

Regional Healthcare Partnership (RHP) Plan Companion Document

October 25, 2012

The purpose of the Companion Document is to provide a quick reference tool to Regional Healthcare Partnerships (RHPs) to assist them as they prepare RHP Plans for submission to the Texas Health and Human Services Commission (HHSC) and, by HHSC, to the Centers for Medicare and Medicaid Services (CMS).

The Companion Document is a living document and will be updated as additional information becomes available.

Questions about the RHP Plan can be sent to TXHealthcareTransformation@HHSC.state.tx.us.

Getting Started

RHP Plan Tools

The following documents should be referenced when developing a Regional Healthcare Partnership (RHP) Plan:

- The Program Funding and Mechanics (PFM) Protocol (identifies the Delivery System Reform Incentive Payment, or DSRIP, funding requirements) and RHP Planning Protocol (identifies the allowable DSRIP projects and requirements) which serve as the basis for RHP Plan development.
- The RHP Plan Checklist, which not only guides the development of the RHP Plans, but also helps ensure that the Plans will be completed correctly and, thereby, minimizes the risk of not being approved for funding.
- The RHP Plan Template is completed by Anchors in collaboration with Performing Providers, Intergovernmental Transfer (IGT) Entities, and other stakeholders.
- The Electronic Workbook is completed by Performing Providers and Anchors to assist them in meeting PFM requirements.

Determining the Quality of the RHP Plan

According to the requirements of the 1115 Medicaid waiver both the Centers for Medicare and Medicaid Services (CMS) and the Health and Human Services Commission (HHSC) will review RHP Plans to ensure that their content meets the expectations for a quality Plan. The RHP Plan should address the following elements:

- Planning process that demonstrates regional collaboration.
- Projects selected address community needs and are consistent with the RHP Planning Protocol menu.
- Projects selected demonstrate regional transformation, stressing integration and synergy among providers, including addressing the triple aim.
- Each project reflects the integration of the four project categories.
- RHP Plans ensure that DSRIP payments do not duplicate federal initiatives funded by the U.S. Department of Health & Human Services.
- Capital projects will be considered on a case-by-case basis and evaluated in the context of the whole plan. Providers must demonstrate the project is necessary to achieve long-term quality improvements.
- “Other” projects allowable within approved project area, but must have significant justification

DSRIP is not intended to fund Medicaid services or coverage expansion.

DSRIP Providers

Eligible Performing Providers include hospitals, community mental health centers (CMHC), local health departments, physician practice plans affiliated with an academic health science center, and physician practice plans not affiliated with an academic health science center. Providers that are not eligible Performing Providers may serve as subcontractors. Eligible subcontractors include, but are not limited to, Federally Qualified Health Centers (FQHC), Emergency Medical Services (EMS), and Dental Providers.

Public Funds for Intergovernmental Transfer (IGT)¹

The 1115 Medicaid waiver provides for supplemental funding to certain Medicaid providers in Texas in the form of two new pools: the Uncompensated Care (UC) Pool and the Delivery System Reform Incentive Payment (DSRIP) Pool. In order to receive that supplemental funding, some governmental entity must provide funding to HHSC which will then have those funds “matched” by the federal government and sent to the Medicaid provider designated by the funding governmental entity. The process by which funds are transferred to HHSC for the purpose of a federal match is called an “intergovernmental transfer” or “IGT.”

Funds can be transferred by:

- any unit of local government (including, but not limited to, a public hospital, hospital district, county, city, or Local Mental Health Authority); or
- any state agency.

A governmental entity can transfer funds to HHSC if:

- the funds are in the governmental entity’s administrative control;
- the funds are not federal funds;
- the funds are public funds, not private funds;
- there is no statutory or constitutional provision that requires the funds to be used solely for another purpose or prohibits the transfer;
- the transfer satisfies a statutory or constitutional requirement that relates to the funds, including Article III, section 52 of the Texas Constitution or the state General Appropriations Act; and
- the funds are not impermissible provider-related donations.

A provider-related donation is:

- a voluntary donation from a non-governmentally operated health care provider or entity related to a private health care provider;
- in cash or in kind;
- made to a governmental entity, whether or not that entity provides for an IGT; and
- is directly or indirectly related to a Medicaid payment or other payment to providers.

Federal regulations prohibit private healthcare providers from making donations to HHSC, whether directly or indirectly through another government agency. However, federal law recognizes that private providers can undertake to support community activities. Local governmental entities may take that support into account when determining to make an IGT that will be used to fund Medicaid payments to those providers. It is vital that, in such a situation, the existence or amount of an IGT is not contingent upon the existence of such community support or the amount of the community support.

¹ The principles listed are not intended to be exhaustive. Individual entities involved in arranging financing for Waiver activities are in the best position to know all of the relevant facts to determine if such an arrangement is legal and workable. As such, it is vital that all potential Waiver participants discuss IGT arrangements with their attorneys.

Regional Healthcare Partnership (RHP) Plan Submission/Review Timeline

The timeline below targets submission of Pass 1 by November 16 and the final RHP Plan by December 31, 2012. However, with regional consensus, RHPs are welcome to submit plans sooner.

- Sep. 21 – RHP Plan Template & Pass 1 workbooks for Performing Providers (PPs) available to RHPs
- Sep. 21 – Anchor call
- Sep. 21 – Oct. 19 – PPs complete Pass 1 DSRIP, including Categories 1-4 narratives within the RHP Plan Template and all steps in the workbook
- Sep. 25 – RHP Planning Protocol training (session 1)
- Sep. 26 – RHP Plan Template training
- Sep. 28 – RHP Planning Protocol training (session 2) / Anchor call
- Oct. 5 – Anchor call
- Oct. 10 – Anchor Workbook, Pass 2 Workbook for PPs, and Pass 3 (Anchor Pass) Workbook posted
- Oct. 12 – Anchor call
- Oct. 19 – Anchor call
- Oct. 22 – Nov. 2 – Anchors review & compile Pass 1 DSRIP submitted by PPs and ensure requirements are met. Anchors work with PPs to adjust narratives and workbooks as needed.
- Oct. 26 – Anchor call
- **Oct. 31 – Anchors submit Sections I, I, & III of RHP Plan Template and Community Needs Supplemental Information electronically to HHSC**
- Nov. 2 – Anchor call
- Nov. 5 – Anchors generate Pass 2 funding for all participating Pass 2 PPs and send to PPs
- Nov. 5 – 9 – Anchors post Pass 1 DSRIP for public comment
- Nov. 6 – 19 – PPs complete Pass 2 DSRIP, including Categories 1-4 narratives within the RHP Plan Template and all steps in the workbook
- Nov. 9 – Anchor call
- **Nov. 16 – Anchors submit Pass 1 DSRIP to HHSC with all sections of the RHP Plan completed for Pass 1. Estimated IGT must be identified for all DSRIP.**
- Nov. 16 – Anchor call
- Nov. 20 – Dec. 6 – Anchors review & compile Pass 2 DSRIP submitted by PPs and ensure requirements are met. Anchors work with PPs to adjust narratives and workbooks as needed.
- Nov. 30 – Anchor call
- Dec. 7 – Anchor call
- Dec. 7 – 14 – Anchors identify any DSRIP funding available after Pass 2 and complete Anchor Pass (if applicable) in collaboration with PPs and IGT Entities.
- Dec. 14 – Anchor call
- Dec. 17 – 21 – Anchors post Pass 2 & Anchor Pass DSRIP within complete RHP Plan for public comment
- **Dec. 31 – Pass 2 and Anchor Pass projects within complete RHP Plan due to HHSC**
- Jan. 2 - Formal 30-day HHSC review begins
- Feb. 5 – Formal 45-day CMS review begins

Definitions

1. **Affiliation Number:** A number assigned by HHSC that depicts the specific affiliation agreement between a unique hospital or provider to the unique Intergovernmental Transferring (IGT) public entity. This number is used for identifying purposes only for HHSC's payment process and is assigned once the necessary certification forms are complete and filed.
2. **Anchoring Entity (Anchor):** The IGT entity identified by HHSC as having primary administrative responsibilities on behalf of the RHP.
3. **Baseline:** The starting point of a project, milestone, or measure. A project must be an expansion of an existing project or a new project initiated after the waiver start date of December 2011. All projects must have milestones and measures that are established by demonstration year. Each milestone or measure must represent activities or performance achieved during the applicable demonstration year. (Carry forward policies may also apply as specified in the PFM).
4. **Delivery System Reform Incentive Payment (DSRIP):** Incentive payments available for projects to enhance access to healthcare or to increase the quality of care, the cost-effectiveness of care provided and/or the health of the patients and families served. Projects eligible for incentive payments must come from the RHP Planning Protocol (also known as DSRIP menu) and be included in the HHSC and CMS-approved RHP plan with corresponding metrics and milestones.
5. **Demonstration Year (DY):** A 12-month period beginning October 1 and ending September 30. The waiver consists of five demonstration years from 2012 to 2016.
6. **Domain:** Categories of outcome measures in Category 3 and 4.
7. **DSRIP Menu (also known as RHP Planning Protocol):** A menu of HHSC and CMS-approved projects that contribute to delivery transformation and quality improvement. Only projects from this menu performed as outlined in the RHP Plan with corresponding metrics and milestones are eligible for payments from the DSRIP pool.
8. **Intergovernmental Transfer (IGT) Entity:** A governmental entity that provides an IGT to fund the waiver.
9. **Metric:** Quantitative or qualitative indicator of progress toward achieving a milestone from a baseline. There are one or more metrics associated with each milestone. The RHP participants may tailor the targets in the metric, as appropriate.
10. **Milestone:** An objective for DSRIP performance comprised of one or more metrics. (See Section V: DSRIP Projects for more information.)
 - a) **Process Milestones:** Objectives for completing a process that is intended to assist in achieving an outcome.
 - b) **Improvement Milestones:** Objectives, such as outputs, to assist in achieving an outcome.
11. **Milestone Bundle:** A set of milestones for a Category 1 or 2 project or the set of measures for a Category 3 intervention for a given demonstration year.
12. **Outcome:** CMS defines as: "Measures that assess the results of care experienced by patients, including patients' clinical events, patients' recovery and health status, patients' experiences in the health system, and efficiency/cost."

- a) **Standalone Outcomes:** Measures that meet the PFM definition of an outcome and can be the sole Category 3 outcome for a project (see Section X for more information on Category 3 Outcomes)
 - b) **Non-Standalone Outcomes:** Measures that must be combined with Standalone outcomes or other non-standalone outcomes in order to be used as Category 3 outcomes (see Section X for more information on Category 3 Outcomes)
13. **Ownership Types** as required in the RHP Plan Template, Section I. RHP Organization:
- a) **State-owned entity:** The state directly receives the Medicaid-claims payments.²
 - b) **Non-State-owned public entity:** A governmental entity other than the state directly receives the Medicaid-claims payments.
 - c) **Private entity:** A non-governmental entity directly receives the Medicaid-claims payments.
14. **Performing Provider:** A participating Medicaid provider that implements DSRIP projects.
15. **Program Funding and Mechanics Protocol (PFM Protocol):** The document, drafted by HHSC and approved by CMS, outlining DSRIP requirements for RHPs including the minimum number of projects, organization of the RHP Plan, plan review process, required reporting, allocation of available pool funds, valuation of projects, disbursement of funds, and plan modifications.
16. **Regional Healthcare Partnership (RHP):** A collaboration of interested participants that work collectively to develop and submit to the state a regional plan for health care delivery system reform. Regional Healthcare Partnerships will support coordinated, efficient delivery of quality care and a plan for investments in system transformation that is driven by the needs of local hospitals, communities, and populations.
17. **RHP Planning Protocol** (also known as DSRIP Menu): A menu of HHSC and CMS-approved projects that contribute to delivery transformation and quality improvement. Only projects from this menu performed as outlined in the RHP Plan with corresponding metrics and milestones are eligible for payments from the DSRIP pool.
18. **TIN:** Texas Identification Number
19. **TPI:** Texas Provider Identifier
20. **Uncompensated Care (UC) Pool:** Funding available to RHP participants under the waiver to defray uncompensated care costs.
21. **Upper Payment Limit (UPL):** Historic supplemental payments made to certain hospitals and providers to make up the difference between what Medicaid actually paid for Medicaid clients and what Medicare would have paid for the same services. UC and DSRIP funds available under the waiver replaced funding available under the former UPL program.

² If a governmental entity receives some of the Medicaid-claims payments and a non-governmental entity (e.g., a private operator of the hospital) receives some of the Medicaid-claims payments, please indicate this arrangement in the “Ownership Type” column for your entity.

RHP Plan Identifiers

HHSC requires the RHP Plan to use the following naming convention and references in identifying community needs, projects, milestones, measures, and metrics.

- 1. Community Need Identification Number:** Each community need shall have a unique identification number based on the number of community needs identified by the RHP, using the format of “CN.[Community Need Number]”. For example, the first community need identified through the assessment shall be numbered CN.1. The Community Need Identification Numbers shall be included in Section III. Community Needs Assessment and referenced in each project/intervention narrative in Section V. DSRIP Projects.
- 2. RHP Project Identification Number:** Each Category 1-3 project or outcome measure shall have a unique identification number based on the number of DSRIP projects selected by the RHP, using the format of “[Performing Provider TPI].[Category Number].[Performing Provider Selected Project Number]”. For example, the second Category 1 project selected by a Performing Provider with TPI 110000000 shall be numbered 110000000.1.2. The project numbering restarts based on different Performing Providers. For example, the second Category 1 project selected by a Performing Provider with TPI 223000000 shall be numbered 223000000.1.2. The RHP Project Identification Number shall be included in Section II. Executive Summary, Section V. DSRIP Projects, and Section VI. Allocation of Funds, and matched to the electronic workbooks.
- 3. Category 1-2 Identifiers:** Category 1-2 projects and their related project options, milestones, and metrics have unique identifiers that tie together these related project components. For example, the identifier for a Category 1 project metric might be 1.2.5.P-3.1 with each number in the numbering convention identifying a unique project element as follows:
1[Category].2[Project].5[Project Option].P-3[Milestone].1[Metric]

Please note that the identifier for a milestone will be preceded by either a ‘P’ indicating a process milestone or an ‘I’ indicating an improvement milestone. The identifiers shall be used in Section V. DSRIP Projects.
- 4. Category 3 Identifiers:** Category 3 outcome measures are composed of two parts – process milestones and improvement targets – which each have unique identifiers. The unique identifier for each part is preceded by a “3” to indicate the category number. For example, the identifier for a Category 3 process milestone might be 3.P-1, and the identifier for the outcome improvement target (IT) might be 3.IT-2.1.

The identifiers shall be used in Section V. DSRIP Projects.

Summary of Texas DSRIP Project Requirements

	Categories 1 & 2	Category 3	Category 4
Performing Provider	Hospital and non-Hospital Providers	Hospital and non-Hospital Providers	Hospital Providers* only
Pass 1 Projects & Requirements			
	<u>RHP Level Requirement</u>	<u>Performing Provider Level Requirement</u>	
Project Begins	DY 2	DY 2 and DY 3	DY 3 and DY 4
RHP Tier 1	Minimum 20 projects (At least 10 from Category 2)	Must adopt outcome measures that tie back to projects in Categories 1 and 2. Must establish outcome improvement targets by the beginning of DY 4 (October 1, 2014).	5 Domains of Measures: <ul style="list-style-type: none"> ▪ PPAs ▪ PPRs ▪ PPCs ▪ Patient Centered Health Care ▪ Emergency Department DY 2 DSRIP for status report on system changes.
RHP Tier 2	Minimum 12 projects (At least 6 from Category 2)		
RHP Tier 3	Minimum 8 projects (At least 4 from Category 2)		
RHP Tier 4	Minimum 4 projects (At least 2 from Category 2)		
Broad Participation Target/ Pass 2	<ul style="list-style-type: none"> ▪ RHPs shall have minimum participation by non-profit and other private hospitals (Tier 1 & 2: 30%; Tier 3: 15%, Tier 4: 5%). ▪ RHPs shall have minimum participation by major safety net hospitals (Tier 1: five; Tier 2: four; Tier 3: two; Tier 4: one) ▪ An RHP that meets minimum provider participation requirements in Pass 1 may participate in Pass 2 and fund additional projects with unused DSRIP allocation amounts. 		
Plan Modification			DSRIP Requirements for UC Pool Participants
All RHPs	<ul style="list-style-type: none"> ▪ An RHP may request to add new projects/outcome measures to begin in DY 3 from Categories 1, 2, or 3. ▪ Proposals must be submitted during DY 2 (October 1, 2012 – September 30, 2013). ▪ RHP may also delete or modify projects/outcome improvement targets, under certain circumstances. ▪ Plan modifications are subject to HHSC and CMS review and approval. 		<ul style="list-style-type: none"> ▪ Hospitals that participate in UC pool shall be required to report on a subset of Category 4 measures. ▪ Fourth quarter UC payments are contingent on Category 4 reporting. ▪ Participation in an annual learning collaborative. ▪ Certain exceptions apply.

*Certain small hospitals and rural hospitals are exempt from reporting Category 4 measures (see paragraph 11.f of Attachment J: Program Funding and Mechanics Protocol).

Highlights of Texas DSRIP Funding Methodology

DSRIP Allocation to RHPs				
<ul style="list-style-type: none"> Initial DSRIP amounts allocated to RHPs for DYs 1-5 based on a formula that consider three factors (low-income population and historic Medicaid and supplemental payments). HHSC shall re-assess RHP allocation amounts in DY 2: uncommitted amounts shall be redistributed to RHPs that implement new projects in DYs 3-5, subject to plan modification approval. 				
RHP DSRIP Allocation to Performing Providers (DYs 2-5)				
Pass 1				
<ul style="list-style-type: none"> 75% to Hospital Providers that participated in DSH program in FFY 2012 or UPL program in FFY 2011 (formula distributes a specific amount to each hospital based on uncompensated care, Medicaid spending, and supplemental payments); 10% to Community Mental Health Centers; 10% to Physician Practices Affiliated with Academic Health Science Centers; and 5% to Local Health Departments. Small hospital collaboration: Within an RHP categorized as Tier 1 or 2, hospitals with a DY 2 allocation of \$2 million or less may combine their individual DSRIP allocations together to fund a project(s) led by one Performing Provider. Tier 3 and Tier 4 collaboration: Within an RHP categorized as Tier 3 or 4, Performing Providers may combine their individual DSRIP allocations together to fund a project(s) led by one Performing Provider. 				
Pass 2				
<ul style="list-style-type: none"> Uncommitted DSRIP in Pass 1 may be used to fund additional projects from Categories 1-3. 15% to hospitals that did not participate in Pass 1 (i.e. did not participate in the DSH program or former UPL program). 10% to physician practices unaffiliated with Academic Health Science Centers. 75% to Performing Providers that participated in Pass 1 based on the value of DSRIP projects funded in Pass 1 in DYs 2-5. Within an RHP, Performing Providers may combine their individual Pass 2 DSRIP allocations to fund a DSRIP project led by 1 Performing Provider. 				
Rules of the Road				
To get to Pass 2, RHP must meet (1) minimum number of individual Category 1 and 2 projects; (2) show minimum participation by major safety net hospitals; and (3) demonstrate minimum participation by non-profit/private hospitals.				
Performing Provider Project Valuations (DYs 2-5)				
Performing providers shall allocate their DSRIP funding to projects in a manner that comports with the category funding allocation requirements below. Cat 1 and 2 project values may not exceed the greater of 10 percent of the Performing Provider's Pass 1 allocation or \$20 million over the DYs 2-5 period				
	DY 2 (10/1/12- 9/30/13)	DY 3 (10/1/13-9/30/14)	DY 4 (10/1/14-9/30/15)	DY 5 (10/1/15-9/30/16)
Hospitals*				
Categories 1 & 2	No more than 85 %	No more than 80%	No more than 75 %	No more than 57 %
Category 3	At least 10 %	At least 10%	At least 15 %	At least 33 %
Category 4	5 %	10 % - 15%	10%- 15 %	10 % - 15 %
Non Hospitals:				
Categories 1 & 2	95 %-100 %	No more than 90 %	No more than 90 %	No more than 80 %
Category 3	0 %- 5 %	At least 10 %	At least 10 %	At least 20 %

* Small hospitals and rural hospitals exempted from Category 4 reporting shall allocate Category 4 funding to Categories 1-3.

RHP Plan Template: Section-by-Section Additional Instructions

Section I: RHP Organization:

To be completed by Anchor in collaboration with Performing Providers, UC-only hospitals, and other stakeholders

TexNet Enrollment and TIN (Texas Identification Number) Setup

Providers must select a single TPI that has an associated TIN, for which they have received past payments for which their DSRIP payments will be processed under.

If you have a pending TPI (awaiting application approval), indicate “Pending” in the TPI fields. DSRIP will be paid to Performing Providers with active TPIs. There will not be retroactive DSRIP payments for Performing Providers with pending TPIs.

1. **89-103 (TexNet Payor Information Form):** The first step in the TexNet process, ideally filled out with the AP-152 simultaneously, this form sets up the initial TexNet Account so vendors may phone in or login to their account and send an Intergovernmental Transfer (IGT). (Required) <http://www.hhsc.state.tx.us/rad/hospital-svcs/downloads/tex-net-enroll-form.pdf>
2. **AP -152 (Application for Texas Identification Number):** This form establishes the Texas Identification Number (TIN) that is derived from the 9 digit FEIN (Federal Identification Number). It is used to link a hospital name, address, and bank account. It is not unusual for a hospital to have several TINs in order to route specific payments to preferred accounts; Direct Deposit accounts have a different mail code from the parent TIN. (Required) <http://www.window.state.tx.us/taxinfo/taxforms/ap-152.pdf>

A typical TIN is 14 digits long and looks like this:

Texas Hospital dba Hospital of Texas
17XXXXXXXX 9 000

- a) The underlined portion (7XXXXXXXX) is the original FEIN.
 - b) To make up a complete TIN, a ‘1’ will be added to the beginning of the FEIN.
 - c) Next a check code is applied (here, it is ‘9’).
 - d) A mail code will then be added to link to the TIN to the hospital address and is always three digits. In this example, the mail code is 000.
3. **Vendor Direct Deposit/Advance Payment Notification Authorization (74-178):** This form should accompany the AP-152 and establishes a Direct Deposit TIN. When used, funds will be automatically deposited into the linked banking account and paper checks will no longer be mailed but. (Required) <http://www.window.state.tx.us/taxinfo/taxforms/74-176.pdf>
 4. **74-157 (Payee Change Request):** This form is used to amend information for an established TIN from the original AP-152. For example, this form could be used to amend a mail code. (Required only as necessary) <http://www.window.state.tx.us/taxinfo/taxforms/74-157.pdf>
 5. **TexNet Payment Instructions Booklet:** This guide was created for Vendors by the Comptroller’s Office and provides TexNet Transfer Instructions and customer service numbers. <http://www.window.state.tx.us/taxinfo/etf/96-590.pdf>

Section II: Executive Overview of RHP Plan:

To be completed by Anchor

Enter unique RHP Project Identifiers:

- [TPI].[Category].[Performing Provider Project Number]
- Project numbering restarts with each Performing Provider

Section III: Community Needs Assessment:

To be completed by Anchor in collaboration with stakeholders

Supplemental Materials

HHSC prefers that RHPs limit additional supplemental materials to essential supporting community needs information. A list of web pages may be provided to link to additional documents. HHSC prefers the supplemental information be limited to no more than 50 pages.

Federal Initiatives

CMS has indicated that they are interested in whether Performing Providers are participating in or are implementing DSRIP projects to expand upon the following federal initiatives.

CMS Innovation Center Grants:

- Accountable Care Organizations (ACOs)
- Advance Payment Model
- Pioneer ACO Model
- Bundled Payments for Care Improvement
- Comprehensive Primary Care Initiative
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Graduate Nurse Education Demonstration
- Health Care Innovation Awards
- Independence at Home Demonstration
- Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents
- Medicaid Emergency Psychiatric Demonstration
- Partnership for Patients
- State Innovation Models Initiative
- Strong Start for Mothers and Newborns

HITECH payments:

- EHR incentive payments
- Health Information Exchange Grant
- Other HITECH grant or payment

HRSA grants:

- FQHC/ RHC/ School-based health center grants, including capital grants
- Health professions loans and workforce development grants
- Ryan White funding
- Maternal and child health grants

SAMSHA Funding ([list of SAMSHA grants by state](#)):

- Community Mental Health services block grant
- Substance Abuse Prevention and Treatment Block Grant
- Other mental health and substance abuse grants

CDC grants ([list of CDC funding by state](#)):

- Immunization grants
- CLASBI/ Hospital acquired infection initiatives

Section IV: Stakeholder Engagement:

To be completed by Anchor

Section V: DSRIP Projects:

To be completed by Performing Providers and Anchor

Pass 2 Projects

- A Pass 2 project must be a new project.
- Pass 2 projects do not include the expansion of a Pass 1 project.

Continuous Quality Improvement

- CMS requires most projects to include QI as a core component.
- Projects are required to describe QI activities in the RHP Planning Template project narrative.
- CMS is strongly encouraging the selection of a QI Process Milestone, but this is not required. CMS has recommended using one or more QI Process Milestones that are included in the Appendix to the RHP Planning Protocol. Providers can also propose a more customized QI Process Milestone for a project.

Project Inclusion

- An Anchor cannot eliminate DSRIP projects in Pass 1 from a Performing Provider (PP) who has funding for the project.
 - Ideally, the region developed a master list of projects with consensus from all potential PPs regarding what this list of projects would contain.
 - If there is no master list, then the Anchor should err on the side of not limiting the PP's participation in the plan.
- An Anchor must work to avoid submitting a Plan that includes overlapping projects in which two or more Performing Providers intend to conduct the same project targeted at the same population.

- If the Anchor, as a Performing Provider, has a project that overlaps with another Performing Provider, the Anchor cannot prevent the other Performing Provider from proposing the project. If the Anchor's project is chosen over the other Performing Provider's, the Anchor must provide a rationale for the inclusion of the Anchor's project that is defensible to HHSC and CMS.

Project Valuation

You must value projects based on estimated available IGT. Project valuation cannot exceed the amount of IGT entered in the workbooks plus the matching funds associated with that IGT.

Category 1 and 2

This section describes the various elements that you will see in the RHP Planning Protocol related to projects in Categories 1 and 2.

- **Project Area:** The overarching subject matter the project addresses. An example of a "project area" is: 1.1 Expand Primary Care Capacity.
- **Project Goal:** The purpose of performing a project in the project area.
- **Project Option:** A comprehensive intervention a Performing Provider may undertake to accomplish the project goal. An example of a "project option" is 1.1.1 Establish more primary care clinics.
- **"Other" Project Options:** Each Category 1 and 2 project area includes an "other" project option. Providers that wish to implement an innovative, evidence-based project that is not included on the list of project options for a project area may choose the "other" project option. Providers implementing an "Other" project option may design their project using the process and improvement milestones specified in the project area or may include one or more customizable process milestones P-X and/or improvement milestones I-X, as appropriate for their project. "Other" project options will be subject to additional scrutiny during the plan review and approval process.
- **Project Component:** Activities that may occur in conjunction with one another to carry out a project option. Project components may be required core components or optional components. Required core components are listed with the project options with which they must be completed. Providers either must incorporate all required core components in their plan narrative or they must provide justification for why they are not including a core component (e.g., the provider was at a more advanced stage with the project and had already completed one or more core components). An example of a project option with associated project components follows:

1.10.1 Enhance improvement capacity within people

Required core project components

- Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.
 - Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.
- **Milestone:** An objective for DSRIP performance comprised of one or more metrics.

- **Process Milestones:** Objectives for completing a process that are intended to assist in achieving an outcome.
- **Improvement Milestones:** Objectives, such as outputs, to assist in achieving an outcome
- **Metric:** Quantitative or qualitative indicator of progress toward achieving a milestone from a baseline. There are one or more metrics associated with each milestone. The RHP participants may tailor the targets in the metric, as appropriate.
- **Data Source:** The data source often lists multiple options that could be used for the data being measured by the metric. Please note that these options identify appropriate sources of information, but as allowed, Performing Providers may identify alternative sources that are more appropriate to their individual systems and that provide comparable or better information. The RHP plans will specify the exact data source being used for the metric each year.

DSRIP for Transportation: Transportation can only be a component of a project that assists the provider in achieving a larger goal and is documented as a milestone in Category 1 or 2. It may be included in a Project as a means to an end, such as Expand Primary Care Capacity and Enhance Service Availability to appropriate levels of behavioral health care. It can be included in the approach, as a component, and/or as a milestone, depending on the Project Option selected. There must be a clearly documented need for the project in the Community Needs Assessment for the region. The narrative must specify how the need exceeds services required to be provided through Medicaid or services that otherwise already exist in the community.

Each project must be linked to outcome improvement targets no later than DY4 and DY5.

Category 3

Each Category 1 and 2 project must have at least one related Category 3 outcome measure, and each outcome measure for each project must have a narrative. If an outcome measure is used more than once for different projects, please complete a narrative for each use of the outcome measure specific to its project. You may refer back to another narrative or paste text from another narrative where appropriate.

Outcomes for Category 3 include:

- Process Milestones for DY 2 and DY3
- Improvement Targets for DY4 and DY5 (could also be in DY3 for hospital inpatient projects)

Outcomes measured are based on a specific patient population served by the project.

Improvement targets are labeled as stand-alone measures or non-standalone measures organized in the domains. Providers can propose additional outcomes not included in the protocol that meet the definition and are evidence-based and nationally endorsed.

Non-stand-alone outcomes are similar to Category 1 & 2 Improvement milestones. If a provider selects a particular Improvement milestone in Category 1 or 2, it cannot propose that same measure as an outcome in Category 3.

Providers can select among the following methods to meet Category 3 requirements for each Category 1 and 2 project:

- At least one standalone measure: Providers can select a standalone measure from any outcome domain listed in the table below for Category 1 and 2 projects. Cost-related outcomes may be used as the standalone outcome only for project area 2.5 (Cost Containment). Cost outcomes can be selected as non-standalone measures for other project areas.
- At least one standalone measure and additional non-standalone measure(s): One or more non-standalone measures from any outcome domain can be combined with at least one standalone measure. If the selected measures are from different domains, the provider must include a valid, evidence-based rationale explaining how the measures are complementary.
- A combination of at least 3 non-standalone measures from the same outcome domain: A provider can select a combination of 3 non-standalone measures for a Category 1 or 2 project as long as the measures come from the same outcome domain.

Hospital Performing Providers must select outcome measure(s), but can indicate 'TBD' for the achievement levels for improvement targets (i.e. performance achievement of x% instead of 5%) in the initial plan submission. Non-hospital Performing Providers are permitted to indicate 'TBD' for both the improvement targets and their associated achievement levels in the initial plan submission. In order to receive Category 3 payment in DY 2, providers must, at a minimum, indicate the process milestones they will implement in DY 2.

All outcome measures and outcome improvement targets must be valued, including those designated 'TBD'. A Performing Provider has the flexibility to assign different values to Category 3 outcomes and related milestones and outcome improvement targets, as long as total payments meet the annual category allocation amounts defined in 25.e in the PFM Protocol and the valuations are sufficiently justified.

Given mixed evidence for outcomes of outpatient initiatives, outcome targets can be modest and adjusted, if necessary, based on experience as the project is implemented; outcomes will be reported on an annual basis.

Partial payment for meeting outcome targets will be made in increments of 25, 50, 75, or 100%. Carry-forward for outcomes targets can occur if the target set for DY 4 is met in DY 5.

Category 4

Category 4 is valued at 10 percent for DY 3-5 if completing the five required domains of:

- Potentially Preventable Admissions
- Potentially Preventable Readmissions
- Potentially Preventable Complications
- Patient-Centered Healthcare
- Emergency Department

The optional 6th domain (Initial Core Set of Measures for Adults and Children in Medicaid/CHIP) must be completed to value Category 4 up to the maximum of 15 percent for DY 3-5.

Performing providers that only report on the required reporting domains may designate to Categories 1, 2, or 3 the 5 percent valuation they are unable to obtain in Category 4 by foregoing reporting on the optional domain.

For Performing Providers to be eligible for a Category 4 measure exemption due to lack of a sufficiently large population to produce statistically valid data, as allowed under the Program Funding and Mechanics Protocol paragraph 11.e, the following apply:

- **Potentially Preventable Readmissions:** a hospital must report if there are at least 40 initial admissions, at least 5 actual readmissions, and at least 5 expected readmissions.
- **Potentially Preventable Admissions:** a hospital must report if there are at least 5 hospital discharges.
- **Potentially Preventable Complications:** a hospital may be exempt based on a measure-by-measure basis; however, a hospital is not exempt from all PPC reporting.
- **Emergency Department:** there are no reporting exemptions; however, if there are less than 30 cases, the hospital would not be included in statewide reporting.
- **Patient Centered Healthcare:** there are no reporting exemptions; however if there are less than 30 cases, the hospital would not be included in statewide reporting.

Section VI: RHP Participation Certifications:

To be completed by Performing Providers, IGT Entities, UC-only hospitals, and Anchor

HHSC leaves it to participants to determine who is eligible to sign this section. If an entity identifies a representative who can sign off on the included statements, that will be acceptable.

Section VII: Addendums:

If a Performing Provider has complied with the following requirements in their Uncompensated Care (UC) application submission, then these documents do not need to be resubmitted with the RHP Plan. Affiliations must be executed by October 26, 2012 for DY 1 UC payments.

Private Hospitals:

Private hospitals are subject to eligibility requirements in addition to those applicable to public hospitals. See 1 Tex. Admin. Code § 355.8201(c)(1)(C). In particular, to be eligible for any type of waiver payment, private hospitals must submit to HHSC an indigent care affiliation agreement and forms certifying certain information regarding funding for the hospital's payments. These forms must be submitted to HHSC prior to a hospital receiving a waiver payment.

- HHSC defines "private hospital" in its Hospital Waiver Payment rule as a hospital "that is not owned or operated by a governmental entity." See 1 Tex. Admin. Code § 355.8201(b) (11).
- The term "owned" is not defined in the rule. HHSC has determined that hospital ownership is determined by which entity directly receives the Medicaid-claims payments, prior to any assignment of the payment. Consequently, where a governmental entity leases the operation of its facility to a private entity and the private operator receives the Medicaid claims payments directly, HHSC considers the hospital a "private hospital" subject to the additional eligibility requirements for receiving waiver payments.
- Hospitals that meet this definition of "private hospital" that previously participated in public upper payment limit (UPL) programs were not subject to these requirements in those programs. However, such hospitals are required to meet the eligibility requirements for waiver payments.

Affiliation agreements

- An indigent care affiliation agreement is a contract between one or more hospitals and one or more governmental entities to collaborate on the funding for and provision of health care to indigent individuals in a community or region of Texas.
- HHSC does not prescribe the form of affiliation agreements.
- Private hospitals receiving transition payments may rely on the affiliation agreements already on file with HHSC, so long as the parties to the agreement have not changed.
- The hospital's participation in a Regional Healthcare Partnership plan is not a substitute for submission of the affiliation agreement.
- Non-hospital Performing Providers do not need affiliation agreements and certifications. HHSC only needs an Indigent Care Affiliation Agreement & Certification Form (private & government) if a private hospital is entering into an affiliation with a governmental entity (e.g. county, hospital district, city).

Certifications

- Every private hospital and the governmental entity or entities that will provide the non-federal share of waiver payments to that hospital must execute certification documents in the form prescribed by HHSC.
- Certification forms are posted on [HHSC's website](#).
- Private hospitals that received UPL or transition payments **may not** rely on the forms previously submitted to HHSC.

Private Physician Group Practices:

Private physician group practices are subject to eligibility requirements in addition to those applicable to publicly-owned group practices. *See 1 Tex. Admin. Code § 355.8202(c)(3)*. In particular, to be eligible for any type of waiver payment, private physician group practices must submit to HHSC forms certifying certain information regarding funding for the physician group practice's payments. These forms must be submitted to HHSC prior to the group practice receiving a waiver payment.

- The private physician group practice and the governmental entity or entities that will provide the non-federal share of waiver payments to that practice must execute certification documents in the form prescribed by HHSC.
- Certification forms are posted on [HHSC's website](#).
- Private physician practice groups that received UPL or transition payments **may not** rely on the forms previously submitted to HHSC.

Electronic Workbook:

To minimize technical issues with the electronic workbook, please adhere to the following:

- Do not rename the workbook file or the tabs within the workbook.
- Do not select to end the macro before it has been completed.
- Enter data in the yellow cells. The other cells have been locked from editing to ensure the data correctly populates the workbook. If you are asked for a password, it is likely that you were trying to enter data in a cell that is not yellow.