Program Funding and Mechanics (PFM) Protocol for Demonstration Years (DY) 7-8
Summary of Stakeholder Feedback and HHSC Responses

On January 31, 2017, HHSC released the draft DSRIP Program Funding and Mechanics (PFM) Protocol for Demonstration Years (DY) 7-8 for stakeholder feedback. The PFM Protocol describes the RHP Plan Update process, Performing Provider requirements for DY7-8 DSRIP participation, incentive payment methodologies, and reporting requirements. HHSC hosted a webinar on February 9, 2017 to provide an overview of the draft DY7-8 PFM proposed requirements and answer questions. Stakeholders submitted feedback through an online survey that closed on February 28, 2017.

This document summarizes the stakeholder feedback HHSC received through the 173 respondents to the survey and through a submission of combined Anchor feedback. The DSRIP team reviewed stakeholder comments, drafted responses, and determined PFM changes through multiple team meetings and discussion with leadership. HHSC grouped together similar comments and responses rather than including individual feedback. Changes to the PFM Protocol based on stakeholder feedback and leadership direction are reflected in the updated PFM Protocol and noted in the responses herein.

HHSC submitted the PFM Protocol for DY7-8 to CMS on May 17, 2017 for review and feedback. All DY7-8 requirements are subject to CMS approval and HHSC will continue to work with CMS to achieve timely approval. HHSC is targeting August 2017 for CMS approval of the DSRIP protocols.

Contents

A. RHP Plan Update Submission, Review, and Approval

1. Multiple stakeholders expressed concern regarding the timeline for submission of the RHP Plan Update.
   a. Over 30 comments expressed concern that the RHP Plan Update, including measure bundle selections, will not be approved by HHSC until months into DY7. The timing of approval makes it challenging to begin reporting in April 2018. Providers may need to implement DY7-8 requirements prior to approval due to measurement periods.
   b. In contrast, over 20 comments suggested submitting minimal information in November 2017 and delaying measure bundle selection and approval until April 2018. The rationale is that Calendar Year (CY) 2017 would be completed and providers would have time to set up systems or electronic medical records (EMRs) to determine baseline data prior to selecting measures.
   c. 10 stakeholders proposed a transition period to prepare for the DY7-8 requirements, ranging from an unspecified transition period, four to six months, to two years.

   HHSC RESPONSE:

   i. HHSC has updated the RHP Plan Update due date to January 31, 2018 to allow additional time for Performing Providers to review CY2017 baseline data, select measure bundles, and not overlap with October DY6 reporting. Although the final HHSC approval date remains as March 31, 2018, HHSC plans to provide feedback on and approval of measure bundle selections earlier than full RHP Plan Update approval to allow Performing Providers time to prepare for April reporting. Performing Providers may report Category C baselines in April 2018 or October 2018.
   ii. DY7 Category A will be based on April to September 2018 activities to allow the first half of DY7 to serve as a transition period from current project activities and ensure HHSC approval prior to the implementation of core activities.
   iii. Based on the current measures under consideration, most measures include data that already exists in EMRs or other medical records so extensive system changes should not be necessary. Measures under consideration are taken from the most common Category 3 measures from DY3-6, as well as common, authoritative sources that align with other state and federal initiatives including the CMS Medicaid Adult and Child Core Sets, CMS Consensus Measure Sets, MACRA MIPS Measure Sets, and NQF endorsed measures. If providers have to do chart reviews to access certain data points, they may use a sampling methodology. HHSC will provide additional guidance regarding sampling methodologies.
   iv. Based on the updated due date of the RHP Plan Update, Anchors may receive 80 percent of their DY6A payment in October 2017 with submission of their documentation demonstrating implementation of the DY6A learning collaborative plan. The remaining 20 percent will be included with April 2017 DSRIP reporting payments for submission of the RHP Plan Update.

2. Multiple stakeholders expressed concern that CMS may not approve the DSRIP protocols in a timely manner.

a. Over 20 comments suggested that additional time be allowed to submit the RHP Plan Updates based on when the approval occurs to allow providers time to review approved protocols and templates.
b. Over 20 comments recommended maximum flexibility and additional pay-for-reporting to account for potential delays.
c. 10 stakeholders requested HHSC include language that protects providers due to late CMS approval or policy changes.

HHSC RESPONSE: To account for a potential delay in CMS approval, HHSC has updated the RHP Plan Update due date to January 31, 2018. HHSC has also included a payment for submission of the RHP Plan Update to account for the level of work required to prepare for the changes from DY2-6 to DY7-8. This is consistent with current DSRIP payment patterns wherein 15-20 percent of total DSRIP valuation for the current DY is typically paid in the first reporting period. All DY7-8 requirements are dependent on CMS approval, and HHSC will continue to work with CMS to achieve timely approval.

3. Over 20 CMHCs indicated their preference for one "home" region while one physician practice preferred to remain in separate regions.

HHSC RESPONSE: HHSC plans to include cross-regional providers in a single "home" region for reporting and payment purposes while activities will be required to continue in multiple regions. HHSC will work with the physician practice to remain in separate regions.

4. A few stakeholders wanted clarification of which entities would need to certify and be included in the RHP Plan Update.

HHSC RESPONSE: HHSC has updated the requirement under paragraph 10 to include IGT Entities for Performing Providers. UC-only hospitals are required to be included in the RHP Organization but are not required to certify the RHP Plan Update. UC-only IGT Entities may be included in the RHP Organization at the time of RHP Plan Update submission.

B. Plan Modifications for DY7-8

Category B - MLIU PPP Plan Modifications

5. Stakeholders wanted clarification on the definition of "good cause", were concerned about the timing of Plan Modifications, and wanted to know how frequently they could change the PPP goals based on population fluctuation.

HHSC RESPONSE: HHSC restructured the plan modifications section to separate Category B and Category C changes. HHSC believes the restructured section includes flexibility for reporting achievement of the MLIU PPP by providing an "allowable variance" threshold and partial achievement. Nevertheless, providers may submit requests to change MLIU PPP

baselines and goals. Category B change requests will be considered for approval if they meet the following criteria:

i. Request for change must be received 90 days before the achievement reporting deadline (October or April).
ii. "Good Cause" for change must be substantial. Reasons may include (1) significant change to system definition; (2) error in data uncovered subsequent to baseline reporting; (3) significant policy change at the state or federal level that redefines eligibility for Medicaid or other eligibility-based programs that would be captured in the MLIU population; or (4) significant shift in population served by provider.

Category C - Measure Bundles and Measures Plan Modifications

6. Stakeholders requested clarification regarding whether it is the Performing Provider or the RHP/Anchor who has the authority to change a selected Category C Measure Bundle or measure.

   HHSC RESPONSE: HHSC has revised the PFM protocol proposal to clarify that it is the Performing Provider who has the authority to request changes to its selected Category C Measure Bundles or measures.

7. Stakeholders requested that Performing Providers be able to delete a selected Measure Bundle or measure and reallocate the funds associated with the deleted Measure Bundle or measure to the Performing Provider's other Measure Bundles or measures, or to other Performing Providers in the RHP.

   HHSC RESPONSE: HHSC has revised the PFM protocol proposal to prohibit a hospital or physician practice from deleting a selected Category C Measure Bundle. HHSC has also revised the PFM protocol proposal to prohibit a hospital or physician practice from deleting a required measure from a selected Category C Measure Bundle. However, a hospital or physician practice may request to delete an optional measure from a selected Category C Measure Bundle. If a hospital or physician practice submits a request to HHSC to delete an optional measure from a selected Category C Measure Bundle, and HHSC approves the request, the funds associated with the deleted optional measure will be reallocated to the remaining measures in the Measure Bundle such that the remaining measures' valuations are equal.

   HHSC has also revised the PFM protocol proposal to prohibit a CMHC or LHD from deleting a selected Category C measure. However, a CMHC or LHD may request to replace a selected Category C measure with one or more other Category C measures with point values greater than or equal to the point value of the measure being replaced and initial selection standalone and non-standalone selection requirements are still met.

8. Stakeholders requested that Performing Providers be able to replace a selected Measure Bundle or measure with a different Measure Bundle or measure.

HHSC RESPONSE: A hospital or physician practice may not replace a selected Category C Measure Bundle or measure with a different Measure Bundle or measure.

A CMHC or LHD may submit a request to HHSC to replace a selected Category C measure with one or more other Category C measures with point values greater than or equal to the point value of the measure being replaced, with the total valuation for all measures being equal to the valuation prior to replacement process. This request may be submitted in cases where a performing provider is unable to report a selected measure due to low volume or data limitations. The CMHC or LHD must submit the request to HHSC prior to reporting a baseline for the measure and no later than 30 days prior to the first day of the second reporting period of DY7.

9. Stakeholders requested clarification regarding the impact of a Performing Provider deleting a selected Measure Bundle or measure on: 1) the Performing Provider's Categories B and D; and 2) Category D for the other Performing Providers in the RHP.

   HHSC RESPONSE: HHSC has revised the PFM protocol proposal to prohibit a hospital or physician practice from deleting a selected Category C Measure Bundle. In addition, HHSC has revised the PFM protocol proposal to prohibit a hospital or physician practice from deleting a required measure from a selected Category C Measure Bundle. However, a hospital or physician practice may submit a request to HHSC to delete a selected optional measure from a selected Category C Measure Bundle. The deletion of an optional measure from a selected Category C Measure Bundle has no impact on the Performing Provider's other Categories or on other Performing Providers in the RHP.

   HHSC has also revised the PFM protocol proposal to prohibit a CMHC or LHD from deleting a selected Category C measure. However, a CMHC or LHD may submit a request to HHSC to replace a selected Category C measure with one or more other Category C measures with point values greater than or equal to the point value of the measure being replaced. The replacement of a selected Category C measure has no impact on the Performing Provider's other Categories or on other Performing Providers in the RHP.

10. Stakeholders requested clarification regarding the changes Performing Providers may make with HHSC approval, the changes they may make without HHSC approval, and the process and deadlines for making such changes.

    HHSC RESPONSE: Changes for which a Performing Provider must submit a request to HHSC and receive HHSC approval to implement and the associated process and timeline are described in the revised PFM paragraph 12. A Performing Provider may change its Category A core activities without requesting and obtaining HHSC approval or submitting advanced notice to HHSC.

C. Performing Provider Valuation

11. Most stakeholders agreed with or did not have comments on maintaining the total provider valuation from DY6A in DY7 and DY8. A few providers requested clarification to the PFM Protocol language to specify that each DY is equal to the DY6A valuation instead of DY7-8 valuation in total.

    HHSC RESPONSE: Paragraph 14.a. was updated to clarify total valuation for each DY.

12. A few stakeholders requested that if a provider elects not to use the funds associated with a withdrawn project, then the funds should be available to the region.

    HHSC RESPONSE: Unused funds from withdrawn projects will be included with the statewide remaining unused funds proposal that may be submitted in DY7 or later rather than distributed to regions in DY7. Given the updated timeline of January 2018 RHP Plan Update submissions and March 2018 HHSC approvals to begin April DY7 reporting, there is limited time to conduct redistribution "passes" for DY7 implementation. In addition, in DY7-8, there are no regional allocations given the redistribution of DY3-5 regional allocations through 3-year projects, DY6 combined projects, and consolidating cross-regional Performing Providers into one "home" region for DY7-8.

D. DSRIP Funding Distribution among Categories

13. Many stakeholders were concerned about the large amount of funding in Category C.
    a. Over 90 comments requested some valuation added to Category A, ranging from a general increase to 5-25 percent with most comments requesting 10 percent.
    b. Some stakeholders also requested an increase in Category B or Category D valuation and potentially including an incentive to increase MLIU PPP.
    c. There were multiple proposals to increase pay-for-reporting (P4R) in general with some stakeholders recommending that Category B in particular be changed to P4R or a portion be P4R.
    d. A handful of providers suggested lowering the amount of pay-for-performance (P4P) in Category C in DY7 and then increasing P4P in DY8 to allow providers time to transition.

    HHSC RESPONSE:
    i. HHSC has shifted 20 percent of a Performing Provider's total valuation for DY7 from Category C to submission of the RHP Plan Update. This is to account for the level of work required to prepare for the changes from DY2-6 to DY7-8. The eligible DSRIP payment for submission of the RHP Plan Update will be included with July 2018 payments for April DY7 reporting. This is consistent with current DSRIP payment patterns wherein 15-20 percent of total DSRIP valuation for the current DY is typically paid in the first reporting period.

ii. Category D was also increased from 5 to 10 percent to 5 or 15 percent based on continued private hospital participation to strengthen the incentive and shift additional funds from Category C to P4R.
iii. Category A will remain as required reporting to be eligible for any payments in Category B-D. This is similar to recent 1115 waiver approvals and maintains the focus on measure reporting and achievement.

E. Category A - Eligibility for DY7-8 Payments

Core Activities

14. Stakeholders requested additional details related to core activities, including a definition of core activities. Stakeholders also asked if there is any reporting for Category A in the first round of reporting in each demonstration year.

    HHSC RESPONSE: A definition for "Core Activities" is included in paragraph 4 of the PFM. The PFM specifies that the reporting for Category A will take place during October (Round 2) reporting of each demonstration year. HHSC will work on the list of potential core activities and will make it available for stakeholder feedback in June 2017.

15. Stakeholders suggested that HHSC offer a lot of flexibility in core activities to adequately address new measure bundles.

    HHSC RESPONSE: The currently proposed shift from project-level to provider-level reporting allows for sufficient flexibility in determining what activities to continue and/or implement. Performing Providers will decide which activities from the current DY2-6 projects to continue in DY7-8, and any new activities to undertake.

16. Stakeholders requested clarification on how the reporting on core activities will be done.

    HHSC RESPONSE: HHSC will work on the list of potential core activities and will make it available for stakeholder feedback in June 2017. After CMS approval of the DSRIP protocols, HHSC will clarify how reporting will take place (e.g., online reporting system, template, etc.)

Alternative Payment Models (APMs)

17. Stakeholders recommended HHSC consider hosting workshops or forums around APMs in DY7-8 for providers and MCOs.

    HHSC RESPONSE: HHSC plans to host provider and managed care organization (MCO) forums in the larger context of value based purchasing (VBP). Be on the lookout for information targeted for this spring/summer 2017.

18. Stakeholders wanted clarification on what constitutes progress and what they are required to do in order to meet the requirements. Stakeholders were also looking for more information regarding APM, clinical measures for which MCOs are accountable, and definition of other payers.

    HHSC RESPONSE: Each Performing Provider is required to fill out the progress update. This is a qualitative response, and a response of no progress would be acceptable. Attending a workshop specific to VBP could be part of a progress update. This could be reported at the provider level or on the basis of a core activity. HHSC will provide additional information about APMs on the waiver website. MCO quality metrics will be provided with the Sustainability Template in DY6. "Other Payers" can be private insurance, community partners, federal grant partners, cities or other public or private entities.

Costs and Savings

19. Over 40 stakeholders sought additional information and clarification on the costs and savings requirement, including: the content of HHSC's template, definitions of costs and savings, and whether or not standard definitions and methodology would be used.

    HHSC RESPONSE:

    PFM language has been updated to:

    Performing Providers who have a total valuation of one million dollars or more per DY are required to submit the costs of at least one core activity of choice and the forecasted or generated savings of that core activity. Performing Providers must submit this information in a template approved by HHSC or a comparable template. Providers should include costs and savings specific to their organization and other contracted providers if that information is available. A progress update must be submitted during DY7 and a final report of costs and savings must be submitted in DY8.

    In DY8, Performing Providers must submit:

    i. A summary report of costs and savings. Performing Providers may use the Return on Investment Forecasting Calculator for Quality Initiatives by the Center for Health Care Strategies, Inc. (available online here: http://www.chcsroi.org/Welcome.aspx). If using this template, providers must submit the summary page which includes the target population, utilization assumptions, savings per intervention group member, program costs, and the return on investment result. A comparable template may be used that must include, at a minimum, a description of the intervention, the timeframe/duration of the initiative, the target population, program costs/operating costs, and utilization changes and/or savings.
    ii. A short narrative including core activity chosen, methodology and assumptions made for the analysis.

20. Multiple stakeholders indicated that DSRIP is an incentive-based program and was not designed to measure spending versus payment. Additionally, multiple stakeholders sought clarification on the purpose of collecting this information.

    HHSC RESPONSE: Although DSRIP provides incentive payments, Section 1115 waivers aim to use innovative delivery systems that improve care, increase efficiency, and reduce costs for Medicaid and other low-income populations. Analyzing costs and savings is a way to determine the efficiency of DSRIP activities. These analyses can demonstrate to payers, including managed care organizations, communities, and health systems, that a core activity is a worthwhile investment and demonstrates potential for a value-based payment arrangement. Value-based purchasing has the potential to direct clinical services in the most appropriate manner. Over time, linking healthcare payments to value should result in improved outcomes and greater efficiencies. HHSC intends for providers to utilize the costs and savings reports to determine what activities lead to greater efficiencies and better outcomes for the healthcare system. This can demonstrate to payers the potential benefit of continuing certain activities.

21. Multiple stakeholders indicated that the costs and savings requirement would be too difficult, cumbersome, costly, and for some providers, impossible. Multiple rural hospitals said they do not have the infrastructure in place (i.e., software, human resources) to do this. Additionally, some providers do not have infrastructure in place to capture costs and indicated that they may need to redesign accounting systems to do this.

    HHSC RESPONSE: Only providers with a valuation of one million dollars or more per DY will be required to complete one costs and savings report.

22. Many stakeholders indicated that the move from project to system/provider level brings further complexities to being able to define costs and savings.

    HHSC RESPONSE: Performing Providers will only be required to report on costs and savings of one DSRIP core activity of their choice. Although the process of determining costs and savings is complex, providers can focus on collecting costs of the DSRIP core activity of choice and not all DSRIP activities.

23. Several stakeholders recommended removing the costs and savings requirement.

    HHSC RESPONSE: Costs and savings reporting can demonstrate to payers the potential benefit of continuing certain activities and is in the best interest of providers to complete.

24. Multiple questions regarding the level of confidentiality of this information collected and whether or not this information is subject to audit or could affect valuation.

    HHSC RESPONSE: HHSC follows all state and federal laws concerning privacy including the exceptions to the Texas Public Information Act. Please explain 1) your concerns regarding

our privacy policy and 2) the legal authority you're claiming that the information requested should be kept confidential.

All DSRIP reporting is subject to audit. HHSC does not expect impacts to DY7-8 valuation; however, HHSC does not have information regarding the potential impact of costs and savings reporting on valuation for waivers beyond DY7-8.

Collaborative Activities

25. Several stakeholders requested additional information about reporting requirements for attendance at a learning collaborative or other regional meeting.

    HHSC RESPONSE:

    i. HHSC will create a template for Category A reporting that will include questions regarding regional collaborative/meeting participation. The template will provide instructions for completing the questions related to collaborative activities.
    ii. These questions will be similar to those found on the Learning Collaborative participation template that HHSC has made available for prior reporting periods, and answers should include evidence of collaborative activity attendance and lessons learned.
    iii. Because collaborative attendance will not be project-specific, a single individual from an entity may attend one activity to fulfill this provider requirement (regardless of system definition for Category B or the provider's valuation), and lessons learned should be relevant at the provider level or to some provider core activity/activities.
    iv. Reporting on collaborative activities will occur in the second reporting period of each demonstration year.
    v. The collaborative activities requirement may be achieved through a collaborative of DSRIP providers doing similar projects across RHPs.
    vi. Providers operating in multiple RHPs may choose one RHP in which to participate in a collaborative activity. HHSC encourages providers to participate in activities in other RHPs they operate in, although this is not required.

26. Several Anchors requested clarification of Anchor level requirements regarding regional learning collaboratives.

    HHSC RESPONSE*:* Anchors will be required to submit a regional learning collaborative plan for DY7-8. Language will be added to the PFM Protocol for DY7-8. HHSC is not prescribing the format or content of RHP learning collaborative activities for DY7-8. Tier 4 regions are not exempt from submitting a plan for some sort of regional learning opportunity in DY7-8, which may include regional stakeholder meetings instead of a larger regional learning collaborative event.

    PFM language has been updated to include:

35. Learning Collaborative Plans

Recognizing the importance of learning collaboratives in supporting continuous quality improvement, RHPs will submit learning collaborative plans by December 15, 2017, to reflect opportunities and requirements for shared learning among the DSRIP providers in the region. The DY7-8 learning collaborative plan may include an annual regional learning collaborative and/or smaller, targeted learning collaboratives or stakeholder meetings. Two or more regions may work together to submit a cross-regional DY7-8 learning collaborative plan. HHSC will develop a template for submission of RHP learning collaborative plans.

27. Two anchors recommended that providers be required to attend a regional learning collaborative, instead of allowing attendance at a learning collaborative or other regional meeting.

    HHSC RESPONSE: HHSC declines to require participation specifically at a regional learning collaborative. This would be a new requirement for providers aside from those providers who chose project milestones related to learning collaborative participation in DY2-5. While HHSC values participation in learning collaboratives, the intent of this requirement is to encourage the continuation of some level of regional participation by providers, including in those regions whose Anchor may choose not to host a regional learning collaborative.

F. Category B - Medicaid and Low-Income or Uninsured (MLIU) Patient Population by Provider (PPP)

Rationale for Patient Population by Provider: As DSRIP shifts from project-level reporting to system-level reporting, HHSC wants to ensure that providers maintain a focus on serving the target population: Medicaid or Low-Income or Uninsured (MLIU) patients. Because DSRIP reporting will no longer be project-specific, HHSC is requesting that providers demonstrate that they are maintaining a certain level of service to the MLIU target population. In addition, HHSC does not want providers to stop serving the MLIU population in an effort to enhance achievement on Category C measures. The Category B system definition and Patient Population by Provider (PPP) is meant to define the universe of patients that will be served by a provider; Category C measure denominators will naturally be limited by settings of services or measure specifications. The PPP is meant to measure the volume a provider serves at large and, in effect, is substituting for an attribution methodology that would determine which providers are responsible for which patients.

System Feedback and Considerations

28. Stakeholders wanted flexibility to define the Performing Provider's system. There seemed to be confusion about how to apply the same definition of system for Category B and C and about moving away from project-specific parameters for patient counts and outcome measurement. Providers want the option to define "system" for each measure bundle or

even each measure. Providers want to be able to count contracted or external clinics in some cases, but also do not want to be held accountable for clinics over which they have no direct control.

HHSC RESPONSE:
We have worked to clarify how "system" applies to both Category B and Category C and to allow maximum flexibility while still keeping measurement meaningful.

Clarify key terms and guidelines:

System = universe of population served by the provider and may be measured by the provider.
Setting = the location/service type that may limit the denominator of a Category C measure.
Measure Specification = may also limit the denominator of a Category C measure.

Category B is counting patient population of the system. Category C measures will not necessarily apply to the entire system; measure denominators may be naturally limited by setting or measure specification. However, Category C should not be measuring a population that is not included in the Category B system Total Patient Population by Provider.

The system definition should include a base unit that reflects the provider's current patient care landscape that is striving to advance the triple aim. The base unit could be: the TPI(s) for the provider; the inpatient and outpatient clinics within the four walls of a hospital; the hospital (inpatient and outpatient clinics) and all owned clinics by the provider; multiple locations working under one TPI; a LHD or CMHC that encompass multiple locations; a hospital but only if it does not own or have affiliated clinics. Providers will also have the flexibility to add contracted providers or clinics, if they are supporting the provider's transformational efforts and are not a DSRIP Performing Provider themselves. Providers will define their system in the RHP Plan Update.

Providers should consider the following information in defining their system:

i. Data system capacity and sharing. Providers do not have to limit their system definition by a shared EMR; however, providers should be aware of the capacity for data consolidation for the purposes of reporting both Category B and C. If a provider chooses to include contracted providers in the definition of system, the provider should have assurances that the data necessary for reporting is accessible.
ii. Ownership does not define a system. If a company owns three hospitals across the state of Texas, they should not necessarily be in one system. If they function independently for the purposes of DSRIP, each hospital (and any relevant clinics) should be its own system. If they have functioned as a unit under DSRIP transformation, they could be a system.
iii. Projects that have served people in a non-clinical setting such as a school or a health fair would not include that population in their system. HHSC assumes that these

community-based projects are part of the effort of transformation, and are therefore contributing to improved health or reducing ED utilization, for example, in a traditional setting. HHSC would expect these core activities to continue if they are contributing to the larger transformation. However, unless a location is specifically being measured for part of the Category C measure bundles, it is unlikely that a provider would include this setting as part of their system definition. The limitations of data in these alternative settings underscores the limits of including those locations as part of a system definition. HHSC acknowledges that these settings are often the site of services to a greater proportion of MLIU patients. The providers will not be penalized for providing a PPP baseline count that does not include this population if it is neither definitive of the system nor measurable.

iv. A provider does not need to exclude from their PPP count patients that are "funded" by another federal grant or program. The PPP is not meant to account for the patient impact specific to DSRIP as QPI is. PPP is meant to measure the entire population served by the provider so a provider may include all patients, including those funded through a separate federal grant or program.

Reporting Total Individuals and MLIU patient population for 10 percent of valuation

29. Stakeholders would like an increase in the percentage of total valuation that can be earned for Category B, especially in DY7, to allow for ramp-up time for new DSRIP structure and measure bundle reporting.

    HHSC RESPONSE*:* In most cases, core activities are an extension of ongoing DSRIP projects and quality improvements; there should not be a significant need for "ramp-up time." The focus of DY7-8 is on meaningful outcome measures. Category B helps stratify risk for DSRIP overall in that it defines the universe population that may be further limited by settings or measure specifications in Category C. In addition, funding has been shifted from Category C to RHP Plan Update submission, which accounts for 20 percent of funding in DY7.

30. Stakeholders would like clarification of the MLIU definition. Providers requested confirmation that the definition is the same as DY6 and the Uncompensated Care (UC) definition. Providers are concerned about counting all MLIU patients within their system when many EMR systems do not capture income levels/family size in order to determine low-income status.

    HHSC RESPONSE: The MLIU definition remains the same as the DY6 definition: Medicaid, Low-income (under 200% FPL), or uninsured. Medicaid may include individuals with Medicaid as secondary coverage and individuals that are dual-eligible for Medicaid and Medicare. Low-income may include patients at or below 200% FPL, including patients that have insurance coverage through a local coverage option, CHIP, or a plan in the Federal exchange. Providers who do not have systems in place to evaluate income status do not need to include low-income in their MLIU count. A provider would be authorized to only count individuals with Medicaid and individuals without insurance. Since Category B will be

a maintenance goal, providers need to ensure that they use the same criteria for counting the MLIU population for the baseline period and achievement period reporting. However, providers will not be penalized for their initial MLIU population volume submitted in the RHP Plan Update.

31. Providers who use a proxy methodology in DY3-6 for estimating their MLIU population wanted to continue to be able to do so.

    HHSC RESPONSE: Most providers authorized to use a proxy population were doing so because of limitations in collecting data due to project location, such as a health fair. For DY7-8, when the patient count is based on system and not project, HHSC believes this allowance is no longer necessary. Based on the definition of service/patient and the definition of system, HHSC believes providers should be able to provide an actual count of patient population within the demonstration year.

32. Stakeholders were concerned about the change to counting only individuals. Some providers raised concerns about shifting from encounters to individuals. Others raised concerns about being able to get an unduplicated count across different EMRs within their system. One provider suggested HHSC recognize these limitations by allowing providers to move toward enhancing EMR systems and data controls as their goal, not actually reporting PPP.

    HHSC RESPONSE: Because of the shift to system-based population counts, HHSC believes utilizing unduplicated individuals provides the best picture of populations and allows for comparability between providers across the state. HHSC believes DSRIP has already laid the groundwork for providers to better collect and utilize data and EMR systems. To the extent that a provider needs additional time to merge systems and verify that individuals are not duplicated, they should opt to report Category B in April of the following DY.

33. Stakeholders requested additional clarification on who may be counted in MLIU PPP. Providers are used to having project-specific guidelines on who can be included in their QPI count, such as face-to-face in office visits for primary care. Providers also requested the specific data fields required for compliance monitoring.

    HHSC RESPONSE: HHSC agrees that guidance will be necessary for accuracy of these counts. Myers and Stauffer, LC (MSLC), the independent assessor, has provided the data fields used for validation as a guide for collectable data. HHSC realizes local health departments (LHD) may not be able to meet all of the data fields required. A significant factor in reporting is that the provider maintain consistency in what is counted and how it is counted when measuring the baseline and achievement.

    MSLC data fields used for encounter/individual data validation during DY2-5 compliance monitoring:

    - Unique Patient ID

- Date of birth
- Encounter date
- Service type
  - This may be a description and/or CPT Code that indicates service(s) received.
  - The data point provided should demonstrate service was received and differentiate services if a patient had more than one encounter on the same day.
- Encounter location
- Physician/practitioner providing service
- For MLIU, MSLC asks for the payor source/insurance in order to assess that the patient is MLIU. HHSC has agreed to take self-attestation of patients as uninsured.

HHSC is amending the PFM Protocol to include the following definition of unique individual: a patient receiving a face-to-face or virtual encounter (a service, billable or not) that is the equivalent of a service that would be provided within the physical confines of the system. This could include home-visits or other venue-based services that are documented. The service should be billable or charted. Providers are not allowed to count phone calls, text messages, or undocumented encounters.

34. Stakeholders requested to know what the PPP template will look like.

    HHSC RESPONSE: The template has not yet been designed, but will likely contain fields for a MLIU PPP number and Total PPP number. HHSC will also likely incorporate fields for identifying the population that the provider has included in its MLIU numbers, similar to the check boxes utilized for the DY6 QPI template. At this time, HHSC does not anticipate collecting encounter data for the entire system. However, Microsoft Excel provides an easy tool for removing duplicates; providers might consider utilizing Excel to remove duplicates when combining data from multiple EMR/EHR systems.

MLIU PPP Baseline

35. Stakeholders were concerned about meeting the timeline for reporting the baseline when DY6 will complete September 30, 2017, and the RHP Plan Update and MLIU PPP baselines are due in November 2017. This concern was especially tied to accessibility/programming of EHR systems, combining data from various EHR systems, and counting unduplicated individuals.

    HHSC RESPONSE: HHSC has agreed to move back the RHP Plan Update due date to January 31, 2018. This should help accommodate a provider's ability to have all of DY6 data available and allow additional time to combine data and remove duplicate individuals.

36. Stakeholders seemed to need additional clarification regarding the baseline being the average of DY5 and DY6 Total PPP and MLIU PPP. Some providers wanted to use one year or the other.

HHSC RESPONSE: The baseline is not the MLIU QPI numbers from DY5 or DY6. Providers will be calculating a completely new baseline for measuring their PPP. The baseline will be a system-wide count, no longer specific to projects. To calculate a provider's Total PPP baseline, a provider will count the system's total patient population in DY5 and add it to the total patient population in DY6, then divide by 2 to get the average total patient population. This will be the baseline.

To calculate a provider's MLIU PPP baseline, the provider will count the system's MLIU patient population in DY5 and add it to the MLIU patient population in DY6, then divide by 2 to get the average MLIU patient population. This will be the MLIU PPP baseline and will serve as the MLIU PPP goal for DY7 and DY8. When reporting the baseline as part of the RHP Plan Update in January 2018, the provider will report the Total PPP for DY5 and DY6, and the MLIU PPP for DY5 and DY6. HHSC is asking the provider to use an average in order to account for natural fluctuation in a system size. HHSC may consider requests for establishing baselines based on one year or the other for good cause indicated in the RHP Plan Update.

MLIU PPP Individuals and Ratio, Allowable Variation

37. Many stakeholders were concerned about maintaining both the MLIU numeric patient population and ratio. They raised concerns about increasing the size of their system, which could reduce the ratio achievement levels. Others were concerned that economic factors or policy changes could impact their populations and might impact their numeric tally. While others wanted to only maintain the ratio and not the numeric total. In general, providers believed they have more stable populations and more control of the size in a project-based measurement.

    HHSC RESPONSE: HHSC does understand the concern regarding shifts in demographics and moves toward including additional clinics or shifts that occur due to system changes. The allowable variation is set up to accommodate minor shifts that may occur as a result of these system or policy changes, but HHSC will also include these items as "good cause" for requesting updates to baselines and goals.

    Achievement of MLIU PPP will require maintenance only of the numeric MLIU value, not the ratio. Providers will be required to report on both the Total Population and the MLIU Population so that HHSC can monitor the MLIU ratio. Providers will not be required to maintain the ratio, but they would be required to explain any changes in ratio. HHSC amended the PFM Protocol to make these changes.

38. Many stakeholders wanted clarification on allowable variation. Providers wanted to know sooner rather than later what the allowable variation could be (not wait until baselines reported). Providers wanted to know how the size and type of provider would impact allowable variation. A number of providers also wanted greater range in variation (or to be completely exempt) if the percentage of MLIU patients was already high.

HHSC RESPONSE: The purpose of the allowable variation is to account for minor system fluctuations without necessitating baseline and goal changes for MLIU PPP. Allowable variation only applies to Category B reporting. In conjunction with partial achievement thresholds, HHSC believes this provides some flexibility for providers while still emphasizing the DSRIP focus on the MLIU target population.

HHSC will not be able to provide the allowable variation thresholds until we have a better understanding of the definition of systems that providers have chosen and the starting point of patient population by provider. However, HHSC will take into account both the overall size of a provider's population and the proportion of their population that is MLIU to set the allowable variance. As MLIU PPP achievement is eligible for partial payment, the allowable variance will not be larger than 10 percent.

39. Stakeholders asked questions about maintaining the MLIU PPP number and ratio and potentially being penalized for increases or decreases. Providers also raised concerns about "diluting" the MLIU population by shifting from project-specific numbers to systems. There was concern about this shift impacting valuation.

    HHSC RESPONSE: HHSC will clarify in the PFM language that achievement will be based on maintaining or increasing over the baseline. HHSC has set maintenance goals so that (1) DSRIP providers will continue to focus on the primary target population of the program; and (2) providers do not adversely select patient populations in an effort to more easily improve on outcome measures. HHSC is not holding providers accountable for the difference between MLIU QPI (DY5 and DY6) and MLIU PPP (DY7-8). HHSC realizes there will be a shift in the reported ratio, if not also the numbers because of what is being counted. Providers will not be penalized for this; there is no apples to apples comparison between DY5 and DY6 and DY7-8. There is no impact on provider valuation related to PPP in DY7-8.

MLIU PPP Reporting

40. Many stakeholders wanted the option to report in October DY7 if they were able to do so. Stakeholders also indicated that the language in the PFM was unclear (requested to use April reporting period instead of first round, etc.)

    ***HHSC RESPONSE*:** HHSC updated the PFM to allow providers to report on MLIU PPP in the October reporting period for the DY for which they are reporting achievement, with the option to carry forward reporting (not achievement) to April of the following DY (the first round of reporting of the following DY). There will only be one carry forward reporting period.

G. Category C - Measure Bundle Requirements for Hospitals and Physician Practices

41. Stakeholders recommended that hospitals and physician practices be able to select individual measures rather than Measure Bundles.

    HHSC RESPONSE: Hospitals and physician practices will be required to select Measure Bundles rather than individual measures to promote the standardization of measures across the hospitals and physician practices, thereby encouraging collaboration among them on interventions to improve performance on shared health outcome measures, and making it easier to assess the effectiveness of interventions on those shared health outcome measures.

42. Stakeholders recommended that each Measure Bundle have required measures and optional measures.

    HHSC RESPONSE: HHSC agrees with this recommendation and has revised the PFM protocol proposal to make some measures in each hospital and physician practice Measure Bundle optional. Under the revised PFM protocol proposal, hospitals and physician practices will select Measure Bundles, which will have both required and optional measures. Hospitals and physician practices will then select which, if any, optional measures they would like to do.

43. Stakeholders expressed concern that the number of measures that Performing Providers are required to report will significantly increase under the new Measure Bundle structure.

    HHSC RESPONSE: HHSC has revised the Minimum Point Threshold (MPT) formula so that, on average, the number of Category C measures that Performing Providers are required to report on for DYs 7-8 will be about the same or slightly more than they were required to report on for DY5.

44. Stakeholders recommended that HHSC update the compendiums to reflect HHSC updates and changes in national standards (such as HPV national guidelines changing from 3 vaccines to 2 vaccines for ages 9 through 14 years).

    HHSC RESPONSE: HHSC intends to release an updated compendium for DY7-8 that will include updated measure specifications and guidelines as applicable to each approved measure.

45. Stakeholders requested clarification regarding the timeline and process for Measure Bundle development, including whether HHSC will work with stakeholder groups to develop the Measure Bundle categories for hospitals and physician practices in addition to the measures within the Measure Bundles.

    HHSC RESPONSE: HHSC is working with Bundle Advisory Teams to develop menus of measures for hospitals and physician practices. Bundle Advisory Teams consist of members

of the Clinical Champions workgroup nominated by the RHPs, the Texas Hospital Association, the Texas Medical Association, and Texas Health and Human Services agency staff. Once the draft menus are developed, HHSC will solicit stakeholder feedback on them, hopefully in June 2017.

46. Stakeholders recommended adding a number of Measure Bundles for hospitals and physician practices.

    HHSC RESPONSE: HHSC has reviewed the recommended Measure Bundles, and is considering adding the following:
    - Rural healthcare
    - Care Transitions and Hospital Readmissions
    - Patient Navigation and Emergency Department Diversion
    - Hepatitis C Screening and Treatment
    - Pediatric Specialty Care
    - Pediatric Hospital Safety
    - Pediatric Chronic Disease Management: Diabetes Care
    - Pediatric Chronic Disease Management: Asthma Care
    - Adolescent Primary Care
    - Stroke
    - Chronic Obstructive Pulmonary Disease (COPD)
    - Pneumonia
    - Pediatric dental

47. Stakeholders recommended that since Performing Providers are not required to make connections between their DSRIP projects for DY1-6 and their Measure Bundles/ measures for DY7-8, the Measure Bundle/ measure menu should be expanded to include new focuses not included in DY2-6, such as inpatient/ hospital quality.

    HHSC RESPONSE: While shifting the reporting emphasis from a project level to a provider system level allows Performing Providers to more easily adapt and modify interventions, HHSC still intends DY7-8 measurement to be a continuation of the DY2-6 DSRIP focus. The DY7-8 Measure Bundle areas allow expansion of successful activities from DY2-6 and build on the Clinical Champions' work to identify the most transformative DSRIP project areas and best practices.

48. Stakeholders suggested aligning the Category C measures with existing outcome measures Performing Providers are already reporting, such as CMS measures, Agency for Healthcare Research and Quality (AHRQ) measures, and National Quality Forum (NQF) measures. They also requested that HHSC use provider-based measure specifications rather than managed care organization (MCO)-based measure specifications.

HHSC RESPONSE: Where possible, HHSC has instructed Clinical Champions - Bundle Advisory Teams to first use the most common measures from the existing DSRIP Category 3 Menu for DY7-8, and to seek additional measures from the CMS Medicaid Core Set of Measures for Adults and Children, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Quality Payment Program (QPP) Priority Measures, and other measures currently endorsed by NQF. HHSC will continue to use provider-based measure specifications where available and modify MCO-based measure specifications if needed.

49. Stakeholders requested clarification regarding how HHSC will determine the point value of each Measure Bundle. They requested that certain factors, such as the amount of effort and work required to achieve improvement on the measure, the measure's impact, and how the measure aligns with the MLIU population be used to determine Measure Bundles' point values.

    HHSC RESPONSE: The Measure Bundle Protocol will specify the methodology for assigning point values to Measure Bundles. Measure Bundles may be assigned point values based on a variety of factors, which may include: 1) the number of Category C P4P measures in the Measure Bundle that are currently used in Category 3 and designated as standalone measures; 2) the number of P4P measures in the Measure Bundle; and 3) whether the Measure Bundle is designated as a state priority.

50. Stakeholders recommended several factors to be included in the MPT formula for hospitals and physician practices, such as the percent by which a hospital's or physician practice's "system" volume for DY7-8 increases from its DSRIP project volume for DY6.

    HHSC RESPONSE: Though HHSC has not included a factor in the MPT formula for hospitals and physician practices that accounts for the change in the number of individuals served by a hospital's or physician practice's DSRIP projects to the number of individuals served by a hospital's or physician practice's system, HHSC has made a number of modifications to the MPT formula for hospitals. For example, Medicaid and uninsured inpatient days and Medicaid and uninsured outpatient costs are now used to determine the Statewide Ratio. HHSC has also modified the MPT formula for physician practices to remove the use of the Statewide Ratio. In addition, HHSC has added a provision specifying that the MPT for a hospital or physician practice that is a specialty hospital or physician practice that has a limited scope of practice will be determined using an alternate methodology to be determined by HHSC.

51. Stakeholders requested clarification regarding whether a hospital or physician practice may select Measure Bundles worth more points than its MPT to spread its risk.

    HHSC RESPONSE: A hospital or physician practice may select Measure Bundles worth more points than its MPT.

52. Stakeholders requested that HHSC consider options for instances when a hospital's or physician practice's Measure Bundle points are just below the MPT; they believe it is unfair that a hospital or physician practice would have to pick another Measure Bundle if, for example, the hospital's or physician practice's Measure Bundle points are only one point beneath the hospital's or physician practice's MPT.

    HHSC RESPONSE: HHSC will maintain the policy that the sum of a hospital's or physician practice's selected Measure Bundles' point values must be greater than or equal to the hospital's or physician practice's MPT.

53. Stakeholders requested clarification regarding the amount by which a hospital's or physician practice's valuation would be reduced if it did not select Measure Bundles worth enough points to meet its MPT. They recommended that if a hospital or physician practice does not select Measure Bundles worth enough points to meet its MPT, the funding should be made available to other Performing Providers in the RHP.

    HHSC RESPONSE: If a hospital or physician practice does not select Measure Bundles worth enough points to meet its MPT, its total DY7 valuation will be reduced proportionately across its RHP Plan Update funds and Categories B-D based on the number of Measure Bundle points selected, and its total DY8 valuation will be reduced proportionately across its Categories B-D based on the number of Measure Bundle points selected.

    Example: A hospital's DY7 valuation is $5 million and its MPT is 50. The RHP's private participation requirements are met, so if it were to select Measure Bundles worth 50 points, its DY7 valuation would be allocated as follows: $1 million for the RHP Plan Update (20%); $500,000 for Category B (10%); $2.75 million for Category C (55%); and $750,000 for Category D (15%).

    However, the hospital selects Measure Bundles worth only 40 points. Its DY7 valuation is decreased to $4 million and is allocated as follows: $800,000 for the RHP Plan Update (20%), $400,000 for Category B (10%), $2.2 million for Category C (55%), and $600,000 for Category D (15%).

    Funds associated with a hospital or physician practice not selecting Measure Bundles worth enough points to meet its MPT will not be made available to other Performing Providers in the RHP.

54. Stakeholders recommended that HHSC reduce the MPT cap for hospitals and physician practices.

    HHSC RESPONSE: HHSC included the MPT cap of 100 in the draft PFM protocol proposal only for the purposes of providing an example of how a hospital's or physician practice's MPT may be determined. HHSC has reviewed stakeholder feedback regarding the volume of measures Performing Providers must report for DY7-8, as well as the average

unduplicated number of Category 3 measures selected by Performing Providers for DY5. Based on the findings of this review, HHSC has set the MPT cap for hospitals and physician practices at 75 points.

55. Stakeholders requested that there be a process for Performing Providers to appeal/ request a reduction to their assigned MPTs.

    HHSC RESPONSE: HHSC has not revised the PFM protocol proposal to include a process for Performing Providers to appeal or request a reduction to their assigned MPTs because the MPT methodology must be applied consistently to ensure fairness.

56. Stakeholders recommended that hospitals and physician practices be allowed to allocate their Category C valuation among their selected Measure Bundles.

    HHSC RESPONSE: Each hospital and physician practice may allocate its Category C valuation among its selected Measure Bundles as it wishes, so long as: 1) no single Measure Bundle is allocated a percentage of the Category C valuation that is less than half of its point value as a percentage of all the selected Measure Bundles' point values; and 2) no Measure Bundle without any standalone measures is allocated a higher percentage of the hospital's or physician's Category C allocation than the Measure Bundle's point value as a percentage of all its selected Measure Bundles' point values.

    The minimum Measure Bundle valuation is calculated using the following formula:
    (Measure Bundle point value/ all selected Measure Bundles' point values)/ 2 * Category C valuation

    The maximum Measure Bundle valuation for a Measure Bundle without any standalone measures is calculated using the following formula:
    (Measure Bundle point value/ all selected Measure Bundles' point values) * Category C valuation

    Example:
    - A hospital has four Measure Bundles each worth 10 points.
    - Measure Bundle A has no standalone measures. Measure Bundles B-D have standalone measures.
    - Each Measure Bundle's point value as a percentage of all the selected Measure Bundles' point values is 25%.
    - The hospital or physician practice may not allocate to Measure Bundles A-D less than 12.5% of its Category C valuation.
    - The hospital or physician practice may not allocate to Measure Bundle A more than 25% of its Category C valuation.

57. Many stakeholders indicated that the valuation for a measure in a Measure Bundle should be based on its point value and/ or other factors, such as its impact/ difficulty. Some

stakeholders requested hospitals and physician practices have the ability to allocate a Measure Bundle's value among the measures in the Measure Bundle as they see fit. Other stakeholders agreed that measures within a Measure Bundle should have equal valuations.

HHSC RESPONSE: HHSC will maintain equal valuations for measures in a Measure Bundle. Equal valuations for measures in a Measure Bundle should help hospitals and physician practices spread their risk and are less administratively complex. Hospitals and physician practices may maximize the valuation of required standalone measures in a Measure Bundle by not selecting optional measures in the RHP Plan Update.

58. Stakeholders requested clarification regarding the methodology for determining the standard point valuation.

HHSC RESPONSE: HHSC has established a standard point valuation of $500,000 and an MPT cap of 75 for hospitals and physician practices so that, on average, the number of Category C measures that hospitals and physician practices are required to report on for DY7-8 will be about the same or slightly more than they were required to report on for DY5. A summary of the data used to determine the standard point valuation and MPT cap for hospitals and physician practices is below.

	Performing Provider Type				
	All	**Hospitals**	**Physician Practices**	**CMHCs**	**LHDs**
Total DY5 SA Selections*	1298	744	142	336	75
Total DY5 NSA Selections*	662	401	108	62	53
Cat 1-4 DY7 Max Valuation	$3,074,559,174	$2,065,179,415	$363,132,216	$492,040,445	$131,355,857
Max DY7 Valuation per DY5 point	$674,837	$784,345	$680,023	$459,851	$472,503

*Total unduplicated measure count so that identical measures (including selection, baseline rate, and performance rate) under a single provider in a single region are counted as one measure.

	Max DY7 Valuation (in Millions) All Performing Provider Types					
	>$20	**$10 - $20**	**$5 - $10**	**$1 - $5**	**$.5 - $1**	**<$.5**
Total DY5 SA Selections*	454	233	230	242	56	83
Total DY5 NSA Selections*	230	101	141	110	15	27
Number of Providers	33	32	55	111	36	56
Cat 1-4 DY7 Max Valuation	$1,891,011,283	$455,683,921	$406,866,967	$278,214,234	$26,517,819	$16,264,951
Max DY7 Valuation per DY5 point	$1,187,821	$569,605	$489,611	$332,792	$144,906	$58,931

*Total unduplicated measure count so that identical measures (including selection, baseline rate, and performance rate) under a single provider in a single region are counted as one measure.

H. Category C - Measure Selection Requirements for Community Mental Health Centers (CMHCs)

59. Stakeholders recommended to allow Community Mental Health Centers (CMHCs) to develop their own measure bundles and/or allow flexibility in choosing measures within the bundle.

HHSC RESPONSE: Based on the revised PFM, CMHCs will no longer need to create a Measure Bundle, and instead they will select measures to report on. As previously proposed by HHSC, providers will have flexibility in selecting measures based on the number of required points.

60. Stakeholders suggested that HHSC add the CMHCs' measures list and final criteria for assigning point values to the measures to the PFM.

    HHSC RESPONSE: HHSC is not including the CMHCs' list of measures in the PFM since this information will be included in the Measure Bundle Protocol. HHSC included additional details in the PFM related to the standard point valuation in paragraph 18.h. HHSC also included a description of the Minimum Point Thresholds for CMHCs in paragraph 18.i.

61. Stakeholders included suggestions for the measures to be considered for the CMHCs' final measures list.

    HHSC RESPONSE: HHSC appreciates the feedback on the measure suggestions and will consider them in the development of the final measures list.

62. Stakeholders suggested that the measure point value be based on the complexity of gathering data for reporting and the nature of the measures.

    HHSC RESPONSE: HHSC will work on the methodology for assigning point values for each measure during April and May of 2017. Measures and the assigned point values will be included in the Measure Bundle Protocol. Stakeholders will have the opportunity to provide feedback on the measures and point values when the protocol is released in June 2017.

63. Stakeholders recommended that instead of valuing measures equally, more value should be placed on measure(s) that have higher point values assigned.

    HHSC RESPONSE: HHSC updated the PFM to reflect that CMHCs can allocate the valuation among selected measures as long as no single measure is allocated less than half of its initial measure valuation, which is determined by the total valuation for Category C divided by the total number of measures selected. CMHCs may not increase the valuation of non-standalone measures. For more information see paragraph 18.g. of the revised PFM.

64. HHSC should allow for a shorter baseline measurement period.

    HHSC RESPONSE: HHSC revised the PFM to allow for shorter baseline measurement periods and delayed baseline measurement periods as described in paragraph 19.

I. Category C - Measure Selection Requirements for Local Health Departments (LHDs)

65. Stakeholders recommended to allow Local Health Departments (LHDs) to develop their own measure bundles and/or allow flexibility in choosing measures within the bundle.

    HHSC RESPONSE: Based on the revised PFM, LHDs will no longer need to create a Measure Bundle, and instead they will select the measures to report on. As previously proposed by HHSC, providers will have flexibility in selecting measures based on the number of required points.

66. Stakeholders recommended that Measure Bundles should be in line with the number of individuals seen and services inclusive of those individuals in the MLIU PPP.

    HHSC RESPONSE: Category B is counting patient population of the system. Category C measures will not necessarily apply to the entire system; measure denominators may be naturally limited by setting or measure specification. However, Category C should not be measuring a population that is not included in the Cat B system Total Patient Population by Provider.

67. Stakeholders suggested allowing the flexibility to change measures within a bundle in cases where the LHD has already met the achievement.

    HHSC RESPONSE: Based on the revised PFM, LHDs will no longer need to create a Measure Bundle, and instead they will select the measures they will report on. LHDs could also submit a request to HHSC to replace a selected Category C measure with one or more other Category C measures with point values greater than or equal to the point value of the measure being replaced. This request will need to be submitted prior to the second reporting period of DY7.

68. Stakeholders recommended that HHSC should consider the timing of the information available to providers, since it may be difficult for LHDs to plan for changes without knowing which measure bundles providers will be required to report on.

    HHSC RESPONSE: Based on the revised PFM, LHDs will no longer need to create a measure bundle, and instead they will select the measures they will report on. It is anticipated that the current list of measures used by LHDs will be available to select from for DY7-8. Performing Providers will also have an option to delay reporting by one reporting period when additional time is needed for data collection.

69. Some stakeholders included suggestions for the measures to be considered for the LHDs' final measure list.

HHSC RESPONSE: HHSC appreciates feedback on the measure suggestions and will consider them in the development of the final measures list.

70. Stakeholders submitted recommendations on how to approach assigning point values to measures. Recommendations included multiple options, such as tying the value of a bundle to the complexity of gathering data for reporting, the size of interventions, or the impact a measure has on improving health or reducing costs. Stakeholders also requested to add the final criteria for assigning point values in the PFM.

    HHSC RESPONSE: HHSC will work on the methodology for determining measure point values as we continue to develop the requirements. HHSC will include LHD measures with the assigned point value in the Measure Bundle Protocol. Stakeholders will be able to provide feedback on measure point values when the Measure Bundle Protocol is released.

71. Some stakeholders recommended alternative approaches in determining the valuation of each measure. Recommendations included options of weighting the measures based on the point value, taking into consideration clinical versus non-clinical status of the measure, or the impact a measure has on improving health or reducing costs.

    HHSC RESPONSE: HHSC updated the PFM to reflect that LHDs can allocate the valuation among selected measures as long as no single measure is allocated less than half of its initial measure valuation, which is determined by the total valuation for Category C divided by the total number of measures selected. LHDs may not increase the valuation of non-standalone measures. For more information see paragraph 18.g. of the revised PFM.

J. Category C - Measurement Periods for P4P Measures

72. Stakeholders recommended that Performing Providers be allowed to use alternate baseline measurement periods for Category C measures, such as shorter, earlier, or delayed baseline measurement periods.

    HHSC RESPONSE: HHSC has revised the PFM protocol proposal to allow for shorter baseline measurement periods and delayed baseline measurement periods as described in paragraph 19. Earlier baseline measurement periods that begin prior to January 1, 2017, are not allowed.

73. Stakeholders requested that performance measurement periods be DYs rather than CYs, as using CYs substantially shifts payments from January (for October reporting) to July (for April reporting), which may cause providers to have cash flow issues.

    HHSC RESPONSE: HHSC has maintained the CY measurement periods because: 1) other Texas Medicaid quality programs, NCQA, etc., use CY measurement periods; and 2) now that HHSC is moving the deadline for RHP Plan Update submission to January 2018, PY1 will

begin at approximately the same time as RHP Plan Update submission (which includes Measure Bundle/ measure selection).

74. Stakeholders recommended that measurement periods be consistent across the DSRIP categories (or at least across the Category C P4P and P4R measures) to minimize Performing Provider confusion and prevent data collection errors.

    HHSC RESPONSE: Given the significant flexibility granted to Performing Providers in selecting baseline measurement periods for Category 3 outcomes for DY3-6, and the carryforward allotted to Quantifiable Patient Impact (QPI) in DY3-6, the standardization in measurement periods by Category represents a significant move towards standardization. Also, the Category B measurement period (the DY) allows Performing Providers to earn some payments in January (for October reporting), while the Category C measurement period (the CY) allows Performing Providers to earn some payments in July (for April reporting).

75. Stakeholders requested that there be no payment for performance for DY7, as Performing Providers will not have sufficient time to implement interventions to impact performance for DY7.

    HHSC RESPONSE: HHSC has revised the PFM protocol proposal to allow carryforward of achievement for Category C outcome measures so that Performing Providers have additional time to impact performance. While HHSC is no longer requiring Performing Providers to report project-level outcomes in DY7-8, the Measure Bundles are an extension of the most common and successful activities in DY2-6 so that Performing Providers can continue and expand their most transformative activities with the flexibility to change current activities or adopt new activities.

76. Stakeholders expressed concern that Performing Providers may not have the necessary data to establish baselines for a measure if they have not been collecting data for the measure during the baseline measurement period (CY2017).

    HHSC RESPONSE: HHSC has revised the PFM protocol proposal to allow for delayed baseline measurement periods with no carry forward of achievement of the DY7 goal achievement milestone.

K. Category C - Measure Milestones

77. Stakeholders recommended that HHSC allow carry forward of achievement for Category C measures.

    HHSC RESPONSE: HHSC agrees with this recommendation and has revised the PFM protocol proposal to allow for carry forward of achievement for Category C P4P measures.

L. Category C - Measure Denominator Population Universe

78. Stakeholders requested clarification regarding what happens if a Category C measure's denominator is too small.

    HHSC RESPONSE: HHSC anticipates that small denominators for Category C measures will be uncommon in DY7-8, as Performing Providers will be moving from a project level of measurement to a system level of measurement.

    However, a hospital or physician practice may only select a Measure Bundle for which all the standalone measures in the Measure Bundle have an estimated all-payer denominator or number of eligible cases of at least 30 for the baseline measurement period, as specified in Attachment TBD "Measure Bundle Protocol."

    Likewise, a CMHC or LHD may only select a measure that has an estimated all-payer denominator or number of eligible cases of at least 30 for the baseline measurement period, as specified in Attachment TBD "Measure Bundle Protocol."

79. Stakeholders requested clarification regarding the disallowance of subsets in the context of broadening the definition of system.

    HHSC RESPONSE: Category C measures may be setting specific so that within a Performing Provider's system there are defined settings such as hospital, emergency department, outpatient primary clinic, and dental clinic.

    While Performing Providers were allowed to modify the eligible denominator population for Category 3 for DY3-6 to specify a single primary clinic, Performing Providers must include all primary care clinics in the Performing Provider's system for a Category C measure specified for the outpatient primary care setting for DY7-8. Performing Providers may not use subsets to modify a measure's eligible denominator population by age, gender, or comorbid condition other than by those definitions included in the approved measure's specifications for DY7-8 or otherwise specified in the Measure Bundle Protocol.

80. Stakeholders requested clarification regarding whether sampling will be an option for Performing Providers to determine a Category C measure's denominator.

    HHSC RESPONSE: HHSC anticipates that sampling will be an option for baseline setting if a Performing Provider cannot pull a specific measure from their electronic health record, with requirements similar to those in place for baselines in DY3.

81. Stakeholders recommended that Performing Providers not be required to report three rates for each Category C measure (Medicaid-only, LIU-only, and all payer) as it is administratively burdensome and adds unnecessary layers of complexity to Category C reporting.

HHSC RESPONSE: The target population for DSRIP in DY7-8 continues to be individuals enrolled in Medicaid and individuals that are low-income or uninsured. Therefore, where possible, Performing Providers should measure the impact of transformative activities on the target population.

HHSC has allowed for exceptions to the requirement that Performing Providers report an all-payer, Medicaid, and LIU rate for Category 3 for DY7-8 when an outcome cannot be tracked by payer type (for example, Days to Third Next Available Appointment or ED Throughput Times). HHSC has also allowed for exceptions to the requirement that achievement milestone goals be based off the combined M/LIU rate when a Performing Provider has a low MLIU volume for a certain measure (for example, for Diabetes Care: HbA1c poor control, if a Performing Provider had a combined MLIU denominator of 25 at baseline, and an all-payer denominator of 50, the achievement milestone goal could be based of the all-payer denominator).

82. Stakeholders expressed concern regarding achievement of Category C pay-for-performance (P4P) measures based on the MLIU rate. They indicated that many Performing Providers do not collect and verify income information from patients and therefore would not be able to accurately identify patients with income below 200% FPL.

    HHSC RESPONSE: Performing Providers are not required to include low-income individuals in reporting the number of MLIU individuals served by their system; they can choose just to report the number of Medicaid and uninsured individuals served by their system.

83. Stakeholders recommended that Performing Providers be given the option as to whether to be paid for performance of a Category C P4P measure based on achievement of the MLIU rate or the all-payer rate. They further recommended that Performing Providers be allowed to decide whether to use the MLIU rate or all-payer rate at the time of baseline reporting instead of at the time of Measure Bundle selection, to allow them adequate time to determine whether low patient volume or data limitations make MLIU rate reporting unfeasible.

    HHSC RESPONSE: Performing Providers will be paid for performance of a Category C P4P measure based on achievement of the MLIU rate. However, a Performing Provider may, in the RHP Plan Update submission, request to be paid for performance based on achievement of the all-payer rate for good cause.

M. Category D - Statewide Reporting Measure Bundle

84. Stakeholders requested that HHSC share additional information on the statewide reporting measure bundles including the list of measures for each provider type.

    HHSC RESPONSE: HHSC anticipates that hospital reporting for Category D will remain similar to Category 4 in DY6A. HHSC will be working with new types of providers, such as CMHCs,

LHDs, and physician practices, on establishing measures for reporting Category D. HHSC will include the list of the measures in the Measure Bundle Protocol, which will be released for stakeholder feedback in June 2017.

85. Several stakeholders requested clarification on the current list of measures for hospitals participating in Category 4, including hospitals that are currently exempt from Category 4 reporting.

    HHSC RESPONSE: Category D will contain six domains for hospital Performing Providers, which is similar to the current Category 4 reporting domains (HHSC plans to split an existing reporting domain (RD-4) into two domains). Hospitals that are exempt from Category 4 reporting (as described in paragraph 12.f. of the PFM) may continue to request exemption from this type of reporting under conditions that will be specified in the Measure Bundle Protocol. The full list of measures proposed for Category D will be included in the Measure Bundle Protocol, which will be released for stakeholder feedback in June 2017.

Private Hospital Participation Incentive

86. Over 20 stakeholders requested that the private hospital participation incentive be strengthened to proportionately reduce a governmental entity's additional DSRIP funding over their Pass 1 allocation if the IGT entity reduces or ends IGT funding for their affiliated private hospitals.

    HHSC RESPONSE: To ensure fairness, an incentive or disincentive must be applied equally for the same action. Due to the following limitations, HHSC proposes to maintain the current Category D incentive; however, HHSC has increased the incentive from a maximum of 10 percent of total valuation in Category D to 15 percent.

    i. Approximately 15 percent of the over 200 DSRIP IGT Entities may be considered Performing Providers. If an IGT Entity that is not a Performing Provider discontinued private hospital funding, then HHSC would not be able to apply the proportionate reduction to Pass 1 allocations.
    ii. The Pass 1 private hospital participation target was a regional requirement with regional benefits. The minimum requirement to access additional funds in later passes was exceeded by all regions. The required Pass 1 DY5 private hospital funding was $289M while the current DY6A private hospital funding is $870M. If HHSC applied the Pass 1 regional requirements, then all Performing Providers in the region would be reduced to Pass 1 allocations if the region went below the following required Pass 1 private hospital funding. If the submitted RHP Plan Updates result in private hospital participation below $289M, then HHSC may consider a change for DY8 requirements.

RHP	Tier	Required Pass 1 Private Hospital Funding DY5	Current DY6A Private Hospital Valuation
1	3	$10,668,019	$38,856,709
2	3	$7,599,230	$12,933,175
3	1	$78,077,756	$133,630,962
4	3	$7,104,471	$64,989,767
5	4	$7,910,557	$108,996,712
6	2	$42,174,300	$68,777,524
7	3	$13,124,987	$84,513,275
8	4	$1,924,058	$9,607,121
9	2	$57,602,389	$124,422,742
10	2	$38,895,598	$50,540,564
11	4	$1,060,404	$21,345,261
12	3	$7,851,352	$40,896,051
13	4	$661,307	$14,111,711
14	4	$867,480	$13,799,933
15	3	$6,126,893	$39,491,671
16	4	$1,450,339	$8,476,165
17	4	$2,202,817	$12,637,136
18	4	$1,417,136	$5,311,040
19	4	$855,612	$5,832,483
20	4	$1,676,036	$11,173,926
TOTAL		**$289,250,742**	**$870,343,929**

iii. A Performing Provider's Pass 1 allocation is not equivalent to the Performing Provider's Pass 1 valuation. This would result in different impacts by provider, if assuming a constant Pass 1 allocation amount as calculated for the original RHP Plan submission in December 2012. The differences in valuation from allocation are due to:

a) Pass 1 projects may have been withdrawn.
b) There was a Pass 1 option for Performing Providers to collaborate on their allocations.
c) HHSC or CMS required changes in project valuation.
d) Category 3 was revalued through the Category 3 outcome selection process in March 2014 which redistributed Pass 1 valuation.
e) Some non-hospital Performing Providers serve as IGT Entities for private hospitals. However, non-hospitals did not have provider-specific Pass 1 allocations, rather there were regional non-hospital provider type allocations.

iv. IGT Entities are currently allowed to change IGT funding before each payment period without penalties. These IGT changes will continue to be allowed in DY7-

8. Most historical changes in IGT Entities or proportion of IGT funding have been replaced by other IGT Entities. If a private hospital is able to continue at the same level of DSRIP with replaced IGT funding, then it does not seem reasonable to proportionately reduce the previous IGT Entity's DSRIP valuation.

87. Stakeholders requested that HHSC maintain the current rule regarding proportionate payment reductions if a governmental entity does not submit the full IGT.

HHSC RESPONSE: HHSC is not planning to change the proportionate payment reduction rule under Title 1 of the Texas Administrative Code §355.8203. The IGT rules are not required for inclusion in the PFM Protocol based on previous CMS guidance.

N. Disbursement of DSRIP Funds/DSRIP Payments

Basis for Payment of Category B - MLIU PPP

88. Stakeholders wanted clarification about payment structure; they wanted to know if they could earn equal parts of the Category B valuation for the three pieces of reporting: Total, MLIU, and ratio.

HHSC RESPONSE: Performing Providers can earn the total Category B valuation if they report both MLIU PPP and Total PPP and maintain the MLIU PPP numeric value. Performing Providers will be required to provide an explanation for any variance in ratio of MLIU PPP to Total PPP in order to be eligible for the payment.

89. Stakeholders were concerned about the tiers or partial payment being 90%, 75% and 50%. Some stakeholders wanted a 25% option to be consistent with Category C partial payments. Some stakeholders indicated equal tiers would be easier to calculate and requested they be set at 10%.

HHSC RESPONSE: HHSC does not believe providers should earn a payment when they have reduced their MLIU patient population by more than half. Since Category B is about maintaining a patient population and not growing a patient population, HHSC believes the thresholds are appropriate. Category B and Category C are very different and measurement is not comparable.

Partial payment will be tiered in the following manner: 100% valuation for achievement at 100% of goal (with allowable variation); 90% of valuation for achievement of 90% to 99% (no allowable variation); 75% of valuation for achievement of 75% - 89% of goal (no allowable variation); or 50% of valuation for achievement of 50% - 74% of goal (no allowable variation). A Provider will not earn any payment for maintaining less than 50% of its MLIU patient population.

Basis for Payment of Category C - Measure Bundles

90. Stakeholders requested that HHSC consider allowing Performing Providers to receive partial payment for P4R Category C measures.

    HHSC RESPONSE: Performing Providers will continue to be eligible to receive full payment for successfully reporting a P4R Category C measure, with no option for partial payment.

91. Stakeholders recommended moving Category C P4P measure partial achievement at the quartile level to the decile level.

    HHSC RESPONSE: HHSC has maintained measure partial achievement of a Category C P4P measure at the quartile level, as the quartile level is used in DY2-6 and in other quality-based payment programs.

92. Stakeholders recommended that HHSC allow partial achievement for maintenance for measures on which the Performing Provider is high performing.

    HHSC RESPONSE: For outcomes designated as QISMC where achievement milestones are set relative to a High Performance Level (HPL), Performing Providers with a baseline above the HPL are required to maintain performance rates above the HPL. Partial achievement is not relevant in this scenario, as Performing Providers may decrease their performance rate and still earn payment so long as performance is above the HPL. Performing Providers with a baseline below the HPL are not eligible for any achievement payments if performance decreases over a reported baseline.

Basis for Payment of Category D - Statewide Reporting Measure Bundle

93. Stakeholders requested additional clarification on the reporting of Category D and how the associated payments will be determined.

    HHSC RESPONSE: Performing Providers will be required to report all measures within each Category D domain that is specific to their provider type. Performing Providers will receive payments for each domain they report on. Depending on the measures in a domain, a domain may be reported in the first or second reporting period of a demonstration year, e.g., DY6A RD-1 Potentially Preventable Admissions (PPA) may be reported in April or October 2017. Different types of Performing Providers will have different statewide reporting measure bundles. HHSC will develop additional details to be included in the Measure Bundle Protocol, which will be released for stakeholder feedback in June 2017.

Carryforward Policy

94. Stakeholders requested carryforward for Category B, C and D. There was concern about inconsistencies between Category B and C with respect to carryforward and DY versus CY. Stakeholders also requested more guidance on Category D to understand the implications of a no carry forward policy.

    HHSC RESPONSE: In response to stakeholder feedback, HHSC will allow reporting of MLIU PPP achievement in October of the achievement DY or carryforward of reporting to April of the following DY. This carry forward will only apply to reporting, not achievement levels or measurement period. HHSC believes providing partial achievement of MLIU PPP is more appropriate for the short timeframe of DY7-8 and consistent with Category C reporting. Because HHSC will allow MLIU PPP reporting in October of the DY, there will be no change to the measurement period.

95. Stakeholders wanted clarification regarding how the reporting period would impact any DY6 carryforward reporting.

    HHSC RESPONSE: Reporting MLIU PPP will not impact DY6 carryforward QPI metrics. The provider is measuring different populations (project versus system) with different methodologies. QPI isolates the population above the pre-DSRIP level of service. MLIU PPP measures the total system population and is not isolating any particular number in that population. Therefore, DY6 QPI can still be carried forward without impacting the reporting period for MLIU PPP. In other words, the provider may count individuals in their MLIU PPP and Total PPP numbers that are also reflected in their carryforward DY6 MLIU QPI.

Remaining DY7-8 DSRIP Funds

96. Stakeholders proposed varied uses for the remaining DSRIP funds:
    a. Over 40 stakeholders requested that the remaining DSRIP funds be reallocated to current DSRIP providers or the region in general, for selection of additional measure bundles, for high performance on measures or improving MLIU PPP, for successful projects, to expand activities, to transition from project to system reporting, for sustainability activities, or for Category A.
    b. Over 20 stakeholders proposed that the remaining DSRIP funds be available to new providers that did not previously participate in DSRIP.
    c. Over 15 stakeholders proposed targeting the remaining DSRIP funds for specific entities that are currently participating in DSRIP. This included rural hospitals, children's hospitals, CMHCs, LHDs, Anchors, and DSRIP Performing Providers that also serve as IGT Entities.
    d. Over 15 stakeholders recommended that the remaining DSRIP funds be used for data sharing, system enhancements, and statewide or regional HIEs.
    e. Multiple stakeholders proposed targeted initiatives for the remaining DSRIP funds including MCO collaboration incentives, statewide initiatives for social determinants of health, rapid-cycle improvement pilots, systems of care for the uninsured, collaborative cross-regional projects, increasing mental health services support, care coordination

referral systems, care transitions pilots, statewide evaluation of DSRIP health outcomes for chronic diseases, targeted initiatives for the elderly, transportation services, and behavioral health projects in previous NorthSTAR counties.

HHSC RESPONSE: Based on HHSC review of the options and discussion with leadership, the remaining DSRIP funds will be allocated to the RHPs that did not fully utilize their original regional DY5 allocation based on DY6 valuation and the valuation associated with withdrawn projects that will be eligible beginning in DY7, excluding combined projects and changes due to home regions. The RHPs will be allocated a portion of the remaining DY7-8 DSRIP funds based on their proportion of the regional DY5 allocation that was not fully utilized out of the statewide total remaining DSRIP funds.

The RHPs may determine how the additional DSRIP funds may be used based on the community needs assessment. The funds may be used for new Performing Providers that are not currently participating in DSRIP and are one of the eligible Performing Provider types (hospital, LHD, CMHC, or physician practice) or for current Performing Providers under the DY7-8 framework (i.e. additional funding to current Performing Providers would be distributed among Categories according to the PFM Protocol). Each RHP will be required to conduct at least two public stakeholder meetings to determine the uses of the additional DSRIP funds. Each Performing Provider must certify that there is a source of IGT for the additional funding. Anchors will be required to describe the process for determining the uses of the additional funds and the interested providers that were or were not allocated additional DSRIP funds in the RHP Plan Update.

The additional regional allocation was determined based on the following:

RHP	DSRIP DY5 Allocation (A)	DY5 Valuation (B)	DY6 Increases to $250K (C)	DY6 Discontinued and Lowered Valuation Projects (D)	DY7 Addition of Withdrawn Projects (E)	Subtotal DY5-7 Valuation (F) (F=B+C-D+E)	Subtotal Difference from DY5 Allocation (G) (G=A-F)	% of Unused out of Statewide (H) (H=G/ $103M)	DY7 Additional Allocation (I) (I=$29M*H)
1	$123,866,713	$116,213,773	$85,000	$125,062	$4,602,509	$120,776,220	$3,090,494	3.0%	$866,635
2	$117,058,434	$106,970,297	$0	$1,325,732	$3,183,341	$108,827,906	$8,230,527	8.0%	$2,308,000
3	$626,826,902	$621,670,292	$62,500	$1,058,245	$20,089,030	$640,763,577	NA	NA	NA
4	$131,208,451	$127,556,048	$230,472	$1,256,131	$2,815,333	$129,345,722	$1,862,729	1.8%	$522,345
5	$217,711,061	$201,604,147	$0	$1,000,000	$0	$200,604,147	$17,106,914	16.6%	$4,797,112
6	$314,548,750	$323,924,613	$0	$4,083,373	$8,950,939	$328,792,179	NA	NA	NA
7	$187,091,981	$194,871,479	$0	$0	$250,000	$195,121,479	NA	NA	NA
8	$51,308,205	$28,891,856	$0	$253,224	$2,201,770	$30,840,402	$20,467,803	19.9%	$5,739,571
9	$442,891,411	$447,121,451	$0	$0	$2,646,800	$449,768,251	NA	NA	NA
10	$301,984,828	$308,388,633	$278,134	$0	$3,257,566	$311,924,333	NA	NA	NA
11	$36,101,803	$37,221,524	$130,197	$0	$250,000	$37,601,721	NA	NA	NA
12	$110,221,742	$116,034,422	$656,886	$0	$358,456	$117,049,764	NA	NA	NA
13	$20,790,221	$21,857,200	$182,992	$140,313	$0	$21,899,879	NA	NA	NA

14	$70,846,879	$74,302,056	$56,691	$1,044,326	$1,783,863	$75,098,284	NA	NA	NA
15	$136,629,661	$144,279,333	$0	$2,852,634	$1,426,416	$142,853,115	NA	NA	NA
16	$40,373,798	$42,221,881	$0	$726,359	$0	$41,495,521	NA	NA	NA
17	$58,741,777	$24,299,140	$4,301	$307,751	$1,635,475	$25,631,164	$33,110,612	32.1%	$9,284,861
18	$37,790,292	$33,089,172	$0	$0	$0	$33,089,172	$4,701,120	4.6%	$1,318,286
19	$29,312,798	$29,249,200	$162,402	$248,967	$248,967	$29,411,602	NA	NA	NA
20	$44,694,294	$27,765,119	$148,983	$0	$2,291,824	$30,205,926	$14,488,368	14.1%	$4,062,821
TOTAL	**$3,100,000,000**	**$3,027,531,635**	**$1,998,558**	**$14,422,118**	**$55,992,290**	**$3,071,100,364**	**$103,058,567**	**100.0%**	**$28,899,632**

O. Compliance Monitoring of DSRIP

97. Stakeholders submitted recommendations that the independent assessor update the compendium of Category 3 measures and/or the PFM Protocol to specify what data will be necessary for future compliance monitoring reviews.

    HHSC RESPONSE: HHSC will explore the feasibility of establishing a guidance document that will include the description of data necessary during the compliance monitoring review. HHSC does not anticipate that the independent assessor will be updating the compendium.

98. Stakeholders requested that the independent assessor provide a description of supporting documentation that will be needed prior to Performing Providers reporting DY7-8.

    HHSC RESPONSE: HHSC will work with the independent assessor to provide as much information as possible about supporting documentation needed for the data reported for DY7-8.

99. Stakeholders suggested adjusting the compliance monitoring review process to allow more time for Performing Providers to compile and submit required information to the independent assessor. Additional recommendations were provided to streamline the process and not to request information during the reporting period.

    HHSC RESPONSE: HHSC will work with the independent assessor to create a reasonable timeframe for the submission of the requested data and other supporting documentation. HHSC's and the independent assessor's current approach is not to request additional information during the reporting period. However, HHSC authorizes the independent assessor to follow up with providers during the reporting period if providers requested extensions, which by doing so moved the deadlines for the requested data submission to the reporting period. HHSC believes that the independent assessor has a good methodology and process in place for selecting metrics and measures for the review.

100. Stakeholders requested that the independent assessor review Category C baselines soon after reporting.

HHSC RESPONSE: HHSC will work with the independent assessor on the timing of the baseline review.

101. Stakeholders recommended that HHSC involve the independent assessor during the development of rules related to the transition from project-level to provider-level reporting to ensure the independent assessor is familiar with the new rules. Performing Providers with similar measure bundles should have workgroup meetings with HHSC and the auditors to ensure everyone is on the same page.

    HHSC RESPONSE: HHSC will involve the independent assessor once the PFM Protocol and Measure Bundle Protocol are approved by CMS.

102. Stakeholders requested that the independent assessor provide monthly updates to Anchors on the status of the compliance monitoring review.

    HHSC RESPONSE: The independent assessor will continue providing monthly updates to Anchors.

103. Stakeholders agreed with continuing compliance monitoring as long as there was a process to appeal the findings of the independent assessor.

    HHSC RESPONSE: HHSC and the independent assessor will continue to have a process in place to work through provider disagreement with the results of the reviews.

P. Other Comments

104. Stakeholders expressed concern about potential delays in CMS approval, late policy changes, backup plans if CMS does not approve the 21 months, and HHSC plans for requesting DSRIP for DY9-10.

    HHSC RESPONSE: To account for a potential delay in CMS approval, HHSC has updated the RHP Plan Update due date to January 31, 2018. All DY7-8 requirements are dependent on CMS approval and HHSC will continue to work with CMS to achieve timely approval. Texas will also continue to work with CMS for plans beyond DY7-8.

105. Stakeholders were concerned about the payment timeline and the majority of reporting occurring in April of each DY.

    HHSC RESPONSE: As noted in other sections, the PFM has been adjusted to allow more opportunities for achieving payments including payment for submission of the RHP Plan Update with April DY7 reporting; allowing October reporting of Category B MLIU PPP rather than limiting it to April of the following DY; and carryforward of achievement for Category C.

106. A few stakeholders were unclear about whether there were changes in DY7-8 from DY1-6. Specifically, whether there were changes in RHP regions, tier definitions, eligible Performing Provider types, IGT carryforward ability, IGT cross-regional funding, and IGT Entity review of reporting.

HHSC RESPONSE: The composition of counties in each RHP remains the same for DY7-8 from the initial waiver period. The tier definitions under paragraph 5.b. align with the previous definitions used for DY1-6. Performing Provider types are limited to the current types of hospital, physician practice, CMHC, and LHD. No new Performing Provider types will be added for DY7-8. IGT carryforward and cross-regional funding requirements for DY7-8 have not changed from DY1-6. The IGT requirements are further defined in the current Title 1 of the Texas Administrative Code (TAC) §355.8203 and §354.1611 rather than in the PFM Protocol. The IGT Entity review of reporting in DY7-8 is consistent with the current optional review of DY2-6 reporting and included in the current TAC §354.1613.

107. A few stakeholders requested clarification or addition of a withdrawal window for DY7-8 DSRIP participation due to the changes from projects to a system approach.

HHSC RESPONSE: HHSC does not consider the transition from projects to a system approach to require a different withdrawal window from the DY6 withdrawal window of January to March 2019. Performing Providers may choose fewer measure bundles in the RHP Plan Update than their required minimum point threshold and have their total valuation proportionately reduced. If a Performing Provider elects to discontinue all DSRIP participation in the RHP Plan Update, then any DSRIP payments received in July 2017 or January 2018 would be recouped.

108. A few stakeholders requested that HHSC use consistent terminology in the PFM Protocol and consider reorganizing the sections by Category.

HHSC RESPONSE: HHSC has attempted to update the PFM Protocol to use Performing Providers, Core Activities, Milestones, and System to clarify the terms. HHSC has also added Category A to the Performing Provider Requirements for DY7-8 section to clarify requirements and payments. Additional companion documents will be provided for the RHP Plan Update submission and reporting to clarify further the Category requirements.

109. There was concern about the potential impact for private hospital participation based on the results of the CMS review of IGT sources used to finance DSRIP.

HHSC RESPONSE: The State and CMS have not come to an agreement about the methods of financing Medicaid supplemental payments. However, the State is confident that its historical practices are appropriate.

110. There was a question about whether other federal funds may be used to finance Category A activities given that there is not a DSRIP payment associated with Category A.

HHSC RESPONSE: Given that there is not a DSRIP payment for Category A activities, HHSC recommends that the Performing Provider refer to the requirements for the other sources of federal funds.

111. There was a request for the elimination of Microsoft Excel spreadsheets and submission of all information through the DSRIP Online Reporting system.

HHSC Response: The State has limited resources to enhance the DSRIP Online Reporting System and frequently requires quick turnaround of changes for reporting and submissions. Use of Excel spreadsheets allows flexibility for multiple changes in a short period of time. HHSC will continue to include data collection in the DSRIP Online Reporting System to the extent that is feasible while continuing to use separate templates as needed.