

# April DY7 Reporting – Companion Document

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## APRIL REPORTING CHECKLIST

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

- (If applicable) DY6 Carryforward reporting information entered and saved in the online system – "Reporting Status" tab indicates "Ready to Submit" or "Report Submitted" for all sections. (As long as the completed reports and supporting attachments have been **saved** by the reporting deadline, they will be considered officially submitted.) *Please note that only projects with DY6 Carryforward milestones and metrics are required to report during the April DY7 reporting period. Carryforward milestones appear with an asterisk on the current year's Project Reporting page.*
- Semi-annual reporting requirements met:
  - "Provider Summary Report" completed in the online reporting system.
    - For each project:
      - "Project Summary" tab – all questions answered online for each Category 1 or Category 2 DSRIP project.
      - "Progress Update" field – completed online for each Category 1 or Category 2 metric and PM-11 Category 3 milestones. The Progress Updates for DY6 carried forward Category 3 milestones should be completed in the Category 3 reporting template.
- Supporting documentation uploaded to the DSRIP Online Reporting System under "Supporting Attachments" for metrics reporting achievement.
  - Document name should follow template naming convention.
- April DY6 QPI Reporting Template** completed and uploaded for DY6 Carryforward QPI metrics reporting achievement.
  - Save as: RHPXX\_ProjectID\_QPI\_AprDY7 (RHP01\_123456789.1.1\_QPI\_AprDY7)
- Category 3 April DY7 Reporting Template & Certification** completed and uploaded to report achievement of DY6 Carryforward milestones (1 template per provider).
  - Save as: RHPXX\_TPIXXXXXX\_Cat3\_AprDY7 (RHP01\_123456789\_Cat3\_AprDY7)
- (If applicable) *Category 3 Stretch Activity 3 (SA3) Program Evaluation Coversheet* completed and uploaded along with the full program evaluation for each PM-11 Stretch Activity 3 (Program Evaluation) milestone.
  - Save SA3 Coversheet as: RHPXX\_Cat3ProjectIDXXXXXXXX.X.X\_SA3\_AprDY7 (RHP01\_123456789.3.1\_SA3\_AprDY7)
- (If applicable) *Category 3 Stretch Activity Report* completed and uploaded directly to the PM-11 Stretch Activity milestone. *HHSC does not require a coversheet for Stretch Activities other than SA3.*
  - Save as: RHPXX\_Cat3ProjectIDXXXXXXXX.X.X\_SA#\_AprDY7 (RHP01\_123456789.3.1\_SA9\_AprDY7)
- All applicable items listed above submitted through the DSRIP Online Reporting System no later than **11:59 p.m. on April 30, 2018.**
- (If applicable) IGT changes in entities or proportion of IGT among entities submitted to HHSC ([TXHealthcareTransformation@hhsc.state.tx.us](mailto:TXHealthcareTransformation@hhsc.state.tx.us)) using the *IGT Entity Change Form* by **June 1, 2018, 5:00 p.m.** (One IGT Entity Change Form per provider).

## KEY POINTS FOR APRIL DY7 REPORTING

Each DSRIP provider should review this entire Companion document to understand the guidelines for how to report DSRIP achievement for the April DY7 reporting period. The Companion Document includes important information about changes to required documentation compared to what was required for DY6 reporting.

Below are several critical points HHSC wants to highlight.

- **DY6 Carryforward Reporting.** Providers with DY6 Carryforward milestones and metrics are required to report on their DY6 projects in April DY7. This includes the completion of **semi-annual reporting (SAR)** requirements. Providers with DY6 Carryforward are required to provide semi-annual reporting information regardless of whether the provider is reporting achievement of metrics/milestones for payment in April. Future DSRIP payments may be withheld until the complete report is submitted. (p. 6)
  - The “Provider Summary Report” must be completed by all providers with DY6 Carryforward as part of the provider-level Semi-Annual Reporting requirement.
  - For each project, all providers with CY6 Carryforward should complete:
    - the “Project Summary” tab – all questions must be answered for each Category 1 or Category 2 DSRIP project.
    - the “Progress Update” field – must be completed for each Category 1 or Category 2 metric and for PM-11 Category 3 milestones. The Progress Updates for the remaining DY6 carryforward Category 3 milestones should be completed in the Category 3 reporting template.
- **Providers with NO DY6 Carryforward milestones and metrics.** Providers in this situation will not be reporting during the April DY7 reporting period (i.e., will not be completing the Provider Summary as part of SAR requirements).
- **Category 3 Alternate Measurement Period for Providers Impacted by Hurricane Harvey<sup>1</sup>:** Providers in FEMA designated disaster counties (see footnote) which are mainly located in RHPs: 2, 3, 4, 7, and 17, who experienced difficulties in reporting due to Hurricane Harvey, may use an alternate measurement period for Category 3 outcome measures for Performance Years (PY) 3 and 4. The exceptions might include an 11-month measurement period instead of 12, or a gap in the data to account for hurricane recovery time. Providers will indicate their need for a change to the measurement period in the **Additional Comments section** of the Category 3 Reporting Template. Please indicate what the new measurement period(s) should be and a brief description of the need for the change.
- **DY7 DSRIP Online Reporting System Changes:**
  - Projects with DY6 Carryforward metrics and milestones will be displayed in the system during the DY7 reporting periods. For example, a provider may see a DY7 project reporting

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<sup>1</sup> Providers impacted by Hurricane Harvey are providers located in counties designated by FEMA for Individual Assistance and Public Assistance (Categories A and B) or Individual Assistance and Public Assistance (Categories A- G). Source: <https://www.fema.gov/disaster/4332>

page for their DY6 project with just the Project Summary tab and a Cat 3 project tab or with a Project Summary tab, both QPI tabs, and a Cat 3 project tab. Projects that have completed all reporting through DY6 will not appear in DY7, as there are no metrics or milestones to report for achievement.

- DY7-8 DSRIP projects will appear in the reporting system during the summer of 2018 after HHSC completes its review of the updated RHP Plans. As DSRIP has changed from the project level to provider level, there will be only one project per provider with reporting tabs for Categories A-D.
- **Reporting Achievement:** Metrics/milestones should only be reported in April if a provider is confident that the metric/milestone was fully achieved by **March 31, 2018**, and can be clearly demonstrated. For any metric/milestone that HHSC does not find sufficient evidence of achievement in the documentation, the provider will only have one opportunity in June/July to submit additional information. If the provider cannot demonstrate during the June/July "needs more information" (NMI) period that the metric/milestone was completed by **March 31, 2018**, the provider will no longer be eligible for payment for that metric/milestone.
- **Reporting Deadline:** Providers should report using the DSRIP Online Reporting System: <https://dsrip.hhsc.texas.gov/dsrip/login> by **11:59 p.m.** on **April 30, 2018**.
- **Reporting Materials:** Companion documents and reporting templates can be found on the Bulletin Board in the DSRIP Online Reporting System. Please note that separate templates are required for QPI reporting and Category 3 reporting.
  - User Guide for the DSRIP Online Reporting System
  - Quantifiable Patient Impact (QPI) Reporting
    - April DY7 QPI Reporting Companion
    - April DY7 QPI Template - Please be sure to download the new QPI Reporting Template from the Bulletin Board as data has been updated and pre-seeded in the template.
  - Category 3 Reporting
    - Category 3 April DY7 Reporting Template
    - Category 3 Stretch Activity 3 (SA3) Coversheet Template

Please send reporting questions to the HHSC waiver mailbox at [TXHealthcareTransformation@hhsc.state.tx.us](mailto:TXHealthcareTransformation@hhsc.state.tx.us). Please remember to include your RHP, Project ID, and Metric ID when submitting your questions.

## OVERVIEW

This document includes information on reporting during the first reporting period of DY7 including timelines, DY6 carryforward instructions, use of HHSC reporting templates, QPI guidance, Category 3 guidance, and an overview of payment and IGT processing.

For technical instructions on using the DSRIP Online Reporting System, please refer to the *DSRIP Online Reporting System User Guide* posted on the **Bulletin Board** in the DSRIP Online Reporting System. Please note that the reporting system refers to April reporting as Round 1 and October reporting as Round 2.

Supporting documentation submitted in previous reporting periods outside of the DSRIP Online Reporting System (August DY2, October DY2, April DY3, and October DY3 provisional NMI period) is not available on the online reporting system.

There are two opportunities to report achievement of DY6 carryforward milestones and metrics in DY7: April and October 2018.

- Milestones and metrics achieved by March 31, 2018, may be reported in April.
- Milestones and metrics achieved by September 30, 2018, may be reported in October.
- October 2018 is the final opportunity to report achievement of DY6 carryforward milestones and metrics.

### **APRIL REPORTING TIMELINE**

- **April 1, 2018** – The DSRIP Online Reporting System will open for providers to begin April DY7 reporting. The templates for QPI reporting and Category 3 will be posted to the Bulletin Board as soon as they are available.
- **April 20, 2018** - Final date to submit questions regarding Category 3 April reporting and inform HHSC of any issues with DY6 data in the Category 3 reporting template or online reporting system.
- **April 25, 2018** – Final date to submit Category 1 & 2 QPI questions regarding April reporting and inform HHSC of any issues with DY6 data in the reporting system.
- **April 30, 2018, 11:59pm** – Due date for providers' submission of April DY7 DSRIP reporting using the DSRIP Online Reporting System and upload of applicable QPI and Category 3. Late submissions will not be accepted.
- **May 1, 2018** – HHSC will begin review of the April reports and supporting documentation.
- **May 17, 2018** – HHSC will post the estimated IGT due for April reporting based on milestones and metrics reported as achieved. Final IGT due will be based on HHSC review and approval.
- **May 18, 2018, 5:00pm** – Due date for IGT Entities to approve and comment on their affiliated providers' April reported progress on metrics using the "IGT Entity Feedback Form" that is posted on the Bulletin Board. The form is not an opportunity to identify technical errors entered in the reporting system. Examples of issues to include are reported progress that was not actually achieved, changes in project scope that were not reported by the provider, and risks to the project that were not reported by the provider. If there are no issues, comments do not need to be submitted and HHSC will assume the IGT Entity has approved the reported information. ***If there is a need to identify any technical errors in the reporting system please use the Waiver mailbox to communicate those errors by April 25, 2018, as stated above.***
- **June 1, 2018, 5:00pm** – Due date for submission of any IGT changes in entities or proportion of IGT among entities submitted to HHSC ([TXHealthcareTransformation@hhsc.state.tx.us](mailto:TXHealthcareTransformation@hhsc.state.tx.us)) using the IGT Entity Change Form that is posted under 1115 Medicaid Waiver Forms on the Bulletin Board.
- **June 8, 2018** – HHSC and CMS will complete their review and approval of April DY7 reports or request additional information (referred to as NMI) regarding the data reported. Note that HHSC completes multiple levels of review prior to determining that a milestone/metric requires additional information.

- If additional information is requested, the DSRIP payment related to the milestone/metric will not be included with July DSRIP payments.
- **July 2, 2018** – IGT settlement date for April reporting, RHP Plan Update submissions, and remaining 20 percent of DY6 Anchor DSRIP payments.
- **July 8, 2018, 11:59pm** – Due date for providers to submit responses to HHSC requests for additional information (NMI requests) on April reported Category 1-3 milestone/metric achievement and Semi-Annual Reporting requirements. Please include "NMI" in the file name when uploading documentation in response to NMI requests.
- **July 17, 2018** – April reporting **DY6 DSRIP payments** processed for transferring hospitals.
- **July 31, 2018** – April reporting **DY5 and DY6 DSRIP payments** processed for all providers that were not paid on July 17, 2018. Remaining DY6 Anchor payments and DY7 DSRIP payments for RHP Plan Update submissions will also be processed at this time. Note that there are separate transactions for each payment for each DY.
- **August 10, 2018** - HHSC and CMS will approve or deny the additional information submitted in response to HHSC comments on October reported milestone/metric achievement. Approved reports will be included for payment in the next DSRIP payment period, estimated for July 2018.

## REQUIRED SEMI-ANNUAL PROGRESS REPORTS

According to the Program Funding and Mechanics Protocol, paragraph 17 (on p. 351 of the waiver amendment approved October 24, 2014), semi-annual progress reports must be submitted to HHSC and CMS. DSRIP payments may be withheld until the complete report is submitted. **In April DY7 reporting, only providers with DY6 carryforward milestones and metrics will be required to submit semi-annual reporting.** This information must be submitted regardless of whether the DY6 carryforward milestones or metrics are reported for achievement. All information will be entered into the online reporting system.

- “Provider Summary Report” - This is a brief overview of your project/s current progress, activities conducted, findings, and outcomes achieved. Providers with multiple projects may submit an executive summary overview of all of their projects in the Provider Summary. Responses should be succinct and provide brief relevant detail.
- For each project:
  - “Project Summary” tab – all questions must be answered for each Category 1 or Category 2 DSRIP project. You may enter “NA” for some of the questions, but there must be an explanation of why the response is “NA” (e.g. NA – no patient impact in DY4 because all project milestones were focused on implementing project. Patient impact will be reported beginning in DY5.)
    - Under “Accomplishments,” describe positive change, forward progression with overall project success (e.g., We have hired a new clinician which will allow us to extend our clinic hours soon.)
    - If there were any variations (difficulties and how they were addressed/plans to address) from the project narrative and metrics that have already been reported as achieved, please provide this information under "Project Overview: Challenges" (e.g., We hired two nurses to meet a DY3 metric, but one of them moved out of the area and we've

been unable to refill that position. This may impact our ability to achieve our QPI metrics.).

- Under "Lessons Learned" describe what worked well, what could be improved, and how it can aid progress (e.g., Incorporating our new patient navigator into the ED team has helped us lower the rate of episodic care in the ED, but we realize that the workload may require additional staff. Patient navigation services could be improved by increasing navigation staff and cultural competency).
- Under "Patient Impact for Medicaid/Low-Income Uninsured Population," please identify the patient impact for the demonstration year and specify the Medicaid/low-income uninsured percentage that was served, including the split percentages if available.
- Under "Progress on Core Components," please list and describe progress on each required core component through the end of demonstration year.
- Under "Continuous Quality Improvement Activities," if not already described under "Progress on Core Components," describe consistently done actions that are devoted to pushing quality improvement forward (i.e., How the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement).
- "Progress Update" field – **must be completed for each Category 1 or Category 2 metric and each carried forward Category 3 milestone.** Please note that the Progress Update for Category 3 milestones PM-10, PM-12, and AM-3.x will be completed in the Category 3 April DY7 Reporting Template. This should be a succinct summary (one to several sentences as needed), e.g.:
  - (If completed) - Two pediatricians were hired in February 2015 and they have begun to serve patients at the neighborhood clinic.
  - (If in progress) – One pediatrician was hired in December 2014. We continue to advertise for the second pediatrician and hope to have them hired by the end of 2015.
  - (If not completed yet) – We began to advertise to hire the two pediatricians in January 2015. We are interviewing now, but have not yet hired either pediatrician. The goal is to have both of them hired and serving patients by the first quarter of 2016.

## CATEGORY 1 AND 2

### M-1 and M-2: QPI Milestones

In DY7, providers have the opportunity to report achievement on their DY6 carryforward Total QPI and MLIU QPI milestones. If a provider is reporting achievement of a DY6 QPI carryforward milestone in April for payment, they must demonstrate in the *April DY7 QPI Reporting Template* that the QPI goal was achieved between October 1, 2016 and March 31, 2018. There cannot be an overlap of the demonstration year dates used to count achievement for different years. In other words, counting toward the DY6 Total QPI milestone and MLIU QPI milestone achievement can begin on or after the end date of the DY5 QPI metric's measurement period.

Please note that DY6 MLIU QPI milestones that are designated as pay-for-reporting (P4R) may report in April as long as the provider has served at least one MLIU patient above the MLIU pre-DSRIP baseline

during the DY6 measurement period. DY6 MLIU QPI milestones that are designated as pay-for-performance (P4P) must meet their MLIU QPI goal in order to report achievement.

Providers should only submit one *QPI Reporting Template* per project per reporting period when reporting achievement. The same template is used for the project's DY6 Total QPI milestone and DY6 MLIU QPI milestone. The template has been updated for April DY7 reporting; a provider that is reporting for DY6 carryforward metric achievement must download the April DY7 template from the Bulletin Board in the DSRIP Online Reporting System so that they can use a template with properly seeded project data.

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

## CATEGORY 3

### General Information

- All providers with Category 3 carryforward milestones **must submit a Category 3 template** in the April DY7 reporting period, whether they are reporting achievement of a Category 3 milestone or not. Providers in multiple regions will submit one template per RHP.
- Providers **will not** use the online reporting system to report or provide progress updates on **Category 3 PM-10, PM-12, and AM-3.x** milestones or **PFPM** milestones. Reporting status and progress updates will be reported solely in the Category 3 Reporting Template for these milestones. Providers will be able to review reporting results in the online reporting system after the end of the reporting review period.
- Providers **will** use the online reporting system to report and provide progress updates on **DY6 carryforward milestone PM-11 (Stretch Activity)**.
- Performance year measurement periods (PYs) that end by 03/31/2018 can be reported during April DY7 reporting for Category 3 outcomes and PFPM milestones with approved baselines. Certain Category 3 outcomes will be eligible to correct baseline and/or reported performance through the April DY7 measurement period. Eligible outcomes can be corrected, even if performance is not being reported at this time. Correction eligibility will be indicated in the template.
- Please send Category 3 questions related to April DY7 reporting to the Healthcare Transformation mailbox as early in the reporting period as possible, especially if they involve making corrections to reporting templates. The deadline for submitting questions related to April DY7 Category 3 reporting is **Friday, April 20<sup>th</sup>**.

### Supporting Documentation

April DY7 reporting documents are available on the **Bulletin Board** in the DSRIP Online Reporting System.

- Category 3 Reporting Template (Required for all providers with a DY6 carryforward Category 3 milestone)
  - This template is required of all providers with a DY6 carryforward Category 3 milestone, whether reporting achievement of Category 3 or not.



- The template is submitted for reporting of both Category 3 outcomes (PM-10, PM-12, AM-3.x) and PFPM milestones (AM-3.x). A separate PFPM template will not be used to report in April DY7.
- The template should be attached only once to the first open Category 3 outcome associated with the first open Category 1 or 2 project in the online reporting system.
- Save the Reporting Template as: RHPXX\_TPIXXXXXXXXX\_Cat3\_AprDY7.xlsm (e.g., RHP01\_123456789\_Cat3\_AprDY7.xlsm).
- Category 3 Reporting Template Certification:
  - The Chief Quality Officer or executive responsible for validating accuracy of Category 3 reporting should print the summary tab of the reporting template, sign, and upload a copy of the signed certification with the reporting template.
- Stretch Activity 3 (SA3) Program Evaluation Coversheet (if applicable):
  - This coversheet should be completed for Stretch Activity 3 (Program Evaluation) alternate improvement activities reporting for achievement and uploaded directly to each PM-11 milestone along with the full program evaluation. **The coversheet alone does not meet requirements of SA3. Providers must also upload a completed project evaluation.**
  - Save the coversheet as: RHPXX\_Cat3ProjectIDXXXXXXXX.X.X\_SA3\_AprDY7 (e.g., RHP01\_123456789.3.1\_SA3\_AprDY7.xlsm).
  - HHSC does not require a coversheet for Stretch Activities other than SA3.
- Stretch Activity 9 (SA9) Cost Benefit Analysis Template (if applicable):
  - When reporting achievement of an SA9 stretch activity, providers must submit an approved template listed on the [SA9 Guidance](#) (or a template that HHSC has approved if provider has requested an exception).
  - Save the template as: RHPXX\_Cat3ProjectIDXXXXXXXX.X.X\_SA9\_AprDY7 (e.g., RHP01\_123456789.3.1\_SA9\_AprDY7.xlsx).
  - The provider should also upload a narrative report addressing the two questions outlined in the Guidance document.
- Stretch Activity Reports (if applicable):
  - Completed reports for Stretch Activities should be uploaded directly to the PM-11 stretch activity milestone. Date ranges that show when the activity/report was completed should be included within each document.
  - Supporting document(s) must be uploaded for each stretch activity metric reporting for achievement. The same document(s) may be used for multiple PM-11 projects if appropriate.
  - Save the report as: RHPXX\_Cat3ProjectIDXXXXXXXX.X.X\_SA#\_AprDY7 (e.g., RHP01\_123456789.3.1\_SA#\_AprDY7.xlsx).

Providers should maintain internal records of the reports used to abstract the numerator and denominator for Category 3 outcomes and PFPM measures to ensure that the same abstraction method is used across measurement periods, should HHSC or the compliance monitor ask to see additional details.

All reporting is subject to compliance monitoring. In cases where compliance monitoring determines that actual achievement is less than reported achievement, payments above actual achievement will be recouped.

Providers are required to adhere to measure specifications as outlined in the Category 3 Compendium and to maintain a record of any variances that were approved by HHSC prior to reporting baseline. Approval of a reported baseline or performance year does not constitute approval to report outside measure specifications. If at any point HHSC or a Compliance Monitor identifies that a provider is reporting a Category 3 outcome outside measure specification, DY6 performance reporting payment may be withheld or recouped and the provider will be required to bring reporting into compliance with Category 3 specifications.

## Measurement Periods

All performance measurement periods should be a full twelve months, even if the measure specifications or administration methodology indicate a shorter measurement period. For example, for flu admission rate specifications (IT-2.19), providers would still report the start and end dates of the measurement period of 12 months, even though the rate will only report on data during flu season as specified. Similarly, a provider might only administer quality of life surveys (for example, IT-10.1.a.x) one month out of a year as they are reporting on the same population year over year, but should report their performance measurement period as a full 12 months for DSRIP reporting purposes. Outcomes reporting performance with less than 12 months of data will result in an NMI determination.

## Baselines:

### Category 3 Outcomes

Category 3 outcomes are required to submit a baseline with 6 - 12 months of baseline data (with few exceptions), with measurement periods that start as early as 01/01/2012 and end no later than 09/30/2014. Baselines that end by 09/30/2014 (the end of DY3) are considered standard baselines for Category 3 milestone and reporting purposes.

In cases where a provider has no or inadequate data to establish a baseline that ends by 09/30/2014 (the end of DY3), DY4 data may be used to establish a baseline. This results in a change to the Category 3 milestone structure in DY4. Outcomes that have been approved by HHSC to report with a DY4 baseline must report a baseline with 12 months of data. The 12-month period should be as early as possible and end no later than the end of DY4. The October DY5 reporting period was the last opportunity for providers who were approved for a DY4 baseline to report a baseline, so no payment will be awarded for the reporting of baseline at this time.

### DY6 PFPM Outcomes

For PFPM milestones newly selected in DY6, the baseline should be a 12-month measurement period aligned with either DY4 (10/01/2014 - 09/30/2015) or DY5 (10/01/2015 - 09/30/2016), with some exceptions.

## Performance Years:

The term demonstration year (DY) refers to the October 1 - September 30 divisions within the waiver lifecycle (e.g., DY5 is 10/1/15 – 9/30/16). While metric funds are tied to a specific DY, the measurement periods for achievement don't always align with the DY. Cat 3 measurement periods for achievement

are referred to as Performance Years (PY). PYs refer to the 12 month period during which a Category 3 metric can be achieved.

Carrying forward due to partial achievement does not result in a change to the Category 3 PY1, PY2, PY3, or PY4 measurement periods, which are the 12 months immediately following the end of the preceding measurement period. Carrying forward performance means shifting the unachieved portions of an improvement target to the next 12 month PY measurement period.

### PY1 and PY2 Measurement Periods

The term PY1, or performance year one, generally refers to the 12 months after a baseline's measurement period, PY2 generally refers to the 12 months following PY1, etc. However, PYs can vary based on the outcome's baseline measurement period and measure type. Some exceptions include:

- In contrast to standard baselines, for outcomes with **DY4 baselines**, the 12 months following baseline is PY2.
- If a provider received approval to report with a **proxy population for baseline**, the first PY measurement period may be non-consecutive from the baseline measurement period. For example, if a provider used a comparable clinic to determine a baseline rate for an outcome using a CY2013 measurement period because the DSRIP project clinic was not open until October 1, 2014, the provider may begin their first PY measurement period (PY1 for Standard Baselines and PY2 for DY4 Baselines) on October 1, 2014. Outcomes not approved to report with a proxy baseline that report a non-consecutive PY measurement period without written prior approval from HHSC will result in an NMI determination.
- PY2 is the first year following the baseline for **DY5 PFPM** outcomes.
- PY1 is used to report achievement of DY4 milestones.
- PY2 is used to report achievement of DY5 milestones and any carried forward DY4 milestones.
- The October DY5 reporting period was the last opportunity for providers to report DY4 milestones, and October DY6 reporting period was the last opportunity for providers to report DY5 milestones. At this time, no payment will be awarded for the reporting of PY1 or PY2.

### PY3A Measurement Period

**PY3A** is used to report achievement of **carried forward DY5** milestones (AM-2.x, PM-12, or DY5 PFPM AM-3.x). It is the standard 12 month period following PY2.

- The October DY6 reporting period was the last opportunity for providers to report DY5 milestones. At this time, no payment will be awarded for the reporting of PY3A.

### PY3B and PY4 Measurement Periods

PY3B and PY4 are used to report achievement of DY6 Category 3 milestones. PY3B and PY4 can be only be reported in April DY7 reporting, if the end date of the performance year is on or before March 31, 2018.

- **PY3B** is used to report achievement of **DY6** milestones. The PY3B measurement period can be defined in the following ways based upon the outcome type:
  - **P4R** (PM-10): PY3B is the 12 month period immediately following the PY2 measurement period approved for use in DYs 3-5.
  - **P4P** (AM-3.x), **Maintenance** (PM-12), or **PFPM** continuing from DY5 (AM-3.x: PY3B can be either the 12 months following PY2 so that PY3A and PY3B use the same measurement period and report the same rates OR the 12 months that align with DY6 (October 1, 2016 - September 30, 2017).
    - Providers opting to use the non-consecutive PY3B measurement period for DY6 achievement still use the standard PY3A measurement period that follows their PY2 measurement period for reporting of DY5 carryforward milestones.
  - **P4P** of **PFPM** Newly Selected for DY6 (AM-3.x): For PFPMs newly selected for DY6 where there was no PFPM milestone in DY6 and the selected measure does not duplicate a PFPM selection from DY5, PY3B is DY6 (October 1, 2016 - September 30, 2017) unless otherwise approved by HHSC. For providers with a PFPM newly selected in DY6, PY3B is the first opportunity to report performance.
- **PY4** is used to report achievement of any **carried forward DY6** milestones. It is the 12 month period following PY3B. A provider with a DY6 carried forward P4P (AM-3.x), Maintenance (PM-12), or PFPM (AM-3.x) milestone will report DY6 achievement using the PY4 measurement period.

#### Summary of Measurement Periods by Outcome Type and Demonstration Year

Outcome Type	DY5 Carryforward of Achievement		DY6		DY6 Carryforward of Achievement	
	Milestone	PY3A Definition	Milestone	PY3B Definition	Milestone	PY4 Definition
<b>P4R</b>	NA	NA	PM-10	12 mos. following PY2	NA	NA
<b>Maintenance</b>	PM-12*	12 mos. following PY2	PM-12	12 mos. following PY2 or DY6	PM-12	12 mos. following PY3B
<b>P4P</b>	AM-2.x*		AM-3.x		AM-3.x	
<b>PFPM</b>	AM-3.x*		AM-3.x		AM-3.x	

### Category 3 Milestone Structures in DY5 and DY6

Category 3 milestone structure for DY6 is determined by the approved milestone structure for DY5. Milestone structures vary based on whether an outcome is Pay for Reporting (P4R), Pay for Performance (P4P) or Maintenance outcome.

Milestone Structure in DY5	Milestone Structure in DY6
<b>DY4 Baseline Maintenance SA</b>	Maintenance
<b>DY4 Baseline P4P</b>	P4P
<b>DY4 Baseline P4R PFP</b>	P4P (of PFPM outcome)
<b>DY4 Baseline P4R SA</b>	P4R and Stretch Activity
<b>DY4 Baseline P4R SA</b>	P4P (of PFPM outcome)
<b>Standard Maintenance PFP</b>	P4P (of PFPM outcome)
<b>Standard Maintenance SA</b>	Maintenance
<b>Standard P4P</b>	P4P
<b>Standard P4R PFP</b>	P4P (of PFPM outcome)
<b>Standard P4R SA</b>	P4R and Stretch Activity
<b>Standard P4R SA</b>	P4P (of PFPM outcome)

The milestone structure assigned to a Category 3 outcome can be confirmed in the Category 3 Summary Workbook, as well as in the April DY7 Category 3 Reporting Template. Details on each milestone structure can be found below.

Standard or DY4 Baseline P4P Outcome

Year	Milestone	Milestone Description	Payment
DY5	AM-2.x*	Achievement of DY5 performance goal	100% of Cat 3 DY5 Allocation
DY6	AM-3.x	Achievement of DY6 performance goal	100% of Cat 3 DY6 Allocation

Standard or DY4 Baseline P4R Outcome with DY5 PFPM

Year	Milestone	Milestone Description	Payment
DY5	PM-10	Successful reporting to approved measure specifications	50% of Cat 3 DY5 Allocation
	AM-3.x*	Achievement of DY5 PFPM goal	50% of Cat 3 DY5 Allocation
DY6	AM-3.x	Achievement of DY6 PFPM goal	100% of Cat 3 DY6 Allocation

Standard or DY4 Baseline P4R Outcome with DY5 Stretch Activity and DY6 Stretch Activity

Year	Milestone	Milestone Description	Payment
DY5	PM-10*	Successful reporting to approved measure specifications	50% of Cat 3 DY5 Allocation
	PM-11*	Successful achievement of Stretch Activity	50% of Cat 3 DY5 Allocation
DY6	PM-10	Successful reporting to approved measure specifications	50% of Cat 3 DY6 Allocation
	PM-11	Successful achievement of Stretch Activity	50% of Cat 3 DY6 Allocation

Standard or DY4 Baseline P4R Outcome with DY5 Stretch Activity and DY6 PFPM

Year	Milestone	Milestone Description	Payment
DY5	PM-10*	Successful reporting to approved measure specifications	50% of Cat 3 DY5 Allocation
	PM-11*	Successful achievement of Stretch Activity	50% of Cat 3 DY5 Allocation
DY6	AM-3.x	Achievement of DY6 PFPM goal	100% of Cat 3 DY6 Allocation

Standard Maintenance Outcome with DY5 PFPM

Year	Milestone	Milestone Description	Payment
DY5	PM-12*	Maintain baseline high performance level	50% of Cat 3 DY5 Allocation
	AM-3.x*	Achievement of DY5 PFPM goal	50% of Cat 3 DY5 Allocation
DY6	AM-3.x	Achievement of DY6 PFPM goal	100% of Cat 3 DY6 Allocation

*Providers will maintain statistically significant maintenance of high performance, defined as two proportion z-test with a significance level of .10 (calculator available here: <http://www.socscistatistics.com/tests/ztest/Default2.aspx>). Providers whose performance stays above their baseline rate do not need to demonstrate statistically significant maintenance. Providers who do not maintain high performance are eligible to carryforward. For example, a provider who did not fully achieve the DY5 PM-12 milestone would be eligible to carryforward for possible achievement in the Category 3 DY6 measurement period.*

Standard or DY4 Baseline Maintenance Outcome with DY5 Stretch Activity

Year	Milestone	Milestone Description	Payment
DY5	PM-12	Maintain baseline High Performance Level (HPL)	50% of Cat 3 DY5 Allocation
	PM-11	Successful achievement of Stretch Activity	50% of Cat 3 DY5 Allocation
DY6	PM-12	Maintain baseline High Performance Level (HPL)	100% of Cat 3 DY6 Allocation

Providers will maintain statistically significant maintenance of high performance, defined as two proportion z-test with a significance level of .10 (calculator available here: <http://www.socscistatistics.com/tests/ztest/Default2.aspx>) Providers whose performance stays above their baseline rate do not need to demonstrate statistically significant maintenance. Providers who do not maintain high performance are eligible to carryforward. For example, a provider who did not fully achieve the DY5 PM-12 milestone would be eligible to carryforward for possible achievement in the Category 3 DY6 measurement period.

## Calculating Performance Goals

### DY5 Performance Goals

For those outcomes where the measure type is P4P, DY5 performance goals are determined by the reported baseline using one of three standard goal setting approaches described below, based on the selected improvement target. Performance goals for P4P outcomes with a Quality Improvement System for Managed Care (QISMC) improvement type are calculated based on where a provider's baseline is relative to nationally set benchmarks (Minimum Performance Level (MPL) and High Performance Level (HPL)). The Category 3 Compendium includes details on the HPL and MPL for each QISMC P4P outcome measure.

The table below outlines how performance goals are calculated for P4P measures, excluding IOS and IOS-Survey based outcomes in OD-10 and OD-11.

Improvement Type		Baseline	DY5 Goal
QISMC	Negative Directionality	Below MPL	$MPL - .10(MPL - HPL)$
		Between MPL & HPL	$Baseline - .20(Baseline - HPL)$
		Above HPL	TA Needed - change to IOS, or maintenance
	Positive Directionality	Below MPL	$MPL + .10(HPL - MPL)$
		Between MPL & HPL	$Baseline + .20(HPL - Baseline)$
		Above HPL	TA Needed - change to IOS, or maintenance

P4P measures where QISMC appropriate benchmarks (HPL and MPL) are not available are designated as Improvement over Self (IOS) measures. In these scenarios, a provider must improve an outcome over the baseline performance. The table below shows the goal settings for IOS P4P goals in DY5. Goals are a 10 percent gap closure towards perfect (the highest possible score - for most outcomes this will be 1 or 0 depending on directionality) over baseline.

Improvement Type		DY5 Goal
IOS	Negative Directionality	$Baseline - .10(Baseline)$
	Positive Directionality	$Baseline + .10(Perfect - Baseline)$

The table below shows the performance goals for survey-based P4P measures in ODs 10 and 11. DY5 performance goals are set based on scenarios selected by the provider at the time of baseline reporting. In Scenario 1, goals are determined by the change in average pretest and posttest scores observed during the baseline measurement period. In Scenarios 2 and 3, goals are determined by a fixed improvement set relative to the minimum possible score and the maximum possible score for a given survey/tool.

Improvement Type		DY5	
IOS - Survey	Negative Directionality	Scenario 1 DY3 = Pretest & Posttest DY4&DY5 = Posttest Only	DY5 Posttest Goal: Baseline Posttest - .10(Baseline Pretest - Baseline Posttest)
		Scenario 2 DY3 = Pretests Only DY4/DY5 = Posttest Only	DY5 Posttest Goal: Baseline Pretest - .10*(Baseline Pretest - Min Score)
		Scenario 3 DY3-5 = Average Score	DY5 Average Score Goal: Baseline - .10*(Baseline --Min Score)
	Positive Directionality	Scenario 1 DY3 = Pretest & Posttest DY4&DY5 = Posttest Only	DY5 Posttest Goal= Baseline Posttest + .10(Baseline Posttest - Baseline Pretest)
		Scenario 2 DY3 = Pretests Only DY4/DY5 = Posttest Only	DY5 Posttest Goal: Baseline Pretest + .10*(Max Score --Baseline Pretest)
		Scenario 3 DY3-5 = Average Score	DY5 Average Score Goal: Baseline + .10*(Max Score -Baseline)

### DY6 Performance Goals

P4P outcomes approved to use a standard baseline, outcomes approved to use a DY4 baseline, and PFFM outcomes will all use the same goal calculations to determine goals for DY6 milestone AM-3.x. The table below shows the goal setting for QISMC P4P outcomes in DY6. For baselines near the high performance level (HPL), a standardized improvement floor is used. For QISMC outcomes with a baseline above the HPL, goals are the lesser absolute value of improvement of a 12.5% gap closure towards perfect, or baseline + 10% of the difference between the HPL and MPL in DY6. Using this formula may result in lower DY6 goals for outcomes with a baseline above the HPL, and higher goals for outcomes with a baseline below the HPL.

### DY6 QISMC Goal Setting for Category 3 P4P Outcomes

Direction	Baseline	DY6 Goal
Negative	Below the MPL	$MPL - .15*(MPL - HPL)$
	Between the MPL & HPL	the lesser of: $baseline - .25*(baseline - HPL)$ ; or $baseline - .10*(MPL - HPL)$ †
	Above the HPL	the greater of: $baseline - .125*(baseline)$ ; or $baseline - .10*(MPL - HPL)$ †
	Below the MPL	$MPL - .15*(MPL - HPL)$
Positive	Below the MPL	$MPL + .15*(HPL - MPL)$
	Between the MPL & HPL	the greater of: $baseline + .25*(HPL - baseline)$ ; or $baseline + .10*(HPL - MPL)$ †
	Above the HPL	the lesser of: $baseline + .125*(1-baseline)$ ; or $baseline + .10*(HPL - MPL)$ †

† Goal set using the improvement floor

The table below shows the goal settings for IOS P4P goals in DY6. Goals are a 12.5 percent gap closure towards perfect (the best possible rate, in most cases this will be 1 or 0 depending on directionality) over baseline.

DY6 IOS Goal Setting for Category 3 P4P Outcomes

Direction	DY6 Goal
Negative	baseline $-.125*(baseline)$
Positive	baseline $+.125*(perfect - baseline)$

The table below shows the IOS - Survey P4P goals in DY6 for survey based outcomes in ODs 10 and 11 based on the various reporting scenarios.

DY6 IOS - Survey Goal Setting for Category 3 P4P Outcomes

Direction	Reporting Scenario	DY6 Goal
Negative	Scenario 1	Posttest baseline $-.125*(pretest baseline - posttest baseline)$
	Scenario 2 & 3	Baseline $-.125*(baseline - min score)$
Positive	Scenario 1	Posttest baseline $+.125*(posttest baseline - pretest baseline)$
	Scenario 2 & 3	Baseline $+.125*(max score - baseline)$

PY1 Equivalent Goals

For P4P outcomes where there is no PY1 goal (i.e., outcomes using a DY4 baseline, or PFPM outcomes) or where the PY3 goal is set using a different methodology than used to determine the PY1 goal (i.e., QISMC outcomes with a DY6 goal set using the improvement floor formula, or some IOS-survey goals), partial payment will be measured as the percent of goal achieved between the PY3 goal and a PY1 equivalent goal, as defined below.

If a category 3 outcome is approved to use a baseline established in DY4 and does not have a DY4 achievement milestone, partial payment will be measured over a PY1 equivalent goal. For PFPM outcomes, partial payment will be measured over a PY1 equivalent goal. The PY1 equivalent goal for these outcomes will follow the QISMC or IOS goal calculations for PY1.

If a QISMC outcome has a PY3 goal that was determined using the improvement floor, partial payment will be measured over the PY1 equivalent goal. If a higher rate (positive directionality) indicates improvement for the outcome, the PY1 equivalent goal is the baseline plus 40 percent of the improvement floor. If a lower rate (negative directionality) indicates improvement for the outcome, the PY1 equivalent goal is the baseline minus 40 percent of the improvement floor.

If an IOS - Survey outcome is using reporting scenario 2 or reporting scenario 3, partial payment will be over the PY1 equivalent goal. If a higher rate (positive directionality) indicates improvement for the outcome, the PY1 equivalent goal is the baseline plus a five percent gap closure towards the maximum score. If a lower rate (negative directionality) indicates improvement for the outcome, the PY1 equivalent goal is the baseline minus a five percent gap closure towards the minimum score.

If a PY1 equivalent goal is used for an outcome, it can be identified in the Goal and Achievement Calculator tab of the Cat 3 Summary Workbook by entering the baseline numerator and denominator into the calculator. In the example below, the provider had a baseline just above the HPL and DY4 and DY5 goals were calculated using the IOS methodology (DY5 goal =  $Baseline + .10*(1-Baseline)$ ). The DY6



goal is set using the improvement floor (DY6 goal = baseline + .10\*(HPL - MPL)) resulting in a slightly lower DY6 goal. Since the DY6 goal is set using the improvement floor, the PY1 goal equivalent for partial payment is also identified.

Example of a PY1 equivalent goal for a DY6 goal set using the improvement floor

Rate Part 1 of 1						
Baseline	Numerator	Denominator	Baseline Rate	PY1 AM-1.1 Goal	PY2 AM-2.1 Goal	PY3 AM-3.1 Goal
Baseline	14000	20000	0.7000	0.7150	0.7300	0.7179
				*PY1 equivalent goal for DY6 AM-3.1 partial achievement is 0.7072		*Improvement floor goal
			Performance Rate	AM-1.1 % of Goal Achieved	AM-2.1 % of Goal Achieved	AM-3.1 % of Goal Achieved
Performance Year 1						
Performance Year 2						
Performance Year 3*						
Performance Year 4						

## Goal Achievement

### Partial Payment and Carryforward

Providers may receive partial payment for making progress toward an eligible P4P outcome improvement target (AM-2.x, AM-3.x). Category 3 P4P outcomes are eligible for partial payment related to percent of goal achieved.

#### Payment Based on Percent of Goal Achieved

Goal Achievement Reported in DY6	Payment
<i>Less than 25% achievement of DY5 Goal</i>	<i>No Payment for AM-2.x in DY6*</i>
<i>At least 25% achievement of DY5 Goal</i>	<i>25% of funds for AM-2.x in DY6*</i>
<i>At least 50% achievement of DY5 Goal</i>	<i>50% of funds for AM-2.x in DY6*</i>
<i>At least 75 % achievement of DY5 Goal</i>	<i>75% of funds for AM-2.x in DY6*</i>
<i>100% Achievement of DY5 Goal</i>	<i>100% of funds for AM-2.x in DY6*</i>
Less than 25% achievement of DY6 Goal	No Payment for AM-3.x in DY6
At least 25% achievement of DY6 Goal	25% of funds for AM-3.x in DY6
At least 50% achievement of DY6 Goal	50% of funds for AM-3.x in DY6
At least 75 % achievement of DY6 Goal	75% of funds for AM-3.x in DY6
100% Achievement of DY6 Goal	100% of funds for AM-3.x in DY6

\*For unachieved portions of DY5 AM-2.x milestones, DY5 and DY6 payments for AM-2.x will not exceed 100% of funds.

Unearned funds can be carried forward into the next Category 3, 12-month performance measurement period. Achievement may not be carried forward beyond the 12 months following the performance measurement period in which initial achievement was less than the goal.

In DY6, for example, a provider could earn carried forward unearned portions of the DY5 funds AND earn DY6 funds. Unachieved portions of AM-2.x milestones were automatically carried forward and were eligible to be earned in the PY3A measurement period. The DY6 AM-3.x milestone may be reported in PY3B, and unachieved portions of the DY6 milestone may be earned in PY4.

## Achievement Calculations

Category 3 goal achievement formulas are determined by the measure directionality (positive or negative) and the baseline measurement period type (Standard or DY4). PFP goals will be calculated the same as other Category 3 outcomes in DY6. Partial achievement for DY6 achievement milestones for PFPs will be measured over a PY1 equivalent goal. Goal achievement can be confirmed in the Category 3 Summary Workbook and Goal Calculator, and is automatically calculated in the April DY7 Category 3 Reporting Template. Goal achievement is calculated as follows:

### Achievement Calculations for Category 3 P4P Outcomes

DY	Milestone	PY	Positive Direction (higher rates indicate improvement)	Negative Direction (Lower rates indicate improvement)
DY5	AM-2-x	PY2	(PY2 achieved - baseline)/(DY5 goal - baseline)	(baseline - PY2 achieved)/(baseline - DY5 goal)
	Carryforward of AM-2.x	PY3A	(PY3A achieved - baseline)/(DY5 goal - baseline)	(baseline - PY3A achieved)/(baseline - DY5 goal)
DY6	AM-3.x	PY3B	(PY3B achieved - PY1 goal or equivalent)/(DY6 goal - PY1 goal or equivalent)	(PY1 goal or equivalent - PY3B achieved)/(PY1 goal or equivalent - DY6 goal)
	Carryforward of AM-3.x	PY4	(PY4 achieved - PY1 goal or equivalent)/(DY6 goal - PY1 goal or equivalent)	(PY1 goal or equivalent - PY4 achieved)/(PY1 goal or equivalent - DY6 goal)

Providers reporting performance will report the numerator and denominator for their 12-month measurement period(s) in the reporting template. The template will calculate the AM-3.x percentage of goal achieved.

### Example of Goal Achievement Calculation with Positive Directionality

Baseline	0.5527
DY4 Goal	0.5666
DY5 Goal	0.5804
DY6 Goal	0.5873
PY2 Achievement Reported in DY5	0.5775
PY3A & PY3B Achievement Reported in DY6 (provider used same measurement period for PY3A and PY3B)	0.5895

DY5 AM-2.1 % of goal achieved in PY2 = (PY2 achieved - baseline)/(DY5 goal - baseline)

$$(0.5775 - 0.5527)/(0.5804 - 0.5527) = 0.8953 \text{ or } 89.5\%$$

**AM-2.1 = 75% of goal achieved in PY2**

DY5 AM-2.1 % of goal achieved in PY3A = (PY3A achieved - baseline)/(DY5 goal - baseline)

$$(0.5895 - 0.5527)/(0.5804 - 0.5527) = 1.33 \text{ or } 133\%$$

**AM-2.1 = 100% of goal achieved in PY3A**

$$\text{DY6 AM-3.1 \% of goal achieved in PY3B} = (\text{PY3B achieved} - \text{PY1 goal or equivalent}) / (\text{DY6 goal} - \text{PY1 goal or equivalent})$$

$$(0.5895 - 0.5666) / (0.5873 - 0.5666) = 1.11 \text{ or } 111\%$$

**AM-3.1 = 100% of goal achieved in PY3B**

In this example, the provider was eligible to receive 75% of funds associated with this AM-2.1 milestone based on PY2 reporting in DY5, and carried forward the unearned 25% into the DY6 reporting period. Based on PY3 reporting in DY6, the provider is eligible to receive the additional 25% of unearned funds carried forward from DY5 milestone AM-2.1 and is eligible to receive 100% of funds associated DY6 milestone AM-3.1.

### Corrections to Category 3 Outcomes

The April DY7 Category 3 Reporting Template will automatically allow corrections for some outcomes. Correction eligibility will be included in the template. Most P4P outcomes that have not yet reported performance will be able to make corrections to the reported baseline numerator and denominator through the reporting template. Most P4R outcomes will be able to make corrections to all prior reporting history. Outcomes that are eligible to make corrections in the reporting template can submit corrections if they are reporting new performance rates for possible payment or providing a status update only.

P4P outcomes that have already reported performance and some outcomes with custom goal calculation methodology (i.e., HHSC Approved Alternate Achievement Request, Maintenance, P4P change to P4R) will not be able to automatically make corrections in the reporting template.

Providers that identify errors in previously reported baseline/performance in the Category 3 reporting template should contact HHSC before **April 20<sup>th</sup>** explaining the error in detail. In some cases, HHSC may give instructions for making corrections in the reporting template. Please contact HHSC as soon as possible if you identify errors in previously reported rates. **Providers should NOT report performance against a baseline known to be incorrect.** HHSC cannot accept corrections to baselines or performance years referenced only in the qualitative fields of the reporting template.

### Stretch Activities (PM-11)

DY6 Stretch Activity milestones (PM-11\*) are eligible to be reported in April DY7, provided they are completed by 03/31/2018.

#### Stretch Activity 3 (SA3) Program Evaluation

When reporting achievement of an SA3 (Program Evaluation) stretch activity, providers must submit both a standard SA-3 Coversheet and a full program evaluation document. HHSC does not require a coversheet for Stretch Activities other than SA3.

#### Stretch Activity 9 (SA9) Cost-Benefit Analysis

When reporting achievement of an SA9 (Cost-Benefit Analysis) stretch activity, providers must submit an approved template listed on the [SA9 Guidance](#) (or a template that HHSC has approved if provider has requested an exception), as well as a narrative report addressing the two questions outlined in the Guidance document. A coversheet is not required for SA9.

## PAYMENT AND IGT PROCESSING

### Categories 1 and 2 Payment Calculations

The amount of the incentive funding paid to a Performing Provider will be based on the amount of progress made and approved within each specific milestone. Each DY6 milestone is valued at 25 percent of the Category 1 or 2 DY6 valuation. Each DY6 milestone must be fully achieved to include it in the incentive payment calculation. A DY5 milestone may consist of one or more metrics. A Performing Provider must fully achieve a Category 1 or 2 DY5 metric to include it in the incentive payment calculation.

Based on the progress reported and approved, each milestone will be categorized as follows:

If consisting of one DY5 metric or is a DY6 milestone:

- Full achievement (achievement value = 1)
- Less than full achievement (achievement value = 0)

If consisting of more than one metric:

- Full achievement (achievement value = 1)
- At least 75 percent achievement (achievement value = .75)
- At least 50 percent achievement (achievement value = .5)
- At least 25 percent achievement (achievement value = .25)
- Less than 25 percent achievement (achievement value = 0)

The Performing Provider is eligible to receive an amount of incentive funding for that milestone determined by multiplying the total amount of funding related to that milestone by the reported achievement value. If a Performing Provider has previously reported progress on a milestone with multiple metrics and received partial funding, only the additional amount it is eligible for will be disbursed.

#### *Example of Category 1 or 2 disbursement calculation:*

A Category 1 Project in DY 5 is valued at \$4 million and has one milestone with two metrics and one milestone with three metrics.

The Performing Provider reports the following progress in April and has been approved by HHSC and CMS:

Milestone 1: 100 percent achievement (Achievement value = 1)

- Metric 1: Fully achieved
- Metric 2: Fully achieved

Milestone 2: 66.7% percent achievement (Achievement value = .5)

- Metric 1: Fully achieved
- Metric 2: Fully achieved
- Metric 3: Not Achieved

Disbursement for April reporting: Milestone 1 (\$2 million \*1 = \$2 million) + Milestone 2 (\$2 Million \*0.5 = \$1 Million) = \$3 Million

By the end of the Demonstration Year, the Performing Provider successfully completes all of the remaining metrics for the project. The provider is eligible to receive the balance of incentive payments related to the project:

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

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

### Category 3 Payment Calculations

April DY7 Category 3 payments are based on performance reported in the *April DY7 Category 3 Reporting Template, documentation submitted for PM-11 Stretch Activity completion if applicable, and approval of the submission by HHSC and CMS.*

For P4R Category 3 milestones, 100 percent of DY6 funding is for reporting to approved measure specifications (PM-10).

For process milestones, a Performing Provider must fully achieve to qualify for the DSRIP payment related to these milestones.

For achievement milestones for an outcome with multiple components/rates, the 50% allocation toward achievement (AM-3) is split evenly between the number of components/rates (e.g. AM-3.1 and AM-3.2) and these achievement milestones can be achieved or partially achieved independently.

#### Example milestone structure for outcomes with multiple components/rates

P4P outcome selected is IT-4.19 Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls. This outcome has 3 components or parts (screening, risk assessment and plan of care) with a DY4 value of \$200K and DY5 value of \$300K. The following is a description of the milestone structure and payment allocation by milestone.

- DY4 Milestones
  - PM-10 Successful reporting to specs (for all components) \$100K—carry forward eligible, not eligible for partial payment.
  - AM-1.1: Achievement of DY4 goal for component 1 (screening) - \$33K- partial achievement and carryforward eligible.

- AM-1.2: Achievement of DY4 goal for component 2 (risk assessment) - \$33K- partial achievement and carryforward eligible.
- AM-1.3: Achievement of DY4 goal for component 3 (plan of care) - \$33K- partial achievement and carryforward eligible.
- DY5 Milestones
  - AM-2.1: Achievement of DY5 goal for component 1 (screening) - \$100K- partial achievement and carryforward eligible.
  - AM-2.2: Achievement of DY5 goal for component 2 (risk assessment) - \$100K- partial achievement and carryforward eligible.
  - AM-2.3: Achievement of DY5 goal for component 3 (plan of care) - \$100K- partial achievement available.

For a detailed explanation of **Partial Achievement**, please refer to p. 21 under *Category 3: Partial Payment and Carryforward*.

For information regarding **PFFPM Partial Achievement**, please refer to p. 22 under *Category 3: Achievement Calculations*.

### Approved October 2018 Needs More Information (NMI) milestones and metrics

In February 2018, HHSC completed review of October 2017 reporting submissions in response to HHSC requests for more information. Approved Needs More Information (NMI) milestones and metrics will be included in the July 2018 payment processing of April reports. NMI milestones and metrics that were not approved will no longer have access to the associated DSRIP funds.

### IGT Processing

In June 2018, HHSC Rate Analysis will notify IGT Entities and Anchors of the IGT amounts by affiliation and IGT Entity by RHP for July 2018 payment processing of approved April reports. The IGT amounts for January 2018 short IGT, approved NMI milestones and metrics, DY5 carry forward achievement, DY6 achievement, DY7 RHP Plan Update submissions, and DY7 monitoring will be indicated as well as a total IGT amount.

Per Texas Administrative Code §355.8204, HHSC may collect up to \$5 million per demonstration year from DSRIP IGT entities to serve as the non-federal share (50 percent IGT/50 percent federal funds) for DSRIP monitoring contracts. For DY7, HHSC will collect \$5 million in Monitoring IGT. The monitoring amount for each IGT Entity is a portion of the \$5 million based on the January 1, 2018 value of the IGT Entity's funded DY7 DSRIP out of all DY7 DSRIP in the state. Note that HHSC may decrease, but not increase, DY7 Monitoring IGT amounts based on changes in the RHP Plan Update submissions.

HHSC will request 100 percent of the DY7 IGT monitoring amount with July 2018 payment processing of April reports. If the full DY7 IGT monitoring amount is not submitted by an IGT Entity in July 2018, it will be requested with January 2019 payment processing of October reports.

An IGT Entity may either transfer the total IGT amount due for DSRIP and monitoring or an amount less than the total IGT due. If less than the total IGT amount is transferred, then HHSC will account for the IGT monitoring amount first and the remaining IGT will be proportionately used to fund DY5, DY6, and DY7 approved DSRIP payments. If an IGT entity does not fully fund its DSRIP payments in July, the remaining IGT amount due for its affiliated projects' achievement may be transferred with January 2019 payment processing of October DY7 reports. **Note that July 2018 is the final opportunity to submit IGT for DY5 payments. Any unpaid DY5 DSRIP after July 2018 will be forfeited.**

DSRIP payments are made using the Federal Medical Assistance Percentage (FMAP) for the federal fiscal year (October 1 – September 30) during which the DSRIP payment is issued and is not based on the demonstration year FMAP of the achieved milestone or metric. The FMAP for FFY2018 and used for July 2018 DSRIP payment processing of April reports is 56.88. The FFY2019 FMAP of 57.32 will be used for January 2019 DSRIP payment processing of October DY7 reports.

### IGT Entity Changes

The IGT Entity(ies) and proportion of funding for each project/outcome are listed on the HHSC website on the [Tools and Guidelines for Regional Healthcare Partnership Participants](#) page under **Demonstration Year 7 Reporting**. By May 17, 2018, HHSC will post the estimated IGT due for April reporting based on milestones and metrics reported as achieved and DY7 estimated RHP Plan Update payments to inform any needed IGT changes. Final IGT due will be based on HHSC review and approval of reporting and RHP Plan Updates. If you have changes to the IGT Entity, either in Entity or proportion of payment among IGT Entities, listed in the reporting system or submitted in the RHP Plan Update, please complete the *IGT Entity Change Form* available at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/IGT-Entity-Change-Form-%28DY4-6%29.xlsx>. IGT Entity changes must be received no later than **June 1, 2018, 5:00 p.m.** for April reporting DSRIP payment processing. Any changes received after June 1, 2018, will go into effect for the October DY7 DSRIP reporting and payments will be delayed until that time. Note that IGT Entity changes submitted for April reporting will not impact the IGT monitoring amounts. Only changes submitted in the RHP Plan Updates will decrease IGT monitoring amounts.

### WARNING NOTICE REGARDING SUBMISSION OF SUPPORTING DOCUMENTATION

All information submitted for DSRIP reporting by Texas Healthcare Transformation and Quality Improvement Program §1115 Waiver participants is subject to the Public Information Act ("Act"), Chapter 552 of the Government Code. Certain information, such as commercial or financial information the disclosure of which would cause significant competitive harm, is excepted from public disclosure according to the Act. If you believe that the documentation submitted through this system is excepted from the Act, please note that belief at the beginning of your submission, including the particular exception you would claim.

Providers are required by the HHSC Medicaid Provider Agreement, as well as state and federal law, to adequately safeguard individually identifiable [Client Information](#). While the DSRIP online reporting system is secure, and access is limited to HHSC program auditors, protected health information (PHI) is not required by HHSC and should not be transmitted. As such, Providers are prohibited from submitting

Personally Identifiable Information about clients, HIPAA Protected Health Information or Sensitive Personal Information in connection with submittal of meeting the metric. Providers are required to only submit De-identified information [as evidence of meeting a metric]. If Provider inadvertently uploads individually identifiable client information or following discovery of an Event or Breach, the Provider should report this to HHSC Waiver Staff and the Provider's designated privacy official or legal counsel to determine whether or not this is a privacy breach which requires notice to your patients. HHSC will remove the PHI-containing files as necessary, but requests that providers submit de-identified versions of the original documentation and description of corrective actions for auditing and recordkeeping purposes. Providers will cooperate fully with HHSC in investigating, mitigating to the extent practicable and issuing notifications directed by HHSC, for any event or breach of confidential information to the extent and in the manner determined by HHSC. Provider's obligation begins at the discovery of an event or data breach and continues as long as related activity continues, until all effects of the event are mitigated to HHSC's satisfaction.

### **Definitions**

**"Breach"** means any unauthorized acquisition, access, use, or disclosure of confidential Client Information in a manner not permitted by [this incentive program] or applicable law. Additionally:

**(1) HIPAA Breach of PHI.** With respect to Protected Health Information ("PHI") pursuant to HIPAA regulations and guidance, any unauthorized acquisition, access, use, or disclosure of PHI in a manner not permitted by the HIPAA Privacy Regulations is presumed to be a Breach unless Provider, as applicable, demonstrates that there is a low probability that the PHI has been compromised. Compromise will be determined by a documented Risk Assessment including at least the following factors:

- i. The nature and extent of the Confidential Information involved, including the types of identifiers and the likelihood of re-identification of PHI;
- ii. The unauthorized person who used or to whom PHI was disclosed;
- iii. Whether the Confidential Information was actually acquired or viewed; and
- iv. The extent to which the risk to PHI has been mitigated.

With respect to PHI, a "breach," pursuant to HIPAA Breach Regulations and regulatory guidance excludes:

(A) Any unintentional acquisition, access or use of PHI by a workforce member or person acting under the authority of HHSC or Provider if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the HIPAA Privacy Regulations.

(B) Any inadvertent disclosure by a person who is authorized to access PHI at HHSC or Provider to another person authorized to access PHI at the same HHSC or Provider location, or organized health care arrangement as defined by HIPAA in which HHSC participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the HIPAA Privacy Regulations.

(C) A disclosure of PHI where Provider demonstrates a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information, pursuant to HIPAA Breach Regulations and regulatory guidance.

**(2) Texas Breach of SPI.** Breach means "Breach of System Security," applicable to electronic Sensitive Personal Information (SPI) as defined by the Texas Breach Law. The currently undefined phrase in the Texas Breach Law, "compromises the security, confidentiality, or integrity of sensitive personal information," will be interpreted in HHSC's sole discretion, including without limitation, directing Provider to document a Risk Assessment of any reasonable likelihood of harm or loss to an individual, taking into consideration relevant fact-specific information about the breach, including without limitation, any legal requirements the



unauthorized person is subject to regarding confidential Client Information to protect and further safeguard the data from unauthorized use or disclosure, or the receipt of satisfactory assurance from the person that the person agrees to further protect and safeguard, return and/or destroy the data to the satisfaction of HHSC. Breached SPI that is also PHI will be considered a HIPAA breach, to the extent applicable.

(3) Any unauthorized use or disclosure as defined by any other law and any regulations adopted there under regarding Confidential Information.

**“Client Information”** means Personally Identifiable Information about or concerning recipients of benefits under one or more public assistance programs administered by HHSC.

**“De-Identified Information”** means health information, as defined in the HIPAA privacy regulations as not Protected Health Information, regarding which there is no reasonable basis to believe that the information can be used to identify an Individual. HHSC has determined that health information is not individually identifiable and there is no reasonable basis to believe that the information can be used to identify an Individual only if:

(1) The following identifiers of the Individual or of relatives, employers, or household members of the individual, are removed from the information:

(A) Names;

(B) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

(i) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(ii) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

(C) All elements of dates (except year) for dates directly related to an Individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

(D) Telephone numbers;

(E) Fax numbers;

(F) Electronic mail addresses;

(G) Social security numbers;

(H) Medical record numbers (including without limitation, Medicaid Identification Number);

(I) Health plan beneficiary numbers;

(J) Account numbers;

(K) Certificate/license numbers;

(L) Vehicle identifiers and serial numbers, including license plate numbers;

(M) Device identifiers and serial numbers;

(N) Web Universal Resource Locators (URLs);

(O) Internet Protocol (IP) address numbers;

(P) Biometric identifiers, including finger and voice prints;

(Q) Full face photographic images and any comparable images; and

(R) Any other unique identifying number, characteristic, or code, except as permitted by paragraph (C) of this section; and

(2) Neither HHSC nor Provider has actual knowledge that the information could be used alone or in combination with other information to identify an Individual who is a subject of the information.”

**“Discovery”** means the first day on which an Event or Breach becomes known to Provider, or, by exercising reasonable diligence would have been known to Provider and includes Events or Breaches discovered by or reported to Provider, its officers, directors, partners, employees, agents, work force members, subcontractors or third-parties (such as legal authorities and/or Individuals).

**“Encryption”** of confidential information means, as described in 45 C.F.R. §164.304, the HIPAA Security Regulations, the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without the use of a confidential process or key and such confidential process or key that might enable decryption has not been breached. To avoid a breach of the confidential process or key, these decryption tools will be stored on a device or at a location separate from the data they are used to encrypt or decrypt.

**“HIPAA”** means the Health Insurance Portability and Accountability Act of 1996, as amended by the HITECH ACT and regulations thereunder including without limitation HIPAA Omnibus Rules, in 45 CFR Parts 160 and 164. Public Law 104-191 (42 U.S.C. §1320d, *et seq.*); Public Law 111-5 (42 U.S.C. §13001 *et. seq.*).

**“HIPAA Privacy Regulations”** means the HIPAA Privacy Regulations codified at 45 C.F.R. Part 160 and 45 C.F.R. Part 164, Subpart A, Subpart D and Subpart E.

**“HIPAA Security Regulations”** means the HIPAA Security Regulations codified at 45 C.F.R. Part 160 and 45 C.F.R. Part 164 Subpart A and Subpart C, and Subpart D.

**“HITECH Act”** means the Health Information Technology for Economic and Clinical Health Act (P.L. 111-5), and regulations adopted under that act.

**“Individual”** means the subject of confidential information, including without limitation Protected Health Information, and who will include the subject’s Legally authorized representative who qualifies under the HIPAA privacy regulation as a Legally authorized representative of the Individual wherein HIPAA defers to Texas law for determination, for example, without limitation as provided in Tex. Occ. Code § 151.002(6); Tex. H. & S. Code §166.164; and Texas Prob. Code § 3. “Legally authorized representative” of the Individual, as defined by Texas law, for example, without limitation as provided in Tex. Occ. Code § 151.002(6); Tex. H. & S. Code §166.164; and Texas Prob. Code § 3, includes:

- (1) a parent or legal guardian if the Individual is a minor;
- (2) a legal guardian if the Individual has been adjudicated incompetent to manage the Individual’s personal affairs;
- (3) an agent of the Individual authorized under a durable power of attorney for health care;
- (4) an attorney ad litem appointed for the Individual;
- (5) a guardian ad litem appointed for the Individual;
- (6) a personal representative or statutory beneficiary if the Individual is deceased;
- (7) an attorney retained by the Individual or by another person listed herein; or
- (8) If an individual is deceased, their personal representative must be the executor, independent executor, administrator, independent administrator, or temporary administrator of the estate.

**“Personally Identifiable Information”** or “PII” means information that can be used to uniquely identify, contact, or locate a single Individual or can be used with other sources to uniquely identify a single Individual.

**“Protected Health Information”** or “PHI” means individually identifiable health information in any form that is created or received by a HIPAA covered entity, and relates to the Individual's healthcare condition, provision of healthcare, or payment for the provision of healthcare, as further described and defined in the HIPAA. PHI includes demographic information unless such information is De-identified, as defined above. PHI includes without limitation, electronic PHI, and unsecure PHI. PHI includes PHI of a deceased individual within 50 years of the date of death.

**“Unsecured Protected Health Information”** means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized Persons through the use of a technology or methodology specified by the HITECH Act regulations and HIPAA Security Regulations. Unsecured PHI does not include secure PHI, which is:

- (1) Encrypted electronic Protected Health Information; or
- (2) Destruction of the media on which the Protected Health Information is stored.