in the RHP Plan Submission and approved by HHSC

3. For Local Health Departments the DSRIP attributed population includes:
    a. Individuals with one eligible encounter during the measurement period OR
    b. Other populations defined by the LHD in the RHP Plan Submission and approved by HHSC

4. Allowable Exclusions for all provider types:
    a. Performing providers may remove from the DSRIP attributed population any individual for which the provider has documentation of any one of the following during the measurement year:
        i. The individual that was previously assigned a PCP, medical home, or clinic with the provider but has changed their care to a PCP, medical home, or clinic that is not with the performing providers DSRIP system.
        ii. The patient has had a total time of incarceration during the measurement period that exceeded 45 days.

For Steps 2 - 4, refer to the introduction section of Appendix A Category C Measure Specifications.

6. Exceptions to MPTs and Measure Bundle Selection for Hospital and Physician Practices with a Limited Scope of Practice

a. Certain performing providers have a limited scope of practice. These performing providers may include children's hospitals and specialty hospitals such as infectious disease hospitals and Institutions for Mental Disease [IMDs].
    i. If such a performing provider is not able to reasonably report on enough bundles to meet its MPT based on its limited scope of practice and available community partnerships, the performing provider may request a lowered MPT equal to the sum of all Measure Bundles that the performing provider could reasonably report. The performing provider must request a lowered MPT prior to the RHP Plan Update submission, by a date determined by HHSC.
    ii. If such a performing provider is not able to reasonably report on at least half of the required measures in Measure Bundles needed to meet its MPT based on its limited scope of practice and available community partnerships, the performing provider may request approval to select measures outside of the Measure Bundle structure prior to the RHP Plan Update submission, by a date determined by HHSC.
        1. The hospital or physician practice must select measures from the Hospital and Physician Practice Measure Bundle Menu, the Local Health Department Measure Menu, or the Community Mental Health Center Measure Menu in accordance with the measure selection requirements for Local Health Departments and Community Mental Health Centers.
    iii. A hospital's or physician practice's request to lower the MPT or to select measures outside of the Measure Bundle structure may be subject to review by CMS. If HHSC and CMS, as appropriate, approve the request, the hospital's or physician practice's total valuation may be reduced.

7. Exceptions to Measure Selection for Local Health Departments

a. Local Health Departments may continue to report measures that an LHD reported for Category 3 in DY6 that are P4P in DY6 and not otherwise included in the L1 Local Health Department Menu.
    i. Grandfathered measures that are classified as standalone measures in DY2-6 will be valued at 3 points. Grandfathered measures that are non-standalone in DY2-6 will be valued at 1 point unless a measure has been given a categorization with a valuation of 2 points in the Measure Bundle Protocol.
    ii. Grandfathered measures will use DY6 (10/01/2016 - 09/30/2017) as the baseline measurement period for determining DY7 and DY8 goal achievement milestones, and standard performance measurement periods so that PY1 is CY2018, PY2 is CY2019, and PY3 is CY2020.
    iii. Duplicated measures will only count once towards a providers MPT. For example, if an LHD has two non-standalone measures that are the same measure selection in DY6 but report different rates for different facilities, the provider may continue to report both measures, but both measures will only contribute 3 points towards the MPT.
b. Local Health Departments may use a combination of grandfathered DY6 Category 3 measures and new measures selected from the L1 Local Health Department Menu in the Measure Bundle Protocol. New measures cannot duplicate grandfathered measures.

Measure Bundles for Hospitals & Physician Practices

Hospital & Physician Practice Measure Bundles	Any PBCO (4 points)	Any Clinical Outcome (3 points)	Base Points	Additional Points	Max Points
A1: Chronic Disease Management: Diabetes *[SP]*	*Required* [1]	Required	11	9	**20**
A2: Chronic Disease Management: Heart Disease *[SP]*	*Required* [1]	Required	8	11	**19**
B1: Care Transitions & Hospital Readmissions	None	Required	11	0	**11**
B2: Patient Navigation & ED Diversion	None	Required	3	9	**12**
C1: Primary Care Prevention - Healthy Texans *[SP]*	*Required* [1]	None	12	4	**16**
C2: Primary Care Prevention - Cancer Screening	None	None	6	0	**6**
C3: Hepatitis C	None	None	4	0	**4**
D1: Pediatric Primary Care *[SP]*	*Required* [1]	Required	14	6	**20**
D3: Pediatric Hospital Safety	None	None	10	0	**10**
D4: Pediatric Chronic Disease Management: Asthma *[SP]*	Required	None	9	0	**9**
D5: Pediatric Chronic Disease Management: Diabetes *[SP]*	Required	None	8	0	**8**
E1: Improved Maternal Care *[HSP]*	None	Required	10	1	**11**
E2: Maternal Safety *[HSP]*	None	Required	8	0	**8**
F1: Improved Access to Adult Dental Care	None	Required	7	0	**7**
F2: Preventive Pediatric Dental	None	None	2	0	**2**
G1: Palliative Care	None	*None* [2]	6	0	**6**
H1: Integration of Behavioral Health in a Primary or Specialty Care Setting *[SP]*	None	Required	12	0	**12**
H2: Behavioral Health and Appropriate Utilization *[SP]*	*Required* [1]	Optional	8	11	19
H3: Chronic Non-Malignant Pain Management *[HSP]*	None	None	10	0	**10**
H4: Integrated Care for People with Serious Mental Illness *[SP]*	None	None	5	0	**5**
I1: Specialty Care [3]	None	None	2	0	**2**
J1: Hospital Safety	None	None	10	0	**10**
K1: Rural Preventive Care [4]	Optional	None	3	10	**13**
K2: Rural Emergency Care [4]	None	None	3	1	**4**
Total Possible Points			187	62	244

[SP] Measure Bundle Designated as a State Priority
[HSP] Measure Bundle Designated as a High State Priority
[1] One or more PBCOs are required as P4P for providers with an MPT 0f 75 that select bundle, optional as P4P for others
[2] Clinical outcome included for cancer hospital only
[3] Requires prior authorization
[4] Can only be selected by hospitals with a valuation at or below $2,500,000 per DY

A1: Improved Chronic Disease Management: Diabetes Care

This bundle is a State Priority.

Objective:
Develop and implement chronic disease management interventions that are geared toward improving management of diabetes and comorbidities, improving health outcomes and quality of life, preventing disease complications, and reducing unnecessary acute and emergency care utilization.

Target Population:
Adults with diabetes

Base Points: 7*1.5 (state priority) = 11
Possible Additional Points: 9
Maximum Total Possible Points: 20

ID	Measure	Steward	NQF #	Required	Measure Points
A1-111	Comprehensive Diabetes Care: Eye Exam (retinal) performed	NCQA	0055	No	+1
A1-112	Comprehensive Diabetes Care: Foot Exam	NCQA	0056	Yes	1
A1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	Yes	3
A1-207	Diabetes care: BP control (<140/90mm Hg)	NCQA	0061	Yes	3
A1-500	PQI 93 Diabetes Composite (Adult short-term complications, long-term complications, uncontrolled diabetes, lower-extremity amputation admission rates)	AHRQ	N/A	Yes*	+4/+0
A1-508	Reduce Rate of Emergency Department visits for Diabetes	N/A	N/A	Yes*	+4/+0

*For providers that select Measure Bundle A1:

- Measures A1-500 AND A1-508 are Population Based Clinical Outcomes and are required P4P measures for providers with an MPT of 75.
- Providers with an MPT less than 75 may opt to report measures as P4P.
- Providers with an MPT below 75 that do not opt to report as P4P that have any numerator volume will report as P4R. Measures reported as P4R will not count towards the measure bundle's point value and do not contribute towards a provider's MPT.

A2: Improved Chronic Disease Management: Heart Disease

This bundle is a State Priority.

Objective:
Develop and implement chronic disease management interventions that are geared toward improving management of heart disease and comorbidities, improving health outcomes and quality of life, preventing disease complications, and reducing unnecessary acute and emergency care utilization.

Target Population:
Adults with heart disease

Base Points: 5*1.5 (state priority) = 8
Possible Additional Points: 11
Maximum Total Possible Points: 19

ID	Measure	Steward	NQF #	Required	Measure Point Value
A2-103	Controlling High Blood Pressure	NCQA	0018	Yes	3
A2-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CMS	N/A	Yes	1
A2-384	Risk Adjusted CHF 30-Day Readmission Rate	N/A	N/A	No	+3
A2-404	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS	N/A	Yes	1
A2-501	PQI 08 Heart Failure Admission Rate (Adult)	AHRQ	N/A	Yes*	+4/+0
A2-509	Reduce Rate of Emergency Department visits for CHF, Angina, and Hypertension	N/A	N/A	Yes*	+4/+0

*For providers that select Measure Bundle A2:

- Measures A2-501 and A2-509 are Population Based Clinical Outcomes and are required P4P measures for providers with an MPT of 75.
- Providers with an MPT less than 75 may opt to report measures as P4P.
- Providers with an MPT below 75 that do not opt to report as P4P that have any numerator volume will report as P4R. Measures reported as P4R will not count towards the measure bundle's point value and do not contribute towards a provider's MPT.

B1: Care Transitions & Hospital Readmissions

Objective:
Implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to improve health outcomes, and prevent increased health care costs and hospital readmissions.

Target Population:
Individuals transitioning out of inpatient care

Base Points: 11
Possible Additional Points: N/A
Maximum Total Possible Points: 11

ID	Measure	Steward	NQF #	Required	Measure Point Value
B1-124	Medication Reconciliation Post-Discharge	NCQA	0097	Yes	1
B1-141	Risk Adjusted All-Cause 30-Day Readmission for Targeted Conditions: coronary artery bypass graft (CABG) surgery, CHF, Diabetes, AMI, Stroke, COPD, Behavioral Health, Substance Use	N/A	N/A	Yes	3
B1-217	Risk Adjusted All-Cause 30-Day Readmission	N/A	N/A	Yes	3
B1-252	Care Transition: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	AMA	0649	Yes	1
B1-253	Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	AMA	0647	Yes	1
B1-287	Documentation of Current Medications in the Medical Record	CMS	0419	Yes	1
B1-352	Post-Discharge Appointment	AHA/ASA, TJC	2455/ 2439	Yes	1

B2: Patient Navigation & ED Diversion

Objective:
Utilize patient navigators (community health workers, case managers, or other types of professionals) and/or develop other strategies to provide enhanced social support and culturally competent care to connect high risk patients to primary care or medical home sites, improve patient outcomes, and divert patients needing non-urgent care to appropriate settings.

Target Population:
Adults utilizing the emergency department

Base Points: 3
Possible Additional Points: 9
Maximum Total Possible Points: 12

ID	Measure	Steward	NQF #	Required	Measure Point Value
B2-242	Reduce Emergency Department (ED) visits for Chronic Ambulatory Care Sensitive Conditions (ACSC)	N/A	N/A	Yes**	*(+3)*
B2-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse	N/A	N/A	Yes**	*(+3)*
B2-392	Reduce Emergency Department visits for Acute Ambulatory Care Sensitive Conditions (ACSC)	N/A	N/A	Yes	*3*
B2-393	Reduce Emergency Department visits for Dental Conditions	N/A	N/A	Yes**	*(+3)*
**Must select one of either B2-242, B2-387, B2-393 May select one or more additional from B2-242, B2-387, B2-393 for up to an additional 6 points.					

C1: Primary Care Prevention - Healthy Texans

This bundle is a State Priority.

Objective:
Provide comprehensive, integrated primary care services that are focused on person-centered preventive care and chronic disease screening.

Target Population:
Adults

Base Points: 8*1.5 (state priority) = 12
Possible Additional Points: 4
Maximum Total Possible Points: 16

ID	Measure	Steward	NQF #	Required	Possible Measure Points
C1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	Yes	1
C1-113	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	NCQA	0057	Yes	1
C1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS	0421 / 2828	Yes	1
C1-268	Pneumonia vaccination status for older adults	CMS	0043	Yes	1
C1-269	Preventive Care and Screening: Influenza Immunization	AMA / PCPI	0041 / 3070	Yes	1
C1-272	Adults (18+ years) Immunization status	ICSI	N/A	Yes	1
C1-280	Chlamydia Screening in Women (CHL)	NCQA	0033	Yes	1
C1-389	Human Papillomavirus Vaccine (age 18 -26)	N/A	N/A	Yes	1
C1-502	PQI 91 Acute Composite (Adult Dehydration, Bacterial Pneumonia, Urinary Tract Infection Admission Rates)	AHRQ	N/A	Yes*	+4/+0

*For providers that select Measure Bundle C1:

- Measure C1-502 is a Population Based Clinical Outcomes and is a required P4P measures for providers with an MPT of 75.
- Providers with an MPT less than 75 may opt to report measure as P4P.
- Providers with an MPT below 75 that do not opt to report as P4P that have any numerator volume will report as P4R. Measures reported as P4R will not count towards the measure bundle's point value and do not contribute towards a provider's MPT.

C2: Primary Care Prevention - Cancer Screening

Objective:
Increase access to cancer screening in the primary care setting.

Target Population:
Adults

Base Points: 6
Possible Additional Points: N/A
Maximum Total Possible Points: 6

ID	Measure	Steward	NQF #	Required	Measure Point Value
C2-106	Cervical Cancer Screening	NCQA	0032	Yes	2
C2-107	Colorectal Cancer Screening	NCQA	0034	Yes	2
C2-186	Breast Cancer Screening	NCQA	2372	Yes	2

C3: Hepatitis C

Objective:
Implement screening program in high risk populations to detect and treat Hepatitis C infections.

Target Population:
Adults

Base Points: 4
Possible Additional Points: N/A
Maximum Total Possible Points: 4

ID	Measure	Steward	NQF #	Required	Measure Point Value
C3-203	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	AMA-PCPI	3059	Yes	1
C3-328	Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection	PCPI	3061	Yes	1
C3-368	Hepatitis C: Hepatitis A Vaccination	American Gastroenterological Association	0399	Yes	1
C3-369	Hepatitis C: Hepatitis B Vaccination	American Gastroenterological Association	0400	Yes	1

D1: Pediatric Primary Care

This bundle is a State Priority.

Objective:
Increase access to comprehensive, coordinated primary care & preventive services focused on accountable, child-centered care that improves quality of life and health outcomes.

Target Population:
Children

Base Points: 9*1.5 (state priority) = 14
Possible Additional Points: 5
Maximum Total Possible Points: 20

ID	Measure	Steward	NQF #	Required	Measure Point Value
D1-108	Childhood Immunization Status (CIS)	NCQA	0038	Yes	1
D1-211	Weight Assessment and Counseling for Nutrition and Physical Activity	NCQA	0024	Yes	1
D1-212	Appropriate Testing for Children With Pharyngitis	AHRQ	0002	Yes	3
D1-237	Well-Child Visits in the First 15 Months of Life	NCQA	1392	Yes	1
D1-271	Immunization for Adolescents	NCQA	1407	Yes	1
D1-284	Appropriate Treatment for Children with URI	NCQA	0069	Yes	1
D1-301	Maternal Depression Screening	NCQA	1401	No	+1
D1-389	Human Papillomavirus Vaccine (age 15-18)	N/A	N/A	No	+1
D1-400	Tobacco Use and Help with Quitting Among Adolescents	CMS	N/A	Yes	1
D1-503	PDI 97 Acute Composite (Gastroenteritis, Urinary Tract Infection Admission Rate)	AHRQ	N/A	Yes*	*+4/*+0
D1-T01	*Innovative Measure*: Behavioral Health Counselling for Childhood Obesity (P4R)	Meadows	N/A	No	0

*For providers that select Measure Bundle D1:

- Measure D-503 is a Population Based Clinical Outcomes and is a required P4P measures for providers with an MPT of 75.
- Providers with an MPT less than 75 may opt to report measure as P4P.
- Providers with an MPT below 75 that do not opt to report as P4P that have any numerator volume will report as P4R. Measures reported as P4R will not count towards the measure bundle's point value and do not contribute towards a provider's MPT.

D3: Pediatric Hospital Safety

Objective:
Reduce hospital errors, improve effectiveness of staff communication (both internally and with patients and their caregivers), improve medication management, and reduce the risk of health-care associated infections.

Target Population:
Children receiving inpatient care

Base Points: 10
Possible Additional Points: N/A
Maximum Total Possible Points: 10

If D3 and J1 are both selected, the points of each bundle will be reduced by 50%.

ID	Measure	Steward	NQF #	Required	Measure Point Value
D3-330	Pediatric CLABSI	Children's Hospitals' Solutions for Patient Safety National Children's Network	N/A	Yes	2
D3-331	Pediatric CAUTI		N/A	Yes	2
D3-333	Pediatric Surgical site infections (SSI)		N/A	Yes	2
D3-334	Pediatric Adverse Drug Events		N/A	Yes	2
D3-335	Pediatric Pressure Injuries		N/A	Yes	2

D4: Pediatric Chronic Disease Management: Asthma

This bundle is a State Priority.

Objective:
Develop and implement chronic disease management interventions that are geared toward improving management of asthma to improve patient health outcomes and quality of life and reduce unnecessary acute and emergency care utilization.

Target Population:
Children with asthma

Base Points: 6*1.5 (state priority) = 9
Possible Additional Points: N/A
Maximum Total Possible Points: 9

ID	Measure	Steward	NQF #	Required	Possible Measure Points
D4-139	Asthma Admission Rate (PDI 14)	AHRQ	0728	Yes	4
D4-353	Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit	University Hospitals Cleveland Medical Center	3170	Yes	1
D4-375	Asthma: Pharmacologic Therapy for Persistent Asthma (Rate 3 only)	The American Academy of Asthma Allergy and Immunology	0047	Yes	1

D5: Pediatric Chronic Disease Management: Diabetes

Objective:
Develop and implement diabetes management interventions that improve patient health outcomes and quality of life, prevent onset or progression of comorbidities, and reduce unnecessary acute and emergency care utilization.

Target Population:
Children with Type 1 and Type 2 Diabetes

Base Points: 5*1.5 (state priority) = 8
Possible Additional Points: N/A
Maximum Total Possible Points: 8

ID	Measure	Steward	NQF #	Required	Measure Point Value
D5-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	NCQA	0024	Yes	1
D5-406	Diabetes Short-term Complications Admission Rate (PDI 15)	AHRQ	N/A	Yes	4
D5-T07	Innovative Measure: Diabetes Care Coordination (P4R)	TBD	N/A	No	0

E1: Improved Maternal Care

This bundle is a High State Priority.

Objective:
Improve maternal health outcomes by implementing evidence-based practices to provide pre-conception, prenatal and postpartum care including early detection and management of comorbidities like hypertension, diabetes, and depression.

Target Population:
Pregnant and postpartum women

Base Points: 5*2 (high state priority) = 10
Possible Additional Points: 1
Maximum Total Possible Points: 11

ID	Measure	Steward	NQF #	Required	Measure Point Value
E1-193	Contraceptive Care – Postpartum Women Ages 15–44	US Office of Population Affairs	2902	No	+1
E1-232	Timeliness of Prenatal Care	NCQA	1517	Yes	1
E1-235	Post-Partum Follow-Up and Care Coordination	CMS	N/A	Yes	3
E1-300	Behavioral Health Risk Assessment for Pregnant Women	AMA-PCPI	N/A	Yes	1

E2: Maternal Safety

This bundle is a High State Priority.

Objective: Improve maternal safety and reduce maternal morbidity through data driven interventions to prevent and manage obstetric hemorrhage.

Target Population:
Women with preterm or full-term deliveries

Base Points: 4*2 (high state priority) = 8
Possible Additional Points: N/A
Maximum Total Possible Points: 8

ID	Measure	Steward	NQF #	Required	Measure Point Value
E2-150	PC-02 Cesarean Section	The Joint Commission	0471	Yes	3
E2-151	PC-03 Antenatal Steroids	The Joint Commission	0476	Yes	1
E2-A01	Quality Improvement Collaborative Activity: Participation in OB Hemorrhage Safety Bundle Collaborative (TexasAIM Plus) through the Texas Department of State Health Services *(P4R for participation in collaborative and implementation of recommended practices in DY7-8)*	N/A	N/A	Yes	0

F1: Improved Access to Adult Dental Care

Objective:
Increase access to timely, appropriate dental care.

Target Population:
Adults

Base Points: 7
Possible Additional Points: N/A
Maximum Total Possible Points: 7

ID	Measure	Steward	NQF #	Required	Measure Point Value
F1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	Yes	1
F1-226	Chronic Disease Patients Accessing Dental Services	N/A	N/A	Yes	3
F1-227	Dental Caries: Adults	Healthy People 2020	N/A	Yes	3
F1-T03	*Innovative Measure*: Oral Cancer Screening (P4R)	A&M College of Dentistry	N/A	No	0

F2: Preventive Pediatric Dental Care

Objective:
Expand access to dental care including screening and preventive dental services to improve long term oral health and quality of life and reduce costs by preventing the need for more intensive treatments.

Target Population:
Children

Base Points: 2
Possible Additional Points: N/A
Maximum Total Possible Points: 2

ID	Measure	Steward	NQF #	Required	Measure Point Value
F2-224	Dental Sealant: Children	Healthy People 2020	N/A	Yes	1
F2-229	Oral Evaluation: Children	American Dental Association	2517	Yes	1

G1: Palliative Care

Objective:
Provide palliative care services to patients and their families and/or caregivers to improve patient outcomes and quality of life with a focus on relief from symptoms, stress, and pain related to serious, debilitating or terminal illness.

Target Population:
Individuals with serious or terminal illness enrolled in a hospice or palliative care program

Base Points: 6
Possible Additional Points: N/A or 6*
Maximum Total Possible Points: 6 or 12*

ID	Measure	Steward	NQF #	Required	Measure Point Value
G1-276	Hospice and Palliative Care – Pain assessment	University of North Carolina-Chapel Hill	1637	Yes	1
G1-277	Hospice and Palliative Care – Treatment Preferences	University of North Carolina-Chapel Hill	1641	Yes	1
G1-278	Beliefs and Values	University of North Carolina-Chapel Hill	1647	Yes	1
G1-361	Patients Treated with an Opioid who are Given a Bowel Regimen	RAND Corporation/UCLA	1617	Yes	1
G1-362	Hospice and Palliative Care -- Dyspnea Treatment	University of North Carolina-Chapel Hill	1638	Yes	1
G1-363	Hospice and Palliative Care -- Dyspnea Screening	University of North Carolina-Chapel Hill	1639	Yes	1
G1-505	Proportion Admitted to Hospice for less than 3 day	American Society of Clinical Oncology	0216	No*	+3
G1-507	Proportion not Admitted to Hospice	American Society of Clinical Oncology	0215	No*	+3
*Measures G1-505 and G1-507 may only be selected by a cancer hospital					

H1: Integration of Behavioral Health in a Primary or Specialty Care Setting

This bundle is a State Priority.

Objective:
Implement depression, substance use disorder, and behavioral health screening and multi-modal treatment in a primary or non-psychiatric specialty care setting.

Target Population:
Individuals receiving primary care services or specialty care services

Base Points: 8*1.5 (state priority) = 12
Additional Points: N/A
Maximum Total Possible Points: 12

ID	Measure	Steward	NQF #	Required	Measure Point Value
H1-146	Screening for Clinical Depression and Follow-Up Plan	CMS	0418	Yes	1
H1-255	Follow-up Care for Children Prescribed ADHD Medication	NCQA	0108	Yes	3
H1-286	Depression Remission at Six Months	MN Community Measurement	0711	Yes	3
H1-317	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	AMA-PCPI	2152	Yes	1
H1-T04	*Innovative Measure:* Engagement in Integrated Behavioral Health (P4R)	Meadows	N/A	No	0

H2: Behavioral Health and Appropriate Utilization

This bundle is a State Priority.

Objective:
Provide specialized and coordinated services to individuals with serious mental illness and/or a combination of behavioral health and physical health issues to reduce emergency department utilization and avoidable inpatient admission and readmissions.

Target Population:
Individuals with serious mental illness

Base Points: 5*1.5 (state priority) = 8
Possible Additional Points: 11
Maximum Total Possible Points: 19

ID	Measure	Steward	NQF #	Required	Measure Point Value
H2-160	Follow-Up After Hospitalization for Mental Illness	NCQA	0576	*(Yes)**	*+3*
H2-216	Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate	N/A	N/A	*(Yes)**	*+3*
H2-259	Assignment of Primary Care Physician to Individuals with Schizophrenia	CQAIMH	N/A	Yes	1
H2-265	Housing Assessment for Individuals with Schizophrenia	CQAIMH	N/A	No	+1
H2-266	Independent Living Skills Assessment for Individuals with Schizophrenia	CQAIMH	N/A	Yes	1
H2-305	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	AMA-PCPI	1365	Yes	1
H2-319	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	0104	Yes	1
H2-510	Reduce Rate of Emergency Department visits for Behavioral Health and Substance Abuse	N/A	N/A	Yes * †	+4/+0
H2-405	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	CMS	N/A	Y	1

† For providers that select Measure Bundle H2 and have an MPT of 75:
Measure H2-510 is a Population Based Clinical Outcome and is a required P4P measure for providers with an MPT of 75.

† * For providers that select Measure Bundle H2 and have an MPT of less than 75:
Providers with an MPT less than 75 must select one of either H2-160, H2-216, or H2-510 as P4P. Providers that do not opt to report H2-510 as P4P that have any numerator volume must report as P4R and select one of either H2-160 or H2-216. Measures reported as P4R will not count towards the measure bundle's point value and do not contribute towards a provider's MPT.

H3: Chronic Non-Malignant Pain Management

This bundle is a High State Priority.

Objective:
Improve individuals' quality of life and reduce pain through lifestyle modification, psychological approaches, interventional pain management, and/or pharmacotherapy while recognizing current or potential substance abuse disorders. Improve providers' ability to identify and manage chronic non-malignant pain using a function-based multimodal approach, and ability to screen for substance use disorder and connect individuals to appropriate treatment.

Target Population:
Adults with chronic pain or on long-term opioid therapy

Base Points: 5*2 (high state priority) = 10
Possible Additional Points: N/A
Maximum Total Possible Points: 10

ID	Measure	Steward	NQF #	Required	Measure Point Value
H3-144	Screening for Clinical Depression and Follow-Up Plan (CDF-AD) for individuals with a diagnosis of chronic pain	CMS	0418	Yes	1
H3-287	Documentation of Current Medications in the Medical Record	CMS	0419	Yes	1
H3-288	Pain Assessment and Follow-up	CMS	0420	Yes	1
H3-401	Opioid Therapy Follow-up Evaluation	N/A	N/A	Yes	1
H3-403	Evaluation or Interview for Risk of Opioid Misuse	N/A	N/A	Yes	1
H3-T05	*Innovative Measure:* Treatment of Chronic Non-Malignant Pain Management with Multi-Modal Therapy (P4R)	San Francisco Health Network, Alameda Health Systems, UC San Diego	N/A	No	0
H3-T06	*Innovative Measure:* Patients on long-term opioid therapy checked in prescription drug monitoring programs (PDMPs) (P4R)	AHRQ/ San Francisco Health Network, Alameda Health Systems, UC San Diego	N/A	No	0

H4: Integrated Care for People with Serious Mental Illness

This bundle is a State Priority.

Objective:
Improve physical health outcomes for individuals with serious mental illness.

Target Population:
Individuals with Serious Mental Illness

Base Points: 3*1.5 (state priority) = 5
Possible Additional Points: N/A
Maximum Total Possible Points: 5

ID	Measure	Steward	NQF #	Required	Possible Measure Points
H4-182	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA	1932	Yes	1
H4-258	Cardiovascular monitoring for people with cardiovascular disease and schizophrenia	NCQA	1933	Yes	1
H4-260	Annual Physical Exam for Persons with Mental Illness	CQAIMH	N/A	Yes	1

I1: Specialty Care

Objective:
Improve quality of life and functional status for individuals with chronic and life impacting conditions receiving services in an outpatient specialty care setting.

Target Population:
Adults & Children with chronic and life impacting conditions

Base Points: 2
Possible Additional Points: N/A
Maximum Total Possible Points: 2

Requires prior authorization and can only be selected once by Hospital and Physician Practices with a specialty care project in DY6.

ID	Measure	Steward	NQF #	Required	Measure Point Value
I1-385	Assessment of Functional Status or QoL	N/A	N/A	Yes	1
I1-386	Improvement in Functional Status or QoL	N/A	N/A	Yes	1

J1: Hospital Safety

Objective:
Improve patient health outcomes and experience of care by reducing the risk of health-care associated infections, and reducing hospital errors.

Target Population:
Individuals receiving inpatient care

Base Points: 10
Possible Additional Points: N/A
Maximum Total Possible Points: 10

If D3 and J1 are both selected, the points of each bundle will be reduced by 50%.

ID	Measure	Steward	NQF #	Required	Measure Point Value
J1-218	Central line-associated bloodstream infections (CLABSI) rates	CDC	0139	Yes	2
J1-219	Catheter-associated Urinary Tract Infections (CAUTI) rates	CDC	0138	Yes	2
J1-220	Surgical site infections (SSI) rates	CDC	0299	Yes	2
J1-221	Patient Fall Rate	American Nurses Association	0141	Yes	2
J1-506	PSI 13 Post-Operative Sepsis Rate	AHRQ	N/A	Yes	2

K1: Rural Preventive Care

This bundle is only available to hospitals with a valuation less than or equal to $2,500,000 per DY.

Objective:
Improve provision of preventive care in rural and critical access hospitals to improve patient health.

Target Population:
Adults and Children in Rural Areas

Base Points: 3
Possible Additional Points: 10
Maximum Total Possible Points: 13

Measure Bundles A1, A2, C1, D1, E1, and H1 cannot be selected if Measure Bundle K1 is selected.

ID	Measure	Steward	NQF #	Required	Measure Point Value
K1-103	Controlling High Blood Pressure	NCQA	0018	No	+3
K1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	Yes	1
K1-112	Comprehensive Diabetes Care: Foot Exam	NCQA	0056	No	+1
K1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	No	+3
K1-146	Screening for Clinical Depression and Follow-Up Plan	CMS	0418	No	+1
K1-268	Pneumonia vaccination status for older adults	CMS	0043	Yes	1
K1-269	Preventive Care and Screening: Influenza Immunization	AMA / PCPI	0041/ 3070	No	+1
K1-285	Advance Care Plan	NCQA	0326	Yes	1
K1-300	Behavioral Health Risk Assessment for Pregnant Women	AMA-PCPI	N/A	No	+1

K2: Rural Emergency Care

This bundle is only available to hospitals with a valuation less than or equal to $2,500,000 per DY.

Objective:
Improve quality of emergency care in rural and critical access hospital to improve patient health.

Target Population:
Adults and Children receiving emergency services in rural areas

Base Points: 3
Possible Additional Points: 1
Maximum Total Possible Points: 4

ID	Measure	Steward	NQF #	Required	Measure Point Value
K2-285	Advance Care Plan	NCQA	0326	No*	+1
K2-287	Documentation of Current Medications in the Medical Record	CMS	0419	Yes	1
K2-355	Admit Decision Time to ED Departure Time for Admitted Patients	CMS	0497	Yes	1
K2-359	Emergency Transfer Communication Measure	University of Minnesota Rural Health Research Center	0291	Yes	1

*K2-285 cannot be selected if measure bundle K1 is selected.

Local Health Department Measures

LHD Measures				
ID	**Measure**	**Steward**	**NQF #**	**Points**
L1-103	Controlling High Blood Pressure	NCQA	0018	3
L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	1
L1-107	Colorectal Cancer Screening	NCQA	0034	2
L1-108	Childhood Immunization Status (CIS)	NCQA	0038	1
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	3
L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS	0421 / 2828	1
L1-160	Follow-Up After Hospitalization for Mental Illness	NCQA	0576	3
L1-186	Breast Cancer Screening	NCQA	2372	2
L1-205	Third next available appointment	Wisconsin Collaborative for Healthcare Quality	N/A	1
L1-207	Diabetes care: BP control (<140/90mm Hg)	NCQA	0061	3
L1-210	317 Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CMS	N/A	1
L1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA	0024	1
L1-224	Dental Sealant: Children	Healthy People 2020	N/A	1
L1-225	Dental Caries - Children	Healthy People 2020	N/A	3
L1-227	Dental Caries - Adults	Healthy People 2020	N/A	3
L1-231	Preventive Services for Children at Elevated Caries Risk - Modified Denominator	American Dental Association	N/A	1
L1-235	Post-Partum Follow-Up and Care Coordination	CMS	N/A	3
L1-237	Well-Child Visits in the First 15 Months of Life (6 or more visits)	NCQA	1392	1
L1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	None	N/A	3
L1-242	Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC)	None	N/A	3
L1-268	Pneumonia vaccination status for older adults	CMS	0043	1

LHD Measures				
ID	**Measure**	**Steward**	**NQF #**	**Points**
L1-269	Preventive Care and Screening: Influenza Immunization	AMA / PCPI	0041 / 3070	1
L1-271	Immunization for Adolescents- Tdap/TD and MCV	NCQA	1407	1
L1-272	Adults (18+ years) Immunization status	Institute for Clinical Systems Improvement	N/A	1
L1-280	Chlamydia Screening in Women	NCQA	0033	1
L1-343	Syphilis positive screening rates	CDC	N/A	1
L1-344	Follow-up after Treatment for Primary or Secondary Syphilis	CDC	N/A	3
L1-345	Gonorrhea Positive Screening Rates	CDC	N/A	1
L1-346	Follow-up testing for N. gonorrhoeae among recently infected men and women	CDC	N/A	3
L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	CDC	N/A	3
L1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse	N/A	N/A	3
L1-400	Tobacco Use and Help with Quitting Among Adolescents	CMS	N/A	1

Community Mental Health Center Measure Menu

CMHC Measures					
ID	**Measure**	**Steward**	**NQF #**	**Points**	**Additional Points for State Priority Measures**
M1-100	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NCQA	0004	3	+1
M1-103	Controlling High Blood Pressure	NCQA	0018	3	+1
M1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	1	+1
M1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	3	
M1-124	Medication Reconciliation Post-Discharge	NCQA	0097	1	
M1-125	Antidepressant Medication Management (AMM-AD)	NCQA	0105	3	
M1-146	Screening for Clinical Depression and Follow-Up Plan (CDF-AD)	CMS	0418	1	
M1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS	0421 / 2828 eMeasure	1	
M1-160	Follow-Up After Hospitalization for Mental Illness	NCQA	0576	3	
M1-165	Depression Remission at 12 Months	MN Community Measurement	0710	*(3)**	+1
M1-180	Adherence to Antipsychotics for Individuals with Schizophrenia	CMS	1879	3	
M1-181	Depression Response at Twelve Months-Progress Towards Remission	MN Community Measurement	1885	*(3)**	+1
M1-182	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA	1932	1	+1

CMHC Measures					
ID	**Measure**	**Steward**	**NQF #**	**Points**	**Additional Points for State Priority Measures**
M1-203	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	AMA-PCPI	N/A / 3059 eMeasure	1	+1
M1-205	Third next available appointment	Wisconsin Collaborative for Healthcare Quality	N/A	1	
M1-207	Diabetes care: BP control (<140/90mm Hg)	NCQA	0061	3	
M1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CMS	N/A	1	
M1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA	0024	1	+1
M1-216	Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate	N/A	N/A	3	
M1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	None	N/A	3	
M1-255	Follow-up Care for Children Prescribed ADHD Medication	NCQA	0108	3	
M1-256	Initiation of Depression Treatment	CQAIMH	N/A	1	
M1-257	Care Planning for Dual Diagnosis	CQAIMH	N/A	1	
M1-259	Assignment of Primary Care Physician to Individuals with Schizophrenia	CQAIMH	N/A	1	
M1-260	Annual Physical Exam for Persons with Mental Illness	CQAIMH	N/A	1	+1
M1-261	Assessment for Substance Abuse Problems of Psychiatric Patients	CQAIMH	N/A	1	+1
M1-262	Assessment of Risk to Self/Others	CQAIMH	N/A	1	
M1-263	Assessment for Psychosocial Issues of Psychiatric Patients	CQAIMH	N/A	1	
M1-264	Vocational Rehabilitation for Schizophrenia	CQAIMH	N/A	1	

CMHC Measures					
ID	**Measure**	**Steward**	**NQF #**	**Points**	**Additional Points for State Priority Measures**
M1-265	Housing Assessment for Individuals with Schizophrenia	CQAIMH	N/A	1	+1
M1-266	Independent Living Skills Assessment for Individuals with Schizophrenia	CQAIMH	N/A	1	
M1-280	Chlamydia Screening in Women	NCQA	0033	1	+1
M1-286	Depression Remission at Six Months	MN Community Measurement	0711	*(3)**	+1
M1-287	Documentation of Current Medications in the Medical Record	CMS	0419	1	+1
M1-305	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	AMA-PCPI	1365	1	+1
M1-306	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	2801	1	
M1-317	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	AMA-PCPI	2152	1	+1
M1-319	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	0104	1	+1
M1-339	Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge	The Joint Commission	1664	1	+1
M1-340	Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period.	APA/ NCQA/ PCPI	N/A	1	+1
M1-341	Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period	APA/ NCQA/ PCPI	N/A	1	+1
M1-342	Time to Initial Evaluation: Evaluation within 10 Business Days	SAMHSA/ CCBHC	N/A	1	

CMHC Measures					
ID	**Measure**	**Steward**	**NQF #**	**Points**	**Additional Points for State Priority Measures**
M1-385	Assessment of Functional Status or QoL *Specific to IDD Services*	N/A	N/A	1	
M1-386	Improvement in Functional Status or QoL *Specific to IDD Services*	N/A	N/A	1	
M1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse	N/A	N/A	3	+1
M1-390	Time to Initial Evaluation: Mean Days to Evaluation	SAMHSA/ CCBHC	NA	1	
M1-400	Tobacco Use and Help with Quitting Among Adolescents	CMS		1	+1
M1-405	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	CMS/CQAIMH	NA	1	+1

**If more than one of M1-165, M1-181, and/or M1-286 are selected, only 4 points will be added to meet MPT.*

Category D

Category D represents a population health perspective for all DSRIP performing providers. Whereas the initial waiver period included Category 4 statewide reporting for hospitals, Category D includes measures for all DSRIP performing provider types including Hospitals, Community Mental Health Centers, Physician Practices, and Local Health Departments. This reporting is designed to assist providers, managed care organizations, Regional Healthcare Partnerships, and state and federal agencies to have regional and statewide views of important health care trends. The Category D reporting measure bundles are:

- Aligned with Medicaid, low-income, and uninsured populations;
- Identified as high priority given the health care needs and issues of the patient population served; and
- Viewed as valid health care indicators to inform and identify areas for improvement in population health within the health care system.

Category D Structure:

Required Statewide Reporting Measure Bundles for each of the performing provider types:

- Hospitals
- Community Mental Health Centers (CMHCs)
- Physician Practices
- Local Health Departments (LHDs)

The Category D emphasis is on the reporting of population health measures to gain information on and understanding of the health status of key populations and to build the capacity for reporting on a comprehensive set of population health metrics; therefore, performing providers will not be required to achieve improvement in Category D. All measures are required and may be reported in the first or second reporting period of each DY. Performing providers will also submit qualitative information describing providers' activities impacting measures. Measure reporting and qualitative information will be submitted in the form prescribed by HHSC.

Hospital Statewide Reporting Measure Bundle

As specified in the PFM hospital performing providers must report on all measures included in this bundle:

- Potentially preventable admissions (PPAs)
- Potentially Preventable 30-day readmissions (PPRs)
- Potentially preventable complications (PPCs)
- Potentially Preventable ED visits (PPVs)
- Patient satisfaction

Hospital performing providers report on the Category D Statewide Hospital Reporting Measure Bundle, including hospitals that were previously exempt from the reporting on population health measures during DY2-6. Each hospital performing provider subject to required Category D reporting must report on all measures.

For PPAs, PPRs, PPCs and PPVs, hospitals with low volume are still required to respond to qualitative questions.

Hospital Reporting Measures

Potentially Preventable Admissions (PPAs)

PPAs are facility admissions that may have resulted from the lack of adequate access to care or ambulatory care coordination. Circumstances associated with PPAs are ambulatory sensitive conditions (e.g., asthma) for which adequate patient monitoring and follow-up (e.g., medication management) can often avoid the need for admission. The occurrence of high rates of PPAs may represent a failure of the ambulatory care provided to the patient. In addition to a significant quality problem, excess PPAs result in unnecessary increases in cost. From the perspective of care providers, one way to improve efficiency and quality and to generate greater value is to better identify and avoid unnecessary hospitalizations.

PPA by Category

CHF (Congestive Heart Failure)
DM (Diabetes)
BH/SA (Behavioral Health/Substance Abuse)
COPD (Chronic Obstructive Pulmonary Disease)
Adult Asthma
Pediatric Asthma
CP & CAD (Angina and Coronary Artery Disease)
HTN (Hypertension)
Cellulitis
Bacterial PNA (Respiratory Infection)
PE & RF (Pulmonary Edema and Respiratory Failure)
Others

Potentially Preventable Readmissions (PPRs)

Readmissions have potential value as an indicator of quality of care because they may reflect poor clinical care and poor coordination of services either during hospitalization or in the immediate post discharge period. A potentially preventable readmission is a readmission (return hospitalization within the specified readmission time interval) that is clinically related to the initial hospital admission. “Clinically related” is defined as a requirement that the underlying reason for readmission be plausibly related to the care rendered during or immediately following a prior hospital admission. A readmission is defined as a return hospitalization to an acute care hospital that follows a prior acute care admission

within a specified time interval, called the readmission time interval. The readmission time interval is the maximum number of days allowed between the discharge date of a prior admission and the admitting date of a subsequent admission. If a subsequent admission occurs within the readmission time interval and is clinically related to a prior admission, it is considered a PPR. The hospitalization triggering a PPR is called an Initial Admission. Subsequent PPRs relate back to the care rendered during or following the Initial Admission.

PPR by Category

CHF (Congestive Heart Failure)
DM (Diabetes)
BH/SA (Behavioral Health or Substance Abuse)
COPD (Chronic Obstructive Pulmonary Disease)
CVA (Cerebrovascular Accident)
Adult Asthma
Pediatric Asthma
AMI (Acute Myocardial Infarction)
CP & CAD (Angina and Coronary Artery Disease)
HTN (Hypertension)
Cellulitis
Renal Failure
C Section (Cesarean delivery)
Sepsis
Others

Potentially Preventable Complications (PPCs)

PPCs are in-hospital complications that are not present on admission, but result from treatment during the inpatient stay. As indicators of quality of care, PPCs represent harmful events or negative outcomes that might result from processes of care and treatment rather than from natural progression of the underlying disease. Increased costs resulting from complications are passed on to payers because the diagnosis codes linked to complications frequently increase Diagnosis Related Group (DRG) payment.

The 3M PPC methodology identifies PPCs based on risk at admission, using information from inpatient encounters, such as diagnosis codes, procedure codes, procedure dates, present on admission (POA) indicators, patient age, sex and discharge status. Accurate coding of the POA indicators is particularly important as it serves two primary purposes: (1) to identify potentially preventable complications from

among diagnoses not present on admission, and (2) to allow only those diagnoses designated as present on admission to be used for assessing the risk of incurring complications.

PPC by Category

Renal Failure without Dialysis
Urinary Tract Infection
Clostridium Difficile Colitis
Encephalopathy
Shock
Pneumonia & Other Lung Infections
Acute Pulmonary Edema and Respiratory Failure without Ventilation
Stroke and Intracranial Hemorrhage
Post Hemorrhagic & Other Acute Anemia with Transfusion
Venous Thrombosis
Ventricular Fibrillation/Cardiac Arrest
Major Gastrointestinal Complications without Transfusion or Significant Bleeding
Other Complications of Medical Care
Moderate Infections
Inflammation & Other Complications of Devices, Implants or Grafts except Vascular Infection
Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Procedure
Septicemia & Severe Infections
Acute Pulmonary Edema and Respiratory Failure with Ventilation
Post-Operative Infection & Deep Wound Disruption without Procedure
Infections due to Central Venous Catheters

Potentially Preventable ED visits (PPVs)

A PPV is an emergency treatment for a condition that could have been treated or prevented by a physician or other health care provider in a nonemergency setting. Because some visits are preventable, they may indicate poor care management, inadequate access to care, or poor choices on the part of the patient. Emergency department visits for conditions that are preventable or treatable with appropriate primary care lower health system efficiency and raise costs.

PPV by Category

Skin and Integumentary System
Breast
Musculoskeletal System
Respiratory System
Cardiovascular System
Hematologic, Lymphatic and Endocrine
Gastrointestinal
Genitourinary System
Male Reproductive System
Female Reproductive System
Neurologic System
Ophthalmologic System
Otolaryngologic System
Radiologic Procedures
Rehabilitation
Mental Illness and Substance Abuse Therapies
Nuclear Medicine
Radiation Oncology
Dental Procedures

Patient Satisfaction

The reporting is limited to the inpatient setting.

For Patient Satisfaction, providers will report the percentage of survey respondents who choose the most positive, or "top-box" response for HCAHPS Reporting Measures:

- Percent of patients who reported that their nurses "Always" communicated well
- Percent of patients who reported that their pain was "Always" well controlled
- Percent of patients who reported that staff "Always" explained about medicines before giving it to them
- Percent of patients who reported that YES, they were given information about what to do during their recovery at home
- Percent of patients who reported that their room and bathroom were "Always" clean
- Percent of patients who reported that the area around their room was "Always" quiet at night
- Percent of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)
- Percent of patients who reported YES, they would definitely recommend the hospital.

Hospitals that do not report HCAHPS as part of Medicare Inpatient Prospective Payment System due to low volume or other exempt status may use an alternative hospital patient satisfaction survey and must include information in their RHP Plan Update that describes the method they will use for reporting.

Community Mental Health Center Statewide Reporting Measure Bundle

Community Mental Health Centers (CMHCs) will report on their activities being carried out to impact rates on the following measures and provide qualitative reporting as required by HHSC[1]:

1. **Effective Crisis Response**

   This measure is the percent of individuals receiving crisis services who avoid inpatient admission after the crisis episode.

2. **Crisis Follow up**

   This measure is the percent of individuals receiving crisis services who receive a crisis follow up services within a defined time period.

3. **Community Tenure (Adult and Child/Youth)**

   This measure is the percent of individuals who successfully avoid psychiatric inpatient care.

4. **Reduction in Juvenile Justice Involvement**

   This measure is the percent of children and youth who demonstrate improvement on indicators of juvenile justice involvement.

[1] These measures may be modified at the end of DY7-8. CMHCs will report based on the modified measure specifications once approved by HHSC.

5. Adult Jail Diversion

This measure is the percent adults who demonstrate improvement on indicators of criminal justice involvement.

Physician Practices Statewide Reporting Measure Bundle

Physician Practices will report on their activities being carried out to impact rates measured by Prevention Quality Indicators (PQIs). Based on the description by the Agency for Healthcare Research and Quality (AHRQ), PQIs are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

Even though these indicators are based on hospital inpatient data, they provide insight into the community health care system or services outside the hospital setting. For example, patients with diabetes may be hospitalized for diabetic complications if their conditions are not adequately monitored or if they do not receive the patient education needed for appropriate self-management.

Based on the regional summary of the PQIs that HHSC will make available to the performing providers, each physician practice will provide qualitative information on their efforts to impact these rates.

1. Diabetes Short-term Complications Admission Rate
2. Perforated Appendix Admission Rate
3. Diabetes Long-term Complications Admission Rate
4. Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
5. Hypertension Admission Rate
6. Heart Failure Admission Rate
7. Low Birth Weight Rate
8. Dehydration Admission Rate
9. Bacterial Pneumonia Admission Rate
10. Urinary Tract Infection Admission Rate
11. Uncontrolled Diabetes Admission Rate
12. Asthma in Younger Adults Admission Rate
13. Lower-Extremity Amputation among Patients with Diabetes Rate

Local Health Departments Statewide Reporting Measure Bundle

Based on the information available via Texas Behavioral Risk Factor Surveillance System (BRFSS)[2], HHS agencies will provide a RHP specific summary for the following areas:

- Access to health care services
- Health status of the population:
- Selected immunizations
- Prevention of sexually transmitted diseases.

Each LHD will provide a qualitative description of what is carried out by that LHD in its region to impact the rates and trends of the following measures:

1. **Time Since Routine Checkup**
   - BRFSS Questionnaire: About how long has it been since you last visited a doctor for a routine checkup?
2. **High Blood Pressure Status**
   - BRFSS Calculated Variable: Doctor diagnosed high blood pressure
3. **Diabetes Status**
   - BRFSS Calculated Variable: Doctor diagnosed diabetes
4. **Overweight or Obese**
   - BRFSS Calculated Variable: Overweight or obese
5. **Smoker Status**
   - BRFSS Calculated Variable: Four-level smoker status (Current Smoker - Every Day; Current Smoker - Some Days; Former Smoker; and Never Smoker)
6. **Selected Immunizations**
   - **Flu Shot Past Year**
     - BRFSS Questionnaire: During the past 12 months, have you had either a seasonal flu shot or a seasonal flu vaccine that was sprayed in your nose?
   - **Ever Had Pneumonia Shot**
     - BRFSS Questionnaire: Have you ever had a pneumonia shot?
   - **Received Tetanus Shot Since 2005**
     - BRFSS Questionnaire: Since 2005, have you had a tetanus shot? Was this Tdap, the tetanus shot that also has pertussis or whooping cough vaccine?
   - **Ever Had MMR Vaccine**
     - BRFSS Questionnaire: Have you ever received the MMR vaccine?
   - **Had All HPV Shots**
     - Calculated Variable: Received all 3 HPV shots
7. **Prevention of Sexually Transmitted Diseases**
   - **Ever Had HIV Test**
     - BRFSS Questionnaire: Have you ever been tested for HIV?

[2] Additional information on BRFSS is available in Appendix B

Appendix B

Regional summaries with selected health information are generated based on the data collected by the Department of State Health Services via Texas Behavioral Risk Factor Surveillance System (BRFSS). BRFSS, initiated in 1987, is a federally supported landline and cellular telephone survey that collects data about Texas residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. Texas BRFSS is an important tool for decision-making throughout the Texas Health and Human Services, Texas Department of State Health Services and the public health community. Public and private health officials at the federal, state, and local levels rely on the BRFSS to identify public health problems, set priorities and goals, design policies and interventions, as well as evaluate the long term impact of these efforts.

This surveillance can be used to monitor the Healthy People 2020 Objectives for current smoking, obesity, high blood pressure, exercise and physical activity, flu and pneumonia vaccinations, cholesterol and cancer screenings, seat belt use, as well as other risk factors.
The BRFSS is administered under the direction of the Centers for Disease Control and Prevention (CDC) so that survey methods and much of the questionnaire are standardized across all BRFSS surveys in the 50 states, three territories, and the District of Columbia. As a result, comparisons can be made among states and to the nation.