DRAFT DY2 Reporting – Companion Document

Contents

Key Points for October 2013 Reporting

Each DSRIP provider should review this entire Companion document to understand the guidelines for how to report DSRIP achievement for the October DY2 reporting period. Below are several critical points HHSC wants to highlight from the document.

- You should not report a metric/milestone as completed until it is completed. For August reporting ONLY, if a provider reported a milestone as completed that actually has not been completed, there will be a one-time opportunity in October to change the status to "No-Partially Completed" in order to carry forward that metric for late achievement reporting in DY3. If a provider reports a metric/milestone as completed in October and it does not supply adequate supporting documentation either in October or December for HHSC/CMS to approve it, the provider will no longer be eligible for payment for that metric/milestone. This applies to DY3-5 reporting as well. (pp. 4-5)

- All providers are required to provide semi-annual report information in the October DY2 Reporting Template for every project regardless of whether the milestone/metric was reported for payment in August or October or will be carried forward to DY3. DSRIP payments may be withheld until the complete report is submitted. (pp. 3-4)
  - "Overall Provider Summary" tab
  - In each Project tab:
    - "DY2 – Project Summary" section – all questions must be answered for each Category 1 or Category 2 DSRIP project.
    - "Progress Update" field – must be completed for each Category 1 or Category 2 metric and each Category 3 milestone.

- Pp. 5-7 of the Companion contains a list of clarifications for October reporting. Read the list carefully as it contains updated information from the previous Companion regarding what HHSC/CMS expect to see for October reporting.

- There will be two ways to earn DY2 Category 3 DSRIP funds during October reporting Since CMS and HHSC have not yet agreed to a revised menu of Category 3 measures for the RHP Planning Protocol and since the standard target setting methodology for Category 3 outcomes also hasn't been determined. You may either report on the Category 3 milestones as outlined in the approved project or provide a status update regarding the provider's planning for Category 3 using the 'Category 3 October DY 2 Reporting Template'. (p. 8)

Overview

This document includes information on DY2 reporting clarifications for the second DY 2 reporting period in October 2013 including Category 3 instructions, timelines, metrics reporting, and guidance on supporting documentation. This guidance is for DY2 reporting only. Guidelines will be updated beginning in DY3 based on HHSC and CMS review of DY2 reporting and data documentation. For technical instructions on completing the DY 2 reporting template, please refer to the *DY2 Reporting Template Instructions*.

There are two opportunities to report progress on metrics in DY 2: August and October 2013. All projects approved by CMS are eligible for October reporting.

There are 48 Category 1 or 2 projects that as of October 4, 2013 are pending a CMS decision. HHSC has indicated in red which projects are pending CMS approval at the beginning of each Project tab. If a pending project that CMS has not approved yet (Table 6 in the initial CMS review letters) is not approved by CMS in October, HHSC will not approve the reported milestones and metrics during the November review of October reports. If a pending project was initially approved by CMS at a lower value than the provider proposed (Table 5 in the initial CMS review letters), HHSC has included the project in the template for now at the lower CMS-proposed value. If in October CMS approves the original project value, HHSC will correct that information for the project so that it is eligible to earn its full DY2 approved value for the October reporting period.

DY2 reporting is a manual process using Excel templates. For DYs 3-5, HHSC has contracted with Cooper Consulting to develop an automated web-based system for providers to enter information and upload documents. The automated system will be able to generate reports that provide reported data that can be imported into other systems.

Required semi-annual progress reports

According to the Program Funding and Mechanics Protocol, paragraph 16 (which is incorrectly labeled paragraph 36 on page 648 of the waiver amendment approved September 6, 2013) , semi-annual progress reports must be submitted to HHSC and CMS. DSRIP payments may be withheld until the complete report is submitted. To meet this requirement, **all providers are required to complete the following in the October DY2 Reporting Template for every project regardless of whether the milestone/metric was reported for payment in August or October or will be carried forward to DY3**:

- "Overall Provider Summary" tab
- In each Project tab:

- "DY2 – Project Summary" section – all questions must be answered for each Category 1 or Category 2 DSRIP project.
- "Progress Update" field – must be completed for each Category 1 or Category 2 metric and each Category 3 milestone. This should be a succinct summary (one to several sentences as needed), e.g.:
    - (If completed) - Two pediatricians were hired in April 2013 and they have begun to serve patients at the neighborhood clinic.
    - (If in progress) – One pediatrician was hired in April 2013. We continue to advertise for the second pediatrician and hope to have them hired by the end of 2013.
    - (If not completed yet) – We began to advertise to hire the two pediatricians when CMS approved the project in May 2013. We are interviewing now, but have not yet hired either pediatrician. The goal is to have both of them hired and serving patients by the first quarter of 2014.

HHSC review of August reports

If you reported progress in the August DY2 reporting template, HHSC and CMS have completed their review and marked the milestone/metric as "Approved" or "Needs More Info" in the "Aug Reporting HHSC Signoff" field. If the milestone/metric is marked as "Needs More Info", HHSC has provided comments in the "Aug Reporting HHSC Comments" field to explain why additional information is needed to approve the reported achievement. "Approved" milestones/metrics will be included in the November payment processing of August reports. For "Needs More Info" milestones/metrics, providers must respond to HHSC comments within the October DY2 Reporting Template by completing the following:

- Enter "Yes-Completed" in "Achieved in Oct Reporting" field.
- If the "Goal Type" is "Number" or "Percentage", enter the numeric goal in "Oct Reporting Progress" field.
- Update "Goal Calculation (if applicable)" field.
- Complete "Progress Update" field.
- Complete "Supporting Attachments" field and submit applicable documentation.

HHSC and CMS will review and approve or deny the additional information submitted in response to HHSC comments on August reported milestone/metric achievement by December 6, 2013. If the additional information is not approved, the DY2 DSRIP funding associated with the milestone/metric will no longer be available for payment.

For “Needs More Info” milestones/metrics, if you do not have the additional information required to support that the milestone/metric has been achieved for October reporting, , then you may carry forward the milestone/metric to report in DY3 by completing the following:

- Enter “No-Partially Completed” in “Achieved in Oct Reporting” field.
- Complete “Progress Update” field.
- Complete “Carryforward Questions (Oct reporting only)” for each applicable milestone/metric.

**Note that this opportunity to carry forward August milestones/metrics marked as “Needs More Info” will only be allowed for August DY2 reporting. October DY2 reported milestone/metric completion will not be allowed to carry forward for late achievement in DY3 if reported as completed in October and the provider is unable to supply supporting documentation to demonstrate it met the milestone/metric by the date in December specified by HHSC.

This applies to DY3-5 as well – the provider should not report a milestone/metric as completed until it is completed, and will have one additional opportunity after initially reporting it completed to supply the required supporting documentation to be eligible for payment for that metric.

Based on HHSC review of August reports, below are clarifications for October reporting:

Much of this information is repeated in the Additional Guidance and Supporting Documentation sections.

Supporting Documentation

- Include dates in supporting documentation (e.g. date a community assessment was completed, date of hire, date a plan was approved). The date should not just be a date reflecting when the supporting documentation was prepared.
- Include the related Project ID in the file name of supporting documentation.
- Clearly identify within the supporting documentation what metric is being met with the documentation and a brief description of how it is being met. This can be provided through a coversheet included with the supporting documentation or in the documentation header. Also, highlight relevant information within the supporting documentation where the support for achieving a particular metric is one section in a larger document.
- Review supporting documentation carefully to ensure no Protected Health Information (PHI) is included. Additional information on PHI is included in the Warning Notice at the end of this document.

- If a link is being provided as supporting documentation, provide an attachment that includes the link (don't just include the link in a cell in the reporting template), include a description of what is being linked to, and direct HHSC to what should be reviewed on the website.
- Handwritten notes will not be accepted as supporting documentation (other than for sign-in sheets from meetings).

Additional Guidance Specific to October DY2 Reporting

- HHSC has updated guidance that DY1 achievement (December 11, 2011 – September 30, 2012) of metrics may be allowable for DY2 metrics if the State deems appropriate; however, providers also should be aware that early achievement of metrics is a criterion that will be looked at in the mid-point assessment review.
- For DY2 reporting, HHSC will accept some variance in metrics such as fewer quarterly meetings or quarterly meetings that are not scheduled quarterly due to the late approval of projects. However, in DY3, HHSC expects meetings to be scheduled and completed as stated in the goals. Beginning in DY3, HHSC will require that metrics regarding meetings include agendas and minutes or summaries of meetings.
- For metrics involving learning collaboratives (including regional learning collaboratives), documentation for October must include the agenda and sign in sheet to demonstrate participation. Beginning in DY3, a summary must also be included for topics discussed and lessons learned relevant to the project.

Additional General Guidance

- For reporting on Category 3 milestones, the supporting documentation should demonstrate that the provider met the milestone as it relates to the specific Category 3 measure (not just the Category 1 or 2 project with no reference to planning related to the Category 3 measure). For example, for a planning milestone, the provider should demonstrate its planning efforts for the project specific to the Category 3 measure.
- If the same or similar documentation is used to support multiple metrics, clearly differentiate how each metric was met with similar documentation (e.g. if a metric is using the same curriculum across multiple clinics or for two different chronic care management programs, then demonstrate how different staff were trained on the same curriculum).
- If a provider has similar projects in more than one region and the supporting documentation is also the same, then the provider must include an explanation that the documentation is the same, and include the other project(s) applicable IDs for the documentation. HHSC will review on a case-by-case basis. This may be allowable for

process metrics when consistent with the approved project. For metrics that report number of patients served, documentation must be provided specific to the patients served in the region. Information is also provided on the Additional Guidance section of this document.

- If a provider is deviating from a metric, then an explanation is required in the "Progress Update" field (e.g. Project Area 1.3, Metric P-1.1 requires number of patients entered in the registry; provider requests that metric be met with number of patients identified in target population to be entered in the registry, not those actually entered). HHSC will review the request using both the approved project language and the RHP Planning Protocol and submit the request to CMS for approval if deemed appropriate. If approved, payment for the requested deviation may be made in the following reporting period (e.g. requested in October 2013, payment would be made with April 2014 reporting period, estimated to be in July 2014). Providers should be aware that beginning in October, once a metric/milestone is reported as completed, the provider will only have one additional opportunity after HHSC/CMS review the supporting documentation to demonstrate that the metric/milestone has been completed (see pg. 5).

Category 3 Instructions for October 2013

Since CMS and HHSC have not yet agreed to a revised menu of Category 3 measures for the RHP Planning Protocol and since the standard target setting methodology for Category 3 outcomes also hasn't been determined, providers will have two ways to earn their unearned DY2 Category 3 funds during October reporting.

1. First, for approved Category 3 measures, you may earn Category 3 funds by reporting on the Category 3 milestones outlined in the approved project (e.g. P-1 Project Planning, P-2 Establish baseline rates, P-3 Develop and test data systems). Reporting for these milestones should be specific to the relevant Category 3 measure.

2. Alternately, for approved, not-yet-approved, or TBD Category 3 measures, you may earn DY2 Category 3 funds not earned in August by instead providing a status update regarding the provider's planning for Category 3 using the 'Category 3 October DY 2 Reporting Template' provided by HHSC. The template must be included in supporting documents using the file naming convention as stated in the DY2 Reporting Template. The template requires the following items. You should provide a response for each question, using 'N/A' if not applicable.
    - Provide a brief update on the status of this measure and your planning related to it. If it is a measure that is not yet approved by CMS, you can state that.
    - Indicate if you plan to change the Category 3 Improvement Target measure.
    - If you are proposing a change, please describe which alternate Category 3 measure you are considering and why you would change to that measure (including why it is appropriate for the project and that you have the data available to report on it). Use the *Draft Revised Category 3 Quality Improvements* spreadsheet (updated 9/11/13) located on the Tools and Guidelines for RHP Participants page on HHSC's website for the list of Category 3 measures you may choose from to answer this question.
    - How are you planning to define the target population for the denominator of the measure? (More guidance will be forthcoming from CMS/HHSC on this issue, but state how you would propose to define the target population for the measure based on the Category 3 guidance available to date.)
    - Provide any baseline information available on the measure you are considering using. (If in an attachment, please list the name of the attachment.) If no baseline information is available, please note that.

If you opt to provide the status update and it is approved as complete, then all of the outstanding DY2 milestones associated with the relevant Category 3 measure will be approved for payment for October reporting.

If you opt to provide the status update, when you report Category 3 achievement in DY3, you won't be paid again for a DY2 milestone for which you opted to provide a status update in October 2013, but it will be assumed that you would need to have done whatever was necessary to get to the reporting point for the DY3 milestone. For example, if you were to have set a baseline in DY2 to show improvement in DY3, when you report improvement in DY3, you will also need to demonstrate that you set the baseline.

October Reporting Timeline

- October 7, 2013 – HHSC will post individual provider *DY 2 Reporting Templates* by RHP on the waiver website under Tools and Guidelines for Regional Healthcare Partnership Participants.
- October 25, 2013 – Final date to inform HHSC of projects or milestones/metrics missing from the October DY2 Reporting Template.
- **October 31, 2013, 5:00pm** – Due date for providers' October DY 2 DSRIP reporting using the *DY 2 Reporting Templates*. Responses to HHSC requests for more information on August reported milestone/metric achievement must also be submitted with the October reports. Late submissions will not be accepted. Please submit the completed template and supporting documentation using one of the following:
    - Email the completed files to DY2DSRIP@deloitte.com (files may not exceed 5MB, please zip large files) with SUBJECT: RHP [XX], Provider [TPI: XXXXXXXXX]; or
    - Email a link(s) to the files to DY2DSRIP@deloitte.com if you have access to an FTP site (e.g. SharePoint, Dropbox) with SUBJECT: RHP [XX], Provider [TPI: XXXXXXXXX]; or
    - Mail a CD containing all files to:

      Tim Egan
      50 South 6th Street, Suite 2800
      Minneapolis, MN 55402

  Deloitte will notify providers of received materials within two business days.
- November 1, 2013 – HHSC will begin review of the October DY 2 reports and supporting documentation.
- November 6, HHSC will share regional summary files of providers' reported progress from the DY2 provider templates for IGT Entities and Anchors to review. If supporting documentation is needed, IGT Entities and Anchors must request them from their Performing Providers directly.
- **November 15, 2013, 5:00pm** – Due date for IGT Entity to notify HHSC (TXHealthcareTransformation@hhsc.state.tx.us) of any issues with their affiliated providers' October DY 2 reported progress on metrics using the *IGT Entity Feedback* template. If there are no issues, a template does not need to be submitted.
- December 6, 2013 – HHSC and CMS will complete their review and approval of October DY 2 reports or request additional information regarding the data reported. If additional information is requested, the DY 2 DSRIP payment related to the milestone/metric will be delayed until the next DSRIP payment period. HHSC and CMS will also approve or deny the additional information submitted in response to HHSC comments on August reported milestone/metric achievement.

- January 3, 2014 – Due date for providers to submit responses to HHSC comments on October reported milestone/metric achievement.
- January 24, 2014 – HHSC and CMS will approve or deny the additional information submitted in response to HHSC comments on October reported milestone/metric achievement.
- Early January 2014 – IGT due for October DY 2 DSRIP payments.
- Late January 2014 – October DY 2 DSRIP payments processed.

Payment Calculations

(as stated in the Program Funding and Mechanics Protocol, paragraphs 29-30)

Categories 1 and 2

With respect to Categories 1-2, a milestone bundle is the compilation of milestones and related metrics associated with a project in a given year. The amount of the incentive funding paid to a Performing Provider will be based on the amount of progress made within each specific milestone bundle. A Performing Provider must fully achieve a Category 1 or 2 metric to include it in the incentive payment calculation.

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

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

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

Example of Category 1 or 2 disbursement calculation:

A Category 1 Project in DY 2 is valued at $3 million and has 5 milestones, which make up the Milestone Bundle. Under the payment formula, the 5 milestones represent a maximum achievement value of 5.

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

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

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

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

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

Milestone 3: 0 percent achievement (Achievement value = 0)

- Metric 1: Not Achieved

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

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

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

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

Total achievement value at 6 months = 2.25

Disbursement at 6 months = $3M x (2.25/5) = $1.35 million

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

Disbursement at 12 months is $3 million - $1.35 million = $1.65 million.

Category 3

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

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

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

Example of Category 3 disbursement calculation:

A hospital Performing Provider has set outcome improvement targets that would decrease potentially preventable readmissions for a target population with a chronic condition by 2 percent in DY 4 and by 5 percent in DY 5.

In DY 4, the Performing Provider achieved a 1 percent reduction in PPR, short of its goal. Under the partial payment policy, the provider would be reimbursed 50 percent of the incentive payment associated with this outcome improvement target because it achieved 50 percent of the target. The Performing provider may earn the remaining DY 4 incentive payment for the outcome improvement target in the following year (DY 5) under the carry-forward policy.

Category 4

In DY 2, a hospital Performing Provider participating in Category 4 reporting shall be eligible to receive an incentive payment equal to 5 percent of its total allocation amount in DY 2 upon submission to HHSC of a status report that describes the system changes the hospital is putting in place to prepare to successfully report Category 4 measures in DYs 3-5.

Other DY 2 Updates

Contact changes: The representative(s) for each organization listed in Section I. of the RHP Plan is the person who is contacted regarding RHP issues including IGT requests and notification of payments. If you have changes to the contacts listed in Section I. of the RHP Plan, please complete the *RHP Contact Change Form* available at http://www.hhsc.state.tx.us/1115-docs/RHP/Plans/Contact-Change.pdf.

IGT Entity changes: The IGT Entity(ies) for each project/improvement target is listed in the October DY2 Reporting Template in each Project tab under "DY2 – Category X IGT Entity Name". If you have changes to the IGT Entity, either in Entity or proportion of payment among IGT Entities, listed in the October DY2 Reporting Template, please complete the *IGT Entity Change Form* available at http://www.hhsc.state.tx.us/1115-docs/RHP/Plans/IGT-Change.xlsx. Complete one form for each IGT Entity. IGT Entity changes must be received no later than **October 31, 2013,** for October DY 2 DSRIP payment processing. Any changes received after October 31, 2013, will go into effect for the April DY3 DSRIP reporting and payments will be delayed until that time.

Additional Guidance for DY2 Metrics Reporting

Providers Performing Projects in Multiple Regions: For Categories 1, 2, and 3, reporting of number served and other applicable data should be specific to each region. If the same supporting documentation is used for projects in multiple regions, the provider must include an explanation that the documentation is the same, and include the other project(s)' applicable IDs for the documentation. HHSC will review on a case-by-case basis. This may be allowable for process metrics when consistent with the approved project.

Providers Hiring Staff for Multiple Projects: For Categories 1 and 2, providers should not report the same achievement for multiple projects. For example, if a provider reports under two different projects that the provider is hiring one physician and one office manager, the provider should clearly explain if the physician and office manager are the same for both projects or if there are two of each. Overlap between projects will be closely reviewed and may not be approved.

Providers Using Same Needs Assessment for Multiple Projects: Providers may submit the same community needs assessment as applicable for multiple projects. However, providers will be expected to clearly highlight and distinguish how the needs assessment addresses each specific project being discussed.

Providers Establishing Additional Clinics Providing Multiple Types of Services: For providers establishing additional clinics, expanding existing clinics, or relocating clinics (Project Option 1.1, Milestone P-1), if the clinic will be used for multiple types of services (e.g., OB/GYN and primary care), the provider should clearly explain how the clinic is utilized for the different services.

Providers Establishing a Care Transitions Protocol for Multiple Projects: For providers developing a care transitions protocol (Project Option 2.12) for multiple projects, the provider should clearly explain how the protocols are different for each project based on the population served, setting, etc.

General Guidance for Supporting Documentation Used for Multiple Metrics: If the same or similar documentation is used to support multiple metrics, clearly differentiate how each metric was met with similar documentation (e.g. if a metric is using the same curriculum across multiple clinics or for two different chronic care management programs, then demonstrate how different staff were trained on the same curriculum).

Learning Collaboratives: For metrics involving learning collaboratives (including regional learning collaboratives), documentation for October must include the agenda and sign in sheet to demonstrate participation. Beginning in DY3, a summary must also be included for topics discussed and lessons learned relevant to the project.

Deviation from a Metric: If a provider is deviating from a metric, then an explanation is required in the "Progress Update" field (e.g. Project Area 1.3, Metric P-1.1 requires number of patients entered in the registry; provider requests that metric be met with number of patients identified in target population to be entered in the registry, not those actually entered). HHSC will review the request using both the approved project language and the RHP Planning Protocol and submit the request to CMS for approval if deemed appropriate. If approved, payment for the requested deviation may be made in the following reporting period (e.g. requested in October 2013, payment would be made with April 2014 reporting period, estimated to be in July 2014). Providers should be aware that beginning in October, once a metric/milestone is reported as completed, the provider will only have one additional opportunity after HHSC/CMS review the supporting documentation to demonstrate that the metric/milestone has been completed (see pg. 5).

Supporting Documentation

Please refer to the RHP Planning Protocols for Categories 1, 2, and 3 for guidance regarding types of supporting documentation and data sources for each metric. The planning protocols are available at the following link: http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml.

Additional guidance is provided below for many of the most commonly selected milestones and metrics. Note: this guidance is regarding information that should be included in supporting documentation. HHSC is not prescribing the format of documentation for DY2 (e.g. outline of gap assessments, format of meeting agendas/sign-ins).

- Include dates in supporting documentation (e.g. date a community assessment was completed, date of hire, date a plan was approved). The date should not just be a date reflecting when the supporting documentation was prepared.
- Include the related Project ID in the file name of supporting documentation.
- Clearly identify within the supporting documentation what metric is being met with the documentation and a brief description of how it is being met. This can be provided through a coversheet included with the supporting documentation or in the documentation header. Also, highlight relevant information within the supporting documentation where the support for achieving a particular metric is one section in a larger document.
- Review supporting documentation carefully to ensure no Protected Health Information (PHI) is included. Additional information on PHI is included in the Warning Notice at the end of this document.
- If a link is being provided as supporting documentation, provide an attachment that includes the link (don't just include the link in a cell in the reporting template), include a description of what is being linked to, and direct HHSC to what should be reviewed on the website.
- Handwritten notes will not be accepted as supporting documentation (other than for sign-in sheets from meetings).

CATEGORY 1

For any metrics requiring completion of a gap assessment, please include additional information to address the following questions:

- Is the selected project in an area of high need for the Medicaid/uninsured population?
- How would the selected project impact/benefit the Medicaid/uninsured population?

- Does the gap assessment include a clear description of what the initiative is going to focus on to address gaps?

Project Option: 1.1

Milestone: P-1 Establish additional/expand existing/relocate primary care clinics

Supporting Documentation Guidance:

- Planning Protocol:
    - Metric P-1.1: Number of additional clinics or expanded hours or space.
    - Provide documentation of detailed expansion plans.
    - Data source: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider.
- Additional Guidance:
    - For additional, expanded, or relocated primary care clinics, provide documentation such as blueprints or design plans, lease/contract, picture of facility with address, new primary care schedule, etc., as applicable. Also include narrative description in metric reporting or attach separately.
    - For new primary care providers and staff (if applicable), provide signed contract(s) or other documentation for new providers and staff with starting dates, new primary care schedule, etc. Sensitive information such as salaries may be redacted.

Project Option: 1.1

Milestone: P-5 Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers

Supporting Documentation Guidance:

- Planning Protocol:
    - Metric P-5.1.: Documentation of increased number of providers and staff and/or clinic sites.
    - Data Source: Provide documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation.
- Additional Guidance:
    - For new primary care providers and staff (if applicable), provide signed contract(s) or other documentation for new providers and staff with starting

dates, new primary care schedule, etc. Sensitive information such as salaries may be redacted.
    - For training, provide documentation of who attended training and when.
    - For increased number of primary care clinics, provide documentation such as blueprints or design plans, lease/contract, picture of facility with address, new primary care schedule, etc., as applicable. Also include narrative description in metric reporting or attach separately.

Project Option: 1.1

Milestone: P-4 Expand the hours of a primary care clinic, including evening and/or weekend hours

Supporting Documentation Guidance:

- Planning Protocol:
    - Metric P-4.1: Increased number of hours at primary care clinic over baseline.
    - Data source: Clinic documentation.
- Additional Guidance:
    - For expanded hours at existing clinics, provide documentation of previous schedule and new schedule.
    - For new primary care providers and staff (if applicable), provide signed contract(s) or other documentation for new providers and staff with starting dates, new primary care schedule, etc. Sensitive information such as salaries may be redacted.

Project Option: 1.2

Milestone: P-2 Expand primary care training for primary care providers, including physicians, physician assistants, nurse practitioners, registered nurses, certified midwives, case managers, pharmacists, dentists

Supporting Documentation Guidance:

- Planning Protocol:
    - Metric P-2.2: Hire additional precepting primary care faculty members. Demonstrate improvement over prior reporting period (baseline for DY2).
    - Provide documentation of applications and agreements to expand training programs.
    - Data source: Training program documentation.
- Additional Guidance:

- For new primary care faculty members, provide signed contract(s) or other documentation with starting dates.

Project Option: 1.9

Milestone: P-1 Conduct specialty care gap assessment based on community need

Supporting Documentation Guidance:

- Planning Protocol:
  - Metric P-1.1: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2).
  - Document gap assessment.
  - Data source: Needs Assessment.
- Additional Guidance:
  - In the gap assessment, the questions outlined in Appendix C of the *CMS Initial Review Findings: Companion Instructions for Resubmission to CMS* should also be addressed: http://www.hhsc.state.tx.us/1115-docs/RHP/Plans/companion.pdf

Project Option: 1.9

Milestone: P-11 Launch/expand a specialty care clinic (e.g., pain management clinic)

Supporting Documentation Guidance:

- Planning Protocol:
  - Metric P-11.1: Establish/expand specialty care clinics.
  - Document number of patients served by specialty care clinics.
  - Data source: documentation of new/expanded specialty care clinic.
- Additional Guidance:
  - For additional or expanded specialty care clinics, provide documentation such as blueprints or design plans, lease/contract, picture of facility with address, new specialty care schedule, etc. Also include narrative description in metric reporting or attach separately.
  - For new specialty care providers and staff (if applicable), provide signed contract(s) or other documentation for new providers and staff with starting dates, new primary care schedule, etc. Sensitive information such as salaries may be redacted.
  - For number of patients served, provide narrative description with data reports to show previous number of patients and expanded number of patients.

Project Option: 1.12

Milestone: P-3 Develop administrative protocols and clinical guidelines for projects selected (i.e., protocols for a mobile clinic or guidelines for a transportation program).

Supporting Documentation Guidance:

- Planning Protocol:
  - Metric: Manual of operations for the project detailing administrative protocols and clinical guidelines
  - Data source: Administrative protocols; clinical guidelines
- Additional Guidance:
  - Provide administrative protocols and clinical guidelines for individual projects based on protocols and guidelines offered by professional associations relevant to the project option domain or based on protocols or guidelines adapted from other states, etc. As applicable, Manual of operations should clearly outline the process related to the services provided, including:
    - who is eligible for services
    - when, how and by whom services will be provided
    - processes around project documentation
    - procedures related to patient follow-up

CATEGORY 2

Project Option: 2.2

Milestone: P-3 Develop a comprehensive care management program

Supporting Documentation Guidance:

- Planning Protocol:
  - Metric P-3.2: Increase the number of patients enrolled in a care management program over baseline.
  - Provide number of patients enrolled in a care management program.
  - Data source: Program enrollment records.
- Additional Guidance:
  - Describe what services are provided in the comprehensive care management program, which patients are eligible, how patients are identified and processes around patient enrollment in the care management program.
  - For number of patients enrolled, provide narrative description with data reports to show baseline number of patients receiving care management services and

expanded number of patients receiving care management services. When possible, provide detail around frequency of services used and other relevant trends in utilization.

Project Option: 2.6

Milestone: P-2 Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community.

Supporting Documentation Guidance:

- Planning Protocol:
  - Metric P-2.1: Document innovational strategy and plan.
  - Data source: Performing Provider evidence of innovational plan.
- Additional Guidance:

Also provide narrative description of how priority interventions were identified, including how the selected priority intervention(s) address the needs assessment and the anticipated impact of the interventions on the target population.

Project Option: 2.7

Milestone: P-1 Development of innovative evidence-based project for targeted population

Supporting Documentation Guidance:

- Planning Protocol:
  - Metric P-1.1: Document innovational strategy and plan.
  - Provide documentation of innovational strategy and plan.
  - Data source: Performing Provider evidence of innovational plan.
- Additional Guidance:
  - Also provide narrative description of how target population was identified, including a description of how evidence based guidelines or interventions have been adapted to fit the target population.

Project Option: 2.8

Milestone: P-1 Target specific workflows, processes and/or clinical areas to improve

Supporting Documentation Guidance:

- Planning Protocol:

    - Metric P-1.1: Performing Provider review and prioritization of areas or processes to improve upon.
    - Submit Performing Provider report of review and prioritization of areas or processes to improve upon.
    - Data source: TBD by Performing Provider.
- Additional Guidance:
    - Provide narrative description of methods used to identify specific workflows, processes, and/or clinical areas were selected for improvement, e.g., Process mapping, root cause analysis, fishbone diagrams, Pareto Analysis, Force field analysis, etc.
    - Provide narrative description of activities and what will be achieved.

Project Option: 2.13

Milestone: P-2 Design community-based specialized interventions for target populations.

Supporting Documentation Guidance:

- Planning Protocol:
    - Metric P-2.1: Project plans which are based on evidence / experience and which address the project goals.
    - Document project plans based on evidence/experience and which address the project goals.
    - Data source: Project Documentation.
- Additional Guidance:
    - In project documentation, provide narrative description of how target population was identified, including a description of how evidence based guidelines or interventions have been adapted to fit the target population.

Project Option: 2.15

Milestone: P-2 Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both in new settings or for physicians to share their office space with behavioral health practitioners.

Supporting Documentation Guidance:

- Planning Protocol:

    - Metric P-2.1: Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations.
    - Document discussions/interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations.
    - Data source: Information from persons interviewed.
- Additional Guidance:
    - Provide list of interviews and analysis of interview results.

Project Option: 2.15

Milestone: P-3 Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa

Supporting Documentation Guidance:

- Planning Protocol:
    - Metric P-3.1: Provide documentation of number and types of referrals that are made between providers at the location.
    - Metric P-3.2: Provide documentation of number of referrals that are made outside of the location.
    - Metric P-3.3: Provide documentation of number of referrals which follow the established standards.
    - Data source for all metrics: Surveys of providers to determine the degree and quality of information sharing; review of referral data and survey results.
- Additional Guidance:
    - Also submit standards that were developed and implemented.

CATEGORY 3

NOTE: See the section on Category 3 Instructions for October 2013 on options for reporting Category 3 milestones this reporting period. If the provider opts to report the individual Category 3 milestones as described in its plan, then it should follow the below guidance. All Category 3 milestones reported should demonstrate activities carried out specific to the Category 3 measure, not just the associated Category 1 or 2 project.

Process Milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

Supporting Documentation Guidance:

- Provide project planning documents such as timelines, implementation plans, and other planning documents as applicable, including a description of how plans were developed with stakeholder engagement; how priority issues/opportunities were identified; who (individuals or organizations/institutions) will have a role to play in the project outcomes; etc.

Process Milestone P-2: Establish baseline rates

Supporting Documentation Guidance:

- Identify one or more target populations for which the outcome will be measured.
- Provide baseline rates with narrative description of how baseline rates were established.

Process Milestone P-3: Develop and test data systems

Supporting Documentation Guidance:

- Provide data system documentation as applicable.
- Provide narrative to describe process for identifying gaps in available data, preparing data system, and evaluating data system.
- Describe what types of data will be input into the system, who and how the data points are collected from clinical records and how data will be used to measure results in the improvement target,
- Provider may also include other outcomes of interest that relate to the project.

Process Milestone P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Supporting Documentation Guidance:

- Provide summary documentation of PDSA cycles, including key outputs from each stage of the cycle.
- Include narrative description of what was tested and why; what the intervention was trying to accomplish; how results were measured; etc.

CATEGORY 4

For Demonstration Year (DY) 2 Reporting, hospitals are required to report readiness for reporting beginning in DY3. Providers can report in either August or October 2013 for earning Category 4 DY 2 payment, if applicable.

HHSC is working with the Institute for Child Health Policy (ICHP) for hospitals to access Category 4 reporting domains RD-1 –Potentially Preventable Admissions, RD-2 – 30-day Readmissions, and RD-3 -- Potentially Preventable Complications. Hospitals will also report on readiness for the RD-4 – Patient Centered Healthcare, RD – 5 Emergency Department measures, and optional RD – 6 Initial Core Set of Health Care Quality Measures if originally indicated in the RHP Plan.

ICHP is setting up a web portal for the Medicaid Managed Care Organizations (MCOs) and plans a separate page for hospitals that are participating in Regional Healthcare Partnership Plans that will include access for each hospital's own data for Potentially Preventable Admissions, 30-Day Readmissions and Potentially Preventable Complications data. The portal would begin in January 2014. The first reporting period for DY 3 is April 2014. Providers would report the most recent data made available to them through the portal.

ICHP has indicated that either Internet Explorer v. 9 or Google Chrome as the browsers that are recommended, but others will work. In the DY 2 Reporting spreadsheet, providers can report what browser they will use to access the data. Providers can also include any other potential issues for the other Category 4 Reporting Domains.

For RDs 1-3, the measures will be generated by the risk-adjusted 3M tool by ICHP. At least initially, these measures will use Medicaid HMO encounter data, with the possibility of adding Fee-For-Service data in later years. The measurement period will be one calendar year based on data inclusive of 3 months of claims lag. Accounting for claims lag plus time for data preparation, the reported data will be available no sooner than June for the prior calendar year. Hospitals must report RDs 1 and 2 starting in DY 3 and RD-3 beginning in DY 4.

For RDs 4 and 5, it is recommended to report most recent calendar year of data available. If provider has an alternate reporting period, it can be stated in the DY 2 report for review.

For providers that are reporting on the optional RD – 6, the provider can include that they are ready to report, or any issues identified.

HHSC will be providing a template to report Category 4 data for all domains for DYs 3-5 that will be uploaded to the DSRIP web-based reporting portal that is in development. The target date for availability is early 2014, which coincides with the ICHP web portal launch.

It is also important to note that carryforward does not apply to Category 4 as it is pay for reporting, as specified in the Program Funding and Mechanics protocol.

WARNING NOTICE Regarding Submission of Supporting Documentation

All information submitted for DY 2 DSRIP reporting by Texas Healthcare Transformation and Quality Improvement Program §1115 Waiver participants is subject to the Public Information Act ("Act"), Chapter 552 of the Government Code. Certain information, such as commercial or financial information the disclosure of which would cause significant competitive harm, is excepted from public disclosure according to the Act. If you believe that the documentation submitted through this system is excepted from the Act, please note that belief at the beginning of your submission, including the particular exception you would claim.

Providers are required by the HHSC Medicaid Provider Agreement, as well as state and federal law to adequately safeguard individually identifiable Client Information. The transmission you are about to make is unsecure and will not be confidential. As such, Providers are prohibited from submitting Personally Identifiable Information about clients, HIPAA Protected Health Information or Sensitive Personal Information in connection with submittal of meeting the metric. Providers are required to only submit De-identified information [as evidence of meeting a metric]. If Provider inadvertently uploads individually identifiable client information or following discovery of an Event or Breach, Provider will notify HHSC immediately, within the first consecutive clock hour, or in a timeframe otherwise approved by HHSC in writing. Notice will be made to HHSC's Privacy and Security Officers via email at: hipaa@hhsc.state.tx.us. Provider will report all reasonably available information. Provider will cooperate fully with HHSC in investigating, mitigating to the extent practicable and issuing notifications directed by HHSC, for any event or breach of confidential information to the extent and in the manner determined by HHSC. Provider's obligation begins at the discovery of an event or data breach and continues as long as related activity continues, until all effects of the event are mitigated to HHSC's satisfaction.

Definitions

"**Breach**" means any unauthorized acquisition, access, use, or disclosure of confidential Client Information in a manner not permitted by [this incentive program] or applicable law. Additionally:

(1) HIPAA Breach of PHI. With respect to Protected Health Information ("PHI") pursuant to HIPAA regulations and guidance, any unauthorized acquisition, access, use, or disclosure of PHI in a manner not permitted by the HIPAA Privacy Regulations is presumed to be a Breach unless Provider, as applicable, demonstrates that there is a low probability that the PHI has been compromised. Compromise will be determined by a documented Risk Assessment including at least the following factors:

i. The nature and extent of the Confidential Information involved, including the types of identifiers and the likelihood of re-identification of PHI;

ii. The unauthorized person who used or to whom PHI was disclosed;
iii. Whether the Confidential Information was actually acquired or viewed; and
iv. The extent to which the risk to PHI has been mitigated.

With respect to PHI, a "breach," pursuant to HIPAA Breach Regulations and regulatory guidance excludes:

(A) Any unintentional acquisition, access or use of PHI by a workforce member or person acting under the authority of HHSC or Provider if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the HIPAA Privacy Regulations.

(B) Any inadvertent disclosure by a person who is authorized to access PHI at HHSC or Provider to another person authorized to access PHI at the same HHSC or Provider location, or organized health care arrangement as defined by HIPAA in which HHSC participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the HIPAA Privacy Regulations.

(C) A disclosure of PHI where Provider demonstrates a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information, pursuant to HIPAA Breach Regulations and regulatory guidance.

(2) Texas Breach of SPI. Breach means "Breach of System Security," applicable to electronic Sensitive Personal Information (SPI) as defined by the Texas Breach Law. The currently undefined phrase in the Texas Breach Law, "compromises the security, confidentiality, or integrity of sensitive personal information," will be interpreted in HHSC's sole discretion, including without limitation, directing Provider to document a Risk Assessment of any reasonably likelihood of harm or loss to an individual, taking into consideration relevant fact-specific information about the breach, including without limitation, any legal requirements the unauthorized person is subject to regarding confidential Client Information to protect and further safeguard the data from unauthorized use or disclosure, or the receipt of satisfactory assurance from the person that the person agrees to further protect and safeguard, return and/or destroy the data to the satisfaction of HHSC. Breached SPI that is also PHI will be considered a HIPAA breach, to the extent applicable.

(3) Any unauthorized use or disclosure as defined by any other law and any regulations adopted there under regarding Confidential Information.

"Client Information" means Personally Identifiable Information about or concerning recipients of benefits under one or more public assistance programs administered by HHSC.

"De-Identified Information" means health information, as defined in the HIPAA privacy regulations as not Protected Health Information, regarding which there is no reasonable basis to believe that the information can be used to identify an Individual. HHSC has determined that health information is not individually identifiable and there is no reasonable basis to believe that the information can be used to identify an Individual only if:

(1) The following identifiers of the Individual or of relatives, employers, or household members of the individual, are removed from the information:

(A) Names;

(B) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

(i) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(ii) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

(C) All elements of dates (except year) for dates directly related to an Individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

(D) Telephone numbers;

(E) Fax numbers;

(F) Electronic mail addresses;

(G) Social security numbers;

(H) Medical record numbers (including without limitation, Medicaid Identification Number);

(I) Health plan beneficiary numbers;

(J) Account numbers;

(K) Certificate/license numbers;

(L) Vehicle identifiers and serial numbers, including license plate numbers;

(M) Device identifiers and serial numbers;

(N) Web Universal Resource Locators (URLs);

(O) Internet Protocol (IP) address numbers;

(P) Biometric identifiers, including finger and voice prints;

(Q) Full face photographic images and any comparable images; and

(R) Any other unique identifying number, characteristic, or code, except as permitted by paragraph (C) of this section; and

(2) Neither HHSC nor Provider has actual knowledge that the information could be used alone or in combination with other information to identify an Individual who is a subject of the information."

"Discovery" means the first day on which an Event or Breach becomes known to Provider, or, by exercising reasonable diligence would have been known to Provider and includes Events or Breaches discovered by or reported to Provider, its officers, directors, partners, employees, agents, work force members, subcontractors or third-parties (such as legal authorities and/or Individuals).

"Encryption" of confidential information means, as described in 45 C.F.R. §164.304, the HIPAA Security Regulations, the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without the use of a confidential process or key and such confidential process or key that might enable decryption has not been breached. To avoid a breach of the confidential process or key, these decryption tools will be stored on a device or at a location separate from the data they are used to encrypt or decrypt.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended by the HITECH ACT and regulations thereunder including without limitation HIPAA Omnibus Rules, in 45 CFR Parts 160 and 164. Public Law 104-191 (42 U.S.C. §1320d, *et seq*.); Public Law 111-5 (42 U.S.C. §13001 *et. seq.*).

"HIPAA Privacy Regulations" means the HIPAA Privacy Regulations codified at 45 C.F.R. Part 160 and 45 C.F.R. Part 164, Subpart A, Subpart D and Subpart E.

"HIPAA Security Regulations" means the HIPAA Security Regulations codified at 45 C.F.R. Part 160 and 45 C.F.R. Part 164 Subpart A and Subpart C, and Subpart D.

"HITECH Act" means the Health Information Technology for Economic and Clinical Health Act (P.L. 111-5), and regulations adopted under that act.

"Individual" means the subject of confidential information, including without limitation Protected Health Information, and who will include the subject's Legally authorized representative who qualifies under the HIPAA privacy regulation as a Legally authorized representative of the Individual wherein HIPAA defers to Texas law for determination, for example, without limitation as provided in Tex. Occ. Code § 151.002(6); Tex. H. & S. Code §166.164; and Texas Prob. Code § 3. "Legally authorized representative" of the Individual, as defined by Texas law, for example, without limitation as provided in Tex. Occ. Code § 151.002(6); Tex. H. & S. Code §166.164; and Texas Prob. Code § 3, includes:

(1) a parent or legal guardian if the Individual is a minor;

(2) a legal guardian if the Individual has been adjudicated incompetent to manage the Individual's personal affairs;

(3) an agent of the Individual authorized under a durable power of attorney for health care;

(4) an attorney ad litem appointed for the Individual;

(5) a guardian ad litem appointed for the Individual;

(6) a personal representative or statutory beneficiary if the Individual is deceased;

(7) an attorney retained by the Individual or by another person listed herein; or

(8) If an individual is deceased, their personal representative must be the executor, independent executor, administrator, independent administrator, or temporary administrator of the estate.

"Personally Identifiable Information" or "PII" means information that can be used to uniquely identify, contact, or locate a single Individual or can be used with other sources to uniquely identify a single Individual.

"Protected Health Information" or "PHI" means individually identifiable health information in any form that is created or received by a HIPAA covered entity, and relates to the Individual's healthcare condition, provision of healthcare, or payment for the provision of healthcare, as further described and defined in the HIPAA. PHI includes demographic information unless such information is De-identified, as defined above. PHI includes without limitation, electronic PHI, and unsecure PHI. PHI includes PHI of a deceased individual within 50 years of the date of death.

"Unsecured Protected Health Information" means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized Persons through the use of a technology or methodology specified by the HITECH Act regulations and HIPAA Security Regulations. Unsecured PHI does not include secure PHI, which is:

(1) Encrypted electronic Protected Health Information; or

(2) Destruction of the media on which the Protected Health Information is stored.