TO: Health and Human Services Commission Executive Council

DATE: February 22, 2018

FROM: John Scott, Director of Operations, Texas Healthcare Transformation Waiver

AGENDA ITEM: 2.g

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

BACKGROUND: ☐ Federal ☐ Legislative ☒ Other: Program Initiative

The Program Funding and Mechanics (PFM) protocol governs DSRIP. The current DSRIP DY7-8 rules mirror the proposed PFM protocol language for DY7-8, submitted to the Centers for Medicare & Medicaid Services (CMS) on May 17, 2017. HHSC has since revised the proposed PFM protocol language for DY7-8 and submitted it to CMS for approval. HHSC is amending the rules to Texas Administrative Code, Title 1, Chapter 354, Subchapter D at this time to make them consistent with the most recent version of the proposed PFM protocol.

ISSUES AND ALTERNATIVES:

These rule amendments reflect the PFM protocol as of December 22, 2017. It is possible that additional changes will be made to the PFM protocol and HHSC may need to amend further the DSRIP DY7-8 rules to make them consistent with the final version of the PFM protocol approved by CMS.

STAKEHOLDER INVOLVEMENT:

Before submitting the proposed PFM protocol to CMS on May 17, 2017, HHSC posted the draft protocol, along with a survey to solicit stakeholder feedback, to the Transformation Waiver website. HHSC received more than 170 responses to the survey and made a number of revisions to the proposed PFM protocol based on these survey responses.

HHSC then developed the Measure Bundle Protocol for DY7-8 and posted it to the Transformation Waiver website on June 22, 2017. Based on stakeholder feedback received, HHSC further revised the PFM protocol proposal and submitted the revised proposal to CMS on August 4, 2017.

These rule amendments reflect the revisions to the PFM protocol proposal and stakeholder input.

FISCAL IMPACT:

☒ None

SERVICES IMPACT STATEMENT:

The proposed rules will continue the transformation of the Texas healthcare system by enhancing access to health care, the quality of care, and the health of patients and families served.

RULE DEVELOPMENT SCHEDULE:

January 19, 2018	Publish proposed rules in *Texas Register*
February 15, 2018	Present to the Medical Care Advisory Committee
February 22, 2018	Present to HHSC Executive Council
April 2018	Publish adopted rules in *Texas Register*
April 2018	Effective date

PROPOSED PREAMBLE

The Texas Health and Human Services Commission (HHSC) proposes amendments to §354.1691, concerning Definitions; §354.1693, concerning Regional Healthcare Partnerships (RHPs); §354.1695, concerning Participants; §354.1697, concerning RHP Plan Update; §354.1701, concerning RHP Plan Update Modifications; §354.1707, concerning Performer Valuations; §354.1711, concerning Category B Requirements for Performers; §354.1713, concerning Category C Requirements for Performers; §354.1715, concerning Category D Requirements for Performers; §354.1719, concerning Disbursement of Funds; and §354.1721, concerning Remaining Funds for Demonstration Years (DYs) 7-8.

BACKGROUND AND PURPOSE

Texas operates a 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 served.

The Program Funding and Mechanics (PFM) protocol governs DSRIP. The current DSRIP DY7-8 rules mirror the proposed PFM protocol language for DY7-8 submitted to CMS on May 17, 2017. Before submitting the proposal to CMS, HHSC posted the draft PFM protocol, along with a survey to solicit stakeholder feedback, to the Transformation Waiver website. HHSC received more than 170 responses to the survey and made a number of revisions to the proposed PFM protocol based on these survey responses.

Following additional stakeholder feedback, HHSC further revised the proposed PFM protocol language for DY7-8 and submitted it to CMS on August 4, 2017. HHSC is amending the rules at this time to make them consistent with the most recent version of the PFM protocol as of December 22, 2017.

SECTION-BY-SECTION SUMMARY

The proposed amendment of §354.1691 clarifies the definitions for the terms “Core activity,” “Measure Bundle,” “performer,” “Statewide hospital factor (SHF),” “Statewide hospital ratio (SHR),” and “System.” It also adds definitions of the terms “Denominator,” “Measure,” and “Volume.”

The proposed amendment of §354.1693 clarifies that a performer with physical locations in more than one RHP may be assigned to a single "home" RHP of its choosing. It also clarifies that HHSC, along with CMS, may approve on a case-by-case basis exceptions to the requirement that a provider 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.

The proposed amendment of §354.1695 clarifies that an IGT entity that is also a performer selects Category C Measure Bundles or measures in accordance with §354.1713 (relating to Category C Requirements for Performers), and that an IGT entity not acting as a performer cooperates with a performer to select Category C Measure Bundles or measures in accordance with §354.1713.

The proposed amendment of §354.1697 adds further detail regarding the requirements for performers in defining their systems in the RHP plan update. It also clarifies that each performer's total Patient Population by Provider (PPP) and Medicaid and Low-income or Uninsured (MLIU) PPP baseline data must be provided in the RHP plan update, and that performers must select Category C Measure Bundles and measures in accordance with both the PFM and the Measure Bundle Protocol. It clarifies that performers will need to provide in the RHP plan update for their RHP a description of the transition of their DY2-6 projects to DY7-8, and an explanation of the rationale for their Category C Measure Bundle and measure selections. In addition, the amendment references rather than restates the requirements in §354.1721.

The proposed amendment of §354.1701 allows a performer that is a hospital or physician practice that has received approval from HHSC to select measures, rather than Measure Bundles, from the Measure Bundle Protocol as described in §354.1713 of this division (relating to Category C Requirements for Performers), to submit to HHSC a request to modify its Category C measures as described in the PFM.

The proposed amendment of §354.1707 clarifies that if a performer participated in DSRIP during the initial demonstration period but not during DY6 and has a total valuation per DY for DY7-8 less than $250,000, the performer may request in the RHP plan update to increase its total valuation to up to $250,000 per DY for DY7-8. It also clarifies that if a performer begins participating in DSRIP in DY7 in accordance with §354.1721 of this division (relating to Remaining Funds for Demonstration Years (DYs) 7-8), its RHP determines its valuation in accordance with §354.1721. Finally, how percentages of a performer's total valuation may be allocated to both

Category C and Category D if the performer's RHP meets its minimum private hospital valuation is moved from §354.1715, which relates only to Category D requirements for performers.

The proposed amendment of §354.1711 makes minor clarifying changes and allows a performer that demonstrates good cause to request in the RHP plan update that: 1) its total PPP baseline equal its total PPP for DY5 only and its MLIU PPP baseline equal its MLIU PPP for DY5 only; or 2) its total PPP baseline equal its total PPP for DY6 only and its MLIU PPP baseline equal its MLIU PPP for DY6 only.

The proposed amendment of §354.1713 clarifies and changes certain Category C requirements for hospitals and physician practices and provides more-detailed requirements for hospitals and physician practices with a limited scope of practice. Under the current rules, hospitals and physician practices with a valuation greater than $2 million per DY that do not have a limited scope of practice must: 1) select at least one Measure Bundle with at least one standalone (three-point) measure; or 2) 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. Under the proposed amendment, such hospitals and physician practices do not have to meet these requirements until their valuation is greater than $2.5 million per DY. The proposed amendment also allows a hospital with a valuation less than or equal to $2.5 million per DY for DY7-8 to select a rural Measure Bundle, clarifies the formula for determining the minimum point threshold (MPT) for: 1) hospitals that do not have the data needed for the SHF calculation; and 2) hospitals that did not participate in DSRIP during the initial demonstration period or DY6, and clarifies the minimum measure denominator criteria. Finally, it limits the percentage of a hospital's or physician practice's Category C valuation that may be allocated to each selected Measure Bundle with a three-point measure.

The proposed amendment of §354.1713 makes subsection (b) applicable only to community mental health centers (CMHCs) and adds measure selection requirements for CMHCs. Under the proposed amendment, CMHCs must select at least two measures, and CMHCs with a valuation greater than $2.5 million per DY for DY7-8 must select at least one three-point measure. Provisions related to Local Health Departments (LHDs) are moved to new subsection (c) and the measure selection requirements for LHDs are changed to: 1) allow for continuation of certain measures used in the initial demonstration period and DY6; 2) require the selection of at least two measures; and 3) require the selection of at least one three-point measure for LHDs with a valuation greater than $2.5 million per DY. The amendment

also limits the percentage of a CMHC's or LHD's Category C valuation that may be allocated to each selected three-point or four-point measure.

The proposed amendment of §354.1713 relating to measurement periods and measure eligible denominator population subsections clarifies that performers must demonstrate good cause to request exceptions to measurement period requirements or eligible denominator population requirements. The amendment also modifies the measurement period requirements, milestones, and carry-forward policy for measures with a delayed baseline measurement period, and clarifies the policy for measures with multiple parts.

The proposed amendment of §354.1713 relating to methodology for P4P measure goal setting specifies that some P4P measures will have a maintenance threshold based on benchmarks and outlines the policy for such measures. The amendment changes how goals are set for QISMC measures with a baseline above the High Performance Level (HPL) and how goals are set for IOS measures. It also adds a provision applicable to certain P4P measures for the baseline measurement period relating to the use of numerators of zero.

The proposed amendment of §354.1715 reflects the move to §354.1707 of language relating to how percentages of a performer's total valuation may be allocated if the performer's RHP meets its minimum private hospital valuation. It also clarifies the deadline by which a performer reports on a measure in the Category D - Statewide Reporting Measure Bundle for its provider type for a DY.

The proposed amendment of §354.1719 clarifies the deadline by which a performer reports on a measure in the Category D - Statewide Reporting Measure Bundle for its provider type for a DY.

The proposed amendment of §354.1721 makes minor clarifying changes.

FISCAL NOTE

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

There are no fiscal implications to local governments as a result of enforcing and administering the amendments as proposed.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years the amendments will be in effect:
(1) the proposed amendments will not create or eliminate a government program;
(2) implementation of the proposed amendments will not require the creation or elimination of employee positions;
(3) implementation of the proposed amendments will not require an increase or decrease in future legislative appropriations to the agency;
(4) the proposed amendments will not require an increase or decrease in fees paid to the agency;
(5) the proposed amendments will not create a new rule;
(6) the proposed amendments will not expand, limit, or repeal an existing rule; and
(7) the proposed amendments will not change the number of individuals subject to the rule.
HHSC has insufficient information to determine the proposed amendments' effects on the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Ms. Rymal has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. Participation in the DSRIP program and in DSRIP DY7-8 is voluntary.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

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

There is no anticipated negative impact on local employment.

COSTS TO REGULATED PERSONS

Texas Government Code, §2001.0045 does not apply to this rule because the rule is necessary to receive a source of federal funds or comply with federal law.

PUBLIC BENEFIT

Enrique Marquez, Deputy Executive Commissioner, HHSC Medical and Social Services Division, has determined that for each year of the first five years

the amendments are in effect, the public will benefit from the adoption of the amendments. The anticipated public benefit as a result of enforcing or administering the amendments 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 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.

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 18R014" in the subject line.

STATUTORY AUTHORITY

The amendments 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 establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code, Chapter 32.

The amendments 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.

TITLE 1	ADMINISTRATION
PART 15	TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 354	MEDICAID HEALTH SERVICES
SUBCHAPTER D	TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM
DIVISION 7	DSRIP PROGRAM DEMONSTRATION YEARS 7-8

§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 improve patient health or quality of care. It [~~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 implemented by a performer 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. It may be implemented by a performer to achieve the performer's Category C measure goals or it may be connected to the mission of the performer's organization.

(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).

(5) Demonstration Year (DY) 9--Federal fiscal year 2020 (October 1, 2019 - September 30, 2020).

(6) Denominator--As it relates to a Category C measure's volume:

(A) the number of Medicaid and low-income or uninsured (MLIU) cases; or

(B) one of the following, which the performer receives approval from HHSC to use for the measure:

(i) the number of all-payer cases;

(ii) the number of Medicaid cases; or

(iii) the number of low-income or uninsured (LIU) cases.

(7) [~~(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.

(8) [~~(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.

(9) [~~(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.

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

(11) Insignificant volume--For most Category C measures, the denominator is considered to have insignificant volume if its volume is greater than zero but less than 30.

(12) Measure--A mechanism to assign a quantity to an attribute by comparison to a criterion. As it relates to Category C, a measure is a standardized tool to measure or quantify healthcare processes, outcomes, patient perceptions, organizational structure, and/or systems that are associated with the ability to provide high-quality health care.

(13) [~~(10)~~] Measure Bundle--A grouping of measures under Category C that share a unified theme, apply to a similar population, and are impacted by similar activities. Measure Bundles are selected by hospitals and physician practices. All Measure Bundles include required measures, and some Measure Bundles also include optional measures. [~~A Measure Bundle may include process measures and patient clinical outcome measures.~~]

(14) [~~(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.

(15) [~~(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.

(16) [~~(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.

(17) [~~(14)~~] Milestone--An objective of DSRIP performance on which DSRIP payments are based.

(18) [~~(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).

(19) No volume--For Category C measures, the denominator is considered to have no volume if its volume is equal to zero.

(20) [~~(16)~~] Performer--A [~~Medicaid~~] provider enrolled in Texas Medicaid that participates in DSRIP and receives DSRIP payments.

(21) [~~(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).

(22) Significant volume--For most Category C measures, the denominator is considered to have significant volume if its volume is greater than or equal to 30.

(23) [~~(18)~~] Statewide hospital factor (SHF)--A factor used to determine the [~~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 [~~§354.1713(a)(4)(A)(i)~~] of this division.

(24 [~~(19)~~] Statewide hospital ratio (SHR)--A factor used to determine the [~~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 [~~§354.1713(a)(4)(A)(ii)~~] of this division.

(25) [~~(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. Essential functions or departments of a performer's provider type are required components that must be included in a performer's system definition. [~~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.~~]

(26) [~~(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.

(27) Volume--For Category C measure denominators, the total number of measured units in the denominator. Volume is used to determine the size of the population for which improvement is being measured.

§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 of its choosing 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, HHSC along with [~~exceptions to this requirement may be approved by~~] the Centers for Medicare & Medicaid Services may approve exceptions to this requirement 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 in accordance with §354.1713 of this division (relating to Category C Requirements for Performers);

(4) if the IGT entity is not acting as a performer, cooperates with a performer to select Category C Measure Bundles or measures in accordance with §354.1713 of this division;

(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 total [~~MLIU~~] Patient Population by Provider (PPP) and MLIU PPP baseline data;

(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 and Measure Bundle 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 and Measure Bundle Protocol;

(F) a description of the transition of the performer's DY2-6 projects to DY7-8 [~~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 the performer's rationale for its [~~how all of the selected~~] Category C Measure Bundle [~~Bundles~~] and measure selections; 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), the information required by that section. [~~:~~]

[~~(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.~~]

§354.1701. 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:

(A) community mental health center;

(B) [~~or~~] local health department; or [~~.~~]

(C) hospital or physician practice that has received approval from HHSC to select measures, rather than Measure Bundles, from the Measure Bundle Protocol as described in §354.1713 of this division (relating to Category C Requirements for Performers).

§354.1707. Performer Valuations.

(a) If a performer participated in DSRIP during the initial demonstration period or DY6, its [~~A performer's~~] total valuation per demonstration year (DY) [~~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 participated in DSRIP during the initial demonstration period but not during DY6 and has [~~began DSRIP participation in DY7 with~~] a total valuation per DY for DY7-8 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 for DY7-8 [~~beginning in DY7~~].

(b) If a performer did not participate in DSRIP during the initial demonstration period or DY6, but begins participating in DSRIP in DY7 in accordance with §354.1721 of this division (relating to Remaining Funds for Demonstration Years (DYs) 7-8), its RHP determines its valuation in accordance with §354.1721.

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

Performer Valuation Funding Distribution

	DY7	**DY8**
RHP Plan Update Submission	20%	NA
Category A - Required Reporting	0%	0%
Category B - MLIU PPP	10%	10%
Category C - Measure Bundles and Measures*	55 or 65%	75 or 85%
Category D - Statewide Reporting Measure Bundle*	15 or 5%	15 or 5%

*If a performer's [~~an~~] RHP meets its minimum private hospital valuation per DY for DY7-8, as described in subsection (d) [~~§354.1715(c)~~] of this section [~~division (relating to Category D Requirements for Performers)~~], the [~~each~~] performer [~~in the RHP~~] may allocate its DY7 and DY8 valuations in accordance with subsection (d) of this section [~~increase its Statewide Reporting Measure Bundle funding to 15% of its valuation~~].

(d) If a performer's RHP meets its minimum private hospital valuation per DY for DY7-8 as described in Figure: 1 TAC §354.1707(d)(2), the performer may allocate its DY7 and DY8 valuations as follows:

(1) 55 percent of its DY7 valuation and 75 percent of its DY8 valuation to Category C - Measure Bundles and Measures; and

(2) 15 percent of its DY7 valuation and 15 percent of its DY8 valuation to Category D - Statewide Reporting Measure Bundle.

Minimum Private Hospital Valuations per DY for DY7-8

RHP	Private Hospital Valuation	Minimum Private Hospital Valuation per DY for DY7-8
1	$38,856,709	$37,691,007
2	$12,933,175	$12,545,180
3	$133,630,962	$129,622,034
4	$64,989,767	$63,040,074
5	$108,996,712	$105,726,810
6	$68,777,524	$66,714,199
7	$84,513,275	$81,977,876
8	$9,607,121	$9,318,907
9	$124,422,742	$120,690,060
10	$50,540,564	$49,024,347
11	$21,345,261	$20,704,903
12	$40,896,051	$39,669,169
13	$14,111,711	$13,688,360
14	$13,799,933	$13,385,935
15	$39,491,671	$38,306,921
16	$8,476,165	$8,221,880
17	$12,637,136	$12,258,022
18	$5,311,040	$5,151,709
19	$5,832,483	$5,657,509
20	$11,173,926	$10,838,708
TOTAL	$870,343,929	$844,233,611

§354.1711. Category B Requirements for Performers.

(a) A performer must provide the following information in the RHP plan update for its RHP to be eligible for its RHP plan update submission funds for DY7 and its Category B valuation for DY7 and DY8:

(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 average [~~sum~~] of its total PPP for DY5 and its total PPP for DY6 with the exception described in subsection (e) of this section [~~divided by 2~~].

(d) A performer's MLIU PPP baseline is equal to the average [~~sum~~] of its MLIU PPP for DY5 and its MLIU PPP for DY6 with the exception described in subsection (e) of this section [~~divided by 2~~].

(e) If a performer demonstrates good cause, the performer may request in the RHP plan update that:

(1) its total PPP baseline equal its total PPP for DY5 only and its MLIU PPP baseline equal its MLIU PPP for DY5 only; or

(2) its total PPP baseline equal its total PPP for DY6 only and its MLIU PPP baseline equal its MLIU PPP for DY6 only.

(f) [~~(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) or (e) of this section, divided by the total PPP baseline, as calculated in subsection (c) or (e) of this section.

(g) [~~(f)~~] A performer's MLIU PPP goal per DY for DY7 and DY8 is equal to its MLIU PPP baseline, as calculated in subsection (d) or (e) of this section.

(h) [~~(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, as calculated in [~~accordance with~~] subsection (f) [~~(e)~~] of this section.

(i) [~~(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 valuation [~~allocation~~] for the DY.

(j) [~~(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 (f) [~~(e)~~] of this section.

(k) [~~(j)~~] A performer must report the information in subsection (j) [~~(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 Hospital and Physician Practice Measure Bundle Menu of the Measure Bundle Protocol in accordance with the requirements in subparagraphs (B) [~~(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 minimum point threshold (MPT) [~~MPT~~] for Measure Bundle selection as described in paragraphs (5) [~~(4)~~] and (6) [~~(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 total 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 point values [~~number~~] of the Measure Bundles it selects [~~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 have significant volume [~~meet the minimum all-payer denominator size criteria as described in the Measure Bundle Protocol~~].

(F) A hospital or physician practice with a valuation greater [~~of more~~] than $2,500,000 [~~$2 million~~] per demonstration year (DY) for DY7-8 must:

(i) select at least one Measure Bundle with at least one required three-point [~~standalone~~] measure for which its denominator for the baseline measurement period has significant volume; or

(ii) select at least one Measure Bundle with at least one optional three-point measure for which its denominator for the baseline measurement period has significant volume, and select at least one optional three-point measure in that Measure Bundle for which its denominator for the baseline measurement period has significant volume.

(G) A hospital or physician practice may only select an optional measure in a selected Measure Bundle for which its [~~the hospital's or physician practice's all-payer~~] denominator for the baseline measurement period has significant volume [~~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 $2,500,000 [~~$2 million~~] per DY for DY7-8 may select a [~~rural~~] Measure Bundle identified as 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, the following requirements apply:

(i) the hospital's or physician practice's total valuation for DY7 and DY8 may be reduced; [~~and~~]

(ii) the hospital or physician practice must select measures from the following menus of the Measure Bundle Protocol in accordance with the requirements in clauses (iii)-(v) of this subparagraph in the RHP plan update for its RHP: [~~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.~~]

(I) the Measure Bundles on the Hospital and Physician Practice Measure Bundle Menu;

(II) the Community Mental Health Center Measure Menu; or

(III) the Local Health Department Measure Menu;

(iii) each measure in a Measure Bundle on the Hospital and Physician Practice Measure Bundle Menu, and each measure on the Community Mental Health Center Measure Menu and the Local Health Department Measure Menu, is assigned a point value as described in the Measure Bundle Protocol;

(iv) the hospital or physician practice is assigned a MPT for measure selection as described in paragraphs (5) and (6) of this subsection; and

(v) the hospital or physician practice must select measures worth enough points to meet its MPT in order to maintain its total valuation for DY7 and DY8. If the hospital or physician practice 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 point values of the measures it selects.

(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 required or selected optional three-point [~~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.

(C) The valuation for each selected Measure Bundle with a required or selected optional three-point measure 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 1.5) 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 has no volume [~~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 has significant volume [~~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 has significant volume [~~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 has significant volume [~~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 has significant volume [~~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 has insignificant volume [~~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 (e)(2) [~~(d)(2)~~] of this section.

(4) Milestone valuation. The measure milestones and corresponding valuations for DY7-8 are as described in subsection (e) of this section.

(5) [~~(4)~~] MPTs [~~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 $500,000 [~~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:

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

(-b-) 40 [~~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 $500,000 [~~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 (5)(A)(i) [~~(4)(A)(i)~~] of this subsection, or if a hospital did not participate in DSRIP during the initial demonstration period or DY6, its MPT is the lesser of: [~~its MPT will be determined using an alternate methodology to be determined by HHSC.~~]

(i) the hospital's DY7 valuation divided by $500,000; or

(ii) 75.

(C) If a hospital has a limited scope of practice, cannot reasonably report on at least half of the required measures in the [~~and there are not enough~~] Measure Bundle(s) appropriate for it [~~,~~] based on its scope of practice and community partnerships, and consequently cannot [~~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 for which the hospital could reasonably report on at least half of the required measures in the Measure Bundle. 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 for DY7 and DY8 may be reduced.

(6) [~~(5)~~] MPTs [~~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 $500,000 [~~the standard point valuation ($500,000)~~]; or

(ii) 75.

(B) If a physician practice has a limited scope of practice, cannot reasonably report on at least half of the required measures in the [~~and there are not enough~~] Measure Bundles appropriate for it[~~,~~] based on its scope of practice and community partnerships, and consequently cannot [~~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 for which the physician practice could reasonably report on at least half of the required measures in the Measure Bundle. 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 for DY7 and DY8 may be reduced.

(b) Requirements for community mental health centers (CMHCs) [~~and local health departments~~].

(1) Measure selection.

(A) A CMHC [~~community mental health center (CMHC) or local health department (LHD)~~] must select measures from the Community Mental Health Center Measure Menu of 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 as described in paragraph (3) of this subsection.

(D) A CMHC [~~or LHD~~] must select measures worth enough points to meet its MPT in order to maintain its total 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 point values of the measures it selects [~~number of measure points selected~~].

(E) A CMHC may only select a measure for which its denominator for the baseline measurement period has significant volume [~~or LHD must select at least one three-point measure~~].

(F) A CMHC must select at least two measures [~~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~~].

(G) A CMHC with a valuation greater than $2,500,000 per DY for DY7-8 must select at least one three-point measure.

(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 one-point [~~non-standalone~~] measure must be less than or equal to the Category C valuation divided by the number of selected measures.

(C) The valuation for each selected three-point or four-point measure must be less than or equal to (the Category C valuation divided by the number of selected measures) multiplied by 1.5.

(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) Requirements for local health departments (LHDs).

(1) Measure selection.

(A) An LHD must select measures from:

(i) the Local Health Department Measure Menu of the Measure Bundle Protocol; or

(ii) its DY6 Category 3 pay-for-performance (P4P) measures.

(B) An LHD may not select the same measure from both the Local Health Department Measure Menu of the Measure Bundle Protocol and its DY6 Category 3 P4P measures.

(C) If an LHD's DY6 Category 3 P4P measures include multiple versions of the same measure, the LHD may select multiple versions of that measure, but the points associated with that measure will only count once toward the LHD's MPT.

(D) Each measure on the Local Health Department Measure Menu is assigned a point value as described in the Measure Bundle Protocol.

(E) Each LHD DY6 Category 3 P4P measure is assigned a point value as described in the Measure Bundle Protocol.

(F) An LHD is assigned an MPT for measure selection as described in paragraph (4) of this subsection.

(G) An LHD must select measures worth enough points to meet its MPT in order to maintain its total valuation for DY7 and DY8. If an 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 point values of the measures it selects.

(H) An LHD may only select a measure for which its denominator for the baseline measurement period has significant volume.

(I) An LHD must select at least two measures.

(J) An LHD with a valuation of more than $2,500,000 per DY for DY7-8 must select at least one three-point measure.

(2) Measure valuation. An 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 one-point measure must be less than or equal to the Category C valuation divided by the number of selected measures.

(C) The valuation for each selected three-point or four-point measure must be less than or equal to (the Category C valuation divided by the number of selected measures) multiplied by 1.5.

(3) Milestone valuation. The measure milestones and corresponding valuations for DY7-8 are as described in subsection (e) of this section.

(4) MPTs. An LHD's MPT is the lesser of:

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

(B) 20.

(d) [~~(c)~~] Measurement periods.

(1) Baseline measurement periods. The baseline measurement period for a measure is calendar year 2017 with the following exceptions: [~~.~~]

(A) the baseline measurement period for a DY6 Category 3 P4P measure selected by a LHD is DY6;

(B) a [~~(A) A~~] performer that demonstrates good cause 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; [~~.~~]

(C) a [~~(B) A~~] performer that demonstrates good cause 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; and [~~.~~]

(D) any other exception specified in the Measure Bundle Protocol or one of its appendices.

(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 unless otherwise specified in the Measure Bundle Protocol or one of its appendices. [~~, 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 unless otherwise specified in the Measure Bundle Protocol or one of its appendices. [~~, 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 unless otherwise specified in the Measure Bundle Protocol or one of its appendices. [~~, 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.

(e) [~~(d)~~] Measure milestones.

(1) The milestones and corresponding valuations for DY7-8 are as follows, with the exceptions [~~exception~~] specified in paragraphs [~~paragraph~~] (2) and (3) of this subsection:

	P4R Measure	**P4P Measure**	~~**P4P Measure with an approved delayed baseline measurement period**~~
DY7	100% RY1 reporting milestone	25% baseline reporting milestone	~~25% baseline reporting milestone~~
		25% PY1 reporting milestone	~~25% PY2 reporting milestone~~
		50% DY7 goal achievement milestone	~~50% DY7 goal achievement milestone~~
DY8	100% RY2 reporting milestone	25% PY2 reporting milestone	~~25% PY3 reporting milestone~~
		75% DY8 goal achievement milestone	~~75% DY8 goal achievement milestone~~

(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 measurement period has insignificant volume [~~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 measurement period has significant volume [~~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 has significant volume [~~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 has significant volume [~~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 has significant volume [~~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 has significant volume [~~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 has significant volume [~~meets the minimum all-payer denominator size criteria~~] are equal.

(3) Measures with multiple parts. Some P4P measures have multiple parts, as described in the Program Funding and Mechanics Protocol and Measure Bundle Protocol.

(A) A measure with multiple parts has one baseline reporting milestone per DY, one PY reporting milestone per DY, and multiple goal achievement milestones per DY.

(B) The valuation for each measure part's goal achievement milestone is equal to the measure's total goal achievement milestone valuation divided by the number of measure parts so that the measure parts' goal achievement milestone valuations are equal.

(C) All measure parts' baseline reporting milestones must be reported during the same reporting period.

(D) All measure parts' PY reporting milestones must be reported during the same reporting period.

(E) Each measure part's goal achievement milestone will have its own goal. Therefore, the percent of goal achieved, as described in §354.1719 of this division (relating to Disbursement of Funds) will be determined for a measure part's goal achievement milestone independently of the percent of goal achieved for the other measure parts' goal achievement milestones.

(4) [~~(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.

(5) [~~(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.

(f) [~~(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 that demonstrates good cause 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 that demonstrates good cause 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 that demonstrates good cause 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 that demonstrates good cause 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.

(g) [~~(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. Some P4P measures will have a maintenance threshold based on benchmarks as defined in the Measure Bundle Protocol.

(3) A P4P measure's goals for its goal achievement milestones are set as follows, with the exceptions described in paragraphs (4) and (5) of this subsection:

		DY7 Goal	DY8 Goal
QISMC	Baseline below MPL	MPL	10% gap closure between the MPL and HPL
	Baseline between MPL and HPL	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	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
	Baseline above HPL	The lesser absolute value of improvement of baseline plus (minus) 4% of the difference between the HPL and MPL or the IOS goal [~~HPL~~]	The lesser absolute value of improvement of baseline plus (minus) 8% of the difference between the HPL and MPL or the IOS goal [~~HPL~~]
IOS		5% gap closure	10% gap closure

(4) A performer that selects a P4P measure for which its baseline is above the maintenance threshold as defined in the Measure Bundle Protocol may either:

(A) improve following the standard QISMC or IOS goal calculation; or

(B) request to use a maintenance goal calculation by a date determined by HHSC.

(5) If a performer requests to use a maintenance goal calculation per paragraph (4) of this subsection, and HHSC approves the request:

(A) the goal for the DY7 and DY8 goal achievement milestones is statistically significant maintenance of baseline high performance as defined by a two proportion z-test with a significance level of 0.10;

(B) the performer must complete an additional cost benefit analysis related to the measure to be eligible for payment of the PY1 reporting milestone;

(C) the performer must complete a shared learning activity as described in the Program Funding and Mechanics Protocol to be eligible for payment of the PY2 reporting milestone; and

(D) the measure is not eligible for partial payment.

(6) A performer may request HHSC approval in the RHP plan update to use a numerator of zero for certain P4P measures for the baseline measurement period, as described in the Program Funding and Mechanics Protocol and Measure Bundle Protocol. If a performer receives HHSC approval to use a numerator of zero for a P4P measure for the baseline measurement period, the goal for the DY7 goal achievement milestone will be equal to the 75th percentile, and the goal for the DY8 goal achievement milestone will be equal to a 10% gap closure between the 75th percentile and the HPL, as described in the Measure Bundle Protocol.

(h) [~~(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 described in subparagraph (B) of this paragraph [~~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) If a measure has a delayed baseline measurement period, a performer will carry forward achievement of its goal achievement milestone so that the DY7 goal achievement milestone may be achieved in PY2.

(C) [~~(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.~~]

Private Hospital Participation

RHP	Private Hospital Valuation	Minimum Private Hospital Valuation for each DY
1	$38,856,709	$37,691,007
2	$12,933,175	$12,545,180
3	$133,630,962	$129,622,034
4	$64,989,767	$63,040,074
5	$108,996,712	$105,726,810
6	$68,777,524	$66,714,199
7	$84,513,275	$81,977,876
8	$9,607,121	$9,318,907
9	$124,422,742	$120,690,060
10	$50,540,564	$49,024,347
11	$21,345,261	$20,704,903
12	$40,896,051	$39,669,169
13	$14,111,711	$13,688,360
14	$13,799,933	$13,385,935
15	$39,491,671	$38,306,921
16	$8,476,165	$8,221,880
17	$12,637,136	$12,258,022
18	$5,311,040	$5,151,709
19	$5,832,483	$5,657,509
20	$11,173,926	$10,838,708
TOTAL	$870,343,929	$844,233,611

(c) [~~(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.

(d) [~~(e)~~] 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 no later than the second reporting period of the DY to be eligible for payment of the measure for the [~~that~~] DY.

§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 in accordance with §354.1715(d) of this division (relating to Category D Requirements for Performers) [~~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 [~~§354.1711(j)(1)~~] of this division (relating to Category B Requirements for Performers) or §354.1713 [~~§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 [~~§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 [~~§354.1707(c)~~] of this division.

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

RHP Remaining Funds Allocations per DY for DY7-8

RHP	Remaining Funds Allocation per DY for DY7-8
RHP 1	$866,635
RHP 2	$2,308,000
RHP 3	$0
RHP 4	$522,345
RHP 5	$4,797,112
RHP 6	$0
RHP 7	$0
RHP 8	$5,739,571
RHP 9	$0
RHP 10	$0
RHP 11	$0
RHP 12	$0
RHP 13	$0
RHP 14	$0
RHP 15	$0
RHP 16	$0
RHP 17	$9,284,861
RHP 18	$1,318,286
RHP 19	$0
RHP 20	$4,062,821
TOTAL	**$28,899,632**

(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 to be performers [~~participants~~] as described in §354.1695 [~~§354.1695(c)(1)~~] of this division (relating to Participants).

(e) An RHP allocated DY7-8 remaining funds 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 intergovernmental transfers [~~IGTs~~] for the funds.

(g) The RHP plan update for an RHP allocated DY7-8 remaining funds 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 the amount of DY7-8 remaining funds allocated to each performer; and

(3) the performers or providers in the RHP that expressed interest [~~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 as described in the Program Funding and Mechanics Protocol, the Measure Bundle Protocol, and the Texas Administrative Code.