Texas Transformation and Quality Improvement Program 1115 Waiver
Draft Program Funding and Mechanics Protocol
May 16, 2012

The following draft Program Funding and Mechanics Protocol is the State's working document for Delivery System Reform Incentive Payment (DSRIP) requirements. **The draft protocol is based on HHSC's developing approach and is subject to change based on feedback from Texas stakeholders, HHSC leadership and the Centers for Medicare & Medicaid Services (CMS). CMS must approve the protocol before Texas regions can move forward with DSRIP projects.** The draft protocol outlines the minimum number of projects, organization of the Regional Healthcare Partnership (RHP) Plan, plan review process, required reporting, allocation of available pool funds, valuation of projects, disbursement of funds, and plan modifications. While the entire protocol is subject to change, HHSC is unsure whether CMS will approve the State's proposed approach to the following items outlined in the draft protocol based on discussions to date: DSRIP requirements to be eligible for Uncompensated Care (UC) payments, UC and DSRIP allocation methodology, methodology for allocating funding among DSRIP Categories, the minimum number of projects, valuation of projects, and variation of requirements across regions.

HHSC will continue to refine requirements to meet stakeholders' needs and negotiate with CMS to obtain federal approval of the protocol by July 2012. The Program Funding and Mechanics Protocol along with the RHP Planning Protocol (DSRIP menu) serve as the basis for RHP Plan development. Texas Administrative Code rules related to DSRIP requirements and the protocols will be expedited this summer for an effective date of August 31, 2012.

HHSC is seeking public feedback on the draft Program Funding and Mechanics Protocol by **Thursday, May 31, 2012.** Comments submitted using the *Draft Program Funding and Mechanics Protocol – Feedback Form* will be considered prior to submission to CMS in June 2012.

Program Funding and Mechanics Principles
In developing the draft Program Funding and Mechanics Protocol, HHSC considered the following principles:

- Ensure compatibility with the 1115 Waiver Standard Terms and Conditions (STCs).
- Ensure flexibility to account for the variability of Texas RHPs in geographic size, number and types of participating Intergovernmental Transfer (IGT) Entities and Performing Providers, local healthcare needs, and available funding.
- Encourage broad provider participation in DSRIP including public and private providers.
- Maximize available pool funding while ensuring equity across RHPs.
- Provide standardization for valuing projects while allowing flexibility for local differences.
- Minimize administrative burden at the local and state level.

Summary of Draft DSRIP Requirements Included in the Protocol
This is the State's DRAFT proposed approach; however, many items are under development, including DSRIP requirements to be eligible for UC payments, UC and DSRIP allocation methodology, the methodology for allocating funding among DSRIP Categories, the minimum number of projects, valuation of projects, and variation of requirements across regions.

- All Performing Providers eligible for DSRIP must have a Medicaid provider identification number.
- Local mental health authorities (LMHAs) and academic health science centers are among the non-hospital entities that are eligible to participate as Performing Providers in DSRIP and serve as the IGT Entity.
- Allocation of DY1 DSRIP funds among RHPs is based on percent of Texas' low income population and historical FFY2011 Intergovernmental Transfers (IGT). Allocation of DY2-5 pool funds among RHPs is under development; however, HHSC is considering using the same factors as DY1. An RHP may exceed its pool allocation under certain circumstances; however, HHSC must ensure that the annual statewide UC and DSRIP pool amounts are not exceeded.
- IGT allocation within an RHP should be divided among the UC and DSRIP pools according to the benchmark percentages specified in the STCs.
- Allocation of DSRIP funding within an RHP among the four DSRIP Categories and valuation of DSRIP projects are under development.
- Minimum number of projects:
    - Each urban RHP must implement at least five Category 1 and Category 2 projects combined with at least two of the five projects from Category 2.
    - Each rural RHP must select at least two Category 1 and Category 2 projects combined with at least one project from each category.
    - Each hospital participating in DSRIP must include one common Category 3 intervention that is selected by the State and one additional Category 3 intervention that is selected by the hospital.
    - Each hospital participating in DSRIP must report on all Category 4 measures beginning in DY3.
    - Each hospital participating in DSRIP must participate in Categories 1, 3, and 4; Categories 2, 3, and 4; or Categories 1, 2, 3, and 4.
- Incentive payments are based on reported achievement of milestones. Partial achievement will be eligible for partial payment based on a milestone bundling methodology. Incentive payments for late milestone achievement are available until the end of the following demonstration year in which the milestone was initially planned; however, there is a penalty for late performance.
- Semi-annual reporting of progress is required to be eligible for incentive payments twice a year. IGT entities must confirm reports from Performing Providers.
- Modifications to RHP Plans will be allowed in DY2 for DY3-5 implementation and DY3 for DY4-5 implementation. Modifications are allowed for addition of new Performing Providers, new IGT Entities, and/or new projects selected from the DSRIP menu. A mid-point assessment is also being considered.

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Attachment J:
Texas DSRIP Program Funding and Mechanics Protocol

I. PREFACE

On December 12, 2011, the Centers for Medicare and Medicaid Services approved the Texas request for a new Medicaid waiver demonstration entitled "Texas Healthcare Transformation and Quality Improvement Program" (Project # 11-W-00278/6) in accordance with section 1115 of the Social Security Act. The new waiver was approved through September 30, 2016.

1. Delivery System Reform Incentive Payment Program

STC 45 of the Demonstration authorizes Texas to establish a Delivery System Reform Incentive Payment (DSRIP) program. Initiatives under the DSRIP program are designed to provide incentive payments to hospitals and other providers for investments in delivery system reforms that increase access to health care, improve the quality of care, and enhance the health of patients and families they serve.

The program of activity funded by the DSRIP shall be based on Regional Healthcare Partnerships (RHPs). Each RHP shall have geographic boundaries and will be coordinated by a public hospital or local governmental entity with the authority to make intergovernmental transfers. The public hospital or local governmental entity shall collaborate with hospitals and other potential providers to develop a DSRIP RHP plan that will accelerate meaningful delivery system reform improvements within the providers participating in the RHP.

The RHP plans must be consistent with regional shared mission and quality goals of the RHP and CMS's triple aims to improve care for individuals (including access to care, quality of care, and health outcomes); improve health for the population; and lower costs through improvements (without any harm whatsoever to individuals, families, or communities).

2. RHP Planning Protocol and Program Funding and Mechanics Protocol

In accordance with STC 45(a) and 45(d)(ii)(A) & (B), the RHP Planning Protocol (Attachment I) defines the specific initiatives that will align with the following four categories: (1) Infrastructure Development; (2) Program Innovation and Redesign; (3) Quality Improvements; and (4) Population-focused Improvements. The Program Funding and Mechanics Protocol (Attachment J) describes the State and CMS review process for RHP plans, incentive payment methodologies, RHP and State reporting requirements, and penalties for missed milestones.

Following CMS approval of Attachment I and Attachment J, each RHP must submit a DSRIP Plan that identifies the projects, population-focused objectives, and specific milestones and metrics in accordance with these attachments and STCs.

3. Organization of "Attachment J: Program Funding and Mechanics Protocol"

Attachment J has been organized into the following sections:

I. Preface
II. DSRIP Eligibility Criteria
III. Key Elements of Proposed DSRIP Plans
IV. State and Federal Review Process of DSRIP Plans

II. DSRIP ELIGIBILITY CRITERIA

4. RHP Regions

Texas has approved the following 20 Regional Healthcare Partnerships whose members may participate in DSRIP program. The approved RHPs share the following characteristics:

- They are based on distinct geographic boundaries that reflect patient flow patterns for the region;
- They have identified local funding sources to help finance the non-federal share of DSRIP payments for their RHP; and
- They have identified an Anchoring Entity to help coordinate the development of an RHP plan and DSRIP activities.

RHPs may vary in size, demographics, number and types of providers, and by available financing. The approved RHPs include:

[List regions and add an attachment/map]

5. RHP Anchoring Entity

Each RHP shall have one Anchoring Entity that coordinates the development of the DSRIP RHP plan for that region. In RHP regions that have a public hospital, a public hospital shall serve as the Anchoring Entity. In regions without a public hospital, the following entities may serve as anchors: (1) a hospital district; (2) a hospital authority; (3) a county; or (4) a State university with a health science center or medical school.

RHP Anchoring Entities shall be responsible for coordinating the following activities:

- Developing and analyzing community needs assessment for the region;
- Engaging stakeholders in the region, including the public;
- Developing the 4-year DSRIP RHP plan in collaboration with local IGT entities and Performing Providers;
- Ongoing communication with HHSC;
- Ongoing communication with IGT Entities financing the non-federal share of DSRIP payments in the region and Performing Providers;
- Ongoing monitoring and reporting to HHSC on status of projects and performance of Performing Providers in the region;
- Ensuring the number of projects from each Category as required by region is met;
- Ensuring that the RHP's DSRIP plan is consistent with the protocol's Uncompensated Care and DSRIP allocation requirements; and

- Facilitating compliance with the RHP Plan Checklist, as presented in Attachment K.

6. IGT Entities

a. Description

Intergovernmental transfer (IGT) Entities are entities that fund the non-federal share of DSRIP payments for an RHP. They include Anchoring Entities, government-owned Performing Providers, and other government entities such as counties.

b. Funding DSRIP payments outside of the IGT Entity's geographic region.

An IGT Entity may fund the non-federal share of DSRIP payments for an RHP project outside of its geographic region if the case is supported by patient flow patterns. For example, an IGT Entity may help fund DSRIP payments for a DSRIP project involving a specialty provider (e.g., children's hospital or trauma hospital) in a region that receives regular patient referrals from the IGT Entity's region. In these cases, the project and DSRIP payments are documented in the RHP plan where the Performing Provider and DSRIP project is physically located.

7. Performing Providers

Providers that are responsible for performing a project in a DSRIP RHP plan are called "Performing Providers." All Performing Providers must have a current Medicaid provider identification number. Performing Providers that complete RHP project milestones as specified in this protocol are the only entities that are eligible to receive incentive payments under DSRIP. Performing Providers will primarily be hospitals, however other types of providers approved by the State and CMS may also participate.

8. DSRIP and Uncompensated Care Pool

a. UC Pool Description

STC 44 establishes an Uncompensated Care Pool to help defray uncompensated care costs provided to Medicaid eligibles or to individuals who have no source of third party coverage, for services provided by hospitals or other selected providers.

b. DSRIP Requirements for UC Pool Program Participants

Under development.

III. KEY ELEMENTS OF PROPOSED DSRIP PLANS

9. RHP Specific DSRIP Plans

Each RHP must submit a DSRIP plan using a State- approved template that identifies the projects, objectives, and specific milestones, metrics, measures, and associated DSRIP values adopted from Attachment I (RHP Planning Protocol) and meet all requirements pursuant to STCs 45 and 46.

10. Organization of DSRIP Plan

a. Executive Summary

The Executive Summary shall provide a summary of the RHP plan, a summary of the RHP's vision of delivery system transformation, a summary of the RHP's community context, a description of the RHP's patient population, a description of the health system, and a table of projects including project titles, brief descriptions of the projects, and the four-year goals. The Executive Summary shall also include a description of key challenges facing the RHP and how the four-year DSRIP plan realizes the RHP's vision.

b. Description of RHP Organization

The DSRIP plan shall describe how the RHP is organized and include information on RHP participants including the Anchoring Entity, IGT Entities, Performing Providers, and other stakeholders.

c. Community Needs Assessment

The DSRIP plan shall include a community needs assessment that has the following elements for the region:

i. Demographic information (e.g., race/ethnicity, income, education, employment, etc.)
ii. Insurance coverage (e.g., commercial, Medicaid, Medicare, uncompensated care);
iii. Description of the region's current health care infrastructure and environment (e.g., number/types of providers, services, systems, and costs; Health Professional Shortage Area [HPSA]);
iv. Description of changes in the above areas, i. – iii, expected to occur during the waiver period of FFYs 2012 – 16.
v. Key health challenges specific to the region (e.g., high diabetes rates, access issues, high ER utilization, etc.)

The RHP's community needs assessment should inform the DSRIP plan and selection of projects.

d. Stakeholder Engagement

The DSRIP plan shall include a description of the processes used to engage and reach out to the following stakeholders regarding the DSRIP program:

i. Hospitals and other providers in the region.
ii. The general public, including processes used to solicit public input into DSRIP plan development and opportunities for public discussion and review prior to plan submission.
iii. A plan for ongoing engagement with public stakeholders.

11. **Number of Projects**

RHPs must select a minimum number of projects from Categories 1, 2, and 3, and Reporting Measures from Category 4 pursuant to Attachment I ("RHP Planning Protocol"). The number of minimum projects will differ for urban and rural RHPs:

a. Definitions

i. Urban area
An urban RHP is defined as an RHP that contains at least all or part of one or more Metropolitan Statistical Areas (MSA) as defined by the U.S. Office of Management and Budget.

ii. Rural area
A rural RHP is defined as an RHP that does not contain any part of an MSA.

b. Categories 1 and 2 Projects

i. RHP in an Urban Area
An RHP located in an urban area must select a minimum of five projects from Categories 1 and 2 combined, with at least 2 of the 5 projects selected from Category 2 in accordance with Attachment I (RHP Planning Protocol), which lists the acceptable projects, milestones, metrics, and data sources.

ii. RHP in a Rural Area
An RHP located in a rural area must select a minimum of two projects from Categories 1 and 2 combined, with at least 1 of the projects selected from Category 2 in accordance with Attachment I (RHP Planning Protocol), which lists the acceptable projects, milestones, metrics, and data sources.

iii. Performing Provider Participation in Categories 1 and 2
1) A Performing Provider in an RHP plan must, at a minimum, participate in a project(s) from either Category 1 or Category 2, and if it chooses to, may participate in projects from both Categories; and
2) Performing Providers in the same RHP may adopt the same project; however, the RHP plan must assure that the incentive payments made to these providers are in no way duplicative.

c. Category 3
Pursuant to STC 45(d)(ii)(A), all DSRIP participating hospitals must report on a core set of Category 3 milestones. In accordance with this requirement, hospital-based Performing Providers in all RHPs must:

i. Implement one common Category 3 intervention identified in the Attachment I (RHP Planning Protocol).

ii. Select one additional Category 3 intervention from within the superset of Category 3 interventions in the RHP Planning Protocol. For its 1 additional intervention, a

hospital-based Performing Provider is precluded from choosing an intervention for which it has achieved top performance for at least 4 consecutive quarters prior to approval of the waiver on December 12, 2011, in aggregate in all process and outcomes measures within the intervention, as defined by Category 3 in the RHP Planning Protocol.

d. Category 4

Pursuant to STC 45(d)(ii)(A), all DSRIP participating hospitals must report on a core set of Category 4 measures. In accordance with this requirement, beginning in DY 3 (FFY 13) hospital-based Performing Providers in all RHPs must include reporting of all core measures, pursuant to Attachment I, "RHP Planning Protocol".

i. Exemptions to Category 4 reporting requirements.

DSRIP hospitals that meet the criteria below and as approved by the State are exempt from Category 4 reporting requirements:

A hospital is located in a county that:

(1) has a population estimated by the United States Bureau of the Census to be not more than 35,000 as of July 1 of the most recent year for which county population estimates have been published; or

(2) has a population of more than 35,000, but that does not have more than 100 licensed hospital beds and is not located in an area that is delineated as an urbanized area by the United States Bureau of the Census; and

(3) is not a state-owned hospital or a hospital that is managed or directly or indirectly owned by an individual, association, partnership, corporation, or other legal entity that owns or manages one or more other hospitals.

12. Organization of RHP Projects

a. Categories 1-4 Descriptions

The DSRIP four-year plan will include sections on each of the 4 categories as specified in the RHP Planning Protocol. They include:

i. Category 1 Infrastructure Development lays the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.

ii. Category 2 Program Innovation and Redesign includes the piloting, testing, and replicating of innovative care models.

iii. Category 3 Quality Improvements is broad dissemination of a set of interventions in which major improvements in care can be achieved within 4 years.

iv. Category 4 Population Focused Improvements is the reporting of measures that demonstrate the impact of delivery system reform investments under the waiver.

b. Categories 1-3 Requirements

For each project selected from Category 1, 2, and 3, DSRIP Plans must include a narrative that includes the following subsections:

i. Identifying information
Identification of the DSRIP Category, name of the project/intervention, and RHP Performing Provider name and Texas Provider Identifier (TPI) involved with the project.

ii. Project Goal
The goal(s) for the project, which describes the challenges or issues of the Performing Provider and brief description of the major delivery system solution identified to address those challenges by implementing the particular project or intervention; the starting point of the Performing Provider related to the project or intervention and based on that, the 4-year expected outcome for the Performing Provider and the patients.

iii. Rationale
As part of this subsection, each Performing Provider will provide the reasons for selecting the project or intervention, milestones, and metrics based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point.

iv. Relationship to Other Projects
A description of how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP Plan.

v. Milestones and Metrics Table
For each project, DSRIP plans shall include milestones and metrics adopted in accordance with Attachment I, "RHP Planning Protocol." In a table format, the DSRIP Plan will indicate by demonstration year when project milestones will be achieved and indicate the data source that will be used to document and verify achievement.

a) For each project from Category 1 and 2, the Performing Provider must include at least 1 milestone based on a Process Measure and at least 1 milestone based on an Improvement Measure over the 4-year period in accordance with Attachment J, "RHP Planning Protocol."
b) For each intervention from Category 3, a Performing Provider shall establish improvement targets to be achieved over the DYs 2-5 period.
c) For each milestone, the estimated DSRIP funding must be identified as the maximum amount that can be received for achieving the milestone.
d) For each year, the estimated available non-federal share must be included and the source of non-federal share identified.

c. Category 4 Requirements

This focus area involves population-focused improvements associated with Categories 1, 2, and 3 projects. Each participating hospital shall report on a core set of comment measures pursuant to Attachment I ("RHP Planning Protocol"). DSRIP Plans must include:

i. Identifying information
Identification of the DSRIP Category 4 measures and RHP Performing Provider name and Texas Provider Identifier (TPI) that is reporting the measure.

ii. Narrative description
A narrative description of the Category 4 measures and how the measures relate to project(s) and interventions in Categories 1, 2, or 3 within the RHP's DSRIP Plan.

iii. Table Presentation
In a table format, the DSRIP Plan will include, starting in demonstration year 3:

a) List of Category 4 measures the Performing Provider will report on;
b) For each measure, the estimated DSRIP funding must be identified as the maximum amount that can be received for reporting on the measure.
c) For each year, the estimated available non-federal share must be included and the source of non-federal share identified.

IV. STATE AND FEDERAL REVIEW PROCESS OF DSRIP PLANS

13. Review Process

The Texas Health and Human Services Commission (HHSC) will review all 4-year DSRIP plan proposals prior to submission to CMS for final approval according to the schedule below. The schedule is based on submission of the State's RHP Planning Protocol (Attachment I) and Program Funding and Mechanics Protocol (Attachment J) to CMS by June 15, 2012, and June 29, 2012, respectively, with anticipated approval by CMS within 30 days of receipt.

The HHSC and CMS review process for 4-year DSRIP plan proposals shall include the following schedule:

14. HHSC Review and Approval Process

a. HHSC Review of Plans

i. By September 1, 2012, each RHP identified in Section II.4 ("RHP Regions") above will submit a 4-year DSRIP plan proposal to HHSC for review. HHSC shall review and assess each plan according to the following criteria:

- The plan is in the format and contains all required elements described herein and is consistent with special terms and conditions, including STCs 45(a), 45(b), 45(c), and 45(d)(iii).
- The plan conforms to the requirements for Categories 1, 2, 3, and 4, as described in Section III ("Key Elements of Proposed DSRIP Plans" above), Attachment I, "RHP Planning Protocol", and Attachment K, "RHP Plan Checklist."
- Category 1, 2, and 3 projects clearly identify goals, milestones, metrics, and expected results. Category 4 clearly identifies the population-focused health improvement measures to be reported.

- The amount and distribution of funding is in accordance with the stipulations of STC 46 and Section VI of this protocol.
- The plan and all of the projects within are consistent with the overall goals of the DSRIP program.

ii. By September 30, 2012, HHSC will complete its initial review of each timely submitted DSRIP plan proposal using the RHP Plan Checklist and based on the Program Funding and Mechanics Protocol and RHP Planning Protocol and will notify the RHP Anchoring Entity in writing of any questions or concerns identified.

iii. The RHP Anchoring Entity shall respond in writing to any notification by HHSC of questions or concerns. The RHP's responses must be received by the date specified in the aforementioned notification. The RHP Anchoring Entity's initial response may consist of a request for additional time to address HHSC's comments provided that the RHP's revised plan addresses HHSC's comments and is submitted to HHSC by October 15, 2012.

b. HHSC Approval of Plans

By October 31, 2012, HHSC will take action on each timely submitted revised DSRIP plan, will approve each such plan that it deems meets the criteria outlined in Attachment I ("RHP Planning Protocol"), Attachment J ("Program and Funding Protocol"), and Attachment K ("RHP Plan Checklist") and submit approved plans to CMS for final review and approval.

15. **CMS Review and Approval Process**

CMS will review each RHP's 4-year DSRIP plan upon receipt of the plan as approved by HHSC. Plans reviewed and approved by HHSC will result in approval by CMS within 45 days of receipt from HHSC, provided the plan(s) meet all DSRIP requirements as outlined in Section III and Attachment I, "RHP Planning Protocol."

Within 45 days of receipt of RHP DSRIP plans (on or about December 15, 2012) from HHSC, CMS will complete its review of each plan and will either:

- Approve the plan; or
- Notify HHSC and the Anchoring Entity if approval will not be granted for a component of the RHP plan. Notice will be in writing and will include any questions, concerns, or issues identified in the application.

RHPs shall develop an acceptable revision to a project for any components of the plan identified by CMS as not approvable. By January 15, 2013, HHSC shall submit revised DSRIP plans to CMS and CMS shall approve or deny the plans in writing to HHSC and the RHP Anchoring Entity by February 1, 2013.

V. RHP AND STATE REPORTING REQUIREMENTS

16. **RHP Reporting for Payment in DY 1**

a. RHP DSRIP Plan Submission
Submission of a DSRIP plan to CMS by October 31, 2012, shall serve as the basis for the full DY 1 payment to the Performing Providers, as prescribed by Section VI. ("Disbursement of DSRIP Funds"). HHSC shall schedule initial payment transaction within 30 days following an RHP's plan submission to CMS.

b. DSRIP Plans Not Approved by CMS by February 1, 2013
All Performing Providers in an RHP whose DSRIP plan is not approved in full by CMS shall be at risk for recoupment of their entire DY 1 incentive payment related to plan submission. Within 10 business days of CMS written denial of a DSRIP plan, the State shall take steps to recoup the DY 1 payment from all Performing Providers in the affected RHP. The recouped DY 1 payment shall be made available to the Performing Providers again after full approval of the DSRIP plan by CMS is attained.

17. **RHP Reporting for Payment in DYs 2-5**

Two times per year, Performing Providers seeking payment under the DSRIP shall submit reports to HHSC demonstrating progress on each project for which they are a Performing Provider, as measured by category-specific milestones achieved during the reporting period. The reports shall be submitted using the standardized reporting form approved by HHSC. Based on the reports, HHSC will calculate the incentive payments for the progress achieved in accordance with Section VI ("Disbursement of DSRIP Funds"). The Performing Provider shall have available for review by Texas or CMS, upon request, all supporting data and back-up documentation. These reports will be due as indicated below after the end of each reporting period:

- Reporting period of October 1 through March 31: the reporting and request for payment is due April 30.
- Reporting period of April 1 through September 30: the reporting and request for payment is due October 31.

These reports will serve as the basis for authorizing incentive payments to Performing Providers in an RHP for achievement of DSRIP milestones. HHSC shall schedule the payment transaction for each RHP Performing Provider within 30 days following HHSC approval of the RHP report.

18. **Intergovernmental Transfer Process**

a. Within 14 days after notification by HHSC of the required nonfederal share amount, the IGT Entity will make an intergovernmental transfer of funds equal to the nonfederal share (as determined by HHSC) that is necessary to draw the federal funding for the incentive payments related to the milestone achievement that is reported by the Performing Provider in accordance with paragraph 17 and approved by the IGT Entity and the State. The State will draw the federal funding and pay both the nonfederal and federal shares of the incentive payment to the Performing Provider. If the IGT is made within the appropriate 14 day timeframe, the incentive payment will be disbursed within 7 days; otherwise the payment will be disbursed within 14 days of when the transfer is made. The total computable payment must remain with the Performing Provider.

b. If only a portion of the required IGT is transferred, incentive payments calculated and validated in the report for payment in accordance with paragraph 17 and Section VI shall be adjusted accordingly for each Performing Provider affiliated with the IGT Entity that has completed a DSRIP milestone. The affected Performing Provider(s) will receive a portion of the value associated with the milestone that is proportionate to the total value of all projects or quality measures that are completed for that period by the Performing Provider affiliated with that IGT Entity.
c. Shortfalls in IGT can be made up at the time of the final DSRIP payment for the demonstration year in question.

19. **Year-end Payment Reconciliation**

Under development

20. **RHP Annual Year End Report**

Each RHP Anchoring Entity shall submit an annual report by December 15 following the end of Demonstration Years 2-5. The annual report shall be prepared and submitted using the standardized reporting form approved by HHSC. The report will include information provided in the interim reports previously submitted for the Demonstration Year, including data on the progress made for all metrics. Additionally, the RHP will provide a narrative description of the progress made, lessons learned, challenges faced, and other pertinent findings. The Performing Providers shall have available for review by the HHSC and CMS, upon request, all supporting data and back-up documentation.

21. **Texas Reporting to CMS**

a. Quarterly and Annual Reporting

DSRIP will be a component of the State's quarterly operational reports and annual reports related to the Demonstration. These reports will include:

i. All DSRIP payments made to Performing Providers that occurred in the quarter;
ii. Expenditure projections reflecting the expected pace of future disbursements for each RHP and Performing Providers; and
iii. A summary assessment of each RHP' DSRIP activities during the given period;
iv. Evaluation activities and interim findings for the evaluation design pursuant to STC 68.

b. Claiming Federal Financial Participation

Texas will claim federal financial participation (FFP) for DSRIP incentive payments on the CMS 64.9 waiver form on a quarterly basis. FFP will be available only for DSRIP payments made in accordance with all pertinent STCs and Attachment I ("RHP Planning Protocol") and Attachment J ("Program Funding and Mechanics Protocol"). Texas and the Performing Providers shall have available for review by CMS, upon request, all supporting data and back-up documentation.

VI. DISBURSEMENT OF DSRIP FUNDS

22. Eligibility for DSRIP Incentive Payments

Each Performing Provider will be individually responsible for progress towards and achievement of its milestone bundles in all categories as defined in the RHP's approved DSRIP plan. As outlined in Section V ("RHP and State Reporting Requirements"), Performing Providers will be eligible to receive DSRIP incentive payments related to achievement of their milestone bundles and Category 4 measures upon submission and approval of the required reports for payment.

23. DY 1 DSRIP Payment

a. Basis for DY 1 DSRIP Payment

An RHP Plan refers to the combined submission of all the individual IGT Entity-Performing Provider DSRIP projects. An RHP Plan submission by the State to CMS is considered a milestone and will serve as the basis for full annual DSRIP payment in DY 1.

b. Formula Allocation of DY 1 DSRIP Funding Among RHP Regions
Under Development

HHSC proposes to allocate DY 1 DSRIP Funding to RHP Regions based on two factors:

(1) A RHP's region's percent of low-income individuals (with income below 200 percent of the federal poverty level) out of the total number of low-income individuals in the state; and
(2) A RHP region's percent of historical IGT for UPL in FFY2011 compared to the rest of state.

The resulting percentages by RHP Region for these two factors are presented in Table 1 below. The information presented below is based on the RHP Region Map issued on May 11, 2012.

HHSC is considering different approaches to use the percentages derived for the two factors to develop an allocation percentage of DY 1 DSRIP Funding for each RHP Region.

Table 1: Percent of Population Under 200% of Poverty and Percent of FFY2011 IGT by RHP to Determine Pool Allocation Percent

RHP	Population Under 200% of Poverty (2006-2010)[1]	Percent Share of Population Under 200% of Poverty	FFY2011 IGT for UPL[2]	Percent Share of FFY2011 IGT for UPL
1	477,907	5.34%	$16,348,344	1.75%
2	460,903	5.15%	$21,870,084	2.34%
3	1,711,685	19.11%	$222,197,202	23.79%
4	283,440	3.16%	$58,235,733	6.24%

RHP	Population Under 200% of Poverty (2006-2010)[1]	Percent Share of Population Under 200% of Poverty	FFY2011 IGT for UPL[2]	Percent Share of FFY2011 IGT for UPL
5	750,365	8.38%	$11,168,121	1.20%
6	841,313	9.39%	$101,212,944	10.84%
7	419,641	4.68%	$61,900,179	6.63%
8	386,401	4.31%	$9,592,607	1.03%
9	969,575	10.82%	$149,111,665	15.96%
10	738,540	8.25%	$145,739,256	15.60%
11	121,964	1.36%	$10,466,380	1.12%
12	195,344	2.18%	$24,307,879	2.60%
13	68,590	0.77%	$5,258,527	0.56%
14	136,931	1.53%	$31,274,932	3.35%
15	405,446	4.53%	$37,467,136	4.01%
16	144,083	1.61%	$8,954,546	0.96%
17	262,327	2.93%	$7,522,963	0.81%
18	319,001	3.56%	$2,789,834	0.30%
19	78,902	0.88%	$6,852,438	0.73%
20	184,927	2.06%	$1,728,843	0.19%
State Total	8,957,285	100%	$933,999,614	100%

[1] Source: U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS).
[2] IGT for FFY2011 former UPL Programs: Large Urban, Rural Inpatient and Outpatient, Private, State, and Physician. Estimated IGT for Children's UPL program for FFY2012 is included.

c. DY 1 RHP Allocation Formula for Performing Providers

The DY 1 DSRIP funding amount allocated to an RHP shall be distributed to Performing Providers based on a formula. The formula divides an RHP DSRIP plan's estimated dollar value of a Performing Provider's DSRIP projects in Categories 1-4 over the DY 2-5 period by the total value of the RHP's DSRIP projects over the DY 2-5 period. The resulting percentage is then multiplied by the RHP's DY 1 DSRIP amount to determine the DY 1 DSRIP payment for the Performing Provider.

Example:

- An RHP reports a total DSRIP valuation of projects in DY 2-4 to equal $500 million across 10 Performing Providers.
- Performing Provider "A's DSRIP valuation for projects over the 4-year period in the RHP is $50 million, or 10 percent of the total DSRIP valuation.
- The RHP's DY 1 DSRIP amount is $20 million. Based on the formula, Performing Provider "A" would be eligible to receive $2 million or 10 percent of the total DY 1 DSRIP payment amount.

The RHP Plan submission must identify the Performing Providers eligible to receive DY1 DSRIP, the estimated DY1 DSRIP funding for each Performing Provider, and the IGT Entity providing the IGT for the DY1 DSRIP for each Performing Provider.

24. DSRIP Incentive Payments in DYs 2-5

a. RHP Allocation Methodology in DYs 2-5

Under development, however, HHSC is considering using the same factors described in 23b above to distribute total UC and DSRIP dollars among RHP regions in DYs 2-5.

Each RHP may submit an RHP Plan which exceeds the maximum pool allocation for the region for DY 2-5, if the RHP identifies more IGT than the amount required for the region's maximum pool allocation, subject to State approval. The State must ensure that the annual statewide UC and DSRIP pool amounts are not exceeded and may request adjustments to RHP Plans during the review process stated in Section IV before granting approval.

b. Benchmark Payment Variation for Uncompensated Care and DSRIP

Under development –HHSC is considering various ways to incentivize meaningful participation in DSRIP, such as a percent variation from the UC and DSRIP pool allocation. An example of this approach is described below:

Payments for Uncompensated Care and DSRIP in a RHP Region shall be proportional and must be within established percentage bands identified in Table 3 below. The percent allocations in Table 3 shall serve as a benchmark for Uncompensated Care (UC) payments and DSRIP payments by demonstration year for a RHP Region.

Table 3: Benchmark Payment Variation by RHP for Uncompensated Care and DSRIP in DYs 2-5

	DY2	DY3	DY4	DY5	Total
% UC	63%	57%	54%	50%	60%
% DSRIP	37%	43%	46%	50%	40%

25. DSRIP Incentive Payment Formula by DSRIP Category

Under development.

This section will include the valuation parameters such as required allocation of funding among DSRIP Categories by demonstration year and factors used to determine values for each project/intervention (e.g. California 1115 Waiver, Attachment P includes Categories 1 and 2 "Rules of the Road", Categories 3 and 4 used formulas with a base amount and other multiplying factors).

26. Payment Based on Achievement of Milestone Bundles

The amount of the incentive funding paid to a Performing Provider will be based on the amount of progress made within each specific milestone bundle. For each milestone within the bundle, the Performing Provider will include in the RHP semi-annual report the progress achieved toward that milestone's target. Based on the progress reported, each milestone will be

categorized as of the following to determine the total achievement value for the milestone bundle:

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

The achievement values for each milestone in the bundle will be summed together to determine the total achievement value for the milestone bundle. The Performing Provider is then eligible to receive an amount of incentive funding for that milestone bundle determined by multiplying the total amount of funding related to that bundle by the result of dividing the total possible achievement value by the reported achievement value. If a Performing Provider has previously reported progress in a bundle and received partial funding, only the additional amount it is eligible for will be disbursed. (See example below of disbursement calculation)

Example of disbursement calculation

Milestone Bundle A (5 milestones = maximum achievement value of 5; Total funding related to Bundle $30 million)

Hospital system reports the following progress at 6 months:

Milestone 1: 100 percent achievement (achievement value = 1)
Milestone 2: 85 percent achievement (achievement value = .75)
Milestone 3: 40 percent achievement (achievement value = .25)
Milestone 4: 25 percent achievement (achievement value = .25)
Milestone 5: 10 percent achievement (achievement value = 0)

Total achievement value at 6 months = 2.25
Disbursement at 6 months = $30M x (2.25/5) = $13.5M

DPH system reports the following progress at 12 months

Milestone 1: 100 percent achievement (achievement value = 1)
Milestone 2: 100 percent achievement (achievement value = 1)
Milestone 3: 90 percent achievement (achievement value = .75)
Milestone 4: 80 percent achievement (achievement value = .75)
Milestone 5: 60 percent achievement (achievement value = .5)

Total achievement value at 6 months = 4.0
Total eligible disbursement at 12 months = $30M x (4/5) = $24M
Minus 6 months disbursement of $13.5M
Total actual disbursement amount at 12 months = 24M – 13.5M = $10.5M

VII. MID-POINT ASSESSMENT AND PLAN MODIFICATION

Consistent with the recognized need to provide RHPs with flexibility to modify their plans over time and take into account evidence and learning from their own experience over time, as well as for unforeseen circumstances or other good cause, an RHP may request changes to its RHP plan through a plan modification process and /or through a mid-point assessment.

27. **Mid-Point Assessment Process**

During the last six months of DY 2, the State and RHPs will review the progress made in each category for each region. This review will provide an opportunity to modify projects and/or metrics based on learning, experience, and new evidence acquired during the DSRIP period. Revisions to a RHP plan as justified by the results of the midpoint assessment will be agreed to by CMS, the State, and the RHP, and shall reflect the plan's overall goals, and must be both practicable and achievable in the remaining demonstration waiver time period.

RHPs that make changes to their plans as a result of the Mid-Point Assessment will submit addendums to their plans specific to DY 3 through DY 5 by DATE X.

28. **Plan Modification**

An RHP may request modifications to a DSRIP plan under the following circumstances:

a. Modifications in Demonstration Year 2

An RHP may amend its plan to include new IGT entities that would fund new projects implemented by existing and/or new Performing Providers that are 3-year in duration, beginning in Demonstration Year 3. Projects added in DY 2 may be selected from Categories 1, 2, or 3 of Attachment I ("RHP Planning Protocol") and is subject to all requirements described herein and in the STCs. Newly added hospital Performing Providers may be required to report Category 4 measures according to Section III above.

b. Modifications in Demonstration Year 3

An RHP may amend its plan to include new IGT entities that would fund new projects implemented by existing and/or new Performing Providers that are 2-year in duration beginning in Demonstration Year 4. Projects added in DY 2 may be selected from Categories 2 or 3 of Attachment I ("RHP Planning Protocol") and is subject to all requirements described herein and in the STCs. The request by an RHP to add new projects of a 2-year duration is subject to the additional requirement that there is a reasonable expectation that the project can be successfully completed within this timeframe. Newly added hospital Performing Providers may be required to report Category 4 measures according to Section III above.

c. Plan Modification Review and Approval Process

Plan modifications must be submitted in writing to HHSC; HHSC shall take action on the plan modification request within 30 days and submit recommended requests to CMS. CMS shall have 30 days to review and approve a plan modification request.

VIII. CARRY-FORWARD AND PENALTIES FOR MISSED MILESTONES

29. **Carry-forward Policy**

a. Categories 1-4

If a Performing Provider does not fully achieve a milestone bundle in Categories 1-3 or a reporting measure in Category 4 that was specified in its RHP DSRIP plan for completion in a particular demonstration year, it will be able to carry forward the available incentive

funding associated with the milestone bundle until the end of the following Demonstration year during which the Performing Provider may complete the milestone and receive full payment.

30. **Penalties for Missed Milestones**

If a Performing Provider does not complete the missed milestone bundle or measure during the 12-month carry-forward period, funding for the incentive payment shall be forfeited and no longer available for use in the DSRIP program.