TO: Medical Care Advisory Committee

DATE: May 17, 2018

FROM: John Scott, Interim Director,
Healthcare Transformation Waiver

Agenda Item No.: 3

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

Amendments to: Texas Administrative Code Title 1, Part 15, Chapter 354 (Medicaid Health Services), Subchapter D (Texas Healthcare Transformation and Quality Improvement Program), Division 7 (DSRIP Program Demonstration Years 7-8), Sections 354.1691, concerning Definitions; 354.1713, concerning Category C Requirements for Performers; and 354.1719, concerning Disbursement of Funds.

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

The Program Funding and Mechanics (PFM) protocol and Measure Bundle Protocol govern DSRIP for Demonstration Years (DYs) 7-8 (October 1, 2017, through September 30, 2019). The current DSRIP rules for DYs 7-8 are consistent with the December 22, 2017, version of the PFM and Measure Bundle Protocol. The protocols have since been revised at the direction of the Centers for Medicare & Medicaid Services (CMS), and CMS approved the protocols on January 19, 2018. HHSC is amending these rules to align them with the CMS-approved protocols. HHSC is also amending these rules to clarify the formulas for calculating Category C payments.

ISSUES AND ALTERNATIVES:

None.

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 DYs 7-8 and posted it to the Transformation Waiver website on June 22, 2017. Based on

stakeholder feedback received, HHSC revised the Measure Bundle Protocol proposal and submitted it to CMS on July 28, 2017. HHSC also further revised the PFM protocol proposal based on stakeholder feedback received and submitted the revised proposal to CMS on August 4, 2017.

FISCAL IMPACT:

☒ None ☐ Yes

RULE DEVELOPMENT SCHEDULE:

May 11, 2018	Publish proposed rules in *Texas Register*
May 17, 2018	Present to the Medical Care Advisory Committee
May 24, 2018	Present to HHSC Executive Council
August 3, 2018	Publish adopted rules in *Texas Register*
August 7, 2018	Effective date

REQUESTED ACTION: (Check appropriate box)

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

☒ Information Only

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

PROPOSED PREAMBLE

The Texas Health and Human Services Commission (HHSC) proposes amendments to §354.1691, concerning Definitions, §354.1713, concerning Category C Requirements for Performers, and §354.1719, concerning Disbursement of Funds.

BACKGROUND AND PURPOSE

On December 12, 2011, the Centers for Medicare & Medicaid Services (CMS) approved Texas' 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 served.

The initial waiver was approved through September 30, 2016, and an initial extension was granted through December 31, 2017. On December 21, 2017, CMS granted a five-year extension of the waiver through September 30, 2022.

The Program Funding and Mechanics (PFM) protocol and Measure Bundle Protocol govern DSRIP for Demonstration Years (DYs) 7-8 (October 1, 2017 through September 30, 2019). The current DSRIP rules for DYs 7-8 are consistent with the December 22, 2017, version of the PFM and Measure Bundle Protocol. The protocols have since been revised at CMS’s direction, and CMS approved the protocols on January 19, 2018. HHSC is amending these rules to align them with the CMS-approved protocols. HHSC is also amending these rules to clarify the formulas for calculating Category C payments.

SECTION-BY-SECTION SUMMARY

The proposed amendment of §354.1691 clarifies the definition for the term "No volume." It also adds and defines the terms "Innovative measure," "Quality improvement collaborative activity," "Population-based clinical outcome measure," and "Target population."

The proposed amendment of §354.1713 adds new subparagraph (a)(1)(G) to require hospitals and physician practices with a minimum point threshold (MPT) of 75 to select at least one Measure Bundle with at least one population-based clinical outcome measure as specified in the Measure Bundle Protocol. It also adds new paragraph (a)(2) to require Performing Providers to determine their DSRIP-attributed population to be applied to their selected Measure Bundles or measures as specified in the Measure Bundle Protocol.

The proposed amendment of §354.1713(a)(3) narrows the range of percentages of a hospital's or physician practice's Category C valuation that may be allocated to a particular Measure Bundle. Under the current rules for hospitals and physician practices, the valuation for each selected Measure Bundle must be greater than or equal to 50 percent of the Measure Bundle's point value divided by the sum of all the selected Measure Bundles' point values multiplied by the Category C valuation. With this rule amendment, the valuation for each selected Measure Bundle must be greater than or equal to 75 percent of the Measure Bundle's point value divided by the sum of all the selected Measure Bundles' point values multiplied by the Category C valuation. The valuation for each selected Measure Bundle with a required or selected optional three-point measure also changes; the valuation must be less than or equal to 125 percent of the Measure Bundle point value divided by the sum of all the selected Measure Bundles' point values multiplied by the Category C valuation. Currently, the valuation must be less than or equal to 150 percent.

New subparagraph (a)(3)(D) requires a hospital or physician practice to provide sufficient justification if it allocates to a Measure Bundle a percentage of its Category C valuation that is one percent greater than the Measure Bundle's point value as a percentage of all its selected Measure Bundles' point values.

The proposed amendment of §354.1713(a)(4) specifies how the valuations for measures within a Measure Bundle that includes an innovative measure will be determined. It also specifies how measures and milestones within a Measure Bundle that includes a population-based clinical outcome measure

are valued if the population-based clinical outcome measure numerator or denominator has no volume or has insignificant volume.

The proposed amendment of §354.1713(b)(3) and (c)(3), respectively, narrows the range of percentages of a community mental health center's (CMHC's) or local health department's (LHD's) Category C valuation that may be allocated to a particular measure. With these rule amendments, the valuation for each selected measure must be greater than or equal to 75 percent of the Category C valuation divided by the number of selected measures. Currently, the valuation must be greater than or equal to 50 percent. The valuation for each selected three-point or four-point measure also changes; the valuation must be less than or equal to 125 percent of the Category C valuation divided by the number of selected measures. Currently, the valuation must be less than or equal to 150 percent.

New subparagraphs (b)(3)(D) and (c)(3)(D), respectively, require a CMHC or LHD to provide sufficient justification if it allocates to a measure a percentage of its Category C valuation that is one percent greater than the Category C valuation divided by the number of selected measures.

The proposed amendment of §354.1713(f) changes the methodology for determining a measure's eligible denominator population. Under the new methodology, a performing provider will first determine its DSRIP attributed population, which includes individuals from the DSRIP system defined in Category B that meet at least one of several criteria, depending on provider type. Any individual who meets any one of the listed criteria would be part of the DSRIP attributed population for that performing provider. If the performing provider is a hospital or physician practice, the performing provider would then determine the individuals in its DSRIP attributed population who are included in the Measure Bundle target population. The target population is the pool of people for which the provider is accountable for improvement for that Measure Bundle or measure. The hospital or physician practice would then determine the individuals from the Measure Bundle target population who meet the denominator criteria defined in the measure specifications. Finally, the hospital or physician practice would determine the payer type for individuals or encounters in the denominator to determine the all-payer, Medicaid, and uninsured rate for each measure. If the performing provider is a CMHC or LHD, the CMHC or LHD would determine the individuals in its DSRIP attributed population who meet the denominator criteria defined in the measure specifications, and then determine the payer type for individuals or encounters in the denominator to determine the all-payer, Medicaid, and uninsured rate for each measure.

The proposed amendment of §354.1713(g) modifies the methodology for pay-for-performance (P4P) measure goal setting and eliminates payment for the maintenance of high performance.

The proposed amendment of §354.1719(d) clarifies the formulas for calculating Category C payments.

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 are no fiscal implications to state government as a result of enforcing and administering the amendments as proposed.

There will be 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 from enforcing and administering the amendments as proposed. Participation in the DSRIP program and in DSRIP DYs 7-8 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 these rules because the rules are necessary to receive a source of federal funds or comply with federal law.

PUBLIC BENEFIT

Stephanie Muth, State Medicaid Director, 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, as well as consistency between the rules and the CMS-approved protocols.

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) 438-2991.

Written comments on the proposal may be submitted to Kimberly Tucker, Health and Human Services Commission, Healthcare Transformation Waiver Unit, John H. Winters Building, 701 West 51st Street, Mail Code W201-MS02 100674, Austin, TX 78751; by fax to (512) 438-5586; 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 18R031" 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.

Legend:
Single Underline = Proposed new language
[~~Strikethrough and brackets~~] = Current language proposed for deletion
Regular print = Current language
(No change.) = No changes are being considered for the designated subdivision

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 may be part of a DSRIP project implemented by a performer during the initial demonstration period 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) 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) 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) 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) Initial demonstration period--The first five demonstration years (DYs) of the waiver, or December 12, 2011, through September 30, 2016.

(11) Innovative measure--A new measure developed for use in Category C. Innovative measures are pay-for-reporting (P4R) in DY7-8.

(12) [~~(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.

(13) [~~(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.

(14) [~~(13)~~] 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.

(15) [~~(14)~~] 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.

(16) [~~(15)~~] 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.

(17) [~~(16)~~] 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.

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

(19) [~~(18)~~] 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).

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

C population-based clinical outcome measure, the numerator is considered to have no volume if the volume is equal to zero.

(21) Quality improvement collaborative activity--An activity related to participating in a learning collaborative to improve targeted health outcomes. As included in Category C, a quality improvement collaborative activity is pay-for-reporting (P4R) in DY7-8.

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

(23) Population-based clinical outcome measure--A Category C clinical outcome measure that measures emergency department utilization or admissions for select conditions for all individuals in the Measure Bundle's target population. It may be required as pay-for-performance (P4P) or pay-for-reporting (P4R) based on the Measure Bundle and the hospital's or physician practice's MPT as specified in the Measure Bundle Protocol.

(24) [~~(21)~~] 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).

(25) [~~(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.

(26) [~~(23)~~] Statewide hospital factor (SHF)--A factor used to determine the MPT that takes into account a hospital's MLIU inpatient days and MLIU outpatient costs compared to all hospitals, as described in §354.1713 of this division.

(27) [~~(24)~~] Statewide hospital ratio (SHR)--A factor used to determine the 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 of this division.

(28) [~~(25)~~] 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.

(29) Target population--For a Category C Measure Bundle, the pool of individuals to be included in a measure denominator for which a hospital or physician practice is accountable for improvement.

(30) [~~(26)~~] 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.

(31) [~~(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.

§354.1713. 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 (J) [~~(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) - (I) [~~(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) for Measure Bundle selection as described in paragraphs (6) [~~(5)~~]) and (7) [~~(6)~~]) 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 of the Measure Bundles it selects.

(E) A hospital or physician practice may only select a Measure Bundle for which its denominators for the baseline measurement period for at least half of the required measures in the Measure Bundle have significant volume.

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

(i) select at least one Measure Bundle with at least one required three-point 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 with an MPT of 75 must select at least one Measure Bundle with at least one population-based clinical outcome measure as specified in the Measure Bundle Protocol.

(H) [~~(G)~~] A hospital or physician practice may only select an optional measure in a selected Measure Bundle for which its denominator for the baseline measurement period has significant volume.

(I) [~~(H)~~] Only a hospital with a valuation less than or equal to $2,500,000 per DY for DY7-8 may select a Measure Bundle identified as a rural Measure Bundle in accordance with the requirements in the Measure Bundle Protocol.

(J) [~~(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;

(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:

(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 an [~~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) DSRIP-attributed population. A hospital or physician practice must determine its DSRIP-attributed population to be applied to its selected Measure Bundles and measures as specified in the Measure Bundle Protocol.

(3) [~~(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) multiplied [~~divided~~] by 0.75 [~~2)~~] multiplied by the Category C valuation.

(B) The valuation for each selected Measure Bundle without any required or selected optional three-point 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 1.25 [~~1.5)~~] multiplied by the Category C valuation.

(D) If a hospital or physician practice allocates to a Measure Bundle a percentage of its Category C valuation that is one percent greater than the Measure Bundle's point value as a percentage of all the selected Measure Bundles' point values, the hospital or physician practice must provide sufficient justification as specified in the Program Funding and Mechanics Protocol.

(4) [~~(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 Measure Bundle includes an innovative measure:

(i) the valuation for each innovative measure in the Measure Bundle is equal to the Measure Bundle valuation divided by the number of the measures in the Measure Bundle subtracted by 0.5 for each innovative measure and divided by 2; and

(ii) the valuation for each measure in the Measure Bundle that is not an innovative measure is equal to the Measure Bundle valuation divided by the number of measures in the Measure Bundle subtracted by 0.5 for each innovative measure.

(B) [~~(A)~~] If a hospital's or physician practice's denominator for a required measure or numerator for a population-based clinical outcome

measure in a selected Measure Bundle for the baseline measurement period or a performance year has no volume, 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 denominator for the baseline measurement period or performance year has significant volume 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 denominator for the baseline measurement period or performance year has significant volume 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 denominator for the baseline measurement period or performance year has significant volume, so that the valuations for the applicable DY for the measures in the Measure Bundle for which the hospital's or physician practice's denominator for the baseline measurement period or performance year has significant volume are equal.

(C) [~~(B)~~] If a hospital's or physician practice's denominator for a required measure or numerator for a P4R population-based clinical outcome measure in a selected Measure Bundle for the baseline measurement period or a performance year has insignificant volume, the measure's [~~measure and~~] milestone valuations are adjusted in accordance with subsection (e)(2) of this section.

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

(6) [~~(5)~~] 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; 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 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 multiplied by (the SHR divided by 3); or

(-b-) 40.

(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 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) 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:

(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 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 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.

(7) [~~(6)~~] 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; 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 Measure Bundles appropriate for it based on its scope of practice and community partnerships, and consequently cannot 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).

(1) Measure selection.

(A) A CMHC 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 is assigned an MPT for measure selection as described in paragraph (3) of this subsection.

(D) A CMHC must select measures worth enough points to meet its MPT in order to maintain its total valuation for DY7 and DY8. If a CMHC 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.

(E) A CMHC may only select a measure for which its denominator for the baseline measurement period has significant volume.

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

(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) DSRIP-attributed population. A CMHC must determine its DSRIP-attributed population to be applied to its selected measures as specified in the Measure Bundle Protocol.

(3) [~~(2)~~] Measure valuation. A CMHC 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) multiplied by 0.75 [~~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 1.25 [~~1.5~~].

(D) If a CMHC allocates to a measure a percentage of its Category C valuation that is one percent greater than the Category C valuation divided by the number of selected measures, the CMHC must provide sufficient justification as specified in the Program Funding and Mechanics Protocol.

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

(5) [~~(3)~~] MPTs. A CMHC's MPT is the lesser of:

(A) the CMHC'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) DSRIP-attributed population. An LHD must determine its DSRIP-attributed population to be applied to its selected measures as specified in the Measure Bundle Protocol.

(3) [~~(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) multiplied by 0.75 [~~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 1.25 [~~1.5~~].

(D) If an LHD allocates to a measure a percentage of its Category C valuation that is one percent greater than the Category C valuation divided by the number of selected measures, the LHD must provide sufficient justification as specified in the Program Funding and Mechanics Protocol.

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

(5) [~~(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) 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 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 performer that demonstrates good cause may request for a 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.

(B) PY2 for a measure is calendar year 2019 unless otherwise specified in the Measure Bundle Protocol or one of its appendices.

(C) PY3 for a measure is calendar year 2020 unless otherwise specified in the Measure Bundle Protocol or one of its appendices.

(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) Measure milestones.

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

	Innovative P4R Measure or Quality Improvement Collaborative Activity	**P4P Measure**
DY7	100% RY1 reporting milestone	25% baseline reporting milestone
		25% PY1 reporting milestone
		50% DY7 goal achievement milestone
DY8	100% RY2 reporting milestone	25% PY2 reporting milestone
		75% DY8 goal achievement milestone

(2) If a hospital's or physician practice's denominator for a required measure in a selected Measure Bundle for the baseline measurement period or a performance measurement period has insignificant volume, 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 denominator for the baseline measurement period or performance measurement period has significant volume 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 denominator has significant volume 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 denominator has significant volume, 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 denominator has significant volume 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 denominator has significant volume, 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 denominator has significant volume 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) 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) 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) Measure eligible denominator population.

(1) Each Measure Bundle for hospitals and physician practices has a target population as specified in the Measure Bundle Protocol.

(2) [~~(1)~~] A measure's eligible denominator population must include all individuals served by the performer's system during a given measurement period that are included in the performer's DSRIP-attributed population and the target population for a measure for hospitals and physician practices, and that meet the measure's specifications as specified in the Measure Bundle Protocol.

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

(3) [~~(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.

(4) [~~(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.

(5) [~~(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) 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: 5% [~~10%~~] gap closure towards HPL, or baseline plus (minus) 2% [~~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) 8% [~~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) 2% [~~4%~~] of the difference between the HPL and MPL or the IOS goal	The lesser absolute value of improvement of baseline plus (minus) 8% of the difference between the HPL and MPL or the IOS goal
IOS		2.5% [~~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.~~]

(4) [~~(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) 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.

(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.

(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) 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.

§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 related to [~~of~~] the milestone.

(2) P4P measure goal achievement milestones. A P4P measure has a goal achievement milestone for each DY. With the exception of P4P measure goal achievement milestones described in subparagraph (B) of this paragraph, partial payment for P4P measure goal achievement milestones is available in quartiles for partial achievement measured over baseline in Performance Year (PY) 1, PY2, and PY3.

(A) To calculate the [~~The~~] payment for a P4P measure goal achievement milestone, multiply the milestone valuation by the achievement value calculated in clause (ii) of this subparagraph. [~~with the exception of a P4P measure goal achievement milestone described in subparagraph (B) of this paragraph, is determined as follows.~~]

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

(I) Measures with [~~If a measure has~~] a positive directionality where [~~for which~~] higher scores indicate improvement:

(-a-) DY7 achievement = (PY1 Achieved - Baseline/ (DY Goal - Baseline).

(-b-) Carryforward of DY7 achievement = (PY2 Achieved - Baseline)/ (DY7 Goal - Baseline).

(-c-) DY8 achievement = (PY2 Achieved - Baseline)/ (DY8 Goal - Baseline).

(-d-) Carryforward of DY8 achievement = (PY3 Achieved - Baseline)/ (DY8 Goal - Baseline).

[~~(-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) Measures with [~~If a measure has~~] a negative directionality where [~~for which~~] lower scores indicate improvement:

(-a-) DY7 achievement = (Baseline - PY1 Achieved)/ (Baseline - DY7 Goal).

(-b-) Carryforward of DY7 achievement = (Baseline - PY2 Achieved)/ (Baseline - DY7 Goal).

(-c-) DY8 achievement = (Baseline - PY2 Achieved)/ (Baseline - DY8 Goal).

(-d-) Carryforward of DY8 achievement = (Baseline - PY3 Achieved)/ (Baseline - DY8 Goal).

[~~(-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) The [~~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 [~~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 for a DY in accordance with §354.1715(d) of this division (relating to Category D Requirements for Performers) 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–of this division (relating to Category B Requirements for Performers) or §354.1713 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.