CMS Initial Review Findings
Companion Instructions for Resubmission to CMS

Contents

Note: Text highlighted in yellow reflects the new content that has been added to the companion document since the 5/3/13 version.

As of April 12, 2013, all RHP plans were submitted to CMS. Submission to CMS commenced a 45-day CMS initial review period for plans. All CMS initial reviews should be complete by late May 2013. This document addresses next steps for RHP anchors and providers after they have received *CMS Initial Review Findings* for their RHP. Project revisions will occur in a four-phase process.

Following initial review, most projects will have received "initial approval," which applies only to DY 2 and 3. No projects will have received approval for DY 4 and DY 5 incentive amounts. Project approval for these demonstration years, which is considered "full approval", will be based on subsequent CMS valuation review and plan revisions.

Contents of Initial Review Findings

CMS will email each RHP a PDF document with the RHP's Initial Review Findings. This CMS email will be followed as soon as possible by HHSC sending cover sheets to the RHP anchor with information specific to each project identified for Phase 1 revisions (target is one week from receiving CMS feedback).

CMS defines activities related to Categories 1, 2, 3, and 4 as separate projects. Hence, each Category 3 outcome that is related to a Category 1 or 2 project will be referenced as a separate Category 3 project. CMS will make separate determination of approval for each project; therefore, a Category 1 or 2 project could be approved but the related Category 3 project could be subject to further revision before approval. However, if a Category 1 or 2 project is not approved, the associated Category 3 project(s) also will not be approved (although the CMS letter may not necessarily state that).

The materials each RHP will receive from CMS and HHSC follow:

- *CMS Initial Review Findings:* A PDF document in which CMS organizes project-specific feedback into tables that categorize review findings as follows:
  - Table 3 – Initially approved projects
  - Table 4 – Initially approved projects with priority technical corrections
  - Table 5 – Projects initially approved, with adjustment to project value
  - Table 6 – Projects not initially approved
  - Table 7 – Category 3 projects not approved at this time

- HHSC Cover Sheets for Phase 1 Projects: A cover sheet will be provided for each project that requires revisions in Phase 1. HHSC will identify in the cover sheet the specific project issues requiring revision. Within the cover sheet, the provider will summarize the changes they have made in the project to address required revisions. When a provider submits project revisions for further review for Phase 1, the project revisions must be accompanied by the project cover sheet.

Projects only formally appear in one table in the CMS Initial Review Findings, but that does not mean the project does not have other issues. HHSC will be working with CMS to include information in the project cover sheets that identifies if a project has any issues not identified by CMS in the *Initial Review Findings*. CMS will formally issue corrections related to RHP Initial Review Findings (likely in early June) after CMS has completed initial review of all RHPs.

Four-phase revision process

Required revisions will occur in a four-phase process. The types of projects that will be addressed in each phase are described below with a reference to the corresponding table in which the projects are categorized in the *CMS Initial Review Findings* document.

PHASE 1
Revise each Phase 1 project as applicable either to receive initial approval, to justify a higher than approved project value, and/or to adjust project value to an alternate, lower amount.

Affected projects:

- Projects initially approved, with an adjustment to project value (Table 5)
- Projects not approved at this time (Table 6)
- Improvement milestones overlap with improvement targets (projects with this priority technical correction identified in Table 4)

Timeline:
The following is the standard timeline for Phase 1 projects; however, the timelines may vary by region if the RHP chooses to expedite.

- As soon as possible after each RHP receives *CMS Initial Review Findings* (the target is within one week), HHSC will provide the RHP anchor with the cover sheets for Phase 1 projects. For those projects that require Phase 1 revisions, RHPs will have **28 days** from the date they receive project cover sheets from HHSC to revise project information and re-submit Phase 1 projects to HHSC. The below information defines the timeframe for the RHP activities during this 28-day period:
    - Providers must give HHSC any information required for pre-review by CMS within **14 days.** HHSC will identify for providers those projects that require pre-review.
    - Goal of **7 days** for CMS to pre-review projects, though some may take longer.
    - Providers working through their anchors will have **7 days** after receiving CMS and HHSC comments on pre-review to revise and re-submit projects to HHSC.
- HHSC has **14 days** to review RHP project revisions and submit to CMS.
- CMS has **15 days** to review project revisions and make decisions on Phase 1 projects.

HHSC still is refining the process for submitting projects for review by CMS in weekly batches, so Phase 1 projects from a single RHP may be sent with different batches. This will allow faster feedback for providers for which the CMS pre-review or formal review can move more quickly.

Outcome of Phase 1 CMS review:

- All projects will either be initially approved for both content and value for DY2 and DY3 or not approved.
- Providers can be making other technical corrections (as identified in the CMS initial review findings or HHSC technical review) in projects they are revising in Phase 1 as long as the provider uses highlights and strikethroughs for content changed after the clean version of the plan was submitted to CMS. However, HHSC will not review technical corrections or other non-Phase 1 issues during Phase 1.
- *Replacement projects*: Providers with projects that are not approved can submit replacement projects according to the options provided in this document related to Table 6 projects.

Replacement projects can be submitted no later than July 31, 2013. CMS will have 45 days to review replacement projects, so it is of great benefit to the provider to submit replacement projects as quickly as possible. If a provider receives feedback during the pre-review that its proposed project revisions likely will not be approved but it chooses to re-submit the project anyway, the provider will not be able to submit a replacement project if the one that was formally resubmitted is disapproved. *Note: If a project is not approved after formal resubmission of Phase 1 projects, then the DY1 DSRIP associated with that project will be recouped. The DY3-5 funds associated with the project will be available to the RHP for new three-year projects to be submitted via the plan modification process before October 1, 2013.*

PHASE 2

Each region will receive one spreadsheet that lists all projects in the RHP and the associated quantifiable patient impact and Medicaid/indigent impact that HHSC has identified for each project. Providers will confirm, revise, or identify the quantifiable patient impact and Medicaid/indigent impact for each project.

Affected projects: All projects

Timeline: Spreadsheets containing quantifiable patient impact and Medicaid/indigent impact information will be distributed in May and returned to HHSC by a specific date in early to mid-June. More details will be shared soon.

PHASE 3

Providers must respond to HHSC requests to make changes to DY 2 milestones and metrics necessary to make DY 2 payments.

Affected projects: Projects with DY2 metrics identified by HHSC as needing revision in order to make DY2 payment.

Timeline:

More detailed instructions on this phase will follow soon. Provider activities related to this process will take place over the course of May to July.

PHASE 4

In this phase, providers will make priority technical corrections and Category 3 changes. As noted below, some of the priority technical corrections already will have been made in Phases 1-3. If that is the case and if they haven't already been incorporated into the project for submission, then these corrections will be added to the project for submission in Phase 4.

Affected projects: All projects

Priority technical corrections:

- Category 3 outcome does not meet criteria for one standalone or three non-standalone measures.
- Category 3 outcome duplicates an improvement milestone (must be addressed in Phase 1 by re-submitting the project).
- All project components are not included.

- Project lacks clearly defined milestones and metrics, including the lack of a quantifiable patient impact milestone for DYs 4 and 5. (For some projects, quantifiable patient information will be submitted with project changes in Phase 1; for all projects, quantifiable patient information will be verified/submitted via spreadsheet in Phase 2; and for some projects unclear DY2 metrics will be clarified via spreadsheet in Phase 3.)
- Any other priority technical correction identified by CMS or HHSC, including HHSC-identified valuation issues with Category 3 (such as an outcome target with a value of $0).

Timeline:
More detailed instructions on this phase will follow. Phase 4 revisions will be due October 1, 2013.

Background Information on State and Federal Valuation Review

HHSC flagged for valuation at the time of RHP Plan submission to CMS Category 1 and 2 projects valued at over $5 million for the four-year period from DY2 – 5 in the following instances:

- The quantifiable patient benefit was not reflected in the milestones (even if it was reflected in the summary/narrative).
    - In some of these cases, the patient benefit information already included in the summary/narrative can be added to the metrics to support project valuation.
    - In other cases, HHSC believes the project may be overvalued based on the milestones and patient scope of the project as described in the summary/narrative.
- The quantifiable patient benefit was in the milestones, but HHSC believes the project may be overvalued relative to other projects in the same project area across the state based on the milestones and the patient scope of the project.

CMS' valuation review for initial approval used a mathematical model that accounted for:

- the project option;
- the provider's Pass 1 DSRIP allocation (a proxy measure of the provider's Medicaid and uninsured volume); and
- the RHP tier.

CMS identified outlier projects based on this model. Where possible, this model was used to propose alternate project values for these projects, which are otherwise initially approvable.

CMS also identified projects that appeared overvalued based on the Category 3 outcome selected and projects that appeared to be outliers compared to other, similar projects.

CMS was not able to include in its valuation model for initial review the quantifiable patient impact of each project. This factor will be included in the full valuation review that CMS will complete by September 1, 2013, to approve DY4 and DY5 valuation. In Phase 2, HHSC will be soliciting information from all DSRIP providers in May on quantifiable patient impact and the benefit of each project to the Medicaid/indigent populations to inform the full approval review this summer.

Detailed information about options for Phase 1 Project revisions

The following information can be used in conjunction with the cover sheet specific to each project identified for Phase 1 revisions. That cover sheet indicates which Table 4, Table 5 and Table 6 items are at issue with each project and identifies a code that corresponds with one or more sections of the following feedback. Each section lists the options available to a provider for the specified issue.

Approach to feedback for projects initially approved, with adjustment to project value (Table 5)

Note: If the provider accepts the lower project value or the proposed project value is not approved, the provider cannot apply the remaining balance to other projects nor can other providers use the funds for currently proposed projects. The DY3-5 balance associated with a project with an adjustment to project value will be available to the RHP for new three-year projects submitted via the plan modification process before October 1, 2013.

5A. HHSC COMMENT: Flagged by the state and confirmed by CMS.

HHSC will provide more detailed information to the provider on why it flagged the project for valuation and what steps the provider may take to remove the state's valuation flag. HHSC will work with the provider to make sure the state flag can be removed before the project is re-submitted to CMS. For projects over $5 million that did not reflect the quantifiable patient scope of the project in the metrics, this quantifiable patient scope information must be added to the milestones table in order to clear the state flag.

OPTIONS FOR PROVIDER ACTION:

1) If the provider does not wish to increase the quantifiable patient impact of the project and/or increase the strength of the metrics, the provider may reduce the proposed value of the project to bring the project into the acceptable valuation range of similar projects, which will be provided by HHSC for each project. The valuation reduction for milestones in DY2 and DY3 will be proportional to the originally proposed DY2 and DY3 values as described further below under INFORMATION APPLICABLE TO ALL TABLE 5 PROJECTS. In accepting a lower valuation level, the provider may not reduce the strength of the project (such as by removing metrics or reducing the strength of metrics.) In cases where CMS also has provided an alternate value for state-flagged projects, then the provider must reduce the project value to the lesser of the state alternate value or the CMS alternate value, if this option is selected. *(Submit cover sheet only.)*
2) The provider may increase the quantifiable patient impact of the project in the milestones and narrative to come within an acceptable valuation range compared to similar projects (HHSC will provide for each project the value that would remove the state flag). *(Submit cover sheet and project for pre-review.)*
3) The provider may increase the strength of its project activities and metrics to demonstrate why the project warrants a higher valuation than similar projects. *(Submit cover sheet and project for pre-review.)*

NOTE: If CMS also identified the project as an outlier based on its model, flagged the project for valuation for another reason, or did not give initial approval to the project, then the provider also will need to address the specific CMS issue(s) for the project.

5B. CMS COMMENT: Project value was an outlier compared to similar projects based on information available to CMS.

OPTIONS FOR PROVIDER ACTION:

1) If the provider does not wish to change or further justify the project, the provider will indicate that it accepts the CMS-proposed lower Category 1 or 2 project value for DY2 and DY3. The valuation reduction for milestones in DY2 and DY3 will be proportional to the originally proposed DY2 and DY3 values as described further below under INFORMATION APPLICABLE TO ALL TABLE 5 PROJECTS. In accepting a lower valuation level, the provider may not reduce the strength of the project (such as by removing metrics or reducing the strength of metrics.) *(Submit cover sheet only.)*

2) If the provider wishes to retain its originally proposed Category 1 or 2 value for DY2 and DY3, then it must explain to CMS why the proposed value is justified based on one or more of the following factors: *(Submit cover sheet and project for pre-review.)*
    a. The original value is required to cover the cost/budget for the project.
    b. The project is broader in scope than the performing provider's scope. (Since the Pass 1 allocation was one of the factors used in the CMS model, if a project is regional in nature or is a joint effort with other providers, then the provider can make this case.)
    c. Any other information the provider wishes to provide to demonstrate why the originally proposed valuation is warranted, including the following items from paragraph 12.e of the Program Funding and Mechanics Protocol - project size, provider size, project scope, populations served, community benefit, cost avoidance, and addressing priority community needs.

NOTE: CMS has indicated that it will require a compelling justification for approving outlier projects at a value above the CMS alternate value shown on the cover sheet.

5C. CMS COMMENT: Patient satisfaction outcome does not support project value.

OPTIONS FOR PROVIDER ACTION:

1) FOR ALL PROVIDER TYPES - If the provider wishes to keep the current patient satisfaction outcome (with no additional outcomes), the provider will indicate that it accepts the CMS-proposed alternate Category 1 or 2 project value for DY2 and DY3. The valuation reduction for DY2 and DY3 will be proportional to the originally proposed DY2 and DY3 values as described further below under INFORMATION APPLICABLE TO ALL TABLE 5 PROJECTS. *(Submit cover sheet only.)*
2) FOR HOSPITAL PROVIDERS (AND OPTIONAL FOR NON-HOSPITAL PROVIDERS AT THIS TIME) - If the provider wishes to retain its originally proposed Category 1 or 2 value for DY2 and DY3, then it must substitute or add one or more clinical outcomes related to the project (either at least one standalone outcome or three non-standalone outcomes). Note: CMS has indicated that it considers all other outcomes in the RHP Planning Protocol as clinical outcomes, with the exception of quality of life-related outcomes. (*Submit cover sheet and Cat 3 project for pre-review.)*
    a. CMS' preference is to replace the patient satisfaction outcome with one or more clinical outcomes.
    b. A provider may retain the patient satisfaction outcome as a secondary outcome as long as it adds one or more clinical outcomes. If this option is chosen, the valuation for the patient satisfaction outcome shouldn't be larger than the valuation for the new Category 3 outcomes.
3) FOR NON-HOSPITAL PROVIDERS ONLY – If the provider wishes to retain its originally proposed Category 1 or 2 value for DY2 and DY3, the provider may indicate that it intends to add one or more clinical outcomes, which are TBD for now, in place of or in addition to the patient satisfaction outcome. The TBD must be determined for the October 1, 2013, plan modification submission. HHSC recommends selecting TBD for now to facilitate faster review at this stage, except that those few non-hospital providers that included a process milestone for DY2 will not be able to claim those funds until they select a Category 3 outcome and complete the milestone appropriate to the newly-selected outcome. *(Submit cover sheet only)*

Recommended options: 2 or 3

5D. CMS COMMENT: Other comment, including that the project appears overvalued based on scope, the Medicaid and uninsured population targeted appears to be very low, and/ or the project needs to describe which types of specialists it will use in order to demonstrate that the project will address an area of high need for the Medicaid and uninsured population (e.g. new urgent care center). HHSC WILL PROVIDE AS MUCH INFORMATION AS POSSIBLE TO THE PROVIDER ON HOW TO RESPOND.

OPTIONS FOR PROVIDER ACTION:

1) If the provider does not wish to change or further justify the project, the provider will indicate that it accepts the CMS-proposed lower Category 1 or 2 project value for DY2 and DY3. *(Submit cover sheet only.)*
2) If the provider wishes to retain its originally proposed Category 1 or 2 value for DY2 and DY3, then it must provide the information requested by CMS for reconsideration to justify the originally proposed value. *(Submit cover sheet and project for pre-review, including specialty services questions from Appendix C as applicable.)*

INFORMATION APPLICABLE TO ALL TABLE 5 PROJECTS:

FOR 5A-5D, if the provider opts retain its originally proposed Category 1 or 2 value (option 2), then it will submit the draft project with a cover sheet to HHSC for state and federal "pre-review" prior to the formal project submission to CMS. HHSC may also include comments on the form for CMS regarding the findings from HHSC's review of the project.

FOR 5A-5D, if the provider opts to accept the lower project value (option 1) *or option 3 in the case of 5C*, then it will submit the cover sheet to HHSC for the project, but does not need to re-submit the full project at this time. The revised full project will be submitted for the October 1, 2013, plan modification process along with other needed project changes (including technical corrections and Category 3 changes).

If the provider accepts the lower value, project funding will be reduced proportionately. For example, if the originally proposed DY2 value was $1 million and the originally proposed DY3 value was $1.5 million (for a total of $2.5 million) and CMS' alternate value is $2 million (80% of the originally proposed value), then DY2 must be reduced to $800,000 (80% of $1 million) and DY3 must be reduced to $1.2 million (80% of $1.5 million). Milestones within a DY also will be reduced proportionately so that milestone values within a given DY remain equal. For cases where a provider accepts a lower value, HHSC will inform the provider of how much each of the DY2 and DY3 milestone values will decrease prior to the October 1, 2013 Phase 4 project re-submission. (NOTE: If this option is chosen, it is likely that at the time of full valuation approval, CMS also will lower the DY4 and DY5 Category 1 or 2 value.)

The lower value that the provider accepts will be the amount included in the project cover sheet labeled "Project value accepted, if revisions are not made." In some cases, this amount may be less or more than what CMS has listed in Table 5 as "Initially approved DY2 – 3 project value." This difference only will occur in instances in which both CMS and HHSC flagged the project for valuation. It may be the case that the HHSC acceptable valuation is less than the CMS acceptable valuation. Alternately, if the HHSC acceptable value is significantly higher than the CMS acceptable value, providers may receive project values equal to the figure CMS has calculated for that project option as 1.5 standard deviations above the expected value for that project option.

Approach to feedback for projects not initially approved (Table 6)

NOTE: If a project is not approved and is not replaced, then the DY1 DSRIP associated with that project will be recouped. The DY3-5 funds associated with the project will be available to the RHP for new three-year projects to be submitted via the plan modification process before October 1, 2013.

6A. CMS COMMENT: It is unclear how this project addresses a community health need and/or an area of high need for the Medicaid and uninsured population. This project is not approvable unless the provider can provide a compelling justification of the project's need and the benefits to the Medicaid and uninsured population and includes corresponding milestones and metrics consistent with the demonstration goals (e.g. inpatient dialysis lab, 911 dispatch system upgrade, new CT scanner, new specialty care clinic with very low volume of Medicaid/uninsured).

OPTIONS FOR PROVIDER ACTION:

1) Replace the project with another project of equal or lesser value (must be on-menu). *(Submit cover sheet and new project.)*

2) Withdraw the project without replacing it with a new four-year project. (*Submit cover sheet only.)*

3) If the provider wishes to pursue getting this project approved, it must provide a compelling justification of the project's need and the benefits to the Medicaid and uninsured population and includes corresponding milestones and metrics consistent with the demonstration goals (HHSC understands this to mean metrics specific to Medicaid/indigent impact). It also would help to describe if the project is being located in a specific geographic location chosen to reach the Medicaid/uninsured populations, or if other strategies will be pursued to target these populations. (*Submit cover sheet and project for pre-review.)*

Recommended option: 1 (CMS has indicated that these projects are not likely approvable.)

6B. CMS COMMENT: Project is off-menu and needs to provide more justification. For some of these projects, it is unclear why the "other" project option was selected instead of a project option described in the RHP planning protocol. This project can be approvable if the provider modifies the project option or provides a compelling justification for choosing an "other" project option. For others, additional information is needed such as CQI.

OPTIONS FOR PROVIDER ACTION:

1) Replace the project with a new project of equal or lesser value (on-menu). *(Submit cover sheet and new project.)*
2) Withdraw the project without replacing it with a new four-year project. (*Submit cover sheet only.)*
3) If the provider wishes to keep the project as an "other" project, it must provide a compelling justification for choosing the "other" project option using the CMS-provided questions for "other" projects, including the evidence-based rationale for the project, and address the CQI core component if CMS noted that. The CMS questions are included in Appendix B. *(Submit cover sheet and Appendix B for pre-review, may also submit project for pre-review.)*
4) Move project on-menu and address all required core components. *(Submit cover sheet and project for pre-review.)*

NOTE: For off-menu projects provided by the community mental health centers and public-health related projects, HHSC will provide on the cover sheets resource names at the Department of State Health Services (DSHS) that are available to help determine if the project could fit on the menu. HHSC will still address the valuation issues related to all projects (not DSHS staff).
NOTE: For projects in areas 2.6 and 2.7, CMS indicated that the provider needs to clearly justify why the focus of the project is a higher need for the region than the on-menu options available in 2.6 or 2.7.

6C. CMS COMMENT: Specialty care project without a clear benefit focusing on the Medicaid/indigent populations, including supply-sensitive, resource-intensive specialty services (e.g. cath lab).

OPTIONS FOR PROVIDER ACTION:

1) Replace the project with another project of equal or lesser value (on-menu). (*Submit cover sheet and new project.)*
2) Withdraw the project without replacing it with a new four-year project. *(Submit cover sheet only.)*
3) If the provider wishes to pursue project approval, it must provide a compelling justification of the project's need and benefits to the Medicaid and uninsured population and include corresponding milestones and metrics consistent with the demonstration goals (HHSC understands this to mean metrics specific to Medicaid/indigent impact). **If a provider adds/clarifies metrics specific to the**

Medicaid/indigent impact, HHSC strongly advises keeping/including in the metrics quantifiable information on all the patients impacted by the project, as this will support the project's value during the CMS valuation review this summer for DY4 and DY5. In addition to any other information provided as justification, providers should also answer the questions in Appendix C. It also would help to describe if the project is being located in a specific geographic location chosen to reach the Medicaid/uninsured populations, or if other strategies will be pursued to target these populations. (*Submit cover sheet and Appendix C for pre-review, may also submit project for pre-review.)*

6D. CMS COMMENT: Need more information about this project to initially approve. CMS' notes depend on the project – e.g. need more information on the specialty care providers being hired (not specified), need to better describe Medicaid impact, need to clarify that the project will complement rather than duplicate federal funding. HHSC WILL PROVIDE AS MUCH INFORMATION AS POSSIBLE TO THE PROVIDER ON HOW TO RESPOND.

OPTIONS FOR PROVIDER ACTION:

1) Replace the project with another project of equal or lesser value (on-menu). (*Submit cover sheet and new project.)*
2) Withdraw the project without replacing it with a new four-year project. *(Submit cover sheet only.)*
3) If the provider wishes to pursue project approval, it must submit to HHSC the additional information CMS requested. (For example, for transitional housing projects, CMS has requested assurance that SAMHSA best practices will be applied and how they will be applied.) *(Submit cover sheet and project for pre-review, including Appendix C as appropriate for specialty care projects. For specialty care projects, also see the instructions under 6C.3)*

INFORMATION APPLICABLE TO MULTIPLE TABLE 6 PROJECTS:

FOR 6A-6D, if the provider opts for #3, then it will submit the draft project with a cover sheet to HHSC for state and federal "pre-review" prior to the formal project submission to CMS. HHSC may also include comments on the form for CMS regarding the findings from HHSC's review of the project.

Approach to priority technical correction: Overlap of improvement target and improvement milestone (Table 4)

To avoid overlap, the provider should compare the numerator of the selected outcome (or the *number* change, rather than percent) to the metric description used in the identified improvement milestone. If the universe (e.g., number of people screened, number of services provided, etc.) is similar in the outcome description and improvement metric, then the overlap likely remains. The provider can get ideas about alternative milestones and outcomes by referencing the list of project summaries for all projects to find projects with the same project option.

OPTIONS FOR PROVIDER ACTION:

1) Remove, replace, or revise the improvement milestone *(Submit cover sheet, Cat 1 or 2 project and overlapping Cat 3 project for pre-review.)*
2) Remove, replace, or revise the improvement target (outcome) *(Submit cover sheet, Cat 1 or 2 project and overlapping Cat 3 project for pre-review.)*

Note: For each option, the provider will have to indicate the project changes on the project cover sheet and resubmit the project with appropriate changes made to the project tables and narratives. There are situations when the overlap is caused not by the chosen measures themselves but rather by the way the provider phrased the goal for a measure. Adjusting the language for the goal may eliminate an overlap. If technical review identified that the overlap or potential overlap was due to how a goal was described, the provider does not need to replace the Improvement Milestone, but needs to adjust the goal description to reflect activities in the metric.

APPENDIX A: Important dates for RHP Plan development and approval

May 29, 2013
Anticipated date by which all RHPs will have received *CMS Initial Review Findings*

June 7, 2013

- Deadline for Table 5 – Projects initially approved, with adjustment to project value to accept lower project value for inclusion in August DY 2 reporting. All initially approved projects will also be able to report in the October DY 2 reporting period.

September 1, 2013
CMS completes first valuation review for DY 4 and DY 5 incentives. CMS either can:

- Give full approval for the DY 4 and DY 5 project valuation; OR
- Request the provider revise the project or valuation to seek full approval by March 31, 2014.

(Projects that receive valuation approval for DY 4 and 5 may still be subject to a DY 4 and 5 modification during the mid-point assessment, including adjustments to metrics or valuation, if the performance of the project substantially deviates from what was approved.)

October 1, 2013

- Priority technical corrections must be submitted to HHSC (a later date may be specified by HHSC or CMS).
- CMS and HHSC complete standard target setting methodology for Category 3 outcomes (methodology will apply prospectively to Category 3 outcomes for DYs 4 and 5 for all projects.)
- RHPs will submit learning collaborative plans by October 1, 2013, to reflect opportunities and requirements for shared learning among the approved DSRIP projects in the region.

March 31, 2014
Deadline for full project approval, including approval of:

- technical corrections
- modifications to projects or valuations to receive full valuation approval
- Category 3 improvement targets for DYs 4 and 5

HHSC and CMS will work with RHPs to submit Category 3 improvement targets once the standard target setting methodology is developed and to refine targets as needed for approval no later than March 31, 2014.

APPENDIX B: Projects not initially approved as an off-menu project without sufficient justification

For projects identified with Issue 6B, not initially approved as an off-menu project without sufficient justification, providers should answer the following questions in addition to any other information included in the project cover sheet:

1) Does the project predominately target the Medicaid and/or uninsured population in an area of high need to the Medicaid and uninsured population?
   (provide information on percent of target population that is Medicaid and or/uninsured; describe area of poor performance and/or health care disparity that is important to the Medicaid and/or uninsured population that this project addresses, and describe how the project aligns with local data, community needs, and state-level health priorities)

2) Is the project evidenced-based? Specifically, what evidence-based literature that is a current standard of care or emerging best practice (i.e. literature cited within the last 10 years) is cited by the project?

3) Did this project already exist before the DSRIP?
   (describe how requested funding would improve and/or expand existing program, and include sources and amounts of current funding and description of activities)

4) Does the project contain appropriate milestones and metrics?
   a. Does the project include a description of the provider's continuous quality improvement activities? What are the QI activities and/or milestones included in the description?
   b. Can measurable improvements be quantified by the proposed milestones and metrics, particularly for the patient population's clinical outcomes (such as number of patients served by the project in DY 4 and DY 5)? What are these quantifiable patient milestones?
   c. If there are any "off-menu" customizable milestones and metrics, are they appropriate for the project? What rationale and evidence are provided to support their use?

5) Does the project plan include a compelling rationale that describes why the project is off-menu? What is this rationale?

APPENDIX C: Specialist projects needing Medicaid/uninsured impact information

For projects identified with Issue 6C, the provider will need to answer one or more of the below questions depending on the type of specialist related feedback for their project. Providers should review these questions as they pertain to their specialist project and determine which are relevant to their project but need further clarification. The provider should answer these questions in addition to any other information provided on the project cover sheet:

1) Are selected specialty areas in high need for the Medicaid/uninsured population?
   (provide adequate justification of why the project was an area of high need for the Medicaid and uninsured population in the region)

2) Are high-intensity specialties in areas of high need for the Medicaid/uninsured population?
   (provide additional detail about the project's target population and include a milestone that relates to the number of Medicaid/uninsured patients served to ensure that the primary benefit of the project is for Medicaid and uninsured individuals)

3) Does the project include a clear description of specialties that the initiative is focusing on?
   (provide sufficient information on types of specialties that are being targeted in the project)