April DY3 Reporting – Companion Document

Contents

Key Points for April 2014 Reporting

Each DSRIP provider should review this entire Companion document to understand the guidelines for how to report DSRIP achievement for the April DY3 reporting period. Below are several critical points HHSC wants to highlight from the document.

- **Do not report a Category 1 or 2 metric/Category 3 milestone as completed until it is completed. Metrics/milestones should only be reported in April if a provider is confident that the metric/milestone was fully achieved by March 31, 2014, and can be clearly demonstrated. For any metric/milestone that HHSC does not find sufficient evidence of achievement in the documentation, the provider will only have one opportunity in June to submit additional information. If the provider cannot demonstrate during the June "needs more information" (NMI) period that the metric/milestone was completed by March 31, 2014, the provider will no longer be eligible for payment for that metric/milestone.**
- Providers should read this companion fully. There are some changes to required documentation compared to what was required for DY 2 reporting (such as including dates to show when all metrics were completed and what type of information must be submitted for learning collaborative metrics).
- A Cover Sheet is required for each Category 1 or 2 project for the provider to clearly outline metric achievement and assist HHSC reviewers in understanding the documentation submitted by the provider.
- There are separate forms that are required for QPI metrics, Category 3 status reports (DY 2 and DY 3) and Category 4.
- Providers that have carry-forward (i.e. late achievement) from DY 2 will report on a separate reporting template from the DY 3 reporting template.
- All providers are required to provide semi-annual report information in the April DY3 Reporting Template for every project and metric regardless of whether the milestone/metric is being reported for payment in April. DSRIP payments may be withheld until the complete report is submitted. (p. 8)
  - "Overall Provider Summary" tab must be completed
  - In each Project tab:
    - "DY3 – 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.
- There will be one way to earn DY3 Category 3 DSRIP funds during April reporting. If you submitted a Category 3 Provider Selection Template by March 10, 2014, you are eligible to report on Category 3 in April using the *Category 3 DY3 Progress Update Template*. The submission of the status report is eligible for 50% of the DY3 payment while the remaining 50% may be earned through submission of the baseline information in October. DY2

Category 3 carry-forward DSRIP funds may be earned by submitting the *Category 3 DY2 Status Report Template.* (p. 9, 23)

April Reporting Checklist

Please review this checklist to ensure you have completed all items for April reporting. This checklist is for informational purposes only and does not need to be submitted with April reporting materials.

- ☐ April DY3 Reporting Template completed – Progress Tracker tab indicates a green "Complete" for all sections. (1 reporting template per DSRIP Performing Provider per RHP. HHSC will not accept multiple DY3 templates from the same provider so please review all information included in the template carefully before completing.)
- ☐ Semi-annual reporting requirements met:
    - ☐ Overall Provider Summary tab completed.
      In each Project tab:
        - ☐ "DY3 – Project Summary" section – all questions answered for each Category 1 or Category 2 DSRIP project.
        - ☐ "Progress Update" field – completed for each Category 1 or Category 2 metric and each Category 3 milestone.
- ☐ (If applicable) April DY2 Carryforward Reporting Template completed – Progress Tracker tab indicates a green "Complete" for all sections. (1 reporting template per DSRIP Performing Provider per RHP)
- ☐ Coversheets completed. (1 coversheet per Category 1 or 2 project - Coversheets include boxes for 9 metrics. If a provider is reporting on more than 9 metrics for a given project in DY3, they will need to submit an additional Coversheet for that project.)
- ☐ QPI template completed, if project includes a metric designated as QPI in DY3. Progress Tracker tab indicates green "Complete". (1 QPI template per Category 1 or 2 project)
- ☐ Supporting documentation – all documents are included, file names reference Project IDs, and dates that show when the metric was completed are included within each document. (Minimum of 1 supporting document linked to each Category 1 or 2 metric, but the same document may be used to demonstrate achievement for multiple metrics if appropriate).
- ☐ *Category 3 Status Update Template* completed. (1 template per Category 3 outcome measure)
- ☐ *Category 4 Reporting Template* completed. (1 template per hospital provider participating in Category 4, 1 tab per Reporting Domain).

- ☐ All materials listed above submitted to Deloitte at DSRIP@deloitte.com or by mail at Tim Egan, 50 South 6th Street, Suite 2800, Minneapolis, MN 55402 by **April 30, 2014, 5:00pm.**
- ☐ IGT changes in entities or proportion of IGT among entities submitted to HHSC (TXHealthcareTransformation@hhsc.state.tx.us) using the IGT Entity Change Form by **April 30, 2014, 5:00pm**. (1 IGT Entity Change Form per provider)

Overview

This document includes information on DY3 reporting for the first DY 3 reporting period in April 2014 including timelines, DY2 carryforward instructions, use of coversheets, QPI instructions, guidance on supporting documentation, and an overview of payment and IGT processing.

For technical instructions on completing the DY 3 reporting template, please refer to the *DY3 Reporting Template Instructions* posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under **DY3 Reporting Templates and Instructions.**

There are two opportunities to report achievement of milestones and metrics in DY 3: April and October 2014.

- Milestones and metrics achieved by March 31, 2014 may be reported in April.
- Milestones and metrics achieved by September 30, 2014 may be reported in October.
- All DY3 metrics must be reported during one of the DY3 reporting periods, even if not achieved, either to indicate that the metric is complete (has been achieved) OR to indicate that the metric will be carried forward into DY4 for late achievement.
- Providers should include a progress update for every metric in both the April and October reporting periods.
- Providers with approved replacement projects and approved carryforward metrics may report achievement of DY2 milestones and metrics in April or October 2014 on the reporting template specific to DY2 carryforward reporting.
- Most new 3-year projects in RHPs 5, 8, 17, and 20 may report in April; however, DSRIP payments will be dependent on CMS approval. These projects are noted in the April DY3 Reporting Template with "New 3-Year Project – Pending CMS Approval" under "Category 1 or 2 PROJECT INFO".
- Providers that submitted a Category 3 Provider Selection Template by March 10, 2014 are eligible to begin reporting on Category 3 for DY3 in April. Providers that submitted a Category 3 Selection Tool by March 31, 2014 are eligible to begin reporting on DY3 Category 3 in October.

- Hospital Performing Providers participating in Category 4 may report on Reporting Domains in April or October and are not held to the reporting period indicated in the RHP Plan (i.e. Planned Reporting Period: 1 or 2). Reporting Domains may be reported separately, i.e. all Category 4 Reporting Domains do not need to be reported at the same time to be eligible for DSRIP payment.

As was the case in DY2 reporting, the April DY3 reporting is a manual process using Excel templates. For reporting in October 2014 (2nd DY3 reporting period) through DY5, 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. DY2 and April DY3 data will be included in this automated system so that providers will have access to historical reporting results. Cooper Consulting and HHSC will offer training to providers on accessing and using the automated system.

April Reporting Timeline

- April 2, 2014 – HHSC will post individual provider April DY3 reporting templates and DY2 carryforward reporting templates by RHP on the waiver website under Tools and Guidelines for Regional Healthcare Partnership Participants.
- April 23, 2014 – Final date to submit questions regarding April reporting and inform HHSC of any issues with the reporting templates.
- **April 30, 5:00pm** – Due date for providers' April DY 3 DSRIP reporting using the *DY 3 Reporting Template* and/or *DY2 Carryforward Reporting Template* and applicable QPI, Category 3, and Category 4 templates. Late submissions will not be accepted. Please submit the completed template and supporting documentation using one of the following:
    - Email the completed files to DSRIP@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 DSRIP@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.
- May 1, 2014 – HHSC will begin review of the April reports and supporting documentation.
- May 7, 2014 – HHSC will share regional summary files of providers' reported progress from the April 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.
    - **May 16, 2014, 5:00pm** – Due date for IGT Entities to notify HHSC (TXHealthcareTransformation@hhsc.state.tx.us) of issues with their affiliated providers' April reported progress on metrics using the *IGT Entity Feedback* template. The form is not an opportunity to identify technical errors entered in the reporting template. Examples of issues to include are reported progress that was not actually achieved, changes in project scope that were not reported by the provider, and risks to the project that were not reported by the provider. If there are no issues, a template does not need to be submitted. **If there is a need to identify any technical errors in the reporting template please use the Waiver mailbox to communicate those errors by April 23, 2014 as stated above.**
- June 20, 2014 – HHSC and CMS will complete their review and approval of April reports or request additional information (referred to as NMI) regarding the data reported. If

additional information is requested, the DSRIP payment related to the milestone/metric will not be included with July DSRIP payments.

- Early July 2014 – IGT due for April reporting DSRIP payments.
- Late July 2014 – April reporting DSRIP payments processed.
- July 11, 2014 – Due date for providers to submit responses to HHSC requests for additional information on April reported milestone/metric achievement.
- August 15, 2014 – HHSC and CMS will approve or deny the additional information submitted in response to HHSC comments on April reported milestone/metric achievement. Approved reports will be included for payment in the next DSRIP payment period, estimated for January 2015.

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 April DY3 Reporting Template for every project regardless of whether the milestone/metric is reported for payment in April**:

- "Overall Provider Summary" tab.
- In each Project tab:
    - "DY3 – Project Summary" section – all questions must be answered for each Category 1 or Category 2 DSRIP project. You may enter "NA" for some of the questions, but there must be an explanation of why the response is "NA" (e.g. NA – no patient impact in DY3 because all project milestones were focused on planning. Patient impact will be reported beginning in DY4.)
    - "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 January 2014 and they have begun to serve patients at the neighborhood clinic.
        - (If in progress) – One pediatrician was hired in December 2013. We continue to advertise for the second pediatrician and hope to have them hired by the end of 2014.
        - (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 third quarter of 2014.

DY2 Carryforward Reporting

An approved carried forward DY2 milestone or metric may be reported in April or October 2014. The carried forward DY2 milestones and metrics are included in the *DY2 April Carryforward Reporting Template*, which is separate from the DY3 milestones and metrics reporting template. Only projects with carried forward DY2 milestones or metrics are included in the separate April reporting template. However, all Category 1 or 2 metrics are included for projects that had carried forward metrics. For the Category 1 and 2 metrics that were not carried forward (i.e., provider previously indicated metric as achieved and HHSC either approved or denied metric payment during DY2 reporting), please select "NA" under "Achieved in April Carryforward Reporting".

The *DY2 April Carryforward Reporting Template* does not require completion of an overall provider summary or project summary questions.

For Category 1 and 2 carried forward milestones and metrics, please follow the same guidance included in “Guidance for Category 1 and 2 Metrics Reporting” starting on p. 10.

For achievement of Category 3 carried forward milestones, please complete the *Category 3 DY2 Status Report Template* posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under **DY3 Reporting Templates and Instructions.** Providers should use Category 3 identifying information preceding the most recent March 2014 selections - Project IDs and historical IT reference numbers included in the *DY2 April Carryforward Reporting Template* - to complete the *Category 3 DY2 Status Report Template*. The outcomes selected in March 2014 only apply to DYs 3-5. One status report template is required per Category 3 outcome measure and can be referenced as the supporting documentation for multiple Category 3 DY2 milestones under “Supporting Attachments”.

Note that the option to carryforward DY3 milestones and metrics will be available in October reporting.

Guidance for Category 1 and 2 Metrics Reporting

Metrics with Multiple Parts: A metric goal must be fully achieved to report "Yes-Completed" under "Achieved in April Reporting" and be eligible for DSRIP payment (e.g. if a goal has two parts of expanding by 4 hours a week and adding one new exam room, both the expanded hours and new exam room would need to be completed).

Metrics with Percentage Goals: For metrics that include percentage goals, whether a metric may be reported in April depends on the specific metric language and whether the provider can demonstrate by April that the metric was fully achieved for DY3. Examples:

- May be reported in April if achieved by March 31, 2014: Metric P-4.1 (Project Option 1.3.1) - Implement/expand a functional disease management registry. Baseline/Goal: To implement a functional registry in 30% of identified sites as calculated by number of sites with registry functionality out of total number of sites. If the provider has implemented the functional registry in 30% of the identified sites by the end of March, it may report achievement in April.
- May be reported in April if achieved by March 31, 2014: Metric I-11.1 (Project Option 1.1.2) - Patient Satisfaction with primary care services. Goal: Improve patient satisfaction by 10% over baseline as calculated by numerator sum of all survey scores and denominator number of surveys completed. If the provider has improved patient satisfaction by 10% over baseline using the appropriate measure specifications, it may report achievement in April. HHSC isn't prescribing a specific baseline timeframe but each measurement period should be at least six months and the 10% improvement should be demonstrated some time in DY3.
- **QPI metrics** may be reported in April if achieved by March 31, 2014: Metric #1: P-101.1 (Project Option 2.10.1) - Increase the number of palliative care consults to meet targets established by the program. Baseline: DY2 Goal: increase the number of Palliative Care Consults by 5% or (additional 42 consults) from Baseline for total number of 894 palliative consults in DY3. QPI goal: 894 consults in DY3. As noted in the QPI section of this Companion (page 13), for QPI metrics that include both a number and a percentage, the number must be achieved to report achievement, and if there is a variance from the percentage goal, that should be explained. The metric will be payable based on the achievement of the number goal. (Note: Even if QPI metrics are achieved by March and reported in April, HHSC plans to request that all providers fill out the QPI template for DY3 QPI metrics in October in order to have a complete picture of DSRIP QPI as of the end of DY3.)

- Should not be reported in April: Metric I-11.1 (Project Option 2.10.1) - Pain screening (NQF-1634) Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter. Goal: Provide screening to at least 50% of palliative care patients (319). In this case, metric 1-11.1 is not a QPI metric, so the primary goal is to screen at least 50% of palliative care patients in DY3. Since DY3 will only be halfway completed by March 2014, this metric should be reported in October (or carried forward if needed).
- Should not be reported in April: Metric P-4.1 (Project Option 2.4.1) - Percent of new employees who received patient experience training as part of their new employee orientation. Baseline: 0. Goal: to have 85% of new employees receive patient experience training as part of their new employee orientation. Numerator: Number of new employees receiving patient experience training. Denominator: Total number of new employees. Since DY3 will only be halfway completed by March 2014, this metric should be reported in October (or carried forward if needed).

Since a provider will only have two opportunities to demonstrate whether it successfully met a metric (which will be April and June if the provider reports in April), HHSC strongly encourages providers to ask for technical assistance prior to submitting April reporting if you have any questions about whether a metric with a percentage should be reported in April.

Providers Performing Projects in Multiple Regions: 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.

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).

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 and how their time is divided among the projects or if there are two of each. Overlap between projects will be closely reviewed and may not be approved.

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 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 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.

Early Metric Achievement: DY2 achievement (October 1, 2012 – September 30, 2013) of metrics may be allowable for DY3 metrics if the State deems appropriate (such as if staff were able to be hired early or a clinic opened a little earlier than expected); 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, particularly if it is at least two years prior to when it was expected to be achieved in the approved RHP Plan. QPI metrics may be achieved late, but not early. For example, if a new project stated it would serve 100 people in DY3, 200 in DY4, and 300 in DY5, it would need to serve 100 people in DY3 in order to achieve the DY3 metric. Early achievement of QPI metrics is not being allowed for administrative reasons (many projects are establishing baselines for QPI in DY2) and also to ensure that projects' impact on patients continues to grow throughout the demonstration.

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 or request additional information. If approved, payment for the requested deviation may be made in the following reporting period depending on approval date (e.g. requested in April 2014, payment would be made with October 2014 reporting period if approval was obtained in July, payment estimated to be in January 2015). If the requested deviation is not approved after HHSC has requested additional information, the provider will no longer be eligible for payment for that metric.

DY2 Reported Achievement has Changed: If the reported and approved achievement of a DY2 metric has changed, please provide an explanation in the Project Summary section under "Project Overview: Challenges" (e.g. Location of DSRIP project has changed from Clinic A to Clinic B due to flooding and water damage at Clinic A. DSRIP services and QPI goals remain unchanged.).

Reporting on QPI

For projects with DY3 QPI metrics, the *QPI Reporting Template* must be used to report QPI achievement along with any other supporting documentation. The *QPI Reporting Template* should only be used for DY3 metrics marked "Yes" in the QPI metric column. **Please read the Instructions included in the first tab of the *QPI Reporting Template* workbook carefully before entering any information.**

If a provider reports a DY3 QPI metric as achieved in April, the provider still will need to fill out the QPI template for that metric in October in order to have a complete picture of DSRIP QPI as of the end of DY3.

Multiple Metric Goals:

- For QPI metrics that include a QPI goal as well as another goal that is not a percentage (e.g. establishing a specialty care clinic), both goals must be completed for the metric to be eligible for payment.
- For QPI metrics that include a percentage goal (e.g. target population met, percentage increase in number served) as well as the numeric QPI goal, the numeric goal is the primary goal, while HHSC may accept variances in the percentage goal with explanation (e.g. lower than expected denominator size for target population).
- For QPI metrics that include a goal for establishing a baseline, both the baseline must be determined as well as the achievement of the QPI goal of number of individuals served or encounters provided.

Counting Individuals/ Encounters:

- For QPI metrics that expand upon existing services (there already were individuals served/encounters provided before the DSRIP project), when reporting the DY3 QPI the provider will need to provide information regarding the pre-DSRIP baseline to demonstrate that the QPI in DY3 is an increase over the previous service volume. Some projects included a clear baseline in the baseline/goal for the metric, but others did not.
- For QPI individuals, include all persons served in the demonstration year even if those same individuals received services in a prior year.

- Patient contacts can only be considered as unique QPI encounters wherein a unique service is delivered. Often this can be thought of as a unique billable event. For example, a registered nurse encounter is not a service distinct from “visit with physician” so it is considered part of the same visit/service/encounter and counted as one encounter for QPI purposes.
- Encounters for primary care or specialty care projects should, in general, only include office visits. They should not include pharmacy visits, lab visits, reminder or follow-up phone calls, etc. that result from or are related to the office visit.
- Telephone calls (including outgoing) may only be counted as a separate QPI events if the call is clinical in nature, the call is specifically related to a project with a goal of telephone outreach, and the call was completed (e.g. the caller reached the intended person [not just their voicemail] and spoke with them about their care. Outgoing calls that would be appropriate would be a follow-up call to check on a patient's status with symptoms to determine if additional care is needed or a call completed through a nurse advice line created as part of the project. Administrative calls such as satisfaction with services or follow-up as to whether a patient went to the ED or PCP, would not be appropriate as they are still part of the same initial encounter. Appointment reminder calls also would not count as QPI encounters.
- Group visits may be counted as multiple encounters equal to the number of individuals targeted by the project that attend the group visit.
- For palliative care projects (Project Area 2.10), QPI goals may count consults as well as additional visits (post consults) toward QPI if these are included in the project.
- For reporting purposes, no DY2 metrics are designated as QPI metrics and no DY2 individuals/encounters were included in cumulative QPI goals. If a project includes a QPI-like metric in DY2 in their workbook, and it serves more individuals or provides more encounters in DY2 than included in the DY2 goals, the additional individuals/encounters from DY2 cannot be included to meet DY3 QPI goals. For example, a project has a DY2 goal to provide 100 encounters and a DY3 QPI goal to provide 200 encounters. The project was able to provide 125 encounters in DY2 and 175 encounters in DY3. The additional 25 encounters in DY2 cannot be used to meet the DY3 goal of 200 encounters.

Supporting Documentation

Please refer to the RHP Planning Protocols for Categories 1 and 2 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.

General Documentation Guidance:

- Must include a coversheet for each project describing how each supporting document demonstrates achievement of each metric. The coversheet template is posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under **DY3 Reporting Templates and Instructions.** Coversheets include boxes for 9 metrics. If a provider is reporting on more than 9 metrics for a given project in DY3, they will need to submit an additional Coversheet for that project.
- All documentation must demonstrate baseline information as well as the increase or total achievement stated in the goal. For example, a metric includes a baseline of 2 physicians and a goal that states 5 physicians providing services by DY3. Documentation must include identification of the 2 original physicians as well as the total of 5 physicians on staff (3 new physicians with hire dates in DY3). The metric may be marked by HHSC as "Needs More Information" if only documentation of 3 new physicians is provided. This also applies to QPI metrics - documentation should demonstrate baseline information as well as the increase in QPI due to the DSRIP project.
- Highlight relevant information within the supporting documentation where the support for achieving a particular metric is one section in a larger document.
- **Must 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.
- Must include the related Project ID in the file name of supporting documentation.
- 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).
- 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.
- Sensitive information such as salaries may be redacted.

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 DY3 (e.g. outline of gap assessments, format of meeting agendas/sign-ins).

- Increased Staff Metrics: For metrics that involve hiring of additional staff to increase care capacity, the goal is that there is an increase in the total number of staff to care for patients due to the DSRIP project and associated funding. HHSC will consider the specific language of the metric and the project when reviewing metrics around increased staff, but the provider should demonstrate as clearly as possible that the staff changes are different than business as usual. For example, business as usual would be "two staff quit on August 31, so we filled those two vacancies within our existing clinic budget." To demonstrate DSRIP achievement, the provider should explain how positions were created or specifically filled to document expansion related to the DSRIP project.
- Learning Collaborative Metrics: For metrics involving learning collaboratives (including regional learning collaboratives), documentation must include the agenda, sign in sheet, and a summary of topics discussed and *lessons learned relevant to the project to demonstrate participation.*
- Metrics Involving Meetings: For metrics involving meetings, all meetings must be scheduled and completed as stated in goals to be eligible for April reporting. Goals stating quarterly, monthly, or bi-weekly meetings are not eligible for April reporting and may be reported in October. Agendas and minutes or summaries of meetings must be submitted as supporting documentation.
- Gap Assessment Metrics: 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?
- Metrics Involving Disseminating Findings: If a milestone or metric requires “disseminate findings”, if the approved project narrative specified any partnerships or collaborations, the findings should be disseminated to those entities. If the project does not specify any relationships, then the type of information collected would guide who the findings should be disseminated to. Another option is to disseminate findings with providers with similar projects or reaching similar populations within the RHP.

- Expanded Hours Metrics: If a goal specifies when the expanded hours are to occur and the expanded hours are changed (e.g., had planned to expand from 5-6 p.m. Monday through Thursday, but instead expanded 5-7 p.m. on Monday and Wednesday), then it will be acceptable as long as the total number of expanded hours remains the same as originally stated and the change makes sense within the context of the project narrative. The documentation must clearly show what the previous hours were (and that they have continued) and that there are additional hours in which appointments are offered.
- "Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions" Metrics: This metric may only be reported in October 2014 or carried forward to DY4 since it is a weekly DY3 metric. For metrics requiring the number of new ideas, tools, or solutions, for each idea, tool, or solution provide documentation of the Plan-Do-Study-Act (PDSA) concepts as well as the ideas, dates, staff involved, and action taken. Another option is to submit a PDSA document for each idea, tool, or solution. A sample template is available on the Institute for Healthcare Improvement (IHI) website at http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx. This site does require registration (at no cost). This site is an excellent resource for providers. A provider may continue to test one or more ideas throughout the year; however, activity must occur weekly.
- "Implement the "raise the floor" improvement initiatives established at the semiannual meeting" Metrics: For metrics requiring implementing "raise the floor" improvement initiatives, the documentation should include a list of ideas that came up during the semiannual meeting that would apply to the project, a description of the provider's agreement to implement at least one idea and rationale for the selection, a description of the status of implementation, and any details related to the impact of the idea on the project (e.g. improvement on project uptake, outcomes, or spread).

CATEGORY 1

Project Option: 1.1

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

Metric P-1.1: Number of additional clinics or expanded hours or space.

- 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

Metric P-5.1.: Documentation of increased number of providers and staff and/or clinic sites.

- 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

Metric P-4.1: Increased number of hours at primary care clinic over baseline.

- 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

Metric P-2.2: Hire additional precepting primary care faculty members. Demonstrate improvement over prior reporting period (baseline for DY2).

- 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

Metric P-1.1: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2).

- 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)

Metric P-11.1: Establish/expand specialty care clinics.

- 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).

Metric P-3.1: Manual of operations for the project detailing administrative protocols and 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

Metric P-3.2: Increase the number of patients enrolled in a care management program over baseline.

- 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.

Metric P-2.1: Document innovational strategy and 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

Metric P-1.1: Document innovational strategy and 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

Metric P-1.1: Performing Provider review and prioritization of areas or processes to improve upon.

- 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.

Metric P-2.1: Project plans which are based on evidence / experience and which address the project goals.

- 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.

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.

- 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

Metric P-3.1: Provide documentation of number and types of referrals that are made between providers at the location.

- Additional Guidance:
    - Also submit standards that were developed and implemented.

CATEGORY 3 Instructions

For **April** reporting, providers that submitted their Category 3 measures no later than March 10, 2014, will submit a status update for each Category 3 measure selected during the March 2014 selection process. The *Category 3 DY3 Status Update Template* is posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under **DY3 Reporting Templates and Instructions.**

The intention of this status report is to describe providers' understanding of the measure specifications, denominator populations, planning for the Alternate Improvement Activities and any technical assistance needs. Providers will earn 50% of their DY3 allocation for the Category 3 measure for successful submission of this April status report. Providers may opt to delay reporting of this process milestone until the October 2014 reporting period or even carry achievement of this process milestone forward into DY4, although this is not recommended if the provider does have or anticipates technical assistance needs. This status report may also be used to inform the review of the Category 3 submissions.

HHSC will be in the process of reviewing Category 3 submissions during the reporting period. If, subsequent to reporting, HHSC advises changing the Category 3 submission, this will not require a plan modification. If HHSC does not advise a change but the provider seeks to switch its Category 3 outcome measure(s), a plan modification will be required in July 2014.

In **October 2014**, to earn 50% of their DY3 allocation for Category 3, providers will submit and validate their baseline rates for each of the selected, and by then approved, Category 3 outcome measures. Validation requires a statement from the provider's head quality officer (or other designee as identified by the provider and responsible for data integrity) to certify that baseline rates are collected per the approved measure specifications and reflect an accurate baseline rate for that outcome. HHSC will provide an Excel template for this baseline submission. Also in October, providers that submit their Category 3 selections between March 11 and March 31, 2014, may submit a status template to earn the other 50% of their DY3 Category 3 funds using the *Category 3 Status Update Template*.

For those providers whose selected outcome type is Pay For Reporting) (P4R), the provider must establish the baseline rate both for the P4R measure and for any associated Population-Focused Priority Measures. In order to earn the 50% of the DY3 allocation for establishing the baseline, a provider must submit the baseline information for the Category 3 P4R measure. The baseline information for the Population-Focused Priority measure will not be tied to this payment, but must be submitted prior to reporting achievement and may be submitted in October.

For P4P measures, these baseline rates will be used to determine achievement targets (goals) for DY4 and DY5 for each measure. For Population-Focused Priority measures, the baseline rates will be used to determine the achievement goal for DY5.

CATEGORY 4 Instructions

For Category 4, providers can report in either April or October 2014 to earn DY 3 funds. There is no carry forward for Category 4, as it is pay for reporting. Providers who do not meet reporting standards may be subject to need more information (NMI) requests from HHSC.

Providers that are exempt from Category 4 reporting will not have a Category 4 tab in their DY3 Reporting Template but may receive Medicaid Potentially Preventable Events reports from HHSC for informational purposes (explained in more detail below for domains 1-3).

Category 4 has six Reporting Domains (RDs). The Institute for Child Health Policy (ICHP), which functions as Texas' Medicaid External Quality Review Organization (EQRO), is preparing reports for hospitals for reporting domains RD-1 – Potentially Preventable Admissions, RD-2 – 30-day Readmissions, and RD-3 – Potentially Preventable Complications. The EQRO will provide the individual reports on RD-1 and RD-2 to HHSC no later than April 15, 2014. HHSC will then provide reports to each hospital provider via the email address we have on file. In order to maintain confidentiality of hospital-specific PPA and PPR information as required by State law, anchors will be notified when reports have been sent, but will not receive copies of the reports. For RD-3, providers are only required to submit a status report in DY3 confirming system capability to report RD-3.

The measurement period for RDs 1 & 2 is Calendar Year 2012. Hospitals are not required to submit qualitative information on these two domains for DY 3 reporting since they will be receiving the data from HHSC in mid-April. In subsequent reporting periods (DY4 and DY5) providers will be required to submit responses to qualitative question regarding provider specific PPA, PPR and PPC results.

Hospitals will also report the RD-4 – Patient Centered Healthcare, RD – 5 Emergency Department measures, and optional RD – 6 Initial Core Set of Health Care Quality Measures if indicated in the RHP Plan. Responses to qualitative questions must be included for RDs 4 & 5 and optional RD-6, if applicable. Guiding questions and a response space for the qualitative component will be provided on the reporting template.

Providers may use a 12-month measurement period of their choosing for RD 4-6. This may be calendar year, state or federal fiscal year, or facility fiscal year if preferred. The measurement period chosen by the provider must be indicated in the space provided on the reporting template. The measurement period must be no earlier than DY2 (10/1/12-9/30/13). Subsequent reporting should be sequential for the same annual period, but a year later).

Reporting Domain 1:

The EQRO has compiled data and reports for Potentially Preventable Admissions, and providers will use data from the first template section "PPA Rates" and the fifth section "PPA Results by Category." Please copy the data from the EQRO report into the RD-1 tab of the Category 4 reporting template.

The following is an example of the PPA Rates section of an EQRO PPA report.

Please report required numbers into the corresponding cells on the Category 4 reporting template.

PPA Rates

	Total Admissions at Risk for PPA	Actual Number of PPAs	PPA Rate	Expected Number of PPAs	Expected PPA Rate
Provider Results	98	18	18.37%	12.99	13.25%

After completing the PPA Rates section, providers will need to complete the PPA Results by Category section for all groupings. The following is an example of the Results by Category Section of the EQRO PPA report:

Report Number of PPAs and PPA Category Rate per 1000 Admissions for all Categories on RD-1 tab.

PPA Results by Category

Category	Number of PPAs	PPA Category Rate per 1,000 Admissions
CHF (Congestive Heart Failure)	0	0
DM (Diabetes)	2	20.4

If a provider's data does not have an adequate sample size to determine statistical significance the EQRO reports will indicate such with a statement saying "*This is a low-volume provider," which the provider will in turn indicate on the reporting template. Providers with no cases in a given PPA category will report the zeroes shown on their EQRO report. . .

Reporting Domain 2:

EQRO is also supplying reports for each provider for Domain 2, Potentially Preventable Readmissions. Similarly to RD-1, providers are asked to report on Section 1 of the template, "PPR Rates" and Section 5 "PPR Results by Category."

For PPR Rates, copy the information in the "Provider Results" row, from the Total Admissions at risk for PPR, Actual number of PPR Chains, and PPR rate, Expected PPR Chains, Expected PPR rate, and p value for the total PPR results columns into the corresponding cells on the Category 4 reporting template.

PPR Admission Rates

	Total Admissions at Risk of PPR	Actual Number of PPR Chains	PPR Rate	Expected Number of PPR Chains	Expected PPR Rate
Provider Results	3	0	0.00%	0.38	12.54%

For the PPR Results by Category Section, copy the Total Admissions at Risk for PPR and PPR Rate data for each category into the corresponding cell on the RD-2 tab of the Category 4 reporting template.

Reporting Domain 4:

Data for patient-centered healthcare must be supplied by the individual provider and entered into the RD-4 tab on your Category 4 template.

Patient Satisfaction - Providers will report the percentage of survey respondents who choose the most positive, or "top-box" response for the following measures, displayed below.

For additional information, visit:
http://www.hcahpsonline.org/files/HCAHPS%20Fact%20Sheet%20May%202012.pdf and

Data is publicly reported and available on Hospital Compare:
https://data.medicare.gov/data/hospital-compare/Patient%20Survey%20Results

- HCAHPS Reporting Measures:
  - Percent of patients who reported that their doctors "Always" communicated well
  - Percent of patients who reported that their nurses "Always" communicated well
  - Percent of patients who reported that they "Always" received help as soon as they wanted
  - Percent of patients who reported that their pain was "Always" well controlled
  - Percent of patients who reported that staff "Always" explained about medicines before giving it to them
  - Percent of patients who reported that YES, they were given information about what to do during their recovery at home.

- Percent of patients who reported that their room and bathroom were "Always" clean
- Percent of patients who reported that the area around their room was "Always" quiet at night
- Percent of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).
- Percent of patients who reported YES, they would definitely recommend the hospital.

Medication Management

For RD-4 section 2, providers will report on NQF measure 0646. The measure specifications can be found on the NQF website here, and in the Category 4 section of the RHP planning protocol.

Providers will report their facility's specific numerator and denominator numbers, as well as the facility rate.

If manual chart review is required, please use the following sampling guidelines.

- For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
- For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
- For a measurement period where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.

Reporting Domain 5:

RD-5 (Admit decision time to ED departure time for admitted patients) specifications are defined in National Quality Forum Measure 0497. The specifications are available here.

If manual chart review is required, please use the following sampling guidelines.

- For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
- For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
- For a measurement period where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health

record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.

Reporting Domain 6:

Providers are only permitted to report on Optional Domain 6 in April if they can report on all of the listed measures. Many of the measures are not hospital-focused, and measures marked with an asterisk (*) in the reporting template are only applicable to providers with outpatient services. HHSC is working with CMS to further develop how Optional Domain 6 may be reported in October since some hospitals that elected to report on Domain 6 have indicated they cannot report all measures in this domain. Please see the links below to the technical specifications and resource manuals for detailed measure guidelines.

Child Set of Core Measures

Adult Set of Core Measures

Measures marked with a double asterisk (**) have been modified to be specific to DSRIP providers, similarly to the changes made in Category 3 measures (e.g. "member" modified to "patient"). Please see the corresponding Category 3 compendium document for these specifics. HHSC recognizes that some measures may additional modification, and more guidance will be available as needed.

April Payment and IGT Processing

Categories 1 and 2 Payment Calculations

The amount of the incentive funding paid to a Performing Provider will be based on the amount of progress made and approved within each specific milestone. A milestone may consist of one or more metrics. 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 and approved, each milestone will be categorized as follows:

If consisting of one metric:

- Full achievement (achievement value = 1)
- Less than full achievement (achievement value = 0)

If consisting of more than one metric:

- 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 Performing Provider is eligible to receive an amount of incentive funding for that milestone determined by multiplying the total amount of funding related to that milestone by the reported achievement value. If a Performing Provider has previously reported progress on a milestone with multiple metrics 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 3 is valued at $4 million and has one milestone with two metrics and one milestone with three metrics.

The Performing Provider reports the following progress in April and has been approved by HHSC and CMS:

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

Disbursement in April: Milestone 1 ($2 million *1 = $2 million) + Milestone 2 ($2 Million *0.5 = $1 Million) = $3 Million

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

Disbursement in October is $4 million - $3 million = $1 million.

Category 3 Payment Calculations

April Category 3 DSRIP payments are based on completion of the *Category 3 DY3 Status Update Template* or *Category 3 DY2 Status Report Template* and approval of the submission by HHSC and CMS.

Partial payments for Category 3 only apply to DY4-5.

Category 4 Payment Calculations

A hospital Performing Provider will be eligible for a Category 4 DSRIP payment for each Reporting Domain if the tab within the Category 4 template for the particular Reporting Domain is completed and approved by HHSC and CMS.

Partial payments do not apply to Category 4.

Approved October DY2 Needs More Information (NMI) milestones and metrics

In February 2014, HHSC completed review of DY2 reporting submissions in response to HHSC requests for more information. Approved Needs More Information (NMI) milestones and metrics will be included in the July payment processing of April reports. NMI milestones and metrics that were not approved will no longer have access to the associated DY2 DSRIP funds.

IGT Processing

In July 2014, HHSC Rate Analysis will notify IGT Entities and Anchors of the IGT amounts by affiliation and IGT Entity by RHP for July payment processing of approved April reports. The IGT amounts for DY2 approved NMI milestones and metrics, DY2 carry forward achievement, DY3 achievement, and monitoring will be indicated as well as a total IGT amount.

Per Texas Administrative Code §355.8204, HHSC may collect up to $5 million per demonstration year from DSRIP IGT entities to serve as the non-federal share (50 percent IGT/50 percent federal funds) for DSRIP monitoring contracts. HHSC is in the process of procuring two contracts for DSRIP monitoring - one for compliance monitoring and one for financial monitoring. The monitoring amount for each IGT Entity is a portion of the $5 million based on the January 1, 2014 value of the IGT Entity's funded DY3 Category 1-4 DSRIP projects out of all DY3 Category 1-4 DSRIP projects in the state. The IGT monitoring amount per IGT Entity per RHP is included in

the *DY3 IGT Monitoring Amounts* that will be posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under **Immediate Guidance to Regional Healthcare Partnerships (RHPs)** in early April**.**

HHSC plans to request 50 percent of the DY3 IGT monitoring amount with July 2014 payment processing of April reports and 50 percent of the DY3 IGT monitoring amount with the January 2015 payment processing of October reports. If the full DY3 IGT monitoring amount is not submitted by an IGT Entity in July 2014 or January 2015, then it will be carried forward and due with DY4 payment processing.

An IGT Entity may either transfer the total IGT amount due for DY2 DSRIP, DY3 DSRIP, and monitoring or an amount less than the total IGT due. If less than the total IGT amount is transferred, then HHSC will account for the IGT monitoring amount first and the remaining IGT will be proportionately used to fund DY2 and DY3 approved DSRIP payments. If an IGT entity does not fully fund its DSRIP payments in July, the remaining IGT amount due for its' affiliated projects' achievement may be transferred with January 2015 payment processing of October reports or for DY3 achievement, with DY4 payment processing. Please note that for DY2 metrics/milestones achievement, the last payment opportunity will be January 2015.

DSRIP payments are made using the Federal Medical Assistance Percentage (FMAP) for the federal fiscal year (October 1 – September 30) during which the DSRIP payment is issued and is not based on the demonstration year FMAP of the achieved milestone or metric. The FMAP for FFY2014 and used for July DSRIP payment processing of April reports is 58.69. The FMAP for FFY2015 and FFY2016 is estimated at 58.05.

IGT Entity Changes

The IGT Entity(ies) for each project/improvement target is listed in the April DY3 Reporting Template in each Project tab under "DY3 – Category X IGT Entity Name" and in the April DY2 Carryforward Template 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 April reporting templates, please complete the *IGT Entity Change Form* available at http://www.hhsc.state.tx.us/1115-docs/RHP/Plans/IGT-Change.xlsx. IGT Entity changes must be received no later than **April 30, 2014, 5:00 p.m.** for April reporting DSRIP payment processing. Any changes received after April 30, 2014, will go into effect for the October DY3 DSRIP reporting and payments will be delayed until that time. Note that IGT Entity changes submitted for April reporting will not impact the IGT monitoring amounts since monitoring contract amounts due for DY3 are based on each IGT entity's proportional share of DY3 Category 1-4 DSRIP projects as of January 1, 2014.

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, the Provider should report this to HHSC Waiver Staff and the Provider's designated privacy official or legal counsel to determine whether or not this is a privacy breach which requires notice to your patients. 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.