DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

August 7, 2020

Stephanie Stephens
State Medicaid Director
Texas Health and Human Services Commission
4900 Lamar Boulevard
MC: H100
P.O. Box 13247
Austin, Texas 78751

Dear Ms. Stephens:

The Centers for Medicare & Medicaid Services is approving modifications to Attachment J for Texas' section 1115(a) demonstration (11-W-00278/6), entitled "Texas Healthcare Transformation and Quality Improvement Program." Attachment J is the Program Funding and Mechanics (PFM) protocol, which lays out operational guidelines for Texas' Delivery System Reform Incentive Payment (DSRIP) Program. CMS is approving Texas' requested technical changes to Texas' 1115 demonstration for DSRIP-related flexibilities amidst COVID-19, which reflect the impact of the public health emergency (PHE) on performance and measurement during calendar year 2020.

This change, reflected in an attachment to the STCs does not require an amendment, and is consistent with what CMS is approving for other states with impacted 1115 quality improvement programs.

Your project officer for this demonstration is Mr. Eli Greenfield. He is available to answer any questions concerning your section 1115 demonstration. Mr. Greenfield's contact information is:

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Sincerely,

[redacted]

Angela D. Garner
Director, Division of System Reform Demonstrations

cc: Ford Blunt, State Lead, Medicaid and Chip Operations Group

Attachment J
Program Funding and Mechanics Protocol

TEXAS
Health and Human Services

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 through 10. 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 Updates (updates 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 Updates 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. RHP Plan Updates for DY9-10 will give Performing Providers an opportunity to update their selections of outcomes and Core Activities.

DY7-10 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 and update the system they will utilize in DY7-10 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 Performing Providers maintain a focus on serving the target population: MLIU patients. Because DSRIP reporting will no longer be project-specific, HHSC requires that Performing Providers demonstrate that they are maintaining a certain level of service to the MLIU target population. In addition, HHSC does not want Performing Providers to stop serving the MLIU population in an effort to enhance achievement of 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 the system definition. Performing Providers will define and update their system in the RHP Plan Updates.

Categories 1-4 in DY2-6 are transitioned to the following Categories in DY7-10:

- 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 17.
- 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 and later for DY9-10 in accordance with these attachments and the STCs.

This version of the Program Funding and Mechanics Protocol is approved as of TBD 2019.

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
IV. Review and Approval Process of RHP Plan Updates
V. RHP Plan Update Modifications for DY7-10
VI. Performing Provider Requirements for DY7-10
VII. Disbursement of DSRIP Funds for DY7-10
VIII. RHP and State Reporting Requirements
IX. Data Quality Assurance

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 DY7-10, or a new activity implemented by a Performing Provider in DY7-10.

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. Demonstration Year (DY) 9 - Federal fiscal year (FFY) 2020 (October 1, 2019 - September 30, 2020). This is also reporting year (RY) 3.

f. Demonstration Year (DY) 10 - Federal fiscal year (FFY) 2021 (October 1, 2020 - September 30, 2021). This is also reporting year (RY) 4.

g. Demonstration Year (DY) 11 - Federal fiscal year (FFY) 2022 (October 1, 2021 - September 30, 2022).

h. Initial Demonstration Period - The first five demonstration years (DY) of the waiver, or December 12, 2011, through September 30, 2016.

i. 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.

j. 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 or Children's Health Insurance Program (CHIP) 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.

k. 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.

l. 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.

m. 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, PY3 is CY 2020, and PY4 is CY 2021.

n. 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. Optional components should be included if they are a prominent component of a Performing Provider's system of care. The system may not be limited by patient type, payer or diagnosis.

o. 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.

p. 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. RHP Composition

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:

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

- RHP 3: Austin, Calhoun, Chambers, Colorado, Fort Bend, Harris, Matagorda, Waller, Wharton
- RHP 4: Aransas, Bee, Brooks, DeWitt, Duval, Goliad, Gonzales, Jackson, Jim Wells, Karnes, Kenedy, Kleberg, Lavaca, Live Oak, Nueces, Refugio, San Patricio, Victoria
- RHP 5: Cameron, Hidalgo, Starr, Willacy
- RHP 6: Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Kendall, Kerr, Kinney, La Salle, McMullen, Medina, Real, Uvalde, Val Verde, Wilson, Zavala
- RHP 7: Bastrop, Caldwell, Fayette, Hays, Lee, Travis
- RHP 8: Bell, Blanco, Burnet, Lampasas, Llano, Milam, Mills, San Saba, Williamson
- RHP 9: Dallas, Denton, Kaufman
- RHP 10: Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, Tarrant, Wise
- RHP 11: Brown, Callahan, Comanche, Eastland, Fisher, Haskell, Jones, Knox, Mitchell, Nolan, Palo Pinto, Shackelford, Stephens, Stonewall, Taylor
- 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
- RHP 13: Coke, Coleman, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Pecos, Reagan, Runnels, Schleicher, Sterling, Sutton, Terrell, Tom Green
- RHP 14: Andrews, Brewster, Crane, Culberson, Ector, Glasscock, Howard, Jeff Davis, Loving, Martin, Midland, Presidio, Reeves, Upton, Ward, Winkler
- RHP 15: El Paso, Hudspeth
- RHP 16: Bosque, Coryell, Falls, Hamilton, Hill, Limestone, McLennan
- RHP 17: Brazos, Burleson, Grimes, Leon, Madison, Montgomery, Robertson, Walker, Washington
- RHP 18: Collin, Grayson, Rockwall
- RHP 19: Archer, Baylor, Clay, Cooke, Foard, Hardeman, Jack, Montague, Throckmorton, Wichita, Wilbarger, Young
- 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 Updates for that RHP. Each RHP shall have one Anchoring Entity that coordinates the RHP Plan Updates for that RHP. 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 as needed;
- Engaging stakeholders in the RHP, including the public and through the learning collaborative plan (as required in paragraph 38);
- Coordinating the RHP Plan Updates that best meet community needs in collaboration with RHP participants;
- Ensuring that the RHP Plan Updates are consistent with Attachment R, Attachment J, and all other State/waiver requirements;
- Transmitting the RHP Plan Updates to HHSC on behalf of the RHP;
- Ongoing monitoring and annual reporting (as required in paragraphs 37 and 41) 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 46.

IGT Entities may fund Performing Providers outside of their RHP. Such funding must be documented in the RHP Plan Updates for the RHP in which the Performing Provider is participating.

8. Performing Providers

"Performing Providers" are providers that are responsible for: 1) implementing Core Activities to achieve the Category C measure goals in the RHP Plan Updates; and 2) measuring, reporting, and improving performance on the Category C measure goals in the RHP Plan Updates, 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 DY7-10. 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 Updates 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

In DY7-8, 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

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:

- RHP Organization including collaborating organizations
- Community Needs Assessment
- Stakeholder Engagement
- The Performing Provider's system definition
- 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
- Category B MLIU Patient Population by Provider (PPP) baselines
- Category C Measure Bundles and measures for each Performing Provider
- Category D Statewide Reporting Measure Bundles for each Performing Provider
- DSRIP valuation amounts
- Signed certifications from the leadership of Performing Providers and their affiliated IGT Entities

11. RHP Plan Updates for DY9-10

Each RHP Anchoring Entity must submit an RHP Plan Update for its RHP for DY9-10 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:

- RHP Organization.
- Updates to Community Needs Assessment, if needed.
- Stakeholder Engagement.
- Anchor hosts at least one public meeting prior to submission of the RHP Plan Update for DY9-10.
- Updates to each Performing Provider's system definition, if needed.
- Category A reporting, including updates to the Performing Provider’s Core Activities for DY9-10.

- Updates to Category B MLIU Patient Population by Provider (PPP), if needed. Forecasted breakout of Medicaid individuals and LIU individuals served in DY9-10 based on MLIU individuals served in DY7-8.
- Category C Measure Bundles and measures for each Performing Provider including:
  - Optional addition or discontinuation of Measure Bundles or measures to meet the updated Minimum Point Threshold (MPT) for DY9-10. This includes allowing Performing Providers with an MPT of less than 75 to update population-based clinical outcomes as pay-for-performance (P4P) or pay-for-reporting (P4R). Providers may replace Measure Bundles and measures up to a maximum of 20 points of a provider's assigned MPT for DY9-10 with good cause limited to significant system changes such as a hospital merger or significant change in a measure bundle's required system component of outpatient services or hospital services as identified in Attachment R, "Measure Bundle Protocol".
  - Related Strategies reporting associated with DY9-10 Measure Bundle selections for hospitals and physician practices or DY9-10 measure selections for CMHCs and LHDs.
  - Justification for any Category C changes from DY7-8 and requested exceptions for new selections in DY9-10.
- Category D Statewide Reporting Measure Bundles for each Performing Provider.
- DSRIP valuation amounts.
- Certifications from the leadership of Performing Providers and their affiliated IGT Entities.

IV. REVIEW AND APPROVAL PROCESS OF RHP PLAN UPDATES

12. HHSC Review and Approval Process for DY7-8

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 12.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.

13. HHSC Review and Approval Process for DY9-10

a. Submission of RHP Plan Updates

By November 30, 2019, or 60 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 DY9-10 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 DY9-10 to ensure compliance with elements described in 13.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 DY7-10" and Section VII "Disbursement of DSRIP Funds for DY7-10" 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 January 15, 2020, or 45 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 February 28, 2020, or 90 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 DY7-10

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.

14. 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 30 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 30 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 the first day of the second reporting period of DY7 for DY7-10 measures and the first day of the second reporting period of DY9 for DY9-10 new measures.

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 for DY7-10 measures and no later than 30 days prior to the first day of the second reporting period of DY9 for DY9-10 new measures.

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 for DY7-10 measures and no later than 30 days prior to the first day of the second reporting period of DY9 for DY9-10 new measures. 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 for DY7-10 measures and no later than 30 days prior to the first day of the second reporting period of DY9 for DY9-10 new measures.

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 DY7-10

15. DY7-11 Pool Allocation

a. The DSRIP pool allocation for DY7-11 comports with STC 35.

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.

16. 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. A Performing Provider’s total valuation for each demonstration year of DY9 and DY10 is calculated as follows:

   i. If a Performing Provider has a DY8 total valuation that is less than or equal to $1 million, its total valuation for each demonstration year of DY9 and DY10 is equal to its total valuation for DY8. These valuations are subtracted from the DY9 and DY10 pool amounts.

   ii. If a Performing Provider has a DY8 total valuation that is greater than $1 million, its total valuation for each demonstration year of DY9 and DY10 is calculated as follows:

      A. The remaining DY9 and DY10 pool amounts are divided by the DY8 valuation for all Performing Providers with a DY8 total valuation greater than $1 million to determine the percentage reductions for DY9 and DY10;
      B. The Performing Provider’s DY8 valuation is multiplied by the percentage reduction in valuation from DY8 for the applicable DY to determine the total valuation for each demonstration year of DY9 and DY10; and
      C. The Performing Provider’s total valuation for each demonstration year of DY9 and DY10 is not reduced to less than $1 million.

iii. If a Performing Provider withdrew from participating in DSRIP during DY8 or withdraws during the RHP Plan Update for DY9-10, the Performing Provider's valuation is proportionately distributed among the remaining Performing Providers in the RHP based on each Performing Provider's percent share of DY8 valuation in the RHP.

c. Each Performing Provider's valuation must comport with the following funding distribution in DY7-10.

DSRIP Funding Distribution

	DY7*	**DY8***	**DY9**	**DY10**
RHP Plan Update Submission	20%	NA	NA	NA
Category A - required reporting	0%	0%	0%	0%
Category B - MLIU PPP	10%	10%	10%	10%
Category C- Measure Bundles and Measures	55 or 65%	75 or 85%	75%	75%
Category D - Statewide Reporting Measure Bundle	15 or 5%	15 or 5%	15%	15%

*If an RHP's private hospital participation minimums are met, as described in paragraph 25, then Performing Providers in the RHP may increase the Statewide Reporting Measure Bundle funding distribution to 15% in DY7-8.

17. Category A - Eligibility for DY7-10 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 as indicated in the RHP Plan Updates 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 $1 million 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 analyze: 1) a different Core Activity for the Costs and Savings analysis in DY9-10 than was used for the Costs and Savings analysis in DY7-8; or 2) a different aspect of the same Core Activity for the Costs and Savings analysis in DY9-10 than was used for the Costs and Savings analysis in DY7-8. 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 DY9, and a final report of costs and savings must be submitted during the second reporting period of DY8 and DY10.

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.

18. 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 up to 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 text messages or undocumented encounters.

For DY7-8, Providers are not allowed to count telephone encounters. For DY9-10, individuals who receive a telephone encounter that is the equivalent of a service that would be provided within the physical confines of the defined system may be included in the PPP count.

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 for DY7-8 and revise as needed in the RHP Plan Update for DY9-10. Each Performing Provider is required to submit the forecasted breakout of the total Medicaid individuals and LIU individuals that will be served in DY9-10 based on the MLIU individuals served in DY7-8.

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 and in DY9-10, provide a breakout of the total Medicaid individuals and LIU individuals served during 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 be a maximum percentage below the 100% goal, as determined by HHSC 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.

19. 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 DY7-10.

    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 DY8-10 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 in DY7-8 or greater than $2 million in DY10 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 report at least two population-based clinical outcomes as P4P, 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 in DY7-8 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 19.q.

o. Each hospital and physician practice may allocate its Category C valuation among its DY7-8 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. For DY9-10, each Measure Bundle selected by the hospital or physician practice is allocated a percentage of the hospital's or physician practice's Category C valuation that is equal to the Measure Bundle's point value as a percentage of all of the hospital's or physician practice's selected Measure Bundles' point values.

q. 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.

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

s. 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 19.s.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.

iv. For DY9-10, a hospital's MPT is recalculated using the DY10 valuation in place of the DY7 valuation, with a maximum reduction of 10 points from the MPT used in DY7-8.

t. 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.

iii. For DY9-10, a physician practice's MPT is recalculated using the DY10 valuation in place of the DY7 valuation, with a maximum reduction of 10 points from the MPT used in DY7-8.

20. Category C - Measure Selection Requirements for CMHCs and 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 DY7-10.

   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 DY8-10 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 in DY7-8 and more than $2,000,000 in DY10 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 DY7-8 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 in DY7-8 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.

For DY9-10, all measures selected by a CMHC or LHD are valued equally.

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.

   iii. For DY9-10, a CMHC’s or LHD’s MPT is recalculated using the DY10 valuation in place of the DY7 valuation, with a maximum reduction of 10 points from the MPT used in DY7-8.

21. Category C - Measurement Periods for P4P Measures

a. The baseline measurement period is calendar year (CY) 2017 (January 1, 2017 - December 31, 2017) for measures selected for DY7-10. The baseline measurement period is CY 2019 (January 1, 2019 - December 31, 2019) for measures newly-selected for DY9-10.

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 for measures selected for DY7-10 and no later than September 30, 2020 for measures newly-selected for DY9-10. In cases where a provider has no or insufficient volume to establish a baseline that ends by December 31, 2017 for measures selected for DY7-10 or December 31, 2019 for measures newly-selected for DY9-10, 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 for measures selected for DY7-10 and PY4 for measures newly-selected for DY9-10. A Performing Provider must report PY1 and PY2 for a measure with a delayed baseline measurement period for measures selected for DY7-10. A Performing Provider must report PY3 and PY4 for a measure with a delayed baseline measurement period for measures newly-selected for DY9-10.

iii. For LHD P4P measures that were reported in Category 3 in DY6 and selected for DY7-10, 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. PY4 is CY 2021 (January 1, 2021 - December 31, 2021).

f. 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).

22. Category C - Measure Milestones

a. The Category C measure milestone structure and valuation for DY7-10 is as follows:

	DY7	DY8	DY9	DY10
Innovative Measure or Quality Improvement Collaborative Activity	100% Reporting Year (RY) 1 reporting milestone	100% RY2 reporting milestone	100% RY3 reporting milestone	25% RY4 reporting milestone 75% achievement milestone
P4P Measure - Baseline Reporting Milestone	25%	NA	NA	NA
P4P Measure - Reporting Milestone	PY1 25%	PY2 25%	PY3 25%	PY4 25%
P4P Measure - Achievement Milestone	DY7 Goal 50%	DY8 Goal 75%	DY9 Goal 75%	DY10 Goal 75%
New DY9-10 P4P Measure - Baseline Reporting Milestone	NA	NA	12.5%	NA
New DY9-10 P4P Measure - Reporting Milestone	NA	NA	PY3 12.5%	PY4 25%
New DY9-10 P4P Measure - Achievement Milestone	NA	NA	DY9 Goal 75%	DY10 Goal 75%

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 or PY3 for measures newly-selected for DY9-10).

   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. As part of the DY9 and DY10 reporting milestones, Performing Providers are required to update Related Strategies reporting, as indicated in Attachment R, "Measure Bundle Protocol."

e. 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 29.

23. 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 for DY7-10 measures and the first day of the second reporting period of DY9 for DY9-10 new measures.

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 for DY7-10 measures and no later than 30 days prior to the first day of the second reporting period of DY9 for DY9-10 new measures.

    iii. In order to be eligible for payment for a measure's DY9 goal achievement milestone, the Performing Provider must report the measure’s PY3 performance, PY2 performance for measures selected in DY7-8, and ongoing continuous quality improvement activities in the Core Activities reporting for DY9-10.

24. 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.

P4P Measure Goals for Measures Selected for DY7-10

	QISMC - Baseline below MPL	**QISMC -** Baseline equal to or greater than the MPL and lower than the HPL	**QISMC -** Baseline equal to or greater than the HPL	**IOS**
DY7	MPL	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 lesser absolute value of improvement of baseline plus (minus) 2% of the difference between the HPL and MPL or the IOS goal	2.5% gap closure
DY8	10% gap closure between the MPL and HPL	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	The lesser absolute value of improvement of baseline plus (minus) 8% of the difference between the HPL and MPL or the IOS goal	10% gap closure
DY9	MPL plus 12% gap closure between the MPL and HPL	The greater absolute value of improvement between: 22.5% gap closure towards HPL, or baseline plus (minus) 9% of the difference between the HPL and MPL	The lesser absolute value of improvement of baseline plus (minus) 9% of the difference between the HPL and MPL or the IOS goal	11.75% gap closure
DY10	MPL plus 15% gap closure between the MPL and HPL	The greater absolute value of improvement between: 25% gap closure towards HPL, or baseline plus (minus) 10% of the difference between the HPL and MPL	The lesser absolute value of improvement of baseline plus (minus) 10% of the difference between the HPL and MPL or the IOS goal	12.5% gap closure*

* Innovative Measure F1-T03 continued in DY9-10 will be treated as an IOS measure in DY10 and will have a gap closure of 12.5% over baseline unless an alternate goal based on benchmark data is recommended by the measure steward as part of the measure validation process.

P4P Measure Goals for Measures Newly-Selected for DY9-10

	QISMC - Baseline below MPL	**QISMC** - Baseline equal to or greater than the MPL and lower than the HPL	**QISMC** - Baseline equal to or greater than the HPL	**IOS**
DY9	MPL plus 2.5% gap closure between the MPL and HPL	The greater absolute value of improvement between: 10% gap closure towards HPL, or baseline plus (minus) 4% of the difference between the HPL and MPL	The lesser absolute value of improvement of baseline plus (minus) 4% of the difference between the HPL and MPL or the IOS goal	5% gap closure
DY10	MPL plus 10% gap closure between the MPL and HPL	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	The lesser absolute value of improvement of baseline plus (minus) 8% of the difference between the HPL and MPL or the IOS goal	10% gap closure*

*Innovative Measure FI-T03 newly selected in DY9-10 will be treated as an IOS measure in DY10 and will have a gap closure of 10% over baseline unless an alternate goal based on benchmark data is recommended by the measure steward as part of the measure validation process.

b. In cases where a Performing Provider has significant denominator volume and no measurable 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 for DY7-8 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. For measures approved for a baseline numerator of 0 that are continuing in DY9-10, the DY9-10 goals are determined according to the table in paragraph 24.a. using an updated baseline that is set at the PY1 rate. Measures approved to report with a numerator of 0 in DY7-8 will have standard baseline and PY measurement periods as described in paragraph 21.

25. 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 for DY7-8. Category D may be increased to 15 percent of a Performing Provider's total valuation if the requirements under paragraph 25.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. Category D is valued at 15 percent of a Performing Provider's total valuation for DY9-10.

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

VII. DISBURSEMENT OF DSRIP FUNDS FOR DY7-10

26. 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.

27. Category A - Eligibility for DY7-10 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 next reporting period may be withheld until Category A is completed.

28. 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 18.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); 75% of valuation for achievement of 75% - 89% of goal; or 50% of valuation for achievement of 50% - 74% of goal. A Performing Provider will not earn any payment for maintaining less than 50% of its MLIU patient population. For DY9-10 MLIU PPP, partial payment will be tiered in the following manner: 100% valuation for achievement at 100% of goal (with allowable variation) and remaining valuation

at quartiles based on maximum allowable variation, as determined by HHSC. For example, if allowable variation is 30%, then a provider would earn 100% of valuation for achieving 70% -100% of the provider's goal; or 50% of valuation for achieving 50% - 69% of the goal.

29. 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, PY3, and PY4. The achievement value is multiplied by the milestone valuation to determine payment. 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. For DY9-10, hospital safety measures as identified in Attachment R, "Measure Bundle Protocol" with perfect performance at baseline are eligible for full payment based on maintenance of high performance. If maintenance of high performance is achieved, the achievement milestone is assigned an achievement value of 1.0. Perfect performance at baseline is one in which no numerator cases are reported during the baseline measurement period with one or more eligible denominator cases. Maintenance of high performance is defined as an increase of one numerator case that was not preventable during a performance year. Each provider eligible for maintenance of high performance may determine a valid definition for a numerator case that is not preventable and will submit

documentation to HHSC if reporting maintenance of high performance in a performance year.

iii. The percent of the goal achieved for DY7-10 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)
  - DY9 achievement = (PY3 Achieved - Baseline)/(DY9 Goal - Baseline)
  - Carryforward of DY9 achievement = (PY4 Achieved - Baseline)/(DY9 Goal - Baseline)
  - DY10 achievement = (PY4 Achieved - Baseline)/(DY10 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)
  - DY9 achievement = (Baseline - PY3 Achieved)/(Baseline - DY9 Goal)
  - Carryforward of DY9 achievement = (Baseline - PY4 Achieved)/(Baseline - DY9 Goal)
  - DY10 achievement = (Baseline - PY4 Achieved)/(Baseline - DY10 Goal)

iv. For measures selected for DY7-10, the PY3 achievement value for DY9 achievement milestones and DY8 carryforward achievement milestones will be based on the greater of:
- Provider's approved DY8 achievement value for the measure;
- Average approved DY8 achievement value for the measure if 10 or more providers selected the P4P measure for DY7-8,rounded down to the quartile;

- Average approved DY8 achievement value for the Measure Bundle if less than 10 providers selected the P4P measure for DY7-8, rounded down to the quartile; or
- Percent of DY9 goal achieved as described in paragraph 29.b.iii for DY9 achievement and carryforward of DY9 achievement plus achievement value as described in paragraph 29.b.i.

v. For measures newly-selected for DY9-10, the PY3 achievement value for DY9 achievement milestones will be based on the greater of:
   - Average approved DY8 achievement value for the measure if 10 or more providers selected the P4P measure for DY7-8, rounded down to the quartile;
   - Average approved DY8 achievement value for the Measure Bundle if less than 10 providers selected the P4P measure for DY7-8, rounded down to the quartile; or
   - Percent of DY9 goal achieved as described in paragraph 29.b.iii for DY9 achievement and carryforward of DY9 achievement plus achievement value as described in paragraph 29.b.i.

30. 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 for the measure.

31. 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 for DY7-10 measures and until the first reporting period of DY10 for DY9-10 new measures. 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, the DY8 goal achievement milestone can be achieved in PY2 or PY3, the DY9 goal achievement can be achieved in PY3 or PY4, and the DY10 goal achievement can be achieved in PY4. For DY7-10 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. For new DY9-10 measures with a delayed baseline measurement period, the DY9 goal achievement and DY10 goal achievement can only be achieved in PY4. 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, 2021, DSRIP payment may be claimed after this point, subject to the carry-forward provisions in this section (e.g. final DSRIP payments will be made in January 2023).

32. 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.

33. 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.

34. Withdrawal of a Performing Provider

If a Performing Provider withdraws from DSRIP during the RHP Plan Update submission for DY7-8 or in DY7, DY8, DY9, or DY10, then the funding may not be transferred to other Performing Providers or to the RHP.

If a Performing Provider withdraws after the RHP Plan Update submission for DY9-10, then all DY9-10 DSRIP payments received prior to the withdrawal are recouped and the provider forfeits any remaining DY9-10 DSRIP payments.

VIII. RHP AND STATE REPORTING REQUIREMENTS

35. RHP Reporting in DY7-10

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 DY7-10." 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.

<u>Reporting Exceptions</u>

HHSC and CMS may allow a subset of Category B-D milestones to be fully reported after the reporting period. In such instances, HHSC and CMS will designate those milestones as "provisionally approved." Performing Providers will be required to report in full to HHSC such "provisionally approved" milestones prior to when HHSC processes payments for the next reporting period. HHSC will report to CMS which milestones were "provisionally approved."

For milestones that are "provisionally approved," the Performing Provider will be eligible for full DSRIP payment or payment based on historic achievement, thereby waiving the requirements under paragraphs 27, 28, 29, and 30. For Category B carryforward, payments are based on the most recently reported DY achievement levels. Category C reporting milestones and carryforward of achievement milestones are eligible for full DSRIP payment. If a Category C carryforward milestone is provisionally approved, then the measure's reporting milestone is not eligible for provisional approval. Category D milestones are eligible for full DSRIP payment.

After a "provisionally approved" milestone is fully reported, HHSC will request, if necessary, additional information regarding the data reported by the Performing Provider for each milestone. Additional payments may also be made based on full reporting. If the initial supporting documentation, and any additional information reviewed by HHSC, does not form a sufficient basis for actual milestone achievement, HHSC will recoup the associated overpayments from the Performing Provider. If the Performing Provider does not comply with the recoupment, future Medicaid payments will be withheld.

36. 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 35 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.

37. 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 DY7-10. 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.

38. Learning Collaborative Plans

Recognizing the importance of learning collaboratives in supporting continuous quality improvement, RHPs will submit learning collaborative plans with the RHP Plan Updates, to reflect opportunities and requirements for shared learning among the DSRIP Performing Providers in the region. The DY7-8 and DY9-10 learning collaborative plans 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 or DY9-10 learning collaborative plan. HHSC will develop a template for submission of RHP learning collaborative plans.

39. 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 42(c);

ii. Expenditure projections reflecting the expected pace of future disbursements for each RHP and Performing Providers; and

iii. 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

40. 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.

41. 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.