PHASE 4 COMPANION DOCUMENT

Contents

Phase 4 Overview

This companion document is for Phase 4, which HHSC is using for DSRIP providers to make certain required changes to approved Category 1 and 2 projects and also to allow providers to request plan modifications to approved projects. The activities included in Phase 4 are:

- Priority technical corrections identified by CMS and/or HHSC in the initial CMS approval letters, such as addressing required core components.
- Other technical corrections identified by HHSC needed to be eligible for payment, including updating each DY 3-5 milestone/metric with a goal that currently is TBD or non-quantifiable.
- Provider-requested plan modifications for DY 3-5.

Per the Program Funding and Mechanics Protocol, all corrections requested in Phase 4 must be addressed by the provider and approved by HHSC and CMS in order for a project to be eligible for DSRIP payment starting in DY 3.

Phase 4 Timeline

- **November 4, 2013** – HHSC provides technical corrections comments and feedback on Category 1 and Category 2 milestones/metrics.
- **November 6, 2013, 10:00am** – DSRIP Phase 4 Webinar. Please refer to the waiver website for dial-in information.
- **November 22, 2013** – Final date to submit questions to HHSC regarding Phase 4.
- **December 6, 2013** – RHPs submit responses to HHSC comments along with full project descriptions as needed. RHPs submit requests for plan modifications to the plan narrative or milestones/metrics for DY3-5. Performing Providers must submit any changes or plan modification requests to the Anchor to compile and send in one submission packet to HHSC (TXHealthcareTransformation@hhsc.state.tx.us) by the due date. Anchors may submit the completed Phase 4 documents using one of the following:
    - Email the completed files to DY2DSRIP@deloitte.com; or
    - Email a link(s) to the files to DY2DSRIP@deloitte.com; or
    - Mail a CD or USB containing all files to:

      Andrea Quinn
      4900 North Lamar Blvd. H425
      Austin, TX 78751

- **Mid January 2014** – HHSC provides feedback on Phase 4 submissions.
- **Late January-Early February 2014** – RHPs submit responses to HHSC feedback. Performing Providers must submit responses to HHSC feedback to the Anchor to compile and send in one submission packet to HHSC (TXHealthcareTransformation@hhsc.state.tx.us) by the due date.

Priority Technical Corrections

Per the Program Funding and Mechanics (PFM) Protocol (Section 15(b). Priority Technical Corrections [incorrectly labeled section 35(b) in the most recent version of the PFM Protocol approved by CMS in September 2013]), the following areas represent Priority Technical Corrections that need to be addressed by performing providers to be eligible to earn DSRIP funds beginning in DY3:

- Hospital provider Category 3 outcome does not meet criteria for one standalone or three non-standalone measures.
- **Provider did not include at least one process milestone and one improvement milestone.**
- Category 3 outcome duplicates an improvement milestone.
- **All project components, if required, were not included in the narrative or milestones.**
- **Project lacks clearly defined milestones and metrics, including the lack of a quantifiable patient impact milestone for DYs 4 and 5, as required by paragraph 14.b.i.**
- **Any other priority technical correction CMS specifies for a project in the RHP Plan initial approval letter.**
- **Any other priority technical correction identified by HHSC, including any identified by HHSC subsequent to the RHP Plan initial approval letter, that is needed to clarify a Category 1 or 2 project or Category 3 outcome in order to make payment, such as clearly defined milestones and metrics.**

The bold items in the list above will be addressed in Phase 4. The first item will be addressed at a later date once the Category 3 measures and improvement methodology are finalized, and the third item was addressed in Phase 1.

Instructions

To identify areas of the project that require technical corrections/revisions related to the core components and narrative, providers will review *Project Narrative and Core Comp* tab included in the Master Project List file.

- First column *HHSC Comment* includes technical corrections identified by HHSC and/or CMS. Providers need to review identified technical corrections and update the project to address the concerns.
- HHSC highlighted the cells in orange in cases where the project has technical correction areas identified.
- After the projects are updated, providers need to enter the date of the revision in *Provider Change Date* column of the *Project Narrative and Core Comp* tab and describe changes to the project in the *Provider Change Comment* column.

Technical Corrections Areas

Technical Corrections Related to Category 3

- During original technical review of the plans, HHSC and CMS identified a number of projects with priority technical corrections where Category 3 requirements specified in the Program Funding and Mechanics Protocol were not met. This includes, but is not limited to instances where the projects do not include one stand-alone or three non-standalone measures, or where measures submitted with the projects require additional revisions to meet RHP Planning Protocol requirements.
- HHSC requests that the providers do not make changes to address Category 3 technical corrections at this time since the Category 3 portion of the RHP Planning Protocol is currently under revision. Once the menu is finalized providers will have an opportunity to address Category 3 concerns and update measures.
- Category 3 updates will be collected outside of Phase 4 (targeted for early 2014).
- To indicate which projects had technical corrections related to Category 3, HHSC included a note in the HHSC comment column: ***HHSC had previously included technical correction recommendations related to Category 3, however, the provider is not required to make changes related to Category 3 at this time. Providers will be able to correct issues related to Category 3 when the RHP Planning Protocol is finalized.***

Missing Process or Improvement Milestones

- The Program Funding and Mechanics Protocol requires that each Category 1 or 2 project include at least one process and one improvement milestone.
- If the project is missing a process or improvement milestone, the provider needs to add a milestone using the process described on p. 16 of the companion document and describe the action in the *Provider Change Comment* column.
- Some projects that previously did not have a process or improvement milestone may already have the issue addressed due to the milestone/metric cleanup process included in Phases 3 and 4. If the issue was addressed, the HHSC comment box will have a note stating that this issue was already addressed. The provider will need to include a note in the *Provider Change Comment* column confirming that the project includes both a process and improvement milestone.

Required Core Components

- The RHP Planning Protocol identifies project options that require core components by listing these core components underneath the project option. For example, in Project Area 1.1 Expand Primary Care Capacity only one project option, 1.1.2, requires specific core components.

1.1 **Expand Primary Care Capacity**

Project Options:

1.1.1 Establish more primary care clinics
1.1.2 Expand existing primary care capacity
Required core project components:
a) Expand primary care clinic space
b) Expand primary care clinic hours
c) Expand primary care clinic staffing
1.1.3 Expand mobile clinics

- The majority of the project options require Continuous Quality Improvement (CQI) as a core component; however, in many instances the protocol includes this requirement in a note versus a listing underneath each project option. For example:

Note: All of the project options in project area 2.8 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

If a requirement to include CQI as a core component was specified in the note, HHSC added this component in the *Project Narrative and Core Comp* tab. For example, all project options in project area 2.8 would list a required component A (CQI) in the *Required Core Components* column.

- In case a project did not have all core components included in the narrative or if the provider did not include sufficient explanation of the components, HHSC included the notes of the issues identified in the *HHSC comment* column.
- HHSC also included a reference to the number of required core components in the Required Core Components column. For your convenience, HHSC is providing an Excel version of the required core components by project option that will be posted under Tools and Guidelines for Regional Healthcare Partnership Participants. The providers can use this document to determine if all core components required for each project are clearly described in the project.
- If some core components were not addressed in the project at all, HHSC showed the listing of these components in the *Core Components not included* column and highlighted them in orange.

- In case the provider included some information related to the core components but did not fully describe one or all components, HHSC entered the listing of these components in column *Core Components* and highlighted them in orange.
- Even though HHSC identified projects where selection or explanation of the core components requires updates, HHSC encourages all providers to review how the project addresses the required core components to make sure it is clear how the project is implementing required core components and to clearly explain why a project is not implementing one or more core components if that is the case. Core components will be one of the criteria for the mid-point assessment and ongoing DSRIP monitoring.
- Once providers revise the projects to reflect all required core components in the narrative (including the explanation for the core components that will not be implemented due to certain reasons (e.g. space will not be expanded because the provider has two extra offices available, etc.),the providers will also update the *Project Narrative and Core Comp* tab.
    - Providers should enter all core components (e.g. A, B, etc.) that will be implemented in the project in column - *Core Components included in the Project.*
    - Providers should enter all core components (e.g. A, B, etc.) that will not be implemented in the project in column - *Core Components not included.*
    - Providers should highlight cells that were updated to reflect selected core components in green.
- The provider will also need to include a note in the *Provider Change Comment* column confirming that all required core components are reflected in the project.

Any other priority technical correction CMS specifies for a project in the RHP Plan initial approval letter.

- HHSC included technical correction areas specified by CMS in the RHP Plan initial approval letter. Providers will need to update projects to address CMS comments and include notes in the *Provider Change Comment* column confirming that all issues are addressed.

  Examples of CMS comments:

  > *CMS comment: Needs to provide assurances that Federal funds are not being used for lobbying activities*.
  >
  > *CMS comment: Needs to tie to the Community Needs Assessment*.

- Providers are not required to address CMS comment "Needs to align milestone values with RHP workbook" included in the original approval letter, since this is addressed by Phase 3, Phase 4 and the transitioning to the Excel version of the Milestone and Metric table.

Plan Modifications

Overview of Plan Modification Process

Per the Program Funding and Mechanics Protocol, a DSRIP provider may submit requests to modify elements of an existing project prospectively, including changes to milestones and metrics with good cause. A Regional Healthcare Partnership (RHP) is required to submit plan modification requests to HHSC 90 days prior to when changes go into effect. Since December 2013 is the first opportunity HHSC is offering for demonstration year (DY) 3 plan modification requests, submission in December is acceptable for DY 3 plan modification requests even though DY 3 has begun.

In Phase 4, a provider also may make priority technical corrections at the request of HHSC/CMS, including clarifying metric/milestone language and goals. These changes do not constitute plan modifications unless the provider is substantially changing the content of the project narrative or the milestones/metrics. If a provider is not sure about whether a project change is a plan modification, it should err on the side of submitting it as a plan modification. The types of changes that constitute a plan modification include:

- Change in the type/scope of the services provided.
- Change in the quantifiable patient impact over the life of the waiver (either # of patients served or # of encounters provided).
- Change in the % of project that is targeted toward the Medicaid/low income uninsured populations.
- Change in carrying out the core components.
- Other changes that may cause a project to vary from the project option on the menu, e.g. if the project is required to use an evidence-based model, and the provider is changing the model being used.

The next round of plan modification requests will be accepted by HHSC in June 2014 (specific date to be determined). The June 2014 plan modification requests may apply to DY 4 and/or DY 5. If a performing provider needs to modify a project only for DY 4-5 (not DY 3), HHSC strongly recommends that the plan modifications be submitted in June 2014 rather than December 2013 to avoid duplicate work both for the provider and HHSC. If a provider submits a plan modification for DY 4-5 only in December 2013, HHSC will prioritize review of the request after requests for plan modifications that include DY 3. (It may take HHSC longer than 30 days to take action on a plan modification request for DY4-5 submitted in December.)

HHSC has 30 days to take an action on a plan modification request using a CMS-approved approach, criteria and checklist. Once reviewed and all issues addressed, HHSC will send the state-approved plan modification to CMS along with the review checklist. CMS will validate that HHSC followed the approved procedure and shall take action to approve or disapprove the plan modification request within 30 days of receipt from HHSC.

Provider Instructions

- Each performing provider that seeks to make a plan modification to a project must submit one completed Plan Modification form per Category 1 or 2 project along with other Phase 4 changes to your Anchor. Your Anchor will notify you of the due date. The Anchor will then compile and send all Phase 4 changes and plan modification requests in one submission packet to HHSC no later than December 6, 2013.
- For any plan modifications, please attach a revised narrative and enter any changes to milestones and metrics in the Phase 4 Excel template.
- Please note that Category 3 changes should not be included in the plan modification request submitted in December 2013, since requests for changes to Category 3 measures will be collected outside of Phase 4, (targeted for early 2014), after the revisions to the Category 3 portion of the RHP Planning Protocol are finalized.
- You may not request increases in project valuation through the plan modification process. If you have determined that you are not able to carry out a project based on the approved valuation, you may request to narrow the scope of the project, which HHSC will review in light of the approved valuation.

Other DY 3-5 Updates

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

IGT Entity changes: The IGT Entity(ies) for each project/improvement target is listed in the *Master Projects List* file under the "IGT" tabs. If you have changes to the IGT Entity listed in the *Master Projects List* file, please complete the *IGT Entity Change Form* available at http://www.hhsc.state.tx.us/1115-docs/RHP/Plans/IGT-Change.xlsx. Complete one form for each IGT Entity. IGT Entity changes must be submitted by the due date of the semi-annual reporting of DSRIP milestone achievement to be considered for payments in that period (i.e. by April 30 or October 31 for DY3-5. Any changes received after the due date of semi-annual reports will go into effect for the following reporting period and payments will be delayed until that time.

Milestones and Metrics Table – replaced by Master Projects List file

The Milestones and Metrics tables which were previously included in the RHP Plan for each Category 1-4 project/outcome/reporting domain have been replaced by the data included in the *Master Projects List* file for each provider. The data included in the *Master Projects List* will be used as the basis for payment for Category 1, 2, and 4 for DY3-5. Any Category 3 changes will be submitted through a separate process after the Category 3 approach has been finalized with CMS. The *Master Projects List* file reflects changes from Phase 1 (projects not initially approved by CMS), Phase 2 (QPI impact), and Phase 3 (changes to address DY2 TBD and non-quantifiable goals and missing data sources).

There are 22 Category 1 or 2 Table 5 projects that as of November 1, 2013 are pending a CMS decision regarding valuation. HHSC has included these projects in the *Master Projects List* file for now at the lower CMS-proposed value for DY2 and DY3. If in November CMS approves the original project value, HHSC will correct that information for the project so that it is eligible to earn its full DY2 and DY3 approved value.

The *Master Projects List* does not include CMS feedback on DY4-5 project valuation since this review is still in process.

The *Master Projects List* does not include replacement projects that were submitted in Phase 1.

Note: DY2 information and Category 3 tabs are included for informational purposes only and cannot be changed through Phase 4.

General Notes on Working with the *Master Projects List*

- You may use the filters to select a project; however, do not use the filters to sort projects. This will cause data to be misaligned.
- You may widen the columns or use the formatting option of wrap text; however, do not delete any columns. This will cause errors on the Summary tabs.
- Cells will automatically highlight in green if changes are made in the data worksheets for milestones and metrics. If cells are not automatically highlighting in green, please contact HHSC to fix the file.
- If the Summary tabs do not appear to be working, try going to File→Options→Formulas and check that "Automatic" is selected for "Workbook Calculation."
- If the Summary tab shows an error box when you select a different Project ID, select "End" and the table should populate correctly.
- The main items that need to be updated regarding goals and data sources can be found in the columns in the Category 1 and 2 tabs referring to "Metric #X Baseline/Goal (DYX)", "Metric #X Type", "Numeric Goal", "Metric #X Data Source (DY2)" and "Data Source Provider Manual Desc (if needed)".

Summary Table

Each *Master Projects List* template includes tabs to summarize milestones and metrics for DY2-5 in one table. These summaries are included in the "Cat 1 Summary", "Cat 2 Summary", and "Cat 3 Summary" tabs. The Summary tabs are read-only and data cannot be updated within the Summary tabs. Changes to milestones and metrics must be made in the individual applicable Category and Demonstration Year tabs referred to as the data worksheets.

Quantifiable Patient Impact (QPI) Metrics

Using the Quantifiable Patient Impact (QPI) data that was submitted to HHSC through Phase 2, HHSC has updated DY3-5 milestones/metrics to reflect the QPI goals. QPI metrics are indicated as "Yes" in the "Metric #X QPI (Yes/No)" field for each metric. If the cell is blank or indicates "No", no QPI impact is required for the metric.

Performing Providers are required to meet the numeric goal of total QPI impact to be eligible for payment for the metric. The "Numeric Goal" for QPI metrics shows the number of individuals or encounters that will be impacted by the metric. If the metric goal includes items other than the QPI, those activities must also be achieved to be eligible for payment. The "Numeric Goal" must match the QPI goal even though there may be other numeric goals for the metric. For example, a Project Option of 2.15.1 identified P-6.1: number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system) as the QPI metric.

> Project Option 2.15.1
>
> DY3 Metric P-6.1: number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system)
>
> Metric #1 Baseline/Goal (DY3): one provider achieves Level 4 of interaction. Serve 100 individuals.
>
> Numeric Goal: 100.
>
> Metric #1 QPI (Yes/No): Yes

The provider must report on and provide supporting documentation that one provider achieved Level 4 of interaction and 100 individuals were served to be eligible for payment for the metric.

HHSC requires the cumulative QPI impact to be demonstrated through reporting to be eligible for payment. This is necessary because providers are allowed to carry forward metrics into the following year for late achievement. Cumulative reporting is different than what HHSC and CMS used for Phase 2 valuation review, when HHSC requested that the targets for each DY should indicate the project-based workload in any given year. However, when providers report on QPI metrics for payment purposes, they should report the cumulative QPI figure, which equals the number reported during the current year plus the numbers served in prior DYs. HHSC has pre-populated the QPI metrics with cumulative information based on the information providers submitted for each project in Phase 2.

In the 2.15.1 example above, in DY4, the provider identified I-8.1: X% of individuals receiving both physical and behavioral health care at the established locations as the QPI metric. In the QPI spreadsheet, the provider submitted 100 individuals as the QPI goal for DY3 P-6.1 and 150 individuals as the QPI goal for DY4 I-8.1. The cumulative QPI goal is 250. The existing metric goal stated HHSC has updated the QPI metric "Numeric Goal" for DY4 I-8.1 as 250.

> Project Option 2.15.1
>
> DY3 Metric I-8.1: X% of individuals receiving both physical and behavioral health care at the established locations
>
> Metric #1 Baseline/Goal (DY4): 30% of individuals receiving both physical and behavioral health care in project sites out of total number of individuals receiving services in project sites. Serve 150 individuals in DY4. Total impact of 250 individuals.
>
> Numeric Goal: 250.
>
> Metric #1 QPI (Yes/No): Yes

Along with meeting the percentage goal of 30%, the provider must report on and provide supporting documentation that 250 individuals have been served by the project by DY4 to be eligible for payment for the metric. This includes the 100 individuals from DY3 and 150 individuals from DY4. HHSC is using the cumulative figure for reporting since providers have the opportunity to carry forward a metric into the following DY for late achievement. If a provider does not achieve the 100 individuals in DY3, it must first serve a total of 100 to earn the DY3 payment prior to being eligible to serve the additional individuals to earn the DY4 payment.

Medicaid/Low Income Uninsured Impact

In addition to meeting QPI goals, some projects are required to meet a specified Medicaid/low income uninsured impact as reported in Phase 1 changes. CMS required this information for certain specialty care and other projects to ensure they had a significant impact on the waiver's target populations. Metrics with required Medicaid/low income uninsured impact information are indicated as "Yes" in the "Metric #X Medicaid/Indigent Required (Yes/No)" field for each metric. Performing Providers for these projects are required to include and meet a Medicaid/low income uninsured impact to be eligible for payment for the metric. If the cell is blank or indicates "No", no Medicaid/low income uninsured impact is required for the metric.

While other projects are not required to report on and meet the specified % of project impact on the Medicaid/low income uninsured populations in order to achieve metric payment, all projects should report on Medicaid/low income uninsured impact in the qualitative semi-annual reports. For many Phase 1 projects, providers supported the project to CMS and HHSC by stating that it would have a large impact on the waiver's target populations. Even though this information was not required to be added to the metrics for all projects, it will be important to show in the semi-annual qualitative reporting whether the provider is reaching the Medicaid/low-income uninsured targets that the provider included

either in Phase 1 or Phase 2. This will be one of the criteria for the mid-point assessment and ongoing DSRIP monitoring.

HHSC Comments on Milestones and Metrics

HHSC identified TBD and non-quantifiable goals for DY3-5 in Phase 4 similar to Phase 3 comments to address DY2 goals. Please see the section below for more information on revising these goals. In addition, HHSC provided comments/changes for the following:

- If a metric for the same milestone was used for multiple milestones, HHSC combined the metrics under one milestone and revalued the milestones to be equally valued.
    - For example, if Milestone 1, Metric 1 is P-4.1 and Milestone 2, Metric 1 is P-4.2, then HHSC combined the two milestones into one milestone with two metrics (Milestone 1, Metric 1 [P-4.1] and Metric 2 [P-4.2]).
- If a project used an improvement milestone to establish a baseline in DY3, then HHSC updated the milestone to a customizable milestone.
    - For example, a project includes Project Area 1.9, Metric I-23.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. If the goal stated establish baseline of number of visits, then HHSC updated it to a customizable milestone and metric of P-101.1.
- If a goal varied from a milestone/metric, then HHSC updated the goal to match the metric or requested that the provider update the goal to match the metric.
    - For example, a project includes Project Area 1.7, Milestone P-4: Implement or expand telehealth program for targeted health services, based upon regional and local community need, Metric P-4.1: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents. If the goal stated developed implementation plans, then HHSC updated the goal to developed implementation plans and implemented telehealth program. HHSC has noted in the "HHSC Comment" column if the goal does not match the selected metric.
- If a metric required a numerator and denominator according to the RHP Planning Protocol, then HHSC updated the goal to include the numerator and denominator description from the protocol. Performing Providers may update the numerator and denominator description to match their project.
    - For example, a project includes Project Area 2.1, metric I-16.1: percent of primary care visits at medical home. If the goal stated 50 percent of primary care visits at medical home, then HHSC updated it to include the numerator and denominator from the protocol of 50 percent of enrolled patients' primary care visits with medical home primary care provider/team out of total number of enrolled patients' primary care visits within the Performing Provider.
- If two similar metrics were chosen, then HHSC recommended removal or combination of the similar metrics. This mainly occurred for similar milestones that were provided for use with an innovative project option.

  - For example, Project Area 1.10 includes metrics I-7.1 and I-10.1 which are both: increase the number of reports generated through these quality improvement data systems. If a project used both I-7.1 and I-10.1, then HHSC recommended removal of one of the metrics.
- If a metric is missing a data source, then HHSC noted this for provider correction.

Revising TBD and Non-Quantifiable Milestone/Metric Goals

In the *Provider Correction Template*, HHSC has identified DY 3-5 milestones/metrics with TBD or non-quantifiable goals. These goals must be revised to be eligible for DSRIP payments. Please see below for examples of feedback and suggested changes.

"TBD" goal

If a goal is indicated as "TBD" in the Milestones and Metrics Table, then the goal must be updated to include a number, percent, or deliverable (e.g. completed strategic plan).

Example 1:

- Milestone 1 [P-1]: Conduct stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS, and relevant community behavioral health services providers.
- Metric 1 [P-1.1]: Number of meetings and participants.
- Baseline/Goal: TBD
  HHSC recommended update: Baseline: No stakeholder meetings; Goal: Four meetings will be held during DY 2 with an estimated 30 attendees at each meeting.
- Data Source: Attendance lists and meeting agendas

Example 2:

- Milestone 3 [P-9]: Develop program to identify and manage chronic care patients needing further clinical intervention.
- Metric 1 [P-9.1]: Increase number of inpatients with CHF identified as needing other clinical services or intervention once discharged
- Baseline/Goal: TBD longitudinal Year 2
  HHSC recommended update: Baseline: 25 percent of CHF inpatients (50 patients) are identified as needing other clinical services at discharge. Goal: 40 percent of CHF inpatients (80 patients) are identified as needing other services or interventions at discharge.
- Data Source: EHR, internal patient database

Example 3:

- Milestone 1 [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 1 [P-3.1]: Number and types of referrals that are made between providers at the location.
- Baseline/Goal: [missing]
  HHSC recommended update: Baseline: 20% of clients (100) receiving behavioral health services are referred to a primary care provider/services. Goal: Increase the number of referrals by behavioral health providers to primary care providers/services by 50 percent (150).
- Data Source: Surveys of providers to determine the degree and quality of information sharing. Review of referral data and survey results. EMR and referral records.

Goals not quantified

If a goal is quantifiable (e.g. number of hired staff, number of expanded hours, percent of patients), then the goal must be updated to include a number or percent. Note: an improvement milestone cannot be used to determine baseline. A process milestone from the menu must be selected. If a process milestone to establish the baseline is unavailable, the provider may use P-X. See Example 7.

Example 4:

- Milestone 2 [P-5]: BH case managers are identified and trained for blended care coordination for "at risk" patients with co-occurring mental/physical health needs.
- Metric 1 [P-5.1]: Number of staff identified with the capacity to support the target population will be determined after number of "at risk" patients in mental health program is known.
- Baseline: No BH case managers identified or trained
- Goal: Appropriate numbers of BH case managers are identified, hired and trained to meet the patient needs
  HHSC recommended update: Baseline: No BH case managers trained for blended care coordination. Goal: Identify and train 1 BH case manager per 75 "at risk" patients (estimated need of 5 BH case managers).
- Data Source: Staff rosters and documentation of caseloads/training rosters.

Example 5:

- Milestone 3 [P-4]: Hire and train staff to operate and manage projects selected.
- Metric 1 [P-4.1]: Number of staff secured and trained
- Baseline/Goal: Baseline – 0; Goal - hire and train staff
  HHSC recommend update: Baseline: 0; Goal: Hire and train eight licensed professional counselors.
- Data Source: Project records; Training curricula developed in Milestone 1. Personnel records.

Example 6:

- Milestone 3 [P-5]: Establish extended hours.
- Metric 3 [P-5.1]: Increased number of hours over baseline
- Baseline/Goal: Establish hours of service for expanded services.
- ***HHSC recommended update:*** Baseline: Clinic open 40 hours/week Monday-Friday; Goal: Expand clinic hours by 15 hours per week (50 hours/week Monday-Friday and 5 hours/week Saturdays).

- Data Source: Number of patients served in extended hours. Documentation of extended hours.

Example 7: In the case when the provider uses an Improvement Milestone for the purposes of establishing a baseline only, the provider must use a process milestone P-X if one does not exist in the project area

- Milestone 2[I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.
- Metric 1 [I-23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.
- Baseline/Goal to establish a baseline in DY2.
- ***HHSC recommended update:*** Milestone 2 [P-X]: Establish baseline for specialty care clinic volume of visits.
  Metric 1 [P-X.1]: Documentation of number of visits.
  Baseline: Number of visits is unavailable; Goal: Establish baseline for number of specialty care clinic visits.
- Data Source: EHR

Adding New Milestone or Metrics

If you are adding a new milestone or metric due to a plan modification request or in response to HHSC comments on priority technical corrections, then please follow the instructions below.

Adding a New Milestone:

- Update the "# of Milestones in DYX" field to the new number of milestones for the year. Additional cells will open up to the right after the existing milestones to allow entry of the new milestone information (i.e. will no longer be shaded).
- Go to the new Milestone and enter "Milestone #" - milestone number from the plan (e.g. P-1, I-10) or for customizable milestones P-101 or I-101. If you have existing customizable milestones, continuing numbering consecutively, e.g. project currently includes P-101 and P-102, then enter the new customizable milestone as P-103.
- Enter "Milestone Desc" – milestone description from the RHP Planning Protocol. For a customizable milestone, leave this field blank.
- Optional: Enter "Milestone Provider Manual Desc (if needed)" – if the milestone language varies from the protocol, the description is entered in this field. For a customizable milestone, enter the description in this field.
- Enter "# of metrics for Milestone #X" – number of metrics for the particular milestone. Additional cells will open up to the right to enter the metric information (i.e. will no longer be shaded).
- Enter "Metric #X (DYX)" – metric number from the plan (e.g. P-1.1, I-10.1). For a customizable metric, use the numbering similar to the Milestone number with the addition of ".1".

- Enter "Metric #X Description (DYX)" – metric description from the RHP Planning Protocol. For a customizable metric, leave this field blank.
- Optional: Enter "Metric Provider Manual Desc (if needed)" – if the metric language varies from the protocol, the description is entered in this field. For a customizable metric, enter the description in this field.
- Enter "Metric #X Baseline/Goal (DYX)" – the baseline and goal information is entered in this field. If the goal requires a percentage, enter the numerator and denominator description from the protocol or enter your own. Be sure to enter a quantifiable goal if the metric requires it.
- Enter "Metric #X Type" – this is <u>one</u> of the following:
    - Yes/No – this is for goals that can be answered with a Yes or No that it is completed, e.g. completing a plan, implementing protocols, completing an installation.
        - The one exception is if there are multiple numeric goals within a goal, e.g. 10% increase in staff with 5 trainings. Because the system can only handle one numeric goal, these types of goals are identified as Yes/No but all numeric goals must be met to be eligible for payment.
    - Number – this is for goals with a number in the goal, e.g. train 5 nurses
    - Percentage – this is for goals with a percentage in the goal, e.g. 10% increase in encounters
- Enter "Numeric Goal" – if "Metric #X Type" is a number or percentage, then a Numeric Goal is entered. This field can only include one number and not any text.
- Enter "Metric #X Data Source (DYX)" – data source description from the RHP Planning Protocol. For a customizable metric, leave this field blank.
- Optional: Enter "Data Source Provider Manual Desc (if needed)" – if the data source varies from the protocol, the description is entered in this field. For a customizable metric, enter the data source in this field.
- Enter "Milestone #X DSRIP (DYX)" – value for the new Category 1 or 2 milestone and update the remaining milestone values. Cat 1 and 2 milestones are valued equally within a demonstration year. The milestone value can be determined by taking the "Project DSRIP Allocation DYX" and dividing it by "# of Milestones in DYX"
- Optional: Enter "IGT Needed for Milestone #X (DYX)" – IGT needed for each Category 1 or 2 milestone. The FMAP is 58.69 for DY3 and 58.16 for DY4-5. The IGT needed can be determined by taking the "Milestone #X DSRIP (DYX)" and multiplying by DY3 0.4131 or DY4-5 0.4184.

<u>Adding a New Metric:</u>

- Go to the Milestone that you would like to add a Metric and update "# of metrics for Milestone #X" for the new number of metrics. Additional cells will open up to the right after the existing metrics to allow entry of the new metric information (i.e. will no longer be shaded).
- Go to the new Metric columns and enter "Metric #X (DYX)" – metric number from the plan (e.g. P-1.1, I-10.1). For a customizable metric, use the numbering similar to the Milestone number with the addition of ".1".

- Enter "Metric #X Description (DYX)" – metric description from the RHP Planning Protocol. For a customizable metric, leave this field blank.
- Optional: Enter "Metric Provider Manual Desc (if needed)" – if the metric language varies from the protocol, the description is entered in this field. For a customizable metric, enter the description in this field.
- Enter "Metric #X Baseline/Goal (DYX)" – the baseline and goal information is entered in this field. If the goal requires a percentage, enter the numerator and denominator description from the protocol or enter your own. Be sure to enter a quantifiable goal if the metric requires it.
- Enter "Metric #X Type" – this is one of the following:
    - Yes/No – this is for goals that can be answered with a Yes or No that it is completed, e.g. completing a plan, implementing protocols, completing an installation.
        - The one exception is if there are multiple numeric goals within a goal, e.g. 10% increase in staff with 5 trainings. Because the system can only handle one numeric goal, these types of goals are identified as Yes/No but all numeric goals must be met to be eligible for payment.
    - Number – this is for goals with a number in the goal, e.g. train 5 nurses
    - Percentage – this is for goals with a percentage in the goal, e.g. 10% increase in encounters
- Enter "Numeric Goal" – if "Metric #X Type" is a number or percentage, then a Numeric Goal is entered. This field can only include one number and not any text.
- Enter "Metric #X Data Source (DYX)" – data source description from the RHP Planning Protocol. For a customizable metric, leave this field blank.
- Optional: Enter "Data Source Provider Manual Desc (if needed)" – if the data source varies from the protocol, the description is entered in this field. For a customizable metric, enter the data source in this field.

Columns Included in each Category 1 and Category 2 tab for DY3-5

Note: X indicates a number that varies based on the year or number of the milestone/metric referenced.

1. "HHSC Comment" – HHSC comment for Phase 4.
2. "Provider Change Date" – Provider to enter date if changes are made.
3. "Provider Change Comment" – Provider to enter comment for any changes in response to "HHSC Comment", technical corrections made, or plan modifications.
4. "Plan Modification to Milestones/Metrics (Yes/No)" – Provider to indicate Yes if there are modifications to milestones/metrics. Please complete the Plan Modification form as well.
5. "CMS Initial Approval Comment" – Ignore this field. This was only applicable for DY2. However, the column remains so that DY2-5 tabs have the same number of columns.
6. "TPI" – Provider TPI used in Project IDs that were initially submitted in fall 2012. If the TPI was updated, it is not reflected here; however, HHSC has record of the correct TPI for payment purposes.

7. "Project ID" – Project ID that was submitted in the final plan submission in spring 2013 or updated through Phase 1 changes.
8. "Project Area" – Project Area number from the plan, e.g. 2.2.
9. "Project Area Title" – Project Area title from the RHP Planning Protocol.
10. "Project Area Option Title" – Project Area Option title from the RHP Planning Protocol.
11. "RHP" – RHP number for the project.
12. "Project Area Option #" – Project Area Option number from the plan, e.g. 1.9.1.
13. "Provider Name" – provider name that was submitted in the final plan submission in spring 2013.
14. "Number of Milestones (DY 2 – 5)" – total number of milestones for DY2-5. You may update as needed; however, HHSC will update for all projects after Phase 4 corrections have been submitted.
15. "Project DSRIP Allocation DY2-5" – total project valuation for DY2-5. This may not include lower DY2-3 valuations for projects pending a CMS decision. You may update as needed; however, HHSC will update for all projects after receiving final CMS decisions.
16. "Total Milestones DSRIP Add Up?" – Ignore this field. This was used when the milestones were being transferred from the Word version of the Milestones and Metrics Table into Excel. The field indicated if the values in the Word document matched the Excel calculation for each milestone. This is no longer applicable because the Excel values will be used regardless of the values in the former Word version.
17. "# of Category 3 Outcomes"
18. "# of Milestones in DYX" - number of milestones within the year based on the plan table .
19. "Project DSRIP Allocation DYX" – total project valuation for the applicable demonstration year for the applicable Category.
20. "Milestone #" - milestone number from the plan (e.g. P-1, I-10).
    a. For a customizable milestone, numbering begins from P-101 or I-101.
21. "Milestone Desc" – milestone description from the RHP Planning Protocol.
    a. For a customizable milestone, this field is blank.
22. "Milestone Provider Manual Desc (if needed)" – if the milestone language varies from the protocol, the description is entered in this field.
    a. For a customizable milestone, the description included in the plan is entered in this field.
23. "# of metrics for Milestone #X" – number of metrics for the particular milestone.
24. "Metric #X (DYX)" – metric number from the plan (e.g. P-1.1, I-10.1).
    a. For a customizable metric, numbering begins from P-101.1, I-101.1
25. "Metric #X Description (DYX)" – metric description from the RHP Planning Protocol.
    a. For a customizable metric, this field is blank.

26. "Metric Provider Manual Desc (if needed)" – if the metric language varies from the protocol, the description is entered in this field.
    a. For a customizable metric, the description included in the plan is entered in this field.
27. "Metric #X Baseline/Goal (DYX)" – the baseline and goal information included in the plan is entered in this field.
28. "Metric #X Type" – this is one of the following:
    a. Yes/No – this is for goals that can be answered with a Yes or No that it is completed, e.g. completing a plan, implementing protocols, completing an installation.
        i. The one exception is if there are multiple numeric goals within a goal, e.g. 10% increase in staff with 5 trainings. Because the system can only handle one numeric goal, these types of goals are identified as Yes/No but all numeric goals must be met to be eligible for payment.
    b. Number – this is for goals with a number in the goal, e.g. train 5 nurses.
    c. Percentage – this is for goals with a percentage in the goal, e.g. 10% increase in encounters.
29. "Numeric Goal" – if "Metric #X Type" is a number or percentage, then a Numeric Goal is entered. For the examples above under 27.b and c, the numeric goal would be 5 and 0.10.
    a. This field only includes one number and not any text.
30. "Metric #X Data Source (DYX)" – data source description from the RHP Planning Protocol.
    a. For a customizable metric, this field is blank.
31. "Data Source Provider Manual Desc (if needed)" – if the data source varies from the protocol, the description is entered in this field.
    a. For a customizable metric, the data source included in the plan is entered in this field.
32. "Milestone #X DSRIP (DYX)" – value for each Category 1 or 2 milestone. Cat 1 and 2 milestones are valued equally within a demonstration year.
33. "IGT Needed for Milestone #X (DYX)" – IGT needed for each Category 1 or 2 milestone. The FMAP is 58.69 for DY3 and 58.16 for DY4-5.