October DY3 Reporting – Companion Document

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Key Points for October 2014 Reporting

Each DSRIP provider should review this entire Companion document to understand the guidelines for how to report DSRIP achievement for the October DY3 reporting period. The Companion Document includes important information about changes to required documentation compared to what was required for April DY 3 reporting and new information regarding using the DSRIP Online Reporting System for October reporting.

Below are several critical points HHSC wants to highlight from the document.

- **Metrics/milestones should only be reported in October if a provider is confident that the metric/milestone was fully achieved by September 30, 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 December/January to submit additional information. If the provider cannot demonstrate during the December/January "needs more information" (NMI) period that the metric/milestone was completed by September 30, 2014, the provider will no longer be eligible for payment for that metric/milestone. If DY3 achievement has not occurred by September 30, 2014, the provider must request Carryforward to report on the metric in DY 4.**
- A Coversheet is required for each Category 1 or 2 project for the provider to clearly outline metric achievement and to assist HHSC reviewers in understanding the documentation submitted by the provider. The format of the *Coversheet* has changed from April DY3 reporting. Please be sure to download the new version from the Waiver website.
- Separate forms are required for QPI reporting, Category 3 status reports (DY 2 and DY 3), Category 3 baseline reporting, and Category 4 reporting. The format of the *QPI Reporting Template* has changed from April DY3 reporting. Please be sure to download the new version from the Waiver website. The April DY3 pilot version of the *QPI Template* will not be accepted.
- There is a separate User Guide for the DSRIP Online Reporting System and a Companion Document for completing the *QPI Template*.
- **All providers are required to provide semi-annual reporting information regardless of whether the provider is reporting for payment in October or reported during April reporting. DSRIP payments may be withheld until the complete report is submitted. (p. 7)**
- The "Provider Summary Report" must be completed as part of the provider-level Semi-Annual Reporting requirement.
- For each project, the provider should complete:
    - the "Project Summary" tab – all questions must be answered for each Category 1 or Category 2 DSRIP project.
    - the "Progress Update" field – must be completed for each Category 1 or Category 2 metric and each Category 3 milestone.

- the *QPI Template* - must be submitted for each project that includes a metric designated as QPI in DY3.

October Reporting Checklist

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

- ☐ October DY3 Reporting information entered into the online system – "Reporting Status" tab indicates "Ready to Submit" or "Report Submitted" for all sections. (As long as the completed reports and supporting attachments have been **saved** by the reporting deadline, they will be considered officially submitted.)
- ☐ Semi-annual reporting requirements met:
  - ☐ "Provider Summary Report" completed in the online reporting system.
    For each project:
    - ☐ "Project Summary" tab – all questions answered online for each Category 1 or Category 2 DSRIP project.
    - ☐ "Progress Update" field – completed online for each Category 1 or Category 2 metric and each Category 3 milestone.
    - ☐ (if a DY 3 QPI metric) *QPI Template* - completed and uploaded for each project that includes a metric designated as QPI in DY3. Progress Tracker tab within the *QPI Template* indicates green "Complete." (1 template per Category 1 or 2 project)
- ☐ (If applicable) October DY2 Carryforward Reporting information entered into the online system. Carryforward milestones appear with an asterisk on the current year's Project Reporting page.
- ☐ *Coversheet*(s) completed and uploaded. (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.)
- ☐ Supporting documentation submitted – all documents are uploaded to the DSRIP Online Reporting System under "Supporting Attachments", file names reference Project IDs, and date ranges that show when the metric was completed are included within each document. (Minimum of 1 supporting document uploaded for 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 and uploaded to report achievement of PM-8: Submission of DY3 Status Report. (1 template per Category 3 outcome measure)

- ☐ *Category 3 Baseline Template* completed and uploaded to report achievement of PM-9: Successful reporting and validation of baseline rates. (1 template per Category 3 outcome measure)
- ☐ (If applicable) *Category 4 Reporting Template* completed and uploaded. (1 template per hospital provider participating in Category 4, 1 tab per Reporting Domain if reporting for October achievement).
- ☐ All items listed above submitted through the DSRIP Online Reporting System no later than 11:59 p.m. on **October 31, 2014.**
- ☐ (If applicable) 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 **October 31, 2014, 11:59 p.m**. (1 IGT Entity Change Form per provider)

Overview

This document includes information on reporting during the second DY 3 reporting period in October 2014 including timelines, DY2 carryforward instructions, use of *Coversheets* and other HHSC reporting templates, QPI guidance, guidance on supporting documentation, and an overview of payment and IGT processing.

For technical instructions on using the DSRIP Online Reporting System, please refer to the *DSRIP Online Reporting System presentation* and *DSRIP Online Reporting System User Guide* posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under **October DY3 Reporting.** Note that the reporting system refers to April reporting as Round 1 and October reporting as Round 2.

- Milestones and metrics achieved by September 30, 2014 may be reported in October.
- DY 3 Category 1 and 2 metrics and Category 3 milestones not achieved by September 30, 2014 may be requested to be carried forward into DY4 for late achievement. Category 4 is not eligible for carryforward.
    - The DY3 milestones and metrics approved for carryforward may be reported in April or October 2015.
- October 2014 is the final opportunity for providers with approved DY2 carryforward milestones and metrics to report achievement.
- Changes submitted through the Change Requests (Plan Modification and Technical Change Requests) process in August 2014 are for DY 4 and DY 5 only and will not be considered for DY3 reporting review. If there are variations in baselines or previously reported achievement, please address it in reporting as outlined in this companion document under "Guidance for Category 1 and 2 Metrics Reporting" on p. 10.

October Reporting Timeline

- **October 1, 2014** – The DSRIP Online Reporting System will open for providers to begin October reporting. The templates for *Coversheets*, QPI reporting, Category 3, and Category 4 will be posted to the waiver website.
    - Some providers have difficulty downloading files from the waiver website using Internet Explorer. We suggest downloading files using Chrome or another browser if possible.
- **October 24, 2014** – Final date to submit questions regarding October reporting and inform HHSC of any issues with DY3 data in the reporting system.
- **October 31, 2014, 11:59 p.m.**
    - Due date for providers' submission of October DY 3 DSRIP reporting using the DSRIP Online Reporting System and upload of applicable *Coversheets*, supporting documentation, and QPI, Category 3 and Category 4 templates. Late submissions will not be accepted.
    - Due date for submission of any IGT changes in entities or proportion of IGT among entities submitted to HHSC (TXHealthcareTransformation@hhsc.state.tx.us) using the IGT Entity Change Form located at: http://www.hhsc.state.tx.us/1115-docs/DY3-Templates/April2014/IGT-Entity-Change-Form.xlsx.
- **November 3, 2014** – HHSC will begin review of the October reports and supporting documentation.
- **November 14, 2014, 5:00pm** – Due date for IGT Entities to approve and comment on their affiliated providers' October reported progress on metrics using the "IGT Info" tab for each project. The tab is not an opportunity to identify technical errors entered in the reporting system. 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, comments do not need to be submitted and HHSC will assume the IGT Entity has approved the reported information. **If there is a need to identify any technical errors in the reporting system please use the Waiver mailbox to communicate those errors by October 24, 2014 as stated above.**
- **December 8, 2014** – HHSC and CMS will complete their review and approval of October reports or request additional information (referred to as NMI) regarding the data reported. Note that HHSC completes multiple levels of review prior to determining that a milestone/metric requires additional information.
    - If additional information is requested, the DSRIP payment related to the milestone/metric will not be included with January DSRIP payments.
- **January 2, 2015** – IGT due for October reporting DSRIP payments.

- **January 20, 2015** – October reporting DY3 DSRIP payments processed for transferring hospitals and top 14 IGT Entities.
- **January 30, 2015** - October reporting DY2 DSRIP payments processed for all providers and DY3 DSRIP payments processed for remaining providers.
- **January 16, 2015, 5:00pm** – Due date for providers to submit responses to HHSC requests for additional information (NMI requests) on October reported Category 1-4 milestone/metric achievement and Semi-Annual Reporting requirements.
- **February 13, 2015** – HHSC and CMS will approve or deny the additional information submitted in response to HHSC comments on October reported milestone/metric achievement. Approved reports will be included for payment in the next DSRIP payment period, estimated for July 2015.

Required Semi-annual Progress Reports

According to the Program Funding and Mechanics Protocol, paragraph 16 (on page 351 of the waiver amendment approved May 21, 2014 although dated March 6, 2014), 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 items below for October DY3 Reporting for every project regardless of whether the milestone/metric is reported for payment in October**. With the exception of the *QPI Reporting Template*, all information will be entered into the online reporting system.

- "Provider Summary Report."
- For each project:
  - "Project Summary" tab – 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.)
    - If there were any variations from the project narrative and metrics that have already been reported as achieved, please provide this information under "Project Overview: Challenges" (e.g. We hired two nurses to meet a DY2 metric, but one of them moved out of the area and we've been unable to refill that position. This may impact our ability to achieve our QPI metrics.).
    - Under "Patient Impact for Medicaid/Low-Income Uninsured Population," please identify the patient impact in DY3 and specify the Medicaid/low-income uninsured percentage that was served, including the split percentages if available.

        - Under "Progress on Core Components," please list and describe progress on each required core component through September 30, 2014.
    - "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 May 2014 and they have begun to serve patients at the neighborhood clinic.
        - (If in progress) – One pediatrician was hired in June 2014. 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 in January 2014. 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 2015.
    - *QPI Reporting Template* - **must be completed for each designated DY3 QPI metric even if the QPI metric was achieved in April 2014 reporting.**

DY2 Carryforward Reporting

The final opportunity for an approved carried forward DY2 milestone or metric to be reported is in October 2014. The carried forward DY2 milestones and metrics are included in the online system under DY3 Round 2 along with the DY3 milestones and metrics and are identified with an asterisk. The carried forward DY2 milestones or metrics are pre-populated with the responses provided in DY2 October 2013 reporting or DY3 April 2014 reporting.

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 (PM-7: DY2 Carryforward remaining to report), 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 **October DY3 Reporting.** Providers should use Category 3 identifying information included in the reporting system to complete the *Category 3 DY2 Status Report Template*. Detailed responses are not required; a short answer to each question will suffice. One status report template is required per Category 3 outcome measure and can be uploaded as the supporting documentation for multiple Category 3 DY2 milestones as appropriate under "Supporting Attachments."

Requesting Carryforward for DY3 Milestones and Metrics

In October reporting, providers may request that Category 1, 2, and 3 DY3 milestones and metrics be carried forward into DY4 for late achievement.

If a milestone or metric will not be achieved by September 30, 2014, under "Achieved by Sept 30?" please select "Partially Completed" or "No-Not Started." To request carryforward, answer the "Carryforward Questions" for each Category 1 or 2 metric or Category 3 milestone on the Round 2 milestone tab:

- Enter a response for "If applicable, please explain why your achievement is less than expected."
- Select "Yes" for "Do you want to carry this metric into the next demonstration year?"
- Enter a response for "What is your plan to improve performance by the end of the following DY?"

Note that if you are requesting carryforward for a percentage improvement metric that is included in DY3 and DY4, then the DY3 carried forward metric must be demonstrated prior to the DY4 metric. For example, a project includes a DY3 goal: 10% decrease in no-show rates from DY2 baseline and DY4 goal: 15% decrease in no-show rates from DY2 baseline. The provider is requesting carryforward because the no-show baseline rate was not determined until DY3 - June 2014. To report achievement of the DY3 goal, a minimum of six months of data must be used to demonstrate 10% decrease from the baseline. The DY3 carried forward metric may be reported in April or October 2015. Because this is an annual metric, the DY4 achievement of 15% decrease from the baseline may only be reported in October and use a 12 month period. The DY4 12 month period may overlap with the period used for reporting DY3 carryforward.

Guidance for Category 1 and 2 Metrics Reporting

When determining whether a metric was achieved, HHSC reviews the specific metric description language, baseline/ goal language, numeric goal (if applicable) and data source. HHSC also references the project narrative when clarification of the metric intent or target population is needed. Providers should be sure that the documentation they are submitting in support of a metric is in line with this information and that any information not included in these sources or that requires clarification is included in the supporting documents and/ or *Coversheet*. (Please remember that changes submitted through the Change Request process in August 2014 will not be considered for DY3 reporting review since the August 2014 Change Request process only applied to DY4 and DY5.)

Milestones with Multiple Metrics: For milestones with multiple metrics, each metric may be reported in separate reporting periods based on when it is achieved (e.g. P-12.1 and P-12.2 do not need to be reported at the same time to be eligible for payment).

Metrics with Multiple Parts: All metric goals must be fully achieved to report "Yes-Completed" under "Achieved by September 30" 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).

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, include the other project's(s') applicable IDs for the documentation, and explain how this documentation meets the metric goals for both projects. 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 unless it is clear from the approved projects that is the case. 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 should also be sure to only include data for the type of service that is targeted by their project in their metric calculations.

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 where (page numbers) and 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 non-QPI 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 in the subsequent demonstration year, but not in an earlier demonstration year. 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 to ensure that projects' impact on patients continues to grow throughout the demonstration period.

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). The provider should also reference the progress update information in their *Coversheet*. 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 October 2014, payment would be made with April 2015 reporting period if approval was obtained in January 2015, payment estimated to be in July 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 or DY3 April Reported Achievement has Changed: If the reported and approved achievement of a DY2 or DY3 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.).

Baseline has Changed: If the baseline reported in DY2 has changed, please provide an explanation in the "Progress Update" field for the metric. The stated DY3 goals must still be achieved. If the DY3 goal is an improvement over baseline, HHSC will review in context of the entire project to determine appropriateness.

Reporting on QPI

For projects with DY3 QPI metrics (metrics marked "Yes" for QPI), the *QPI Template* must be completed for each project as a requirement of semi-annual reporting (SAR), regardless of whether the QPI metric is being reported for payment, was reported in April, or is being requested for carryforward.

If a provider is also reporting on the QPI metric in October for payment, it must demonstrate in the *QPI Template* that the QPI goal was achieved between October 1, 2013 and September 30, 2014.

Providers should only submit one *QPI Template* per project per reporting period. The template will serve to meet both metric achievement and SAR requirements.

Please read the *QPI Companion Document* carefully before entering any information and refer to Instructions included in the first tab of the *QPI Template* workbook for general guidance.

Supporting Documentation

Please refer to the RHP Planning Protocols for Categories 1 and 2 and your project specific information 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-docs/DSRIP-Protocols.pdf.

General Documentation Guidance:

- Providers must include a *Coversheet* for each project for which they are reporting metric achievement, describing how supporting documents demonstrate achievement of each metric on which they are reporting. The *Coversheet* template is posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under **October DY3 Reporting.**
    - *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.
    - If you are reporting a metric as "No-Partially Achieved" or "No-Not Started", then that metric should not be included in the *Coversheet* and supporting documentation should not be submitted for the metric. For these metrics, enter "NA" in the "Supporting Attachments" field and complete the "Progress Update" field as required by semi-annual reporting.
- Providers should submit documentation in common file formats (e.g., pdf, Microsoft Word, Microsoft Excel, Microsoft PowerPoint, zip files) that are allowed by the reporting system.
- Providers are strongly encouraged to submit data in an Excel spreadsheet rather than in a document table (e.g., pdf, Word), as this is more conducive to efficient review of your metric. If submitting data in a document, providers should include column totals.
- Providers should rotate document pages using landscape and/ or portrait settings as appropriate, so that pages are not upside down or sideways.
- 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. Please refer to the *QPI Companion Document* for guidance specific to QPI baselines.
- Highlight relevant information within the supporting documentation where the support for achieving a particular metric is one section in a larger document. Be sure to include pages numbers for the relevant information in the *Coversheet*.

- **Providers must include dates in supporting documentation to demonstrate achievement occurred by September 30, 2014** (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.
- The related Project ID should be included in the file name of supporting documentation.
- Links will not be accepted as supporting documentation due to broken links provided in previous reporting periods.
- Handwritten notes will not be accepted as supporting documentation (other than for sign-in sheets from meetings).
- Providers should 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.) Providers should confirm that confidential information is not visible or accessible before submitting documentation to HHSC. If, for example, the provider redacts (i.e., blacks out) information on a document and scans it, they should confirm that information is not visible on the scanned copy. When submitting data in a spreadsheet, providers should be sure that fields containing confidential information are de-identified or deleted. Providers should not rely on hiding columns in a spreadsheet to protect confidential information, because columns can easily be unhidden.
- Sensitive information such as salaries may be redacted.
- Staff names should not be redacted (e.g. hiring forms, training logs).

Additional guidance is provided below for many of the most commonly selected milestones and metrics.

- 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.
    - Staff must have begun employment and not only signed a contract/agreement to be counted towards increased staff/hiring metrics. (For example, if an employment contract was signed on August 31, 2014, but the physician's start date is December 1, 2014, this metric should be carried forward and reported in April 2015.)

- For Project Area 1.9 projects, mid-level providers may not be counted towards achieving I-22.1 (increase in number of specialist providers) unless they were explicitly stated in the goal as the providers to be hired.

- Learning Collaborative Metrics: For metrics involving learning collaboratives (including regional learning collaboratives), documentation must include the date, agenda, sign in sheet, and a summary of topics discussed and *lessons learned relevant to the project to demonstrate participation.* The provider is not required to make a presentation at the learning collaborative event to demonstrate achievement of the metric.
- Metrics Involving Meetings: For metrics involving meetings, all meetings must be scheduled and completed as stated in goals to be eligible for October reporting. Dates, 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 to whom the findings should be disseminated. 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). Providers with similar projects do not need to select the same "raise the floor" initiative.
- Training metrics: For metrics that involve training, the documentation should include the training materials and training logs/sign-in sheets. Training logs/sign-in sheets should clearly identify staff being trained, organizations represented, number of people trained, and when the training occurred. For example, stating that "Andy, Mary, and Julie met with Alex and Nancy on the phone to provide diabetes training on 9/2/14" is unclear as to whether 2, 3, or 5 people were trained.
- Establishing a plan metrics:
    - For metrics that require an implementation plan, the following should be included:
        - Roles and responsibilities of those involved in implementation (providers, partner agencies, working group, etc.).
        - Timeline, including:
            - List of tasks to be completed (e.g., development of policies, procedures, or protocols, staff training, steps to address software needs, etc.).
            - Status of each task (e.g., Not started, In progress, Completed).
            - Scheduled start and completion dates for tasks.
            - Actual start and completion dates for tasks.
            - Name(s) of those responsible for completing tasks.
    - For metrics that require an evaluation plan, the following should be addressed:
        - Type of evaluation implementing (e.g., process and/or outcome evaluation).
        - Evaluation questions and measurable outcomes (outputs and outcomes).
        - Resources required (funds, partnerships, staff, technology, survey tools, etc.).
        - Major activities (including timeline and who is responsible).
        - Method for data collection.
        - Method for data analysis.
        - Plan for communicating and reporting results.

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, floor plans, etc., as applicable. Please include clear evidence that the construction/remodel/expansion is complete, the date of completion, and the date the location opened.
    - 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. Staff names should NOT 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. Staff names should NOT 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 such as brochures or advertisements showing hours before and after expansion, screen shots from a clinic scheduling system clearly showing hours before and after expansion, or other official documents such as letters, memoranda, or meeting minutes describing hours before and after expansion.
- 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. Staff names should NOT 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. Staff names should NOT 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: 2.1

Milestone: P-11 Identify current utilization rates of preventive services and implement a system to improve rates among targeted population.

Metric P-11.1: Implement a patient registry that captures preventive services utilization.

- Additional Guidance:
  - HHSC does not have a template or a set criterion to be used by providers. However, the registry should be designed to allow for the tracking of patient interactions and clinical studies (e.g. lab reports, patient histories) as necessary and pertinent to the DSRIP project.
  - Helpful references from the American Academy of Family Physicians regarding the development and role of patient disease registries:
    - http://www.aafp.org/fpm/2006/0400/p47.html

- http://www.aafp.org/practice-management/pcmh/quality-care/patient-reg.html

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. (If this metric is designated as QPI, use the *QPI Template*.)

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: 2.11

Milestone: I-8: Identify patients with chronic disease who receive medication management in their discharge instructions appropriate for their chronic disease.

Metric I-8.1: X percent increase of patients with chronic disease who receive appropriate disease specific medication management.

- Additional Guidance:
    - "Discharge" is considered a discharge from an acute care setting (typically a hospital) to an ambulatory care setting.
    - Medication management instruction documentation would generally include medication schedules or charts in combination with teaching or counseling documentation. Documented activities may include providing and discussing written materials related to medications with patients to ensure that they understand the purpose of various medications, when they should be taken, consequences of drug omission, precautions related to over-the-counter drugs, toxic side effects, etc.

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.
    - A referral for a service would count only once during the initial period in which the person was referred. The same person could not be counted towards P-3.1 in subsequent DYs.

Project Option: 2.15

Milestone: P-6 Develop integrated behavioral health and primary care services within co-located sites.

Metric P-6.1: Number of providers achieving Level 4 of interaction.

- Additional Guidance:
    - Documentation would need to demonstrate that the client/patient is coming to a single facility and receiving a set of integrated services. This could include a "scheduler" or calendar that shows both primary care and behavioral health providers sharing the same client/patient in the same facility on a shared record (EHR). Documentation could also describe how the providers are interacting. (e.g., case conferences).

CATEGORY 3 Instructions

Overview of Category 3 Milestones that appear in DY3 Reporting

- Milestone PM-7: DY2 Carry-forward (only for providers that did not report all DY2 milestones).
    - Providers submit a status update for each approved Category 3 measure. The *Category 3 DY2 Status Update Template* is posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under October DY3 Reporting.
    - Providers will earn any remaining DY2 allocation for the Category 3 measure for successful submission of this status report.
    - In order to successfully achieve this milestone, the provider must ensure that the Category 3 project ID (TPI.3.#) entered into the Status Update template matches the currently approved project ID AND that all required fields include an informative response based on where the provider was related to this outcome in DY2 (which could be that the provider had not yet selected this particular outcome, and was instead intending to do IT-X.X related to X, but based on the revised Category 3 framework decided in 2014 to switch to the current outcome because it's a better fit for the project or the provider has the data necessary to report to specs, etc.).

- Milestone PM-8: Submission of DY3 Status Report (only for providers that did NOT submit a status update in April 2014 (DY3).
    - Providers submit a status update for each approved Category 3 measure. 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 October DY3 Reporting.
    - The intention of this status report is for providers to describe their understanding of the measure specifications, denominator populations, planning for the Alternate Improvement Activities and any technical assistance needs. Providers earn 50% of their DY3 allocation for the Category 3 measure for successful submission of this status report.
    - In order to successfully achieve this milestone, the provider must ensure that the Category 3 project ID (TPI.3.#) entered into the Status Update template matches the currently approved project ID AND that all required fields include an informative response.

- Milestone PM-9: Validation and submission of baseline performance (i.e., submission of baseline template) (for all provider reporting baseline rates in DY3)
    - Providers earn 50% of their DY3 allocation for each Category 3 project with the submission of baseline performance through the *Category 3 Baseline Template*. The *Category 3 Baseline Template* is posted on the HHSC website on the Tools and

Guidelines for Regional Healthcare Partnership Participants page under October DY3 Reporting

- For those providers that are carrying forward baseline reporting into DY4 (i.e. not reporting the baseline template in DY3), providers should indicate in the Baseline Template that this milestone is being carried forward as well as responding to the qualitative carryforward questions in the reporting system.

- Please refer to the section below, *Category 3 Baseline Template,* for detailed instructions on completing the baseline template, goal setting DY4 and DY5, guide to qualitative questions, what type of documentation should be retained for audit purposes, and issues specific to certain projects/outcomes.

Instructions for completing the Category 3 Baseline Template

The Baseline reporting workbook contains all outcome measures (Category 3 project IDs) for a provider and is organized at the level of the associated Category 1 or 2 project. All providers should submit this template, even if baseline reporting is being carried forward. Please see the step by step instructions below.

PLEASE FOLLOW THE BELOW STEP-BY-STEP INSTRUCTIONS WHEN COMPLETING THE TEMPLATE. Templates that are not filled out completely will result in a need more information designation (NMI) during the reporting review and will result in payment delays.

- Step 1: Access the template and save a copy
  - Click on the Category 3 Baseline Template hyperlink on the Tools and Guidelines for Regional Healthcare Partnership Participants page on the HHSC website under October DY3 Reporting. When the version opens, save a copy to your local workspace using the following naming convention: "Category 3 Baseline Template.TPI.mmddyy"

- Step 2: Create provider specific template

  First Tab (Step 1)
  - **Rows 12-14:** Include the name, email and phone number of the individual who will be submitting the template. Progress indicator in row 6 will change from 'Incomplete' to 'Complete.'
  - **Rows 18-19:** Select RHP and TPI using the dropdown function. Provider name will populate row 20. Confirm that this is accurate before moving on. Progress indicator in row 7 will change from 'Incomplete' to 'Complete.'
  - **Row 27:** Click the 'Create Category 1 or 2 Outcome Tabs' button. This will create tabs in the workbook for each of your Category 1 or 2 projects as well as a Summary tab. Progress indicator in row 8 will change from 'Incomplete' to 'Complete.'
  - Click Save.

- Step 3: Orientation to the Summary tab

  Second Tab (Summary)

- This tab will automatically update as you report baseline performance (or carryforward) of the outcomes in the following tab. The only action required at this time is to ensure that all active Category 1 or 2 projects as well as the outcomes associated are listed.
    - IF there are any projects not listed here (Cat 1, 2 or 3) that you are expecting to report on, please notify HHSC immediately by sending an email to the Waiver mailbox (TXHealthcareTransformation@hhsc.state.tx.us) with subject line "Incomplete Category 3 Baseline Template. [TPI]" and attach your copy of the template to the email.
- At the bottom of this tab is a section for certification. This should only be completed after all the subsequent project tabs are completed.
    - Certification/validation of baseline rates requires an agreement 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.

- Step 4: Orientation to the Category 1 or 2 project ID tab (TPI.1 or 2. #)
    - This tab contains all Category 3 outcome measures associated with the Category 1 or 2 project specified. Outcome #2 (if applicable) is listed BELOW Outcome #1 so that providers are moving down the page instead of across the page.
    - The 'Progress Indicator' section has a row for each of the Category 3 outcomes associated with this project. When all of the required information for a single outcome is entered this indicator will change from 'Incomplete' to 'Complete.'
    - The next section is prepopulated with provider and Cat 1, 2 project details. Confirm that this information is correct.
    - **Row 25-28:** "Outcome Details" contains the outcome details and is prepopulated to include the Category 3 project ID, IT reference number, outcome title and outcome description per the measure specifications.
        - This description is the standard description of the measure and does not reflect any approved denominator subsets applied to this outcome.
    - **Rows 30-40:** Review the valuation details for this project. This table contains a breakdown of values by milestones by DY. The content for these milestones is dictated by the measure type (P4P or P4R).
        - There are some scenarios where the measure type will be changing following baseline reporting, in which case the milestones may change across DYs, however the allocation by DY would remain the same. For more description of the instances when measure types may change from P4P to P4R, please see p. 36, section **Baseline review process**
    - **Rows 45-85:** Review additional outcome details for approved denominator subsets (if any), measure type (P4P or P4R), goal setting methodology for P4P measures (QISMC or IOS), alternate improvement activities selected for P4R measure (PFP measure or Stretch Activity) and the outcome interpretation. The content listed in this section applies to baseline years as well as DY4 and DY5.

- IF improvement methodology is QISMC, the Benchmark Details (HPL and MPL) will be listed.
- IF the improvement methodology is IOS, the Benchmark Details will state NA.
- The outcome interpretation contains a description of the outcome selected including approved denominator subsets. This description was agreed upon by HHSC and the provider during the Category 3 selection feedback process.

- Step 5: Indicate readiness to report baseline performance during this reporting period
  - **Row 89:** If responding 'Yes' to readiness to report, additional fields below will open up that allow provider to continue reporting baseline performance.

    OR

    If baseline performance reporting is being carried forward to DY4, you must select 'No' using the drop down function.
    - If responding 'No' to readiness to report, another field will open and prompt providers to indicate carryforward of this milestone in the reporting system as well as respond to the qualitative carryforward questions. IF these questions are not responded to the milestone is not considered carried forward and will result in a NMI for this milestone.
    - Indicate 'Yes' that you have completed the requirements to carryforward this milestone using the drop down function. This will complete the steps you need to take for this outcome and the progress indicator for this outcome will change to 'Complete'.

- Step 6: Respond to measurement period, alignment of baseline population with approved outcome description and survey administration method
  - **Row 90:** Confirm that you are reporting a baseline measurement period of at least 6 months ending no later than DY3 by using the drop down to select 'Yes.' The specific measurement period will be populated in a subsequent section.
    - IF your baseline measurement period is less than 6 months, use the drop down to select 'No' and specify this shorter measurement period using the mm/dd/yy - mm/dd/yy format. **Please see p. 33, section **Supporting Documentation for Category 3 Milestones** regarding the use of shorter measurement periods**
  - **Row 91:** Indicate if the denominator population you are reporting on aligns with the approved denominator description by using the drop down.
    - IF your baseline population aligns with the approved measure definition (including subsets) select 'Yes' using the drop down function.
    - IF you are reporting on a proxy population (a cohort that deviates from the approved definition and different in some characteristic from the group you will be reporting in DY4 and DY5) select 'No' using the drop down function. **Please see p. 33, section **Supporting Documentation for Category 3 Milestones** regarding the use of proxy populations**

- IF you select 'No' to indicate that you are using a proxy population, a field will open that asks you to describe the similarities and distinctions between the characteristics of your baseline population and the group reported on in DY4 and DY5.
- A meaningful description will include:
    - *Why the use of a proxy population was necessary to report baseline performance (e.g., clinic not yet open and outcome has approved denominator subset of patients receiving services at this clinic).*
    - *How and why this proxy population was selected (i.e., how it is similar to the group that will be reported in DY4 and DY5).*
    - *How this proxy population is distinct from the group to be reported in DY4 and DY5. Specifically, are there any meaningful characteristics of this proxy population that may have effect on the reported outcome performance*?

- **Row 92:** IF the selected outcome is a survey or tool OD-10 (Quality of Life) or OD-11 (Behavioral Health), please indicate the survey administration scenario used using the dropdown function. ****Please refer to HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3** for additional guidance on *Pre-posttest Guidance for Quality of Life and BH Tools* regarding the description of survey administration options (i.e., scenario).
    - This selection will impact the data entry fields available in the subsequent section.

- Step 7: Review standard measure specifications
    - **Rows 100-102:** The description of the denominator and numerator per the standard measure specifications is pre-populated. If this outcome has multiple parts (e.g. IT-1.18; 7 and 30 day follow-up after hospitalization for mental illness) you will see that each part has a distinct section for quantitative data entry as well as a numerator and denominator description that applies to that part.
        - In most instances the pre-populated denominator description and count entered by the provider will be the same across parts of the same outcome (from IT-1.18 example above, denominator would read "patients discharged from acute setting with principle BH diagnosis"). ***It is important that these fields be entered for each part to ensure that the rates are calculating correctly.***

- Step 8: Enter denominator value
    - **Row 100:** If the outcome does not utilize an approved denominator subset (indicated on rows 45 to 49), enter the number of cases in the denominator per the measure specifications listed in the data entry box in row 100 called denominator count.

      OR

If the outcome is approved for the use of a denominator subset (indicated on rows 45 to 49, with subset description included in outcome interpretation in row 85), enter the number of cases in the denominator per the approved measure denominator. This is the number of cases in your approved denominator subset; e.g., IT-1.10- patients aged 18-75 years old with diabetes receiving services at Healthy Patients Primary Care Clinic.

- Providers with an approved subset may also enter the full denominator (if that data is available) in cell R100 so that the differences in volume between these two groups can be noted. The baseline rate will not be calculated using this full denominator value; it would be reported for informational purposes only. This is not required for providers that have an approved denominator subset with the exception of those providers who are requesting an alternate achievement level in DY4 and DY5. **Please see pg. 33, **Supporting Documentation for Category 3 Milestones** regarding requests for deviations from the standard achievement methodology.

- Step 9: Enter numerator value and define measurement period
  - **Row 101:** Enter the number of cases that occur in the numerator according to the description of the measure specifications.
  - Using the drop down function, define the baseline measurement period.
  - **Row 102:** If your measurement period is not included in the list, please select the last option "other" and define your measurement period in using a mm/dd/yy - mm/dd/yy format.
  - **Row 104:** The resulting baseline rate will be displayed in row 104. This is the value that will be used to determine DY4 and DY5 performance goals for P4P measures. **Please see p. 36, **Baseline review process and establishing DY4 and DY5 performance goals** for more information on goal setting subsequent to baseline reporting.

- Step 10: Respond to Qualitative Questions

  The baseline reporting template includes questions that are applicable to all measures as well as questions that are specific to certain types of outcomes**.** All qualitative questions that are applicable to the outcome being reported on are visible and require a response.

  - **Row 167-172: If the outcome is a risk adjusted rate (ONLY)** from OD-2, OD-3 or IT-4.1, respond to all questions in rows 167 to row 172.
    - ****Please refer to HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3 for additional information on DSRIP approved Risk Adjustment Methodologies**
    - Are the reported rates supplied by a vendor or calculated using vendor supported software (e.g., 3M, UHC, MIDAS, etc.)?
      - If Yes- what vendor (free text field)?

- If No- did you use the indirect standardization approach?
    - If Yes [indirect standardization was used]- select the normative data used from the drop down list:
        - TX CY2012 Medicaid norms
        - FL All-payer norms
        - Other (includes provider developed norms based on 2 years of historical data)
    - If No [indirect standardization was NOT used] - describe (briefly) how the rates were calculated or obtained. If data reported is based on Category 4 reports provided in April of 2014 by HHSC, simply state Category 4 values.

- **Row 171:** Define the number of eligible cases used to calculate the observed and expected rates.
    - For a readmission measure (OD-3) this would be the number of discharges during the measurement period that were eligible for a readmission.
    - For an admission measure (OD-2) this would be the number of individuals in the population eligible for admission.
- **Row 172:** Describe the findings of the observed (numerator) and expected (denominator) rates.
    - A meaningful description could include:
        - *What are some factors that could be contributing to this difference?*
        - *How does the normative data used (which drives the expected rate) affect these findings?*
        - *Are there any meaningful trends in socio-demographics or service delivery line that can be abstracted from the data?*

- **(ONLY) If the outcome is a P4P survey or tool from OD-10 or OD-11**
    - ****Please refer to guidance around pre and post testing with OD-10 and OD-11 tools, found on HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.**
    - If **Scenario 1** was selected (row 92): Baseline period includes pre- and post-test scores:
        - Enter pretest score information from the baseline measurement period. This information is not used to calculate baseline rate but is required to calculate DY4 and DY5 performance goals under scenario 1.
            - Enter a numeric value for the "Sum of Pretest Scores".
            - Enter a numeric value for the "Total number of individuals receiving Pretest".
            - This will automatically calculate the “Average Pretest Score" for the baseline period.

- If **Scenario 2** was selected (row 92): Pretest only baseline:
    - Enter posttest information from the baseline measurement period. This information is not used to calculate the baseline rate or calculate DY4 and DY5 performance goals and would be for informational purposes only.
        - Enter a numeric value for "[Optional] Sum of most recent Posttest Scores".
        - Enter a numeric value for "[Optional] Total number of individuals receiving Posttest".
        - This will automatically calculate the "Average most recent Posttest Score".
    - And **Scenario 3** was selected (row 92): Average score:
        - No additional fields visible under this option.

- **For all Category 3 outcomes**
    - **Row 173:** Does the baseline rate reported reflect all cases that fit the approved denominator description or was a sampling methodology used?
        - Use the drop down function to select 'all eligible patients' or 'sample.'
            - If a sampling methodology was used, respond to question regarding the estimated size of the eligible population and provide a brief description of how the sample population was obtained.
                - Example: We determined that we had approximately 500 denominator eligible cases. Because this outcome requires chart review to collect, we selected a random sample of these 500 cases, with a sample size of 150 cases. We used a random number generator to determine which cases would be selected for the sample and the reported rate is based on the findings from group.
    - **Row 174:** Describe the data base type.
        - Enter the record structure that contains the data used to report this rate (e.g., EMR, paper records, surveillance registry, etc.).
    - **Row 175:** Describe how the data was abstracted.
        - A meaningful description will include:
            - How the numerator and denominator cases were identified.
                - If electronic structure, describe what filters or codes were applied to build the report.
                - If paper structure, how was the eligible denominator population identified and where in the medical record was the determination made for inclusion in the numerator.
    - **Row 176:** Summarize the meaning of the reported baseline performance.

- Example for IT-1.9: During calendar year 2012 (01/01/2012-12/31/2012), of those adult patients with major depression and an initial depression score on the PHQ-9 greater than 9, 45% achieved remission (score of 5 or less) at the 12 month re-measurement period.

- Step 11: Describe impact to the intervention only population
  - **Rows 179 - 183**
  - For many Category 3 projects, the reported baseline rate represents a denominator bigger or different than the cohort that actually received the services described in the Category 1 or 2 projects (i.e., the intervention population). This section is an opportunity for providers to set the stage for reporting impact in outcome performance as a direct result of the intervention. For many providers this intervention only population will be the most useful description of how effective the intervention is in improving patient outcomes.
    - **Row 179**: Does the denominator reported in the baseline rate include individuals who did NOT receive the Category 1 or 2 intervention? Use the drop down function to indicate 'Yes' or 'No.'
      - If 'Yes,'
        - Do you have your data stratified in a way that you are you able to report the outcome in ONLY those individuals that have received the intervention?
        - Enter the number of individuals that received intervention that meet the criteria of the numerator.
        - Enter the number of individuals that received intervention that meet the criteria of the denominator.
        - This will calculate your intervention only baseline rate.
        - Describe (row 183) the differences in the baseline rate for individuals in the intervention only as compared to the full denominator.

- Step 12: Request an alternate achievement level
  - **Row 185:** Indicate if an alternate achievement level is being requested.
    - If 'Yes,' you must complete an Alternate Achievement Level form which can be found posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under October DY3 Reporting.

- Step 13: For P4R measures, indicate baseline performance on selected Alternate Improvement Activity (i.e. Stretch Activity or Population Focused Priority (PFP) Measure

  If the approved Alternate Improvement Activity is a Stretch Activity (indicated in row 81):

- **Row 189:** Describe any activities that your system has engaged in (during DSRIP period or prior) that are related to the selected Stretch Activity. If none, state that.
- **Rows 190-193**: If the approved Alternate Improvement Activity is a PFP Measure:
  - Enter the denominator count per the approved measure specifications (subsets are not used for PFP measures; this should reflect a system wide denominator).
  - Enter the numerator count per the approved measure specifications.
  - **Row 192**: The baseline rate will be calculated here and this rate is what is used to determine DY5 goals for this measure.
  - **Row 193**: Describe how the data for this baseline rate was abstracted.
- ****Please refer to the full description of the Alternate Improvement Activities on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.**

- Step 14: Progress indicator check for this outcome
  - **Row 6:** Check the progress indicator at the top of the page states 'Complete'
    - If not, confirm that all yellow cells that are visible have been populated.

- Step 15: Move to the next outcome
  - If you have another outcome for this Category 1 or 2 project your next outcome will be below the first outcome. The row numbers will be different for subsequent options under the same Category 1 or 2 project.
  - If this Category 1 or 2 project is associated with a sole Category 3 project, you have completed the requirements for this tab and can move to the next Category 1 or 2 project score.

- Repeat Steps 4 through 14 for each outcome listed in the workbook. *Save your work frequently!*

- Step 16: Certify that baseline data reported is accurate and adheres to approved measure specifications

  Certification/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.
  - Navigate back to the second tab (Summary)
  - **Rows 19 - 48:** (some rows may be hidden) Confirm that all intended baseline rates have been captured.
    - If the baseline has been reported the status will state "Reported in October 2014"
    - If baseline reporting has been carried forward the status will state "Carried Forward"

- **Row 56-58:** Below the Provider Status section there is a certification section. This section must be completed prior to baseline submission. If this section is not completed, all Category 3 milestones for baseline submission will receive a NMI during the review process and will result in payment delays.
    - The quality officer or designee should populate the fields in this section.

- Step 17: Confirm that all required fields are complete
    - Navigate to the last tab in the workbook (Progress Report) and confirm that all required steps are complete
        - IF there is a field that indicates 'Incomplete,' return to that tab to ensure that all of the canary yellow fields are populated.

Supporting Documentation for Category 3 Milestones that appear in DY3 Reporting

Beyond the DY2/DY3 Status Update Templates and the Baseline Reporting Template, which should be referenced as supporting documents for milestone achievement in the reporting system, most providers will not need to submit any additional documentation during the reporting period with a few exceptions. The scenarios below are described in greater detail in the subsequent section.

- Providers who requested TA around baseline reporting and received approval from HHSC to use a proxy population or a baseline measurement period shorter than six months.
- Providers reporting risk adjusted rates and using an internally developed algorithm to determine 'risk.' This is not applicable to providers who are using:
    - vendor supported software, or
    - Category 4 PPA/PPR reported values.
- Providers using a survey or tool from OD-6, OD-10 or OD-11.
- Providers who are requesting a deviation from the standard achievement level methodology for goal calculation in DY4 and DY5 (P4P measures only).

All providers should maintain records (internally) of the reports used to abstract baseline numerator and denominator: a.) To ensure that the same abstraction method is used in DY4 and DY5, and b.) Should HHSC or the compliance monitor ask to see these details.

- Providers who have requested deviation from standard baseline measurement period policies
    - Per the Category 3 planning protocol, baseline measurement periods should be a minimum of six months long and end no later than September 30, 2014. Baseline measurement periods should be as recent as possible and no older than the beginning of DY1.
    - Due to delayed project approval and outcome selections, there are some instances where providers were not able to meet these requirements. Those providers contacted HHSC and received technical assistance to determine the

best course of action relative to the Category 1 or 2 project with the goal of reporting a representative baseline rate in DY3 when possible.

- Providers received approval to capture a shorter measurement period if the minimum number of denominator cases outlined in the compendium documents was met.
- Providers received approval to use a proxy population if the denominator population that was approved has not yet received services.
- Provider received approval to carryforward the baseline measurement period into DY4 if there was no data (on denominator OR proxy population) available to report in DY3.

- All Category 3 projects that fit into one of the scenarios above have been (or will be prior to October 31, 2014 reporting deadline) discussed with the project managers and a resolution was agreed upon between the provider and HHSC. HHSC developed a description of the issue and the resolution. **This description (Baseline Exemption Form) should be submitted with the baseline reporting template to demonstrate that a shorter measurement period or use of a proxy population was approved.**

- Providers using an internally developed risk adjustment algorithm including indirect standardization will be required to submit a description (narrative is acceptable) of the method used to calculate these rates.
  - A meaningful description would include the following:
    - *Codes for index admission.*
    - *How a "readmission" was defined (e.g., a readmission chain or a single occurrence event).*
    - *Was clinically relevant readmission criteria applied?*
    - *How is preventable defined, was planned vs unplanned admissions taken into account?*
    - *If logistic regression (or any other modeling technique) what other factors were considered?*
    - *How was validation testing complete (not applicable for indirect standardization method)?*
    - *What is the evidence base for algorithm (not applicable for indirect standardization method)?*
    - *For admissions only, how was the admission eligible population (denominator) defined (i.e. how was the population at risk for an admission captured)?*

- Providers reporting a patient satisfaction, quality of life, or behavioral health survey tool from OD-6, OD-10, or OD-11 will submit a Cat 3 Survey Administration Form qualitatively describing their survey administration methodology. ****Please refer to the Survey Administration Form on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.**

- All OD6, OD10, & OD11: Providers will describe their method of survey administration including who issues the survey and how it is administered (in person, via email, over the phone, etc.), and any licensing acquired or training for individuals issuing surveys.
    - OD6 ONLY: Providers will describe their time between providing service and issuing the tool and if they are using an external survey administrator.
    - OD-10 and OD-11 ONLY: Providers will describe their selected reporting scenario (Scenario 1, 2, or 3), their rationale for their selected scenario, their retest period between pre and posttest if applicable.
    - OD-10 and OD-11 ONLY: excluding the CDC-HQOL: Provider will indicate if they have opted to use a pretest score boundary to normalize their population, and how they arrived at their final score boundary.
- Providers using the same tool and same survey administration process across multiple projects and/or regions should submit one Survey Administration Form per region, indicating each Cat 1 or 2 project in the "Project ID" section of the form.

- <u>Requesting a deviation from the standard achievement levels for goal calculation in DY4 and DY5 (P4P measures only)</u>
  Providers with P4P outcomes who are requesting a deviation from the standard achievement methodology will be required to complete and submit the form for this request. The *Achievement Level Deviation Request Form* can be found **on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.**
    - For those projects that meet ANY of the following criteria:
        - If the intervention population, same as the Category 1 or 2 intervention QPI, is much smaller than the denominator size reported in the baseline template defined with a threshold of:
            - Intervention to Outcome volume ratio = (cumulative QPI)/ (Cat 3 baseline denominator) < 0.25.
        - If the cohort reported in the baseline denominator is significantly different than the denominator required in the measure specifications (a proxy population), or
        - If the benchmarks provided (for QISMC measures only) are calculated on a cohort that is distinctly different, in terms of outcome measurement, than the cohort used to report the approved denominator population.
            - E.g., with the use of approved denominator subsets for age or ethnicity, the HPL and MPL for outcome IT-1.10- A1c poor control (>9%) may not be an appropriate fit as this HEDIS benchmark was captured on a level of all insured diabetics age 18-75 years of age.

Baseline review process and establishing DY4 and DY5 performance goals- next steps following baseline submissions

Providers who submit baseline performance rates in DY3 will receive payment for the activity of completing the baseline template for that outcome. Following that, HHSC staff will review the actual rates reported to determine the numeric performance goals for DY4 and DY5 for P4P measures (this includes PFP measures associated with a P4R outcome) with the formulas described in the compendium documents.

If, during that review, HHSC has questions or feedback regarding how the rate was calculated we will communicate any concerns to providers prior to April 2015 reporting. This will be an opportunity for providers to "true up" baseline performance if there were any errors in the abstraction process. In addition, HHSC staff will be looking for any reported baseline rates that fit into the following scenarios and offering resolution:

- Baseline measurement periods that are carried forward into DY4
    - For most of these instances, HHSC and the providers have already agreed that these outcomes would switch to P4R with a required improvement in DY5 relative to the baseline established in DY4.
- Reported baseline results in less than 15 cases in a six month measurement period or 30 cases in a 12 month measurement period (i.e., small N).
- Requests for deviations from the Standard achievement levels (defined in brief below):
    - IOS: 5% in DY4 and 10% in DY5.
    - QISMC: 10% gap reduction between baseline and HPL or achievement of MPL in DY4 and 20% gap reduction between baseline and HPL or gap reduction of 10% between MPL and HPL in DY5.
- Internally developed risk adjustment algorithms.
- Providers that are high performing in the outcome at baseline.
    - For QISMC measures this is at a rate higher than the HPL.
    - For IOS measures this is at a rate higher 95% or 5% (depending on measure directionality)

CATEGORY 4 Instructions

The final opportunity for providers to report DY3 Category 4 is in October 2014. 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 who 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 is Texas' Medicaid External Quality Review Organization (EQRO), prepared reports for hospitals for reporting domains RD-1 – Potentially Preventable Admissions, RD-2 – 30-day Readmissions, and RD-3 – Potentially Preventable Complications. HHSC provided the individual reports on RD-1 and RD-2 (based on Medicaid and CHIP data) to hospitals by email on April 16, 2014 (for RHPs 1, 4, 5, 6, 7, 8, 9, 10, 14, 15, 16, 17, 18, and 20) and April 17, 2014 (for RHPs 2, 3, 11, 12, 13, and 19). This data will not be re-sent for October 2014 reporting. If an individual report needs to be re-sent to a provider, please contact HHSC at TXHealthcareTransformation@hhsc.state.tx.us. 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 received the data from HHSC in mid-April. In subsequent reporting periods (DY4 and DY5) providers will be required to submit responses to qualitative questions 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 are provided on the reporting template.

Providers are not required to submit additional documentation beyond the *Category 4 Reporting Template.* However, providers are subject to additional monitoring at any time and should maintain the documentation for their Category 4 data.

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). HHSC will not accept measurement periods of less than 12 months.

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. The numbers entered in the numerator and denominator fields should be all-payer data. If the provider is able to report on HCAHPS rates for the DSRIP-only population, please include it in the qualitative response section. HHSC is unable to grant exceptions to the use of HCAHPS unless there is a reason that using HCAHPS would be inappropriate for the population served.

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.

Alternate Approaches for Medication Management under review by CMS—please note that HHSC will provide an update once guidance is received from CMS on whether alternate approaches that are best practices can be approved for payment. At this time, it is not known whether payment can occur.

- Some hospitals have expressed concern that implementation of this measure per specifications are counter to what they have experienced as best practices for medication management in their facilities and have alternate approaches to medication management.
- HHSC has proposed to CMS to allow providers to report an alternate method of medication management based on best practices as a basis for Category 4 payment to occur for these alternate methods.
- For DSRIP reporting, providers would enter "0" in the reporting field, and report on their alternate method in the qualitative reporting.

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. Note: "Time" and "Provider Time" in the numerator and denominator are used interchangeably. The numbers entered should be all-payer data. Please also include the ED admit decision time to ED departure time for admitted patients information for DSRIP eligible patients in the qualitative response section if available.

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 must report on all of the listed measures; however, for measures that cannot be reported, providers may provide a justification to explain why a measure cannot be reported.

Possible acceptable rationales for not reporting on a measure include:

- The hospital does not serve the population that is being measured.
- The hospital does not provide outpatient services that are being measured.
- There is not a statistically significant population to report the measure – defined as at least 30 cases included in the denominator.

- The hospital's current data systems do not allow for the measure to be reported; if so, include information about what the hospital is doing to be able to report it in later years.
- The identical data is being reported as a Category 3 outcome (including same denominator as Category 3).

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.

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.

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

October 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 October 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 for October reporting: 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 for October reporting is $4 million - $3 million = $1 million.

Note that DSRIP funds are Medicaid incentive payments that are earned for achieving approved metrics at agreed upon values. Once those funds are earned, neither HHSC nor CMS is prescribing how they are to be spent, but we certainly encourage providers to spend them to improve healthcare delivery, particularly for the Medicaid and low-income uninsured populations.

Category 3 Payment Calculations

October Category 3 DSRIP payments are based on completion of the *Category 3 DY3 Status Update Template, Category 3 DY2 Status Report Template, Category 3 Baseline 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 April 2014 Needs More Information (NMI) milestones and metrics

In July 2014, HHSC completed review of April 2014 reporting submissions in response to HHSC requests for more information. Approved Needs More Information (NMI) milestones and metrics will be included in the January 2015 payment processing of October reports. NMI milestones and metrics that were not approved will no longer have access to the associated DSRIP funds.

IGT Processing

In December 2014, HHSC Rate Analysis will notify IGT Entities and Anchors of the IGT amounts by affiliation and IGT Entity by RHP for January 2015 payment processing of approved October reports. The IGT amounts for April 2014 approved NMI milestones and metrics, DY2 carry forward achievement, DY3 achievement, and remaining DY3 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.

HHSC requested 100 percent of the DY3 IGT monitoring amount with July 2014 payment processing of April reports. If the full DY3 IGT monitoring amount was not submitted by an IGT Entity in July 2014, it will be requested with January 2015 payment processing of October reports. If the full DY3 IGT monitoring amount is not submitted by an IGT Entity by 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 FFY2015 and used for January DSRIP payment processing of October reports is 58.05. The FMAP for FFY2016 is estimated at 57.23.

IGT Entity Changes

The IGT Entity(ies) for each project/outcome is listed under "IGT Funding" on the Project Details page. If you have changes to the IGT Entity, either in Entity or proportion of payment among IGT Entities, listed in the reporting system, please complete the *IGT Entity Change Form* available at http://www.hhsc.state.tx.us/1115-docs/DY3-Templates/April2014/IGT-Entity-Change-Form.xlsx. IGT Entity changes must be received no later than **October 31, 2014, 11:59 p.m.** for October reporting DSRIP payment processing. Any changes received after October 31, 2014, will go into effect for the April DY4 DSRIP reporting and payments will be delayed until that time. Note that IGT Entity changes submitted for October 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 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.