TO: Medical Care Advisory Committee

DATE: August 24, 2017

FROM: John Scott, Director of Operations
Texas Healthcare Transformation Waiver
Medicaid/CHIP Services Department, HHSC

Agenda Item No.: 3

SUBJECT: Delivery System Reform Incentive Payment (DSRIP) Program Demonstration Years 7-8

New: Texas Administrative Code Title 1, Part 15, Chapter 354, Subchapter D, Division 7, concerning DSRIP Program Demonstration Years 7-8; Chapter 355, Subchapter J, Division 11, §355.8205, concerning Delivery System Reform Incentive Payments for Demonstration Years 7-8; and §355.8206, concerning Funding for DSRIP Monitoring Program for Demonstration Years 7-8.

BACKGROUND: □ Federal Requirement □ Legislative Requirement ☒ Other: (e.g., Program Initiative)

On December 12, 2011, the Centers for Medicare & Medicaid Services (CMS) approved Texas's request for a new Medicaid demonstration waiver entitled “Texas Healthcare Transformation and Quality Improvement Program” in accordance with Section 1115 of the Social Security Act. The Delivery System Reform Incentive Payment (DSRIP) program is one of the three main components of this waiver.

The initial waiver was approved through September 30, 2016, and an initial extension was granted through December 31, 2017. HHSC has requested an additional 21 months that would extend the waiver through September 30, 2019.

The framework for DSRIP payments is governed by the Program Funding and Mechanics (PFM) protocol that is referenced in the waiver Special Terms and Conditions. HHSC developed the draft PFM protocol proposal for the requested additional 21 months (demonstration years 7-8) and submitted it to CMS on May 17, 2017. These proposed new rules closely mirror the PFM protocol proposal that HHSC submitted to CMS.

ISSUES AND ALTERNATIVES:

Private Hospital Participation
In order to incentivize intergovernmental transfer (IGT) entities to provide IGT for private hospitals to participate in DSRIP in DY7-8, HHSC included a provision in these rules specifying that the percentage of a performing provider’s valuation allocated to Category D - Statewide Reporting Measure Bundle is 5 percent of the performing provider’s valuation if the provider’s Regional Healthcare Partnership (RHP) does not maintain its current level of private hospital participation, or 15 percent if it does. Performing providers are incentivized to shift the percentage of their total valuation in Category C (pay-for-performance) to Category D (pay-for-reporting) to lower their risk of not earning DSRIP payments. However, some stakeholders are concerned that this is not a sufficient incentive for IGT entities to provide IGT for private hospitals.

Remaining Funds Uses

Some stakeholders objected to the methodology for allocating remaining DSRIP funds to RHPs. The PFM protocol proposal specifies that remaining DSRIP funds will be allocated to RHPs that did not fully utilize their original regional DY5 allocation, as follows:

<table>
<thead>
<tr>
<th>RHP</th>
<th>DY7 Remaining Funds Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHP 1</td>
<td>$866,635</td>
</tr>
<tr>
<td>RHP 2</td>
<td>$2,308,000</td>
</tr>
<tr>
<td>RHP 4</td>
<td>$522,345</td>
</tr>
<tr>
<td>RHP 5</td>
<td>$4,797,112</td>
</tr>
<tr>
<td>RHP 8</td>
<td>$5,739,571</td>
</tr>
<tr>
<td>RHP 17</td>
<td>$9,284,861</td>
</tr>
<tr>
<td>RHP 18</td>
<td>$1,318,286</td>
</tr>
<tr>
<td>RHP 20</td>
<td>$4,062,821</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$28,899,632</strong></td>
</tr>
</tbody>
</table>

*Note: These remaining funds allocations are in addition to the standard DY7 allocations.

Minimum Point Threshold (MPT) Formula

Finally, stakeholders expressed concern regarding the formula for calculating the Category C minimum point threshold (MPT) for performing providers. Each performing provider is assigned a MPT for Measure Bundle or measure selection, and must select Measure Bundles or measures worth enough points to meet its MPT in order to maintain its valuation for DY7 and DY8.

The Measure Bundle protocol, which HHSC released for stakeholder feedback on June 22, 2017, includes the number of points assigned to each Measure Bundle. Until HHSC receives stakeholder feedback on the Measure Bundle
protocol, it is unknown if stakeholders will continue to be concerned about the MPT requirements.

**STAKEHOLDER INVOLVEMENT:**

HHSC developed the draft PFM protocol proposal for the requested additional 21 months (demonstration years 7-8), and posted it along with a survey to solicit stakeholder feedback, to the Transformation Waiver website on January 31, 2017. HHSC received more than 170 responses to the survey, and made a number of revisions to the PFM protocol proposal based on these survey responses. HHSC submitted the revised PFM protocol proposal to CMS on May 17, 2017. These proposed new rules closely mirror the revised PFM protocol proposal that HHSC submitted to CMS.

**FISCAL IMPACT:**

☑ None □ Yes

**RULE DEVELOPMENT SCHEDULE:**

- August 17, 2017 Present to Hospital Payment Advisory Committee
- August 24, 2017 Present to the Medical Care Advisory Committee
- August 25, 2017 Publish proposed rules in *Texas Register*
- September 7, 2017 Present to HHSC Executive Council
- November 2017 Publish adopted rules in *Texas Register*
- December 1, 2017 Effective date

**REQUESTED ACTION:** (Check appropriate box)

☐ The MCAC recommends approval of the proposed rules for publication.

☑ Information Only
PROPOSED PREAMBLE

The Texas Health and Human Services Commission (HHSC) proposes new Division 7, concerning DSRIP Program Demonstration Years 7-8, and within the new division: new §354.1691, concerning Definitions; new §354.1693, concerning Regional Healthcare Partnerships (RHPs); new §354.1695, concerning Participants; new §354.1697, concerning RHP Plan Update; new §354.1699, concerning RHP Plan Update Review; new §354.1701, concerning RHP Plan Update Modifications; new §354.1703, concerning Independent Assessor; new §354.1705, concerning Categories; new §354.1707, concerning Performer Valuations; new §354.1709, concerning Category A Requirements for Performers; new §354.1711, concerning Category B Requirements for Performers; new §354.1713, concerning Category C Requirements for Performers; new §354.1715, concerning Category D Requirements for Performers; new §354.1717, concerning Uncompensated Care (UC) Hospital Requirements; new §354.1719, concerning Disbursement of Funds; and new §354.1721, concerning Remaining Funds for Demonstration Years (DYs) 7-8.

BACKGROUND AND JUSTIFICATION

On December 12, 2011, the Centers for Medicare & Medicaid Services (CMS) approved Texas's request for a new Medicaid demonstration waiver entitled "Texas Healthcare Transformation and Quality Improvement Program" in accordance with Section 1115 of the Social Security Act. This waiver authorized the establishment of the Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program provides incentive payments to hospitals and certain other providers to support their efforts to enhance access to health care, the quality of care, and the health of patients and families they serve.

The initial waiver was approved through September 30, 2016, and an initial extension was granted through December 31, 2017. HHSC has requested an additional 21 months that would extend the waiver through September 30, 2019.

The framework for DSRIP payments is governed by the Program Funding and Mechanics (PFM) protocol that is referenced in the waiver Special Terms
and Conditions. HHSC developed the draft PFM protocol proposal for the requested additional 21 months (demonstration years 7-8) and posted it, along with a survey to solicit stakeholder feedback on the proposal, to the Transformation Waiver website on January 31, 2017. HHSC received more than 170 responses to the survey, and made a number of revisions to the PFM protocol proposal based on these survey responses. HHSC submitted the revised PFM protocol proposal for demonstration years 7-8 to CMS on May 17, 2017. These proposed new rules closely mirror the PFM protocol proposal submitted to CMS. HHSC will update these rules, as necessary, in accordance with CMS guidance.

The proposed rules in new Division 7 describe the DSRIP policies for DY7-8. In DY7-8, HHSC proposes an evolution of DSRIP from project-level reporting to core activities supporting performer-level outcomes that measure continued transformation of the Texas healthcare system. DY7-8 will serve as an opportunity for performers to move further towards sustainability of their transformed systems, including development of Alternative Payment Models to continue services for Medicaid and low-income or uninsured (MLIU) individuals after the waiver ends.

SECTION-BY-SECTION SUMMARY

Proposed new §354.1691 defines terms specific to the new division.

Proposed new §354.1693 describes the organization of Regional Healthcare Partnerships (RHPs).

Proposed new §354.1695 describes requirements for the RHP participants, including anchors, intergovernmental transfer (IGT) entities and performers. Anchor requirements include coordinating the update of the community needs assessment and the RHP plan update. IGT entity requirements include providing the non-federal share of DSRIP pool payments for the entities with which they collaborate. Performer requirements include submitting to the anchor the information required for the RHP plan update and semi-annual reporting.

Proposed new §354.1697 describes the requirements for the RHP plan update for DY7-8. It specifies that the following information must be included in the RHP plan update for each performer in the RHP: 1) the definition of the performer’s system; 2) a description of the performer’s core activities for DY7-8; 3) the performer's Category B MLIU Patient Population by Provider (PPP) baseline; 4) if the performer is a hospital or physician practice, the performer's selected Category C Measure Bundles and measures, and requests for allowable changes to the Category C Measure Bundles and measures as described in the Program Funding and Mechanics
Protocol; 5) if the performer is a community mental health center or local health department, the performer's selected Category C measures as described in the Program Funding and Mechanics Protocol; 6) a description of the transition of the performer's DY2-6 projects to its selected Category C Measure Bundles or measures; 7) the performer's Category D Statewide Reporting Measure Bundle; 8) the performer's DSRIP valuation amounts; and 9) the performer's sources of non-federal funds by category and demonstration year.

Proposed new §354.1699 describes the RHP plan update review process. HHSC will review each RHP plan update, verify it meets the RHP plan update requirements, and do one of the following: 1) approve it; 2) request additional information; or 3) request that the anchor modify it.

Proposed new §354.1701 describes the modifications that can be made to the HHSC-approved RHP plan update. A performer may modify: 1) its system definition; 2) its Category B MLIU PPP; and 3) various elements of its Category C Measure Bundles and measures.

Proposed new §354.1703 describes the roles and responsibilities of the independent assessor.

Proposed new §354.1705 describes the four categories of DSRIP for DY7-8, which are as follows: 1) Category A - Required Reporting; 2) Category B - Medicaid and Low-income Uninsured (MLIU) Patient Population by Provider (PPP); 3) Category C - Measure Bundles and Measures; and 4) Category D - Statewide Reporting Measure Bundle.

Proposed new §354.1707 describes performer valuations, and specifies that a performer’s total valuation per DY for DY7-8 is equal to its total valuation for DY6, with exceptions. In addition, it describes the performer valuation funding distribution among the DSRIP categories.

Proposed new §354.1709 describes Category A requirements for performers, which include reporting the following information during the second reporting period of each DY: 1) progress on, and updates to, core activities; 2) progress toward, or implementation of, Alternative Payment Models (APMs); 3) costs and savings of a core activity (for performers with a total valuation greater than or equal to $1 million per DY); and 4) participation in a learning collaborative, stakeholder forum, or other stakeholder meeting.

Proposed new §354.1711 describes Category B requirements for performers. It describes the information that performers must include in the RHP plan update. It also describes how the total PPP baseline, MLIU PPP baseline, MLIU PPP goal, MLIU PPP to total PPP ratio baseline, and allowable MLIU PPP
goal variation are calculated. In addition, it describes what a performer must report to be eligible for payment of its MLIU PPP milestone for a DY.

Proposed new §354.1713 describes Category C requirements for performers. It describes the following for hospitals and physician practices: 1) Measure Bundle and measure selection; 2) Measure Bundle valuations; 3) measure valuations; and 4) minimum point thresholds (MPTs). It describes the following for community mental health centers and local health departments: 1) measure selection; 2) measure valuations; and 3) MPTs. This proposed rule also describes the following for measures: 1) measurement periods; 2) milestones; 3) eligible denominator populations; 4) goal setting for P4P measures; and 5) the carry forward policy.

Proposed new §354.1715 describes Category D requirements for performers. It describes the Statewide Reporting Measure Bundles, performer requirements for Category D payment, and Category D valuation.

Proposed new §354.1717 describes Uncompensated Care (UC) hospital requirements, which include: 1) attending a stakeholder meeting each DY; and 2) reporting on required hospital Statewide Reporting Measure Bundle measures for each DY.

Proposed new §354.1719 describes how DSRIP funds will be disbursed. It describes the basis for payment for RHP plan update submission, Category A requirements to be eligible for payment of Categories B-D, and the basis for payment for Categories B-D.

Proposed new §354.1721 describes the DY-8 remaining funds amounts and how they will be allocated to RHPs.

FISCAL NOTE

Greta Rymal, HHSC Deputy Executive Commissioner for Financial Services, has determined that for each year of the first five years the new sections will be in effect, there will be no fiscal implications to state government as a result of enacting and administering the sections as proposed.

There may be fiscal implications to local governments as a result of enacting and administering the new sections as proposed. The non-federal share of DSRIP payments to DSRIP performing providers, or performers, are funded by IGTs from a governmental entity (an IGT entity). Under these proposed new sections, HHSC may recoup DSRIP payments from performers in the event of an overpayment or disallowance by CMS. In that case, the performer would return the DSRIP payments to HHSC. HHSC would refund the federal share of the payments to CMS, and the non-federal share (the
IGTs) to the IGT entity that transferred the funds. HHSC cannot predict if any DSRIP funds would be recouped. Therefore, HHSC lacks sufficient data to provide an estimate of the possible local government fiscal impact.

Additionally, to fund DSRIP performers allocated remaining funds, an IGT entity would be required to provide additional IGTs to fund the non-federal share. However, since IGTs are voluntary, providing the additional funds would not be required by adoption or implementation of these new sections.

SMALL BUSINESS AND MICRO-BUSINESS IMPACT ANALYSIS

Ms. Rymal has also determined that there will be no adverse impact on small businesses or micro-businesses required to comply with the new sections as proposed. Participation in the DSRIP program and in DSRIP DY7-8 is voluntary, and no small business or micro-business is required to be involved in the program.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There are no anticipated economic costs to persons who are required to comply with the new sections as proposed.

There is no anticipated negative impact on local employment.

PUBLIC BENEFIT

Jami Snyder, State Medicaid Director, has determined that for each year of the first five years the rules are in effect, the public will benefit from the adoption of the rules. The anticipated public benefit will be improved quality of care for individuals served by DSRIP performers.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that this proposal does not restrict or limit an owner’s right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Government Code, §2007.043.

PUBLIC HEARING

A public hearing is scheduled for September 21, 2017, at 9:30 a.m. (central time) in the Brown-Heatly Building, Public Hearing Room, located at 4900 North Lamar Boulevard, Austin, Texas 78751. Persons requiring further information, special assistance, or accommodations should contact Amy Chandler at 512-487-3419.
PUBLIC COMMENT

Questions about the content of this proposal may be directed to Kimberly Tucker, Healthcare Transformation Waiver Unit, at (512) 424-6605.

Written comments on the proposal may be submitted to Kimberly Tucker, Health and Human Services Commission, Healthcare Transformation Waiver Unit, Brown-Heatly Building, 4900 N. Lamar Blvd., Mail Code H-425, Austin, TX 78751; by fax to (512) 424-6974; or by e-mail to TXHealthcareTransformation@hhsc.state.tx.us within 30 days after publication of this proposal in the Texas Register.

To be considered, comments must be submitted no later than 30 days after the date of this issue of the Texas Register. The last day to submit comments falls on a Sunday; therefore, comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) faxed or e-mailed by midnight on the last day of the comment period. When faxing or e-mailing comments, please indicate "Comments on Proposed Rule 1R031" in the subject line.

STATUTORY AUTHORITY

The new sections are authorized by Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b), which provides HHSC with the authority to propose and adopt rules governing the determination of Medicaid reimbursements.

The new sections implement Chapter 531 of the Texas Government Code and Chapter 32 of the Texas Human Resources Code. No other statutes, articles, or codes are affected by this proposal.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be within the agency’s legal authority to adopt.
§354.1691. Definitions.

The following words and terms, when used in this division, have the following meanings unless the context clearly indicates otherwise.

(1) Core activity--An activity implemented by a performer to achieve the performer's Category C measure goals as described in the Measure Bundle Protocol. A core activity may be an activity implemented by a performer as part of a DSRIP project during the initial demonstration period or DY6 that the performer continues in DY7-8, or a new activity implemented by a performer in DY7-8.

(2) Demonstration Year (DY) 6--Federal fiscal year 2017 (October 1, 2016 - September 30, 2017).

(3) Demonstration Year (DY) 7--Federal fiscal year 2018 (October 1, 2017 - September 30, 2018).

(4) Demonstration Year (DY) 8--Federal fiscal year 2019 (October 1, 2018 - September 30, 2019).


(6) DSRIP pool--Funds available to DSRIP performers under the waiver for their efforts to enhance access to health care, the quality of care, and the health of patients and families they serve.

(7) Encounter--An encounter, for the purposes of Medicaid and Low-income Uninsured (MLIU) Patient Population by Provider (PPP) and total PPP, is any physical or virtual contact between a performer and a patient during
which an assessment or clinical activity is performed, with exceptions including those in subparagraph (B) of this definition.

(A) An encounter must be documented by the performer.

(B) A phone call or text message is not considered an encounter.

(8) Federal poverty level (FPL)--The household income guidelines issued annually and published in the Federal Register by the United States Department of Health and Human Services.

(9) Initial demonstration period--The first five demonstration years (DYs) of the waiver, or December 12, 2011, through September 30, 2016.

(10) Measure Bundle--A grouping of measures that share a unified theme, apply to a similar population, and are impacted by similar activities. A Measure Bundle may include process measures and patient clinical outcome measures.

(11) Measure Bundle Protocol--A master list of potential Category C Measure Bundles and measures, as well as Category D Statewide Reporting Measure Bundles and measures.

(12) Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP)--The number of MLIU individuals in a performer's system for which there was an encounter during the applicable DY.

(A) To qualify as a Medicaid individual served, the individual must be enrolled in Medicaid at the time of at least one encounter during the applicable DY.

(B) To qualify as a low-income or uninsured individual served, the individual must either be at or below 200 percent of the FPL or must not have health insurance at the time of at least one encounter during the applicable DY.

(C) If an individual was enrolled in Medicaid at the time of one encounter during the applicable DY, and was low-income or uninsured at the time of a separate encounter during the applicable DY, that individual is classified as a Medicaid individual served for purposes of MLIU PPP.

(13) Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP) Goal--The target number of MLIU individuals in a performer's system for which there will be an encounter during the applicable DY.
(14) **Milestone**--An objective of DSRIP performance on which DSRIP payments are based.

(15) **Minimum point threshold (MPT)**--The minimum number of points that a performer must meet in selecting its Category C Measure Bundles or measures, as described in §354.1713 of this division (relating to Category C Requirements for Performers).

(16) **Performer**--A Medicaid provider that participates in DSRIP and receives DSRIP payments.

(17) **RHP plan update**--An RHP plan for the initial demonstration period and DY6 that is updated for DY7-8, as further described in §354.1697 of this division (relating to RHP Plan Update).

(18) **Statewide hospital factor (SHF)**--A factor used in determining a hospital’s MPT that takes into account a hospital's MLIU inpatient days and MLIU outpatient costs compared to all hospitals, as described in §354.1713(a)(4)(A)(i) of this division.

(19) **Statewide hospital ratio (SHR)**--A factor used in determining a hospital’s MPT that takes into account whether a hospital’s DY7 DSRIP valuation is higher or lower than would be expected based on the hospital's MLIU inpatient days and MLIU outpatient costs compared to other hospitals, as described in §354.1713(a)(4)(A)(ii) of this division.

(20) **System**--A performer’s patient care landscape, as defined by the performer, in accordance with the Program Funding and Mechanics Protocol and Measure Bundle Protocol. The system may include any combination of service locations, including hospitals, clinics, community mental health center locations, local health department locations, and contracted providers or clinics, as appropriate.

(21) **Total Patient Population by Provider (total PPP)**--The total number of individuals in a performer’s system for which there was an encounter during the applicable DY.

§354.1693. Regional Healthcare Partnerships (RHPs).

(a) An RHP has geographic boundaries as prescribed by HHSC.
(b) An RHP is composed of one anchor and other participants, which may include IGT entities, performers, and other regional stakeholders. A single entity may act in multiple roles.

(c) An IGT entity may participate in more than one RHP contingent upon HHSC approval.

(d) A performer may only participate in the RHP plan update for the RHP in which it is physically located. If a performer has physical locations in more than one RHP, the performer may be assigned to a single "home" RHP and participate only in the RHP plan update for its "home" RHP.

(e) A provider must participate in an RHP, as described in §354.1717 of this division (relating to Uncompensated Care (UC) Hospital Requirements), to be eligible to receive a UC pool payment. However, exceptions to this requirement may be approved by the Centers for Medicare & Medicaid Services on a case by case basis.

§354.1695. Participants.

(a) Anchors.

__ (1) An anchor must:

_____ (A) serve as the RHP's single point of contact with HHSC, except as specified in rule;

_____ (B) facilitate transparent and inclusive meetings among participants to discuss RHP activities;

_____ (C) coordinate RHP activities to help ensure that participants properly address both the needs of the region and the requirements placed upon the RHP;

_____ (D) coordinate the update of the community needs assessment included in the RHP plan and submit the updated community needs assessment to HHSC, as prescribed by HHSC;

_____ (E) coordinate with the RHP participants to update the RHP plan in accordance with §354.1697 of this division (relating to RHP Plan Update), the Program Funding and Mechanics Protocol, the Measure Bundle Protocol, and all other state or waiver requirements;
(F) submit the RHP plan update to HHSC, as prescribed by HHSC;

(G) post the approved RHP plan update to the RHP website;

(H) develop and submit an annual progress report on behalf of the RHP, in accordance with the Program Funding and Mechanics Protocol and HHSC requirements;

(I) develop and submit a learning collaborative plan, in accordance with the Program Funding and Mechanics Protocol and HHSC requirements;

(J) ensure that all confidential information obtained through its role as an anchor remains confidential as required by state and federal laws and regulations;

(K) ensure that all waiver information provided to it in its capacity as anchor is distributed to the RHP participants; and

(L) meet all other requirements as specified in the Program Funding and Mechanics Protocol.

(2) An anchor must not:

(A) request reimbursement from a Medicaid provider for the discharge of the anchor's responsibilities, although an anchor and other governmental entities within the RHP may agree to share such costs;

(B) delegate decision-making responsibilities concerning the interpretation of the waiver, HHSC policy, or actions or decisions that involve the exercise of discretion or judgment;

(C) require any IGT entity to provide DSRIP funds to any performers;

(D) require any participant to act as a DSRIP performer; or

(E) prevent or in any way prohibit the collaboration between an IGT entity and a performer.

(3) An anchor may delegate ministerial functions such as data collection and reporting. Any entity to which ministerial functions are delegated under this subchapter must comply with the roles, responsibilities, and limitations of an anchor.
(4) In addition to any funds received under §354.1707 of this division (relating to Performer Valuations), an anchor may be reimbursed for the cost of its administrative duties conducted on behalf of the RHP. The anchor must provide an IGT to HHSC for the purpose of obtaining federal matching funds in accordance with the Administrative Cost Claiming Protocol so that it can be reimbursed for such costs. An anchor may not recover more than the anchor's actual costs.

(b) IGT entities. An IGT entity:

(1) determines the allocation of its IGT funding consistent with state and federal requirements;

(2) participates in RHP planning;

(3) if the IGT entity is itself acting as a performer, selects Category C Measure Bundles or measures;

(4) if the IGT entity is not acting as a performer, cooperates with a performer to select Category C Measure Bundles or measures;

(5) provides the non-federal share of DSRIP pool payments for the entities with which it collaborates; and

(6) may review DSRIP data submitted by associated performers.

(c) Performers. A performer:

(1) is one of the following provider types:

(A) hospital;

(B) physician practice;

(C) community mental health center; or

(D) local health department;

(2) submits to the anchor the information required for the RHP plan update, including the performer's selected Category C Measure Bundles or measures and other required information as described in §354.1697 of this division, the Program Funding and Mechanics Protocol, and the Measure Bundle Protocol;
(3) implements core activities to achieve the Category C measure goals in the RHP plan update;

(4) prepares and submits DSRIP data on a semi-annual basis;

(5) prepares and submits reports as required by HHSC and the Centers for Medicare & Medicaid Services;

(6) participates in RHP planning; and

(7) receives DSRIP.

§354.1697. RHP Plan Update.

(a) A performer may receive DSRIP only if HHSC has approved the RHP plan update for the performer's RHP.

(b) An RHP plan update must:

(1) meet the requirements listed in the Program Funding and Mechanics Protocol and the Measure Bundle Protocol;

(2) update the RHP's community needs assessment, referencing sources used;

(3) include a list of IGT entities, performers, UC hospitals, and other stakeholders involved in the development of the RHP plan update;

(4) include certifications that all the information contained within the RHP plan update is true and accurate;

(5) describe the processes used to engage stakeholders including the public meetings held, public posting of the RHP plan update, and the process for submitting public comment on the RHP plan update;

(6) include the total amount of estimated DSRIP funding to be used by demonstration year (DY);

(7) include for each performer:

(A) the definition of the performer's system;

(B) a description of the performer's core activities for DY7-8;
(C) the performer's Category B MLIU Patient Population by Provider (PPP) baseline;

(D) if the performer is a hospital or physician practice, the performer's selected Category C Measure Bundles and measures, and requests for allowable changes to those Measure Bundles and measures, as described in the Program Funding and Mechanics Protocol;

(E) if the performer is a community mental health center or local health department, the performer's selected Category C measures, and requests for allowable changes to those measures, as described in the Program Funding and Mechanics Protocol;

(F) a description of the transition of the performer's DY2-6 projects to its selected Category C Measure Bundles or measures;

(G) the performer's Category D Statewide Reporting Measure Bundle;

(H) the performer's DSRIP valuation amounts; and

(I) the performer's sources of non-federal funds by category and DY;

(8) include a narrative explaining how all of the selected Category C Measure Bundles and measures will:

(A) address the community needs outlined in the RHP plan update; and

(B) demonstrate health care delivery transformation and improvement in the quality of care provided in that RHP; and

(9) include the following information regarding DY7-8 remaining funds if the RHP is allocated DY7-8 remaining funds as described in §354.1721 of this division (relating to Remaining Funds for Demonstration Years (DYs) 7-8):

(A) a description of the process used to determine how the DY7-8 remaining funds allocated to the RHP will be used;

(B) the performers in the RHP that were allocated remaining DY7-8 funds; and
(C) the performers or providers in the RHP that were interested in receiving remaining DY7-8 funds but were not allocated any remaining DY7-8 funds.

§354.1699. RHP Plan Update Review.

(a) HHSC reviews and assesses each submitted RHP plan update to determine whether it meets the following criteria:

(1) It is in the prescribed format.

(2) It contains all required elements described in the Program Funding and Mechanics Protocol and the Measure Bundle Protocol, and is consistent with the waiver Special Terms and Conditions.

(3) It meets the requirements for Category A - Required Reporting, Category B - MLIU Patient Population by Provider (PPP), Category C - Measure Bundles and Measures, and Category D - Statewide Reporting Measure Bundles, as described in the Program Funding and Mechanics Protocol and the Measure Bundle Protocol.

(4) The funding amount and distribution is in accordance with the Program Funding and Mechanics Protocol.

(5) It is consistent with the goals of the DSRIP program and the objectives of the Medicaid program.

(b) Upon completion of HHSC's review, HHSC notifies the anchor that HHSC:

(1) has approved the RHP plan update;

(2) requires additional information to complete its review; or

(3) requires modification of the RHP plan update, including the specific deficiencies in the RHP plan update that HHSC has identified.

(c) The anchor must respond to a notification as described in subsection (b) of this section in accordance with the directions in the notification. Failure to respond in a timely manner may result in denial of the RHP plan update.
(1) If HHSC requires additional information to complete its review, the anchor must provide the additional information within the time frame specified in the notice.

(2) If HHSC requires a change in the RHP plan update, the anchor must submit a corrected RHP plan update that addresses the specific deficiencies within the time frame specified in the notice.

(d) If after responding to the notice as described in subsection (c) of this section an RHP plan update is not approved, the affected entities may request a review.

(1) If an RHP plan update is not approved, the anchor may request a review by HHSC in accordance with paragraph (3) of this subsection.

(2) The anchor must submit a request for review in writing to HHSC within 12 calendar days of the date HHSC sent the notification under subsection (b) of this section.

(3) The review is:

(A) limited to the RHP's allegations of factual or calculation errors;

(B) supported by documentation submitted by the RHP or used by HHSC in making its original determination; and

(C) not an adversarial hearing.

(4) HHSC notifies the RHP of the results of the review in a timely manner.

§354.1701. RHP Plan Update Modifications.

A performer may submit a request to HHSC to modify elements of the RHP plan update for the performer's RHP prospectively, as described in the Program Funding and Mechanics Protocol, including the performer's:

(1) System definition;

(2) Category B Medicaid and Low-income Uninsured (MLIU) Patient Population by Provider (PPP);

(3) Category C measure payer types for reporting milestones;
(4) Category C pay-for-performance (P4P) measure payer type for goal achievement milestones;

(5) Category C optional measures if the performer is a hospital or physician practice; or

(6) Category C measures if the performer is a community mental health center or local health department.

§354.1703. Independent Assessor.

The independent assessor continually monitors DSRIP performers for compliance with DSRIP program requirements and objectives.

(1) All RHP plan updates are subject to potential audits, including review by the independent assessor, during ongoing compliance monitoring.

(2) Upon request, performers must have available for review by the independent assessor, HHSC, the Centers for Medicare & Medicaid Services, and any other federal entity all supporting data and back-up documentation demonstrating performance for a milestone as described under an RHP plan update for DSRIP payments.

(3) Failure of a performer to provide supporting documentation demonstrating performance for a milestone in a timely manner may result in recoupment of DSRIP payments or withholding of future DSRIP payments.

§354.1705. Categories.

There are four categories for demonstration years (DYs) 7-8:

(1) Category A - Required Reporting, which requires performers to report their progress on core activities, alternative payment model arrangements, costs and savings, and collaborative activities, as described in §354.1709 of this division (relating to Category A Requirements for Performers);

(2) Category B - Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP), which requires performers to maintain or increase the number of MLIU individuals served, as described in §354.1711 of this division (relating to Category B Requirements for Performers);
(3) Category C - Measure Bundles and Measures, which requires performers to improve their performance on clinical outcome and process measures, as described in §354.1713 of this division (relating to Category C Requirements for Performers); and

(4) Category D - Statewide Reporting Measure Bundles, which requires performers to report on certain measures based on their provider type, as described in §354.1715 of this division (relating to Category D Requirements for Performers).

§354.1707. Performer Valuations.

(a) A performer's total valuation per DY for DY7 and DY8 is equal to its total valuation for DY6 with the following exceptions:

   (1) If HHSC determined that a DSRIP project was ineligible to continue in DY6, the performer affected by such a determination may use the funds associated with the DSRIP project beginning in DY7.

   (2) If a performer withdrew a DSRIP project between June 30, 2014, and June 30, 2016, the performer may use the funds associated with the DSRIP project beginning in DY7.

   (3) If a performer began DSRIP participation in DY7 with a total valuation less than $250,000 for DY7, the performer may request in the RHP plan update to increase its total valuation to up to $250,000 per DY beginning in DY7.

(b) A performer's valuation must comport with the following funding distribution for DY7 and DY8:

<table>
<thead>
<tr>
<th>Performer Valuation Funding Distribution</th>
<th>DY7</th>
<th>DY8</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RHP Plan Update Submission</strong></td>
<td>20%</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Category A - Required Reporting</strong></td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Category B - MLIU PPP</strong></td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Category C - Measure Bundles and Measures</strong></td>
<td>55 or 65%</td>
<td>75 or 85%</td>
</tr>
<tr>
<td><strong>Category D - Statewide Reporting Measure Bundle</strong></td>
<td>15 or 5%</td>
<td>15 or 5%</td>
</tr>
</tbody>
</table>

*If an RHP meets its minimum private hospital valuation, as described in §354.1715(c) of this division (relating to Category D Requirements for Performers).
for Performers), each performer in the RHP may increase its Statewide Reporting Measure Bundle funding to 15% of its valuation.

§354.1709. Category A Requirements for Performers.

A performer must fulfill the following Category A - Required Reporting requirements for each demonstration year (DY).

1. Core activities. A performer must select at least one core activity in the RHP plan update for its RHP that supports the achievement of its Category C measure goals, as described in the Measure Bundle Protocol. The performer must report progress on, and updates to, its selected core activities during the second reporting period of each DY.

2. Alternative Payment Models (APMs). A performer must report progress toward, or implementation of, APM arrangements with Medicaid managed care organizations or other payers during the second reporting period of each DY.

3. Costs and savings. A performer with a total valuation greater than or equal to $1 million per DY must report the costs of at least one core activity of its choice, as well as the forecasted or generated savings from that core activity.

   A) The performer must report the costs and savings associated with its selected core activity at the level of the performer's system, to the extent possible.

   B) The performer must submit a progress update on the costs and savings associated with its selected core activity during the second reporting period of DY7.

   C) The performer must submit a final report on the costs and savings associated with its selected core activity during the second reporting period of DY8.

4. Collaborative activities. A performer must attend at least one learning collaborative, stakeholder forum, or other stakeholder meeting during each DY and report on its participation during the second reporting period of each DY.
§354.1711. Category B Requirements for Performers.

(a) A performer must provide the following information in the RHP plan update to be eligible for its RHP plan update submission funds for DY7:

(1) its total PPP for DY5;
(2) its total PPP for DY6;
(3) its MLIU PPP for DY5; and
(4) its MLIU PPP for DY6.

(b) HHSC will use the information provided by a performer in accordance with subsection (a) of this section to calculate the performer's:

(1) total PPP baseline;
(2) MLIU PPP baseline;
(3) MLIU PPP goal;
(4) MLIU PPP to total PPP ratio baseline; and
(5) allowable MLIU PPP goal variation.

(c) A performer's total PPP baseline is equal to the sum of its total PPP for DY5 and its total PPP for DY6 divided by 2.

(d) A performer's MLIU PPP baseline is equal to the sum of its MLIU PPP for DY5 and its MLIU PPP for DY6 divided by 2.

(e) A performer's MLIU PPP to total PPP ratio baseline is equal to the performer's MLIU PPP baseline, as calculated in subsection (d) of this section, divided by the total PPP baseline, as calculated in subsection (c) of this section.

(f) A performer's MLIU PPP goal per DY for DY7 and DY8 is equal to its MLIU PPP baseline calculated in subsection (d) of this section.

(g) A performer's allowable MLIU PPP goal variation per DY for DY7 and DY8 is calculated with consideration of the performer’s:

(1) size;
(2) provider type; and

(3) MLIU PPP to total PPP ratio baseline, calculated in accordance with subsection (e) of this section.

(h) A performer will have a MLIU PPP milestone for each DY. The valuation of the MLIU PPP milestone for a DY is 100 percent of the performer's Category B allocation for the DY.

(i) A performer must report the following to be eligible for payment of its MLIU PPP milestone for a DY:

(1) its MLIU PPP for the DY;

(2) its total PPP for the DY; and

(3) an explanation for any decrease in the performer's MLIU PPP to total PPP ratio for the DY from the calculation in subsection (e) of this section.

(j) A performer must report the information in subsection (i) of this section during the second reporting period of the DY it is reporting to be eligible for payment of the MLIU PPP milestone for the DY, with the exception that a performer may request to carry forward reporting of its MLIU PPP milestone to the first reporting period of the DY immediately following the DY it is reporting; however, if approved, the measurement period would not change.

§354.1713. Category C Requirements for Performers.

(a) Requirements for hospitals and physician practices.

(1) Measure Bundle and measure selection.

(A) A hospital or physician practice, with the exception of those described in subparagraph (I) of this paragraph, must select Measure Bundles from the Measure Bundle Protocol in accordance with the requirements in subparagraphs (E) - (H) of this paragraph in the RHP plan update for its RHP.

(B) Each Measure Bundle is assigned a point value as described in the Measure Bundle Protocol.
(C) A hospital or physician practice is assigned a MPT for Measure Bundle selection as described in paragraphs (4) and (5) of this subsection.

(D) A hospital or physician practice must select Measure Bundles worth enough points to meet its MPT in order to maintain its valuation for DY7 and DY8. If a hospital or physician practice does not select Measure Bundles worth enough points to meet its MPT, its total DY7 valuation will be reduced proportionately across its RHP Plan Update and Categories B-D funds for DY7, and its total DY8 valuation will be reduced proportionately across its Categories B-D funds for DY8, based on the number of Measure Bundle points selected.

(E) A hospital or physician practice may only select a Measure Bundle for which its all-payer denominators for the baseline measurement period for at least half of the required measures in the Measure Bundle meet the minimum all-payer denominator size criteria as described in the Measure Bundle Protocol.

(F) A hospital or physician practice with a valuation of more than $2 million per demonstration year (DY) must:

(i) select at least one Measure Bundle with at least one required standalone measure; or

(ii) select at least one Measure Bundle with at least one optional three-point measure, and select at least one optional three-point measure in that Measure Bundle.

(G) A hospital or physician practice may only select an optional measure in a selected Measure Bundle for which the hospital’s or physician practice’s all-payer denominator for the baseline measurement period meets the minimum all-payer denominator size criteria as described in the Measure Bundle Protocol.

(H) Only a hospital with a valuation less than or equal to $2 million per DY may select a rural Measure Bundle.

(I) If a hospital or physician practice has a limited scope of practice, cannot reasonably report on at least half of the required measures in the Measure Bundle(s) appropriate for it based on its scope of practice and community partnerships, and consequently cannot meet its MPT for Measure Bundle selection, the hospital or physician practice may request HHSC approval to select measures, rather than Measure Bundles, from the Measure Bundle Protocol. The hospital or physician practice must submit a
request for such approval to HHSC prior to the RHP plan update submission, by a date determined by HHSC. Such a request may be subject to review by the Centers for Medicare & Medicaid Services (CMS). If HHSC and CMS, as appropriate, approve such a request:

(i) the hospital’s or physician practice’s total valuation may be reduced; and

(ii) the hospital or physician practice must select measures in accordance with the measure selection requirements for community mental health centers and local health departments, as described in subsection (b)(1) of this section.

(2) Measure Bundle valuation. A hospital or physician practice may allocate its Category C valuation among its selected Measure Bundles in the RHP plan update for its RHP as it chooses, provided the following requirements are met:

(A) The valuation for each selected Measure Bundle must be greater than or equal to ((the Measure Bundle point value divided by the sum of all the selected Measure Bundles' point values) divided by 2) multiplied by the Category C valuation.

(B) The valuation for each selected Measure Bundle without any standalone measures must be less than or equal to (the Measure Bundle point value divided by the sum of all the selected Measure Bundles' point values) multiplied by the Category C valuation.

(3) Measure valuation. The valuation for each measure in a selected Measure Bundle is equal to the Measure Bundle valuation divided by the number of measures in the selected Measure Bundle, so that the valuations of the measures in the selected Measure Bundle are equal, with the following exceptions:

(A) If a hospital’s or physician practice’s all-payer denominator for a required measure in a selected Measure Bundle for the baseline measurement period or a performance year is zero, the measure is removed from the Measure Bundle, and its valuation for the applicable DY is redistributed among the remaining measures in the Measure Bundle for which the hospital’s or physician practice’s all-payer denominator for the baseline measurement period or performance year is greater than zero for the applicable DY. The valuation for the applicable DY for each of the remaining measures in the Measure Bundle for which the hospital’s or physician practice’s all-payer denominator for the baseline measurement...
period or performance year is greater than zero is equal to the valuation for the Measure Bundle for the applicable DY divided by the number of measures for which the hospital’s or physician practice’s all-payer denominator for the baseline measurement period or performance year is greater than zero, so that the valuations for the applicable DY for the measures in the Measure Bundle for which the hospital’s or physician practice’s all-payer denominator for the baseline measurement period or performance year is greater than zero are equal.

(B) If a hospital’s or physician practice’s all-payer denominator for a required measure in a selected Measure Bundle for the baseline measurement period or a performance year does not meet the minimum all-payer denominator size criteria as described in the Measure Bundle Protocol, but is greater than zero, the measure and milestone valuations are adjusted in accordance with subsection (d)(2) of this section.

(4) Minimum point thresholds (MPTs) for hospitals.

(A) The MPT for hospitals, with the exception of those described in subparagraphs (B) and (C) of this paragraph, is calculated as follows:

(i) First, the hospital's statewide hospital factor (SHF) is equal to (.64 multiplied by (the hospital's Medicaid and uninsured inpatient days divided by the sum of all hospitals' Medicaid and uninsured inpatient days)) plus (.36 multiplied by (the hospital's Medicaid and uninsured outpatient costs divided by the sum of all hospitals' Medicaid and uninsured outpatient costs)).

(ii) Second, the hospital's statewide hospital ratio (SHR) is equal to (the hospital's DY7 valuation divided by the sum of all hospitals' DY7 valuations) divided by the SHF.

(iii) Third, the hospital's MPT is determined as follows:

(I) If the SHR is less than or equal to 3, the MPT is the lesser of:

(-a-) the DY7 valuation divided by the standard point valuation ($500,000); or

(-b) 75.

(II) If the SHR is greater than 3 but less than or equal to 10, the MPT is the lesser of:
(I) If the SHR is greater than 10 and the DY7 valuation is less than or equal to $15 million, the MPT is the lesser of:

(-a-) (the DY7 valuation divided by the standard point valuation ($500,000)) multiplied by (the SHR divided by 3); or

(-b-) 75.

(III) If the SHR is greater than 10 and the DY7 valuation is less than or equal to $15 million, the MPT is the lesser of:

(-a-) (the DY7 valuation divided by the standard point valuation ($500,000)) multiplied by (the SHR divided by 3); or

(-b-) 50.

(IV) If the SHR is greater than 10 and the DY7 valuation is greater than $15 million, the MPT is the lesser of:

(-a-) (the DY7 valuation divided by the standard point valuation ($500,000)) multiplied by (the SHR divided by 3); or

(-b-) 75.

(B) If a hospital does not have the data needed for the SHF calculation in paragraph (4)(A)(i) of this subsection, its MPT will be determined using an alternate methodology to be determined by HHSC.

(C) If a hospital has a limited scope of practice and there are not enough Measure Bundle(s) appropriate for it, based on its scope of practice and community partnerships, that are worth enough points to meet its MPT for Measure Bundle selection, the hospital may request HHSC approval for a reduced MPT equal to the sum of the points for all the Measure Bundles the hospital could reasonably report. The hospital must submit a request for such approval to HHSC prior to the RHP plan update submission, by a date determined by HHSC. Such a request may be subject to review by the Centers for Medicare & Medicaid Services (CMS). If HHSC and CMS, as appropriate, approve such a request, the hospital’s total valuation may be reduced.

(5) Minimum point thresholds (MPTs) for physician practices.

(A) The MPT for physician practices, with the exception of those described in subparagraph (B) of this paragraph, is the lesser of:

(i) the physician practice's DY7 valuation divided by the standard point valuation ($500,000); or
(ii) 75.

(B) If a physician practice has a limited scope of practice and there are not enough Measure Bundles appropriate for it, based on its scope of practice and community partnerships, that are worth enough points to meet its MPT for Measure Bundle selection, the physician practice may request HHSC approval for a reduced MPT equal to the sum of the points for all the Measure Bundles the physician practice could reasonably report. The physician practice must submit a request for such approval to HHSC prior to the RHP plan update submission, by a date determined by HHSC. Such a request may be subject to review by CMS. If HHSC and CMS, as appropriate, approve such a request, the physician practice’s total valuation may be reduced.

(b) Requirements for community mental health centers and local health departments.

(1) Measure selection.

(A) A community mental health center (CMHC) or local health department (LHD) must select measures from the Measure Bundle Protocol.

(B) Each measure is assigned a point value as described in the Measure Bundle Protocol.

(C) A CMHC or LHD is assigned an MPT for measure selection.

(D) A CMHC or LHD must select measures worth enough points to meet its MPT in order to maintain its valuation for DY7 and DY8. If a CMHC or LHD does not select measures worth enough points to meet its MPT, its total DY7 valuation will be reduced proportionately across its RHP Plan Update and Categories B-D funds for DY7, and its total DY8 valuation will be reduced proportionately across its Categories B-D funds for DY8, based on the number of measure points selected.

(E) A CMHC or LHD must select at least one three-point measure.

(F) A CMHC or LHD may only select a measure for which the CMHC’s or LHD’s all-payer denominator for the baseline measurement period meets the minimum all-payer denominator size criteria as described in the Measure Bundle Protocol.
(2) Measure valuation. A CMHC or LHD may allocate its Category C valuation among its selected measures, provided the following requirements are met:

(A) The valuation for each selected measure must be greater than or equal to (the Category C valuation divided by the number of selected measures) divided by 2.

(B) The valuation for each selected non-standalone measure must be less than or equal to the Category C valuation divided by the number of selected measures.

(3) MPTs. A CMHC's or LHD's MPT is the lesser of:

(A) the CMHC's or LHD's DY7 valuation divided by the standard point valuation ($500,000); or

(B) 40.

(c) Measurement periods.

(1) Baseline measurement periods. The baseline measurement period for a measure is calendar year 2017.

(A) A performer may request for a measure to have a shorter baseline measurement period consisting of no fewer than six months as specified in the Program Funding and Mechanics Protocol and HHSC guidance.

(B) A performer may request for a pay-for-performance (P4P) measure to have a delayed baseline measurement period that ends no later than September 30, 2018, as specified in the Program Funding and Mechanics Protocol and HHSC guidance.

(2) Performance measurement periods. The performance measurement periods for a P4P measure are as follows:

(A) Performance Year (PY) 1 for a measure is calendar year 2018, with the following exceptions:

(i) if HHSC approved the use of a delayed baseline measurement period for the measure, the measure will not have a PY1; and

(ii) any other exceptions specified in the Measure Bundle Protocol.
(B) PY2 for a measure is calendar year 2019, with the following exceptions:

(i) if HHSC approved the use of a delayed baseline measurement period for the measure, the measure's PY2 is the 12-month measurement period immediately following the delayed baseline measurement period; and

(ii) any other exceptions specified in the Measure Bundle Protocol.

(C) PY3 for a measure is calendar year 2020, with the following exceptions:

(i) if HHSC approved the use of a delayed baseline measurement period for the measure, the measure's PY3 is the 12-month measurement period immediately following PY2; and

(ii) any other exceptions specified in the Measure Bundle Protocol.

(3) Reporting measurement periods. The reporting measurement periods for a pay-for-reporting (P4R) measure are as follows unless otherwise specified in the Measure Bundle Protocol:

(A) Reporting Year (RY) 1 for a measure is DY7; and

(B) RY 2 for a measure is DY8.

(d) Measure milestones.

(1) The milestones and corresponding valuations for DY7-8 are as follows, with the exception specified in paragraph (2) of this subsection:

<table>
<thead>
<tr>
<th></th>
<th>P4R Measure</th>
<th>P4P Measure</th>
<th>P4P Measure with an approved delayed baseline measurement period</th>
</tr>
</thead>
<tbody>
<tr>
<td>DY7</td>
<td>100% RY1 reporting milestone</td>
<td>25% baseline reporting milestone</td>
<td>25% baseline reporting milestone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25% PY1 reporting milestone</td>
<td>25% PY2 reporting milestone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% DY7 goal achievement milestone</td>
<td>50% DY7 goal achievement milestone</td>
</tr>
<tr>
<td>DY8</td>
<td></td>
<td>25% PY2 reporting milestone</td>
<td>25% PY3 reporting milestone</td>
</tr>
<tr>
<td>100% RY2 reporting milestone</td>
<td>75% DY8 goal achievement milestone</td>
<td>75% DY8 goal achievement milestone</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------</td>
<td>----------------------------------</td>
<td></td>
</tr>
</tbody>
</table>

(2) If a hospital’s or physician practice’s all-payer denominator for a required measure in a selected Measure Bundle for the baseline measurement period or a performance year does not meet the minimum all-payer denominator size criteria as described in the Measure Bundle Protocol, but is greater than zero, the valuation for the measure’s goal achievement milestone for the DY is redistributed among the goal achievement milestones for the measures in the Measure Bundle for which the hospital’s or physician practice’s all-payer denominator for the baseline measurement period or performance year meets the minimum all-payer denominator size criteria for the applicable DY. The valuations for the goal achievement milestones for the measures in the Measure Bundle for which the hospital’s or physician practice’s all-payer denominator meets the minimum all-payer denominator size criteria for the DY are calculated as follows:

(A) the valuation for the DY7 goal achievement milestone is equal to 50 percent of the valuation for the Measure Bundle divided by the number of measures in the Measure Bundle for which the hospital’s or physician practice’s all-payer denominator meets the minimum all-payer denominator size criteria, so that the valuations for the DY7 goal achievement milestones for the measures in the Measure Bundle for which the hospital’s or physician practice’s all-payer denominator meets the minimum all-payer denominator size criteria are equal; and

(B) the valuation for the DY8 goal achievement milestone is equal to 75 percent of the valuation for the Measure Bundle divided by the number of measures in the Measure Bundle for which the hospital’s or physician practice’s all-payer denominator meets the minimum all-payer denominator size criteria, so that the valuations for the DY8 goal achievement milestones for the measures in the Measure Bundle for which the hospital’s or physician practice’s all-payer denominator meets the minimum all-payer denominator size criteria are equal.

(3) A performer must report a baseline for a measure, and HHSC must approve the reported baseline for reporting purposes, before a performer can report PY1 (or PY2 if HHSC approved the use of a delayed baseline measurement period for the measure).

(A) A performer must adhere to measure specifications and maintain a record of any variances approved by HHSC prior to reporting a baseline for a measure.
(B) HHSC's approval of a reported baseline for reporting purposes does not constitute approval for a performer to report a measure outside measure specifications. If at any point HHSC or the independent assessor finds that a performer is reporting a measure outside measure specifications, reporting milestone payment and goal achievement milestone payment may be withheld or recouped while the performer works to bring reporting into compliance with measure specifications.

(4) A performer must report a P4P measure's reporting milestone and goal achievement milestone for a given PY during the same reporting period, with exceptions for P4P measures with a delayed baseline measurement period.

(e) Measure eligible denominator population.

(1) A measure's eligible denominator population must include all individuals served by the performer's system during a given measurement period.

(A) A measure may have a specified setting or a definition of active patient as specified in the Measure Bundle Protocol.

(B) A performer may not use a performer-specific facility, co-morbid condition, age, gender, or race/ethnicity subset not otherwise specified in the Measure Bundle Protocol.

(2) Reporting milestones. A performer must report its performance on a measure for the all-payer, Medicaid-only, and Low-income Uninsured-only (LIU-only) payer types to be eligible for payment of the measure's reporting milestones.

(A) A performer may request in the RHP plan update submission to be exempted from reporting its performance on a measure for the Medicaid-only payer type or the LIU-only payer type as specified in the Program Funding and Mechanics Protocol.

(B) A performer may submit a RHP plan update modification request to HHSC to be exempted from reporting its performance on a measure for the Medicaid-only payer type or the LIU-only payer type as specified in the Program Funding and Mechanics Protocol.

(3) Goal achievement milestones. Payment for a P4P measure's goal achievement milestone is based on the performer's performance on the measure for the MLIU payer type.
(A) A performer may request in the RHP plan update submission that payment for a P4P measure's goal achievement milestone be based on the performer's performance on the measure for the all-payer, Medicaid-only, or LIU-only payer type as specified in the Program Funding and Mechanics Protocol.

(B) A performer may submit a RHP plan update modification request to HHSC to change the payer type on which payment for a P4P measure's goal achievement milestone is based as specified in the Program Funding and Mechanics Protocol.

(f) Methodology for P4P measure goal setting.

(1) A P4P measure's goals are set as an improvement over the baseline.

(2) A P4P measure is designated as either Quality Improvement System for Managed Care (QISMC) or Improvement over Self (IOS) as specified in the Measure Bundle Protocol. A P4P measure designated as QISMC has a defined High Performance Level (HPL) and Minimum Performance Level (MPL) based on national or state benchmarks.

(3) A P4P measure's goals are set as follows:

<table>
<thead>
<tr>
<th>QISMC</th>
<th>DY7 Goal</th>
<th>DY8 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline below MPL</td>
<td>MPL</td>
<td>10% gap closure between the MPL and HPL</td>
</tr>
<tr>
<td>Baseline between MPL and HPL</td>
<td>The greater absolute value of improvement between: 10% gap closure towards HPL, or baseline plus (minus) 5% of the difference between the HPL and MPL, not to exceed the HPL</td>
<td>The greater absolute value of improvement between: 20% gap closure towards HPL, or baseline plus (minus) 10% of the difference between the HPL and MPL, not to exceed the HPL</td>
</tr>
<tr>
<td>Baseline above HPL</td>
<td>HPL</td>
<td>HPL</td>
</tr>
<tr>
<td>IOS</td>
<td>5% gap closure</td>
<td>10% gap closure</td>
</tr>
</tbody>
</table>
(g) Carry forward policy.

  (1) Carry forward of reporting. If a performer does not report a measure’s baseline reporting milestone or performance year reporting milestone during the first reporting period after the end of the milestone’s measurement period, the performer may request to carry forward reporting of the milestone to the next reporting period. If a measure has a delayed baseline measurement period:

    (A) a performer may request to carry forward reporting of the measure’s baseline reporting milestone until the first reporting period of DY8;

    (B) a performer may request to carry forward reporting of the measure’s performance year (PY) 2 reporting milestone until the second reporting period of DY8; and

    (C) a performer may request to carry forward reporting of the measure’s PY3 reporting milestone until the second reporting period of DY9.

  (2) Carry forward of achievement.

    (A) A performer may request to carry forward achievement of a measure’s goal achievement milestone so that the DY7 goal achievement milestone may be achieved in PY1 or PY2, and the DY8 goal achievement milestone may be achieved in PY2 or PY3, with the exception that if a measure has a delayed baseline measurement period, a performer may not request to carry forward achievement of the measure’s DY7 goal achievement milestone.

    (B) The performer must report the carried forward achievement of a measure’s goal achievement milestone during the first reporting period after the end of the milestone’s carried forward measurement period, with the exception that if a measure has a delayed baseline measurement period, a performer may report the carried forward achievement for the DY8 goal achievement milestone no later than the second reporting period of DY9.

§354.1715. Category D Requirements for Performers.

(a) There is a Category D - Statewide Reporting Measure Bundle for each provider type, as described in the Measure Bundle Protocol.
(b) Each Category D - Statewide Reporting Measure Bundle consists of one or more measures, as described in the Measure Bundle Protocol.

(c) The valuation of a performer's Category D - Statewide Reporting Measure Bundle is equal to five percent of the performer’s total valuation, with the exception that if the performer's RHP maintains the total private hospital valuation for its RHP, as described in Figure: 25 TAC §354.1715(c), at the time of RHP plan update submission, the performer may increase the valuation of its Category D - Statewide Reporting Measure Bundle to 15 percent of the performer's total valuation.

<table>
<thead>
<tr>
<th>RHP</th>
<th>Private Hospital Valuation</th>
<th>Minimum Private Hospital Valuation for each DY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$38,856,709</td>
<td>$37,691,007</td>
</tr>
<tr>
<td>2</td>
<td>$12,933,175</td>
<td>$12,545,180</td>
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<td>3</td>
<td>$133,630,962</td>
<td>$129,622,034</td>
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<td>$63,040,074</td>
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<td>5</td>
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<td>$105,726,810</td>
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<td>$13,385,935</td>
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<td>TOTAL</td>
<td>$870,343,929</td>
<td>$844,233,611</td>
</tr>
</tbody>
</table>

(d) The valuation for each measure in a performer's Category D - Statewide Reporting Measure Bundle for each DY is equal to the valuation of the performer's Category D - Statewide Reporting Measure Bundle for the DY
divided by the number of measures in the Category D - Statewide Reporting Measure Bundle, so that the valuations of the measures are equal.

(e) A performer must report on a measure in the Category D - Statewide Reporting Measure Bundle for its provider type for a DY to be eligible for payment of the measure for that DY.

§354.1717. Uncompensated Care (UC) Hospital Requirements.

(a) An Uncompensated Care (UC) hospital must:

(1) attend at least one learning collaborative, stakeholder forum, or other stakeholder meeting each demonstration year (DY); and

(2) report on the hospital Statewide Reporting Measure Bundle measures required for UC hospitals, as specified in the Measure Bundle Protocol, for each DY.

(A) If a UC hospital fails to report on the hospital Category D - Statewide Reporting Measure Bundle measures required for UC hospitals by the last quarter of the applicable DY, the hospital forfeits one quarter of its UC payments for that DY.

(B) A UC hospital may request from HHSC a six-month extension from the end of the DY to report any outstanding hospital Statewide Reporting Measure Bundle measures required for UC hospitals. The UC hospital will receive the fourth-quarter UC payment only if all outstanding required measures are reported within that six-month extension.

(3) A UC hospital is not eligible to receive DSRIP for Category D - Statewide Reporting Measure Bundle reporting.

(b) Exceptions to the requirements in subsection (a) of this section may be approved by the Centers for Medicare & Medicaid Services on a case-by-case basis.

§354.1719. Disbursement of Funds.

(a) Basis for payment for the RHP plan update submission. A performer will receive 20 percent of its total DY7 valuation if the anchor of the performer's
RHP submits an RHP plan update and HHSC approves the submitted RHP plan update.

(b) Category A and DSRIP payments. If a performer fails to fulfill all of the Category A requirements described in §354.1709 of this division (relating to Category A Requirements for Performers) for a demonstration year (DY), any DSRIP payments the performer received for the DY will be recouped, and prospective DSRIP payments to the performer will be withheld.

(1) DSRIP payments for DY7 include payments for the RHP plan update submission, as well as any payments for DY7 Category B, Category C, or Category D milestones.

(2) DSRIP payments for DY8 include any payments for DY8 Category B, Category C, or Category D milestones.

(c) Basis for payment of Category B. A performer's payment for its MLIU PPP milestone for a DY is calculated as follows.

(1) If the performer's MLIU PPP goal achievement is greater than or equal to 100 percent minus its allowable MLIU PPP goal variation, the performer's MLIU PPP milestone payment is equal to 100 percent of its MLIU PPP milestone valuation.

(2) If the performer's MLIU PPP goal achievement is greater than or equal to 90 percent, and less than 100 percent minus its allowable MLIU PPP goal variation, the performer's MLIU PPP milestone payment is equal to 90 percent of its MLIU PPP milestone valuation.

(3) If the performer's MLIU PPP goal achievement is greater than or equal to 75 percent, and less than 90 percent, the performer's MLIU PPP milestone payment is equal to 75 percent of its MLIU PPP milestone valuation.

(4) If the performer's MLIU PPP goal achievement is greater than or equal to 50 percent, and less than 75 percent, the performer's MLIU PPP milestone payment is equal to 50 percent of its MLIU PPP milestone valuation.

(5) If the performer's MLIU PPP goal achievement is less than 50 percent, the performer does not receive a MLIU PPP milestone payment.

(d) Basis for payment of Category C.

(1) Reporting milestones. A performer must fully achieve a reporting milestone to be eligible for payment of the milestone.
(2) P4P measure goal achievement milestones. A P4P measure has a goal achievement milestone for each DY.

(A) The payment for a P4P measure goal achievement milestone, with the exception of a P4P measure goal achievement milestone described in subparagraph (B) of this paragraph, is determined as follows.

(i) First, the percent of the milestone's goal achieved by the performer is determined as follows.

(I) If a measure has a positive directionality for which higher scores indicate improvement:

(-a-) DY7 achievement is equal to (PY1 achieved minus baseline) divided by (DY7 goal minus baseline).

(-b-) Carry forward of DY7 achievement is equal to (PY2 achieved minus baseline) divided by (DY7 goal minus baseline).

(-c-) DY8 achievement is equal to (PY2 achieved minus baseline) divided by (DY8 goal minus baseline).

(-d-) Carry forward of DY8 achievement is equal to (PY3 achieved minus baseline) divided by (DY8 goal minus baseline).

(II) If a measure has a negative directionality for which lower scores indicate improvement:

(-a-) DY7 achievement is equal to (baseline minus PY1 achieved) divided by (baseline minus DY7 goal).

(-b-) Carry forward of DY7 achievement is equal to (baseline minus PY2 achieved) divided by (baseline minus DY7 goal).

(-c-) DY8 achievement is equal to (baseline minus PY2 achieved) divided by (baseline minus DY8 goal).

(-d-) Carry forward of DY8 achievement is equal to (baseline minus PY3 achieved) divided by (baseline minus DY8 goal).

(ii) Second, the achievement value is determined as follows.

(I) If 100 percent of the goal is achieved, the achievement value is 1.0.
(II) If less than 100 percent but at least 75 percent of the goal is achieved, the achievement value is 0.75.

(III) If less than 75 percent but at least 50 percent of the goal is achieved, the achievement value is 0.5.

(IV) If less than 50 percent but at least 25 percent of the goal is achieved, the achievement value is 0.25.

(V) If less than 25 percent of the goal is achieved, the achievement value is 0.

(iii) Third, the achievement value calculated in clause (ii) of this subparagraph is multiplied by the milestone valuation.

(B) If a P4P measure designated as Quality Improvement System for Managed Care has a baseline above the High Performance Level, the performer must achieve 100 percent of the goal achievement milestone’s goal to be eligible for payment of the milestone; there is no payment for partial achievement of the goal achievement milestone’s goal.

(e) Basis for payment of Category D. A performer must report on a measure in the Category D - Statewide Reporting Measure Bundle for its provider type, as described in the Measure Bundle Protocol, for a DY during the second reporting period of that DY to be eligible for payment of the measure for that DY.

(f) At no point may a performer receive a DSRIP payment for a milestone more than two years after the end of the DY in which the milestone is to be completed.

(g) If a performer does not complete the remaining milestones as described in §354.1711(j)(1) of this division (relating to Category B Requirements for Performers) or §354.1713(g) of this division (relating to Category C Requirements for Performers), or the Category D - Statewide Reporting Measure Bundle measures as described in subsection (e) of this section, the associated DSRIP funding is forfeited by the performer.

(h) Once the action associated with a milestone is reported by the performer as complete, that milestone may not be counted again toward DSRIP payment calculations.
§354.1721. Remaining Funds for Demonstration Years (DYs) 7-8.

(a) The total remaining funds for DY7 are equal to the DY7 DSRIP pool allocation described in the Program Funding and Mechanics Protocol minus the sum of the DY7 performer valuations described in §354.1707(c) of this division (relating to Performer Valuations).

(b) The total remaining funds for DY8 are equal to the DY8 DSRIP pool allocation described in the Program Funding and Mechanics Protocol minus the sum of the DY8 performer valuations described in §354.1707(c) of this division.

(c) The DY7-8 remaining funds are allocated to RHPs as follows:

<table>
<thead>
<tr>
<th>RHP</th>
<th>Remaining Funds Allocation per DY for DY7-8</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHP 1</td>
<td>$866,635</td>
</tr>
<tr>
<td>RHP 2</td>
<td>$2,308,000</td>
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<td>RHP 3</td>
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<tr>
<td>RHP 4</td>
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<td>RHP 5</td>
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<td>RHP 6</td>
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<td>RHP 7</td>
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<td>RHP 8</td>
<td>$5,739,571</td>
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<tr>
<td>RHP 9</td>
<td>$0</td>
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<tr>
<td>RHP 10</td>
<td>$0</td>
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<tr>
<td>RHP 11</td>
<td>$0</td>
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<tr>
<td>RHP 12</td>
<td>$0</td>
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<tr>
<td>RHP 13</td>
<td>$0</td>
</tr>
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<td>RHP 14</td>
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<td>RHP 15</td>
<td>$0</td>
</tr>
<tr>
<td>RHP 16</td>
<td>$0</td>
</tr>
<tr>
<td>RHP 17</td>
<td>$9,284,861</td>
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<tr>
<td>RHP 18</td>
<td>$1,318,286</td>
</tr>
<tr>
<td>RHP 19</td>
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</tr>
<tr>
<td>RHP 20</td>
<td>$4,062,821</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$28,899,632</strong></td>
</tr>
</tbody>
</table>

(d) An RHP with allocated DY7-8 remaining funds may determine how to allocate those funds among the performers in the RHP based on the community needs assessment update. The RHP may allocate these funds to providers that did not participate in DSRIP during the initial demonstration
period or DY6 and are one of the eligible participants as described in §354.1695(c)(1) of this division (relating to Participants).

(e) An RHP must conduct at least two public stakeholder meetings to determine how its DY7-8 remaining funds allocation will be used.

(f) A performer allocated DY7-8 remaining funds must certify that there is a source of IGTs for the funds.

(g) The RHP plan update must include:

(1) a description of the process used to determine how the RHP's DY7-8 remaining funds allocation will be used;

(2) the performers in the RHP that were allocated DY7-8 remaining funds; and

(3) the performers or providers in the RHP that were interested in receiving DY7-8 remaining funds but were not allocated any DY7-8 remaining funds.

(h) Existing and new performers allocated DY7-8 remaining funds must follow all DSRIP requirements.
PROPOSED PREAMBLE

The Texas Health and Human Services Commission (HHSC) proposes new §355.8205, concerning Delivery System Reform Incentive Payments for Demonstration Years 7-8; and new §355.8206, concerning Funding for DSRIP Monitoring Program for Demonstration Years 7-8.

BACKGROUND AND JUSTIFICATION

On December 12, 2011, the Centers for Medicare & Medicaid Services (CMS) approved Texas's request for a new Medicaid demonstration waiver entitled “Texas Healthcare Transformation and Quality Improvement Program” in accordance with Section 1115 of the Social Security Act. This waiver authorized the establishment of the Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program provides incentive payments to hospitals and certain other providers to support their efforts to enhance access to health care, the quality of care, and the health of patients and families they serve.

The initial waiver was approved through September 30, 2016, and an initial extension was granted through December 31, 2017. HHSC has requested an additional 21 months that would extend the waiver through September 30, 2019.

The framework for DSRIP payments is governed by the Program Funding and Mechanics (PFM) protocol that is referenced in the waiver Special Terms and Conditions. HHSC developed the draft PFM protocol proposal for the requested additional 21 months (demonstration years 7-8) and posted it, along with a survey to solicit stakeholder feedback on the proposal, to the Transformation Waiver website on January 31, 2017. HHSC received more than 170 responses to the survey, and made a number of revisions to the PFM protocol proposal based on these survey responses. HHSC submitted the revised PFM protocol proposal for demonstration years 7-8 to CMS on May 17, 2017. These proposed new rules closely mirror the PFM protocol proposal submitted to CMS. HHSC will update these rules, as necessary, in accordance with CMS guidance.
The proposed rules describe the DSRIP policies for DY7-8. In DY7-8, HHSC proposes an evolution of DSRIP from project-level reporting to core activities supporting performer-level outcomes that measure continued transformation of the Texas healthcare system. DY7-8 will serve as an opportunity for performers to move further towards sustainability of their transformed systems, including development of Alternative Payment Models to continue services for Medicaid and low-income or uninsured (MLIU) individuals after the waiver ends.

SECTION-BY-SECTION SUMMARY

Proposed new §355.8205 describes performer eligibility for payments, the payment methodology, and recoupment.

Proposed new §355.8206 describes how the DSRIP monitoring program is funded.

FISCAL NOTE

Greta Rymal, HHSC Deputy Executive Commissioner for Financial Services, has determined that for each year of the first five years the new sections will be in effect, there will be no fiscal implications to state government as a result of enforcing and administering the sections as proposed.

There may be fiscal implications to local governments as a result of enforcing and administering the new sections as proposed. The non-federal share of DSRIP payments to DSRIP performing providers, or performers, are funded by intergovernmental transfers (IGTs) from a governmental entity (an IGT entity). Under these proposed new sections, in the event of an overpayment or disallowance by CMS, HHSC may recoup DSRIP payments from performers. In that case, the performer would return the DSRIP payments to HHSC. HHSC would refund the federal share of the payments to CMS, and the non-federal share (the IGTs) to the IGT entity that transferred the funds. HHSC cannot predict if any DSRIP funds would be recouped. Therefore, HHSC lacks sufficient data to provide an estimate of the possible local government fiscal impact.

Additionally, to fund DSRIP performers allocated remaining funds, an IGT entity would be required to provide additional IGTs to fund the non-federal share. However, since IGTs are voluntary, providing the additional funds would not be required by adoption or implementation of these new sections.
SMALL BUSINESS AND MICRO-BUSINESS IMPACT ANALYSIS

Ms. Rymal has also determined that there will be no adverse impact on small businesses or micro-businesses required to comply with the new sections as proposed. Participation in the DSRIP program and in DSRIP DY7-8 is voluntary, and no small business or micro-business is required to be involved in the program.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There are no anticipated economic costs to persons who are required to comply with the sections as proposed.

There is no anticipated negative impact on local employment.

PUBLIC BENEFIT

Jami Snyder, State Medicaid Director, has determined that for each year of the first five years the rules are in effect, the public will benefit from the adoption of the rules. The anticipated public benefit will be improved quality of care for individuals served by DSRIP performers.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that this proposal does not restrict or limit an owner’s right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Government Code, §2007.043.

PUBLIC HEARING

A public hearing is scheduled for September 21, 2017, at 9:30 a.m. (central time) in the Brown-Heatly Building, Public Hearing Room, located at 4900 North Lamar Boulevard, Austin, Texas 78751. Persons requiring further information, special assistance, or accommodations should contact Amy Chandler at 512-487-3419.

PUBLIC COMMENT

Questions about the content of this proposal may be directed to Kimberly Tucker, Healthcare Transformation Waiver Unit, at (512) 424-6605.

Written comments on the proposal may be submitted to Kimberly Tucker, Health and Human Services Commission, Healthcare Transformation Waiver
Unit, Brown-Heatly Building, 4900 N. Lamar Blvd., Mail Code H-425, Austin, TX 78751; by fax to (512) 424-6974; or by e-mail to TXHealthcareTransformation@hhsc.state.tx.us within 30 days after publication of this proposal in the Texas Register.

To be considered, comments must be submitted no later than 30 days after the date of this issue of the Texas Register. The last day to submit comments falls on a Sunday; therefore, comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) faxed or e-mailed by midnight on the last day of the comment period. When faxing or e-mailing comments, please indicate "Comments on Proposed Rule 1R031" in the subject line.

STATUTORY AUTHORITY

The new sections are authorized by Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b), which provides HHSC with the authority to propose and adopt rules governing the determination of Medicaid reimbursements.

The new sections implement Chapter 531 of the Texas Government Code and Chapter 32 of the Texas Human Resources Code. No other statutes, articles, or codes are affected by this proposal.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be within the agency’s legal authority to adopt.
§355.8205. Delivery System Reform Incentive Payments for Demonstration Years 7-8.

(a) Introduction. Texas Healthcare Transformation and Quality Improvement Program §1115(a) Medicaid demonstration waiver Delivery System Reform Incentive Payment (DSRIP) program payments for demonstration year (DY) 7 and DY8 are available under this section for eligible performers described in subsection (c) of this section. DSRIP payments to performers must be in compliance with the Centers for Medicare & Medicaid Services (CMS) approved Program Funding and Mechanics Protocol, Health and Human Services Commission (HHSC) instructions, and this section.

(b) Definitions.

(1) Demonstration Year (DY) 6--Federal fiscal year 2017 (October 1, 2016 - September 30, 2017).

(2) Demonstration Year (DY) 7--Federal fiscal year 2018 (October 1, 2017 - September 30, 2018).

(3) Demonstration Year (DY) 8--Federal fiscal year 2019 (October 1, 2018 - September 30, 2019).

(4) Performer--A Medicaid provider that participates in DSRIP and receives DSRIP payments.

(5) Regional Healthcare Partnership (RHP) Plan Update--An RHP plan for the initial demonstration period and DY6 that is updated for DY7-8, as further described in §354.1697 of this title (relating to RHP Plan Update).
(c) Eligibility for DSRIP. For a performer to be eligible to receive DSRIP, the performer must:

(1) be actively enrolled as a Medicaid provider in Texas;

(2) submit to HHSC documentation of completion of a milestone identified in the approved RHP plan update; and

(3) for a private hospital only, comply with the eligibility requirements in §355.8201(c)(1)(B) of this title (relating to Waiver Payments to Hospitals for Uncompensated Care) or §355.8202(c)(3) of this title (relating to Waiver Payments to Physician Group Practices for Uncompensated Care), as applicable.

(d) Source of funding. The non-federal share of funding for payments under this section is limited to timely receipt by HHSC of public funds from a governmental entity.

(e) Payment frequency. DSRIP payments will be distributed at least annually, not to exceed two payments per performer per year, upon achievement of RHP plan update milestones as reviewed and approved by HHSC. The payment schedule or frequency may be modified as specified by CMS or HHSC.

(f) Funding limitations. Payments made under this section are limited by the maximum aggregate amount of funds approved by CMS for DSRIP for each year that the waiver is in effect.

(g) DSRIP maximum payment amounts. The approved RHP plan update establishes the payment amount associated with a particular milestone. DSRIP payments cannot exceed the amount in the RHP plan update.

(h) Payment methodology.

(1) Notice. Prior to making any DSRIP payments, HHSC will give notice of the following information:

(A) the maximum payment amount for the payment period;

(B) the maximum intergovernmental transfer (IGT) amount necessary for a performer to receive the amount described in subparagraph (A) of this paragraph; and

(C) the deadline for completing the IGT.
(2) Payment amount. The approved RHP plan update establishes the payment amount associated with a milestone. DSRIP payments cannot exceed the amount established in the approved RHP plan update. The amount of the payment to a performer will be determined based on the amount of funds transferred by a governmental entity as follows.

(A) If a governmental entity transfers the maximum amount referenced in paragraph (1) of this subsection on behalf of each performer owned by or affiliated with that governmental entity, each performer owned by or affiliated with that governmental entity will receive the full payment amount calculated for that payment period.

(B) If a governmental entity does not transfer the maximum amount referenced in paragraph (1) of this subsection on behalf of each performer owned by or affiliated with that governmental entity, each performer owned by or affiliated with that governmental entity will receive a portion of the value associated with that milestone (as specified in the RHP plan update) that is proportionate to the total value of all milestones that are completed and eligible for payment for that period by all performers owned by or affiliated with that governmental entity.

(3) Final payment opportunity. If a performer does not receive a full DSRIP payment as a result of paragraph (2)(B) of this subsection, a governmental entity may provide the necessary IGT to make up the non-federal share of that shortfall until the last reporting period of the DY following the DY in which the applicable milestone is listed in the RHP plan update. Any shortfall remains the obligation of the original governmental entity until that governmental entity informs HHSC that it will no longer agree to fund that obligation.

(A) If the governmental entity will no longer fund the obligation or a proportion of the obligation, that governmental entity must inform HHSC no later than the last date of the reporting period for the applicable payment period.

(B) A performer may utilize any affiliated governmental entity to fund the shortfall but must inform HHSC of the identity of this governmental entity no later than the last date of a reporting period in order for that affiliated entity to fund the shortfall during the associated payment period.

(i) Recoupment.

(1) In the event of an overpayment identified by HHSC or a disallowance by CMS of federal financial participation related to a performer's receipt or
use of payments under this section, HHSC may recoup an amount equivalent to the amount of the overpayment or disallowance. The non-federal share of any funds recouped from the performer will be returned to the governmental entity that was the source of those funds.

(2) Payments under this section may be subject to adjustment for payments made in error, including, without limitation, adjustments under §371.1711 of this title (relating to Recoupment of Overpayments and Debts), 42 CFR Part 455, and Chapter 403, Texas Government Code. HHSC may recoup an amount equivalent to any such adjustment.

(3) HHSC may recoup from any current or future Medicaid payments as follows.

(A) HHSC will recoup from the performer against which any overpayment was made or disallowance was directed.

(B) If, within 30 days of the performer's receipt of HHSC's written notice of recoupment, the performer has not paid the full amount of the recoupment or entered into a written agreement with HHSC to do so, HHSC may withhold any or all future Medicaid payments from the performer until HHSC has recovered an amount equal to the amount overpaid or disallowed.

§355.8206. Funding for DSRIP Monitoring Program for Demonstration Years 7-8.

(a) Introduction. The Texas Healthcare Transformation and Quality Improvement Program §1115(a) Medicaid demonstration waiver provides for Delivery System Reform Incentive Payment (DSRIP) program payments to eligible performers. In order to ensure that such payments are made properly, the Health and Human Services Commission (HHSC) will contract with one or more independent entities to monitor the DSRIP program. This section describes the method by which HHSC will gain the source of the non-federal share of payments to reimburse the independent entity for its administrative expenses. For purposes of this section, the definitions in §354.1691 of this title (relating to Definitions) apply, except where otherwise indicated.
(b) Funding for DSRIP program monitoring. HHSC will allocate an intergovernmental transfer (IGT) amount to each DSRIP IGT entity to fund DSRIP monitoring activities.

(1) HHSC will determine the amount of the IGT allocation in each demonstration year (DY) for each IGT entity. The amount of the IGT allocation for each IGT entity will be calculated using the following formula:

\[
\text{IGT Allocation} = \left(\frac{\text{AffiliatedValue}}{\text{DYValue}}\right) \times \text{TotalIGT},
\]

where:

(A) "AffiliatedValue" is the portion of the value for which the IGT entity agreed to fund the non-federal share for all DSRIP performers that the IGT entity is affiliated with for a particular DY;

(B) "DYValue" is the value for all DSRIP performers in the state for the same DY as used in subparagraph (A) of this paragraph; and

(C) "TotalIGT" is the total amount of IGT necessary for monitoring activities in a DY, as determined by HHSC, which may not be greater than $5 million.

(2) The values utilized in paragraph (1) of this subsection are the official values as of January 1 of the calendar year in which the calculation occurs.

(3) The full IGT allocation for monitoring will be requested the first time an IGT entity provides an IGT for a DY.

(4) An IGT entity may choose to either provide the IGT allocation from an IGT intended to fund a DSRIP payment or in addition to an IGT to fund a DSRIP payment.

(c) Return of unused IGTs. The balance of any allocation not used to fund monitoring activities will be returned to the IGT entities. The amount returned is calculated on a pro rata basis in accordance with the amount of such entities' IGTs intended to fund the DSRIP monitoring program for the DY for which the refund is made.