DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services
Children and Adults Health Programs Group

August 31, 2012

Billy Millwee
Deputy Executive Commissioner, Office of Health Services
Texas Health and Human Services Commission
11209 Metric Blvd, Building H, Mail Code H100 PO Box 85200
Austin, TX 78758

Dear Mr. Millwee:

Thank you to you and your staff for your work on the Program Funding and Mechanics (PFM) Protocol for the Delivery System Reform Incentive Payment (DSRIP) pool, which is a component of the State's section 1115 demonstration, entitled "Texas Healthcare Transformation and Quality Improvement Program." This PFM Protocol lays the groundwork for the State and CMS's ongoing collaboration on DSRIP activities to achieve our shared goals of meaningful delivery system reform in Texas. We are writing to approve the State's latest revision of the PFM Protocol, submitted August 30, 2012.

We look forward to continuing to work with the State and the Regional Health Partnerships (RHPs) in the development of region-wide transformation plans to promote accountability in Federal funding by achieving measurable improvements in the delivery of care to Medicaid beneficiaries and underserved populations. We encourage a broad spectrum of providers to participate in DSRIP projects, and expect the RHPs to be transparent in the development of their DSRIP plans so that the public can provide meaningful input. We are looking forward to working with you to ensure that each project is valued appropriately and to monitor the achievement of project milestones to ensure that our shared goal of substantial improvements in quality of care and patient outcomes is achieved.

A copy of the approved PFM Protocol is enclosed with this letter. In accordance with special term and condition (STC) 45(d)(ii)(B) of the demonstration, this Protocol will become attachment J of the demonstration's STCs. We are still working with your staff to finalize the details of the Regional Health Plan Planning Protocol in accordance with STC 45(d)(ii)(A), and we will continue to work with you to complete our review expeditiously.

If you have additional questions or concerns, please contact your assigned project officer, Mr. Robert Nelb. His contact information is as follows:

Robert Nelb, Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-1055
E-mail: robert.nelb@cms.hhs.gov

Official communications regarding program matters should also be sent simultaneously to Mr. Bill Brooks, Associate Regional Administrator for our Dallas Regional Office. His contact information is as follows:

Bill Brooks, Centers for Medicare & Medicaid Services
1301 Young St. Suite 714
Dallas, TX 75202
Telephone: (214) 767-4461
E-mail: Bill.Brooks@cms.hhs.gov

We look forward to continuing to work together to insure that the investment we have made contributes to meaningful transformation of the health care delivery system within the Demonstration period.

Sincerely,

Victoria Wachino
Director

cc: Bill Brooks, ARA, CMS Dallas Regional Office

Enclosure

TABLE OF CONTENTS

Attachment J:
Texas DSRIP Program Funding and Mechanics Protocol

I. PREFACE

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

1. Delivery System Reform Incentive Payment Program

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

The program of activity funded by the DSRIP shall be based on Regional Healthcare Partnerships (RHPs). Each RHP shall have geographic boundaries and will be coordinated by a public hospital or local governmental entity with the authority to make intergovernmental transfers. The public hospital or local governmental entity shall collaborate with hospitals and other potential providers to develop an RHP Plan that will accelerate meaningful delivery system reforms that improve patient care for low-income populations. The RHP Plans must be consistent with regional shared mission and quality goals of the RHP and CMS's triple aims to improve care for individuals (including access to care, quality of care, and health outcomes); improve health for the population; and lower costs through improvements (without any harm whatsoever to individuals, families, or communities).

2. RHP Planning Protocol and Program Funding and Mechanics Protocol

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

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

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

Attachment J has been organized into the following sections:

I. Preface
II. DSRIP Eligibility Criteria
III. Key Elements of Proposed RHP Plans

II. DSRIP ELIGIBILITY CRITERIA

4. RHP Regions

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

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

The approved RHPs include the following counties:

RHP 1: Anderson, Bowie, Camp, Cass, Cherokee, Delta, Fannin, Franklin, Freestone, Gregg, Harrison, Henderson, Hopkins, Houston, Hunt, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Trinity, Upshur, Van Zandt, Wood

RHP 2: Angelina, Brazoria, Galveston, Hardin, Jasper, Jefferson, Liberty, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, Tyler

RHP 3: Austin, Calhoun, Chambers, Colorado, Fort Bend, Harris, Matagorda, Waller, Wharton

RHP 4: Aransas, Bee, Brooks, DeWitt, Duval, Goliad, Gonzales, Jackson, Jim Wells, Karnes, Kenedy, Kleberg, Lavaca, Live Oak, Nueces, Refugio, San Patricio, Victoria

RHP 5: Cameron, Hidalgo, Starr, Willacy

RHP 6: Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Kendall, Kerr, Kinney, La Salle, McMullen, Medina, Real, Uvalde, Val Verde, Wilson, Zavala

RHP 7: Bastrop, Caldwell, Fayette, Hays, Lee, Travis

RHP 8: Bell, Blanco, Burnet, Lampasas, Llano, Milam, Mills, San Saba, Williamson

RHP 9: Dallas, Denton, Kaufman

RHP 10: Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, Tarrant, Wise

RHP 11: Brown, Callahan, Comanche, Eastland, Fisher, Haskell, Jones, Knox, Mitchell, Nolan, Palo Pinto, Shackelford, Stephens, Stonewall, Taylor

RHP 12: Armstrong, Bailey, Borden, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Cottle, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Floyd, Gaines, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, Kent, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley 0, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Scurry, Sherman, Swisher, Terry, Wheeler, Yoakum

RHP 13: Coke, Coleman, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Pecos, Reagan, Runnels, Schleicher, Sterling, Sutton, Terrell, Tom Green

RHP 14: Andrews, Brewster, Crane, Culberson, Ector, Glasscock, Howard, Jeff Davis, Loving, Martin, Midland, Presidio, Reeves, Upton, Ward, Winkler

RHP 15: El Paso, Hudspeth

RHP 16: Bosque, Coryell, Falls, Hamilton, Hill, Limestone, McLennan

RHP 17: Brazos, Burleson, Grimes, Leon, Madison, Montgomery, Robertson, Walker, Washington

RHP 18: Collin, Grayson, Rockwall

RHP 19: Archer, Baylor, Clay, Cooke, Foard, Hardeman, Jack, Montague, Throckmorton, Wichita, Wilbarger, Young

RHP 20: Jim Hogg, Maverick, Webb, Zapata

5. RHP Anchoring Entity

The Texas Health and Human Services Commission (HHSC) delegates to the Anchoring Entity the responsibility of coordination with the RHP participants in development of the RHP Plan for that region. Each RHP shall have one Anchoring Entity that coordinates the development of the RHP Plan for that region. In RHPs that have a public hospital, a public hospital shall serve as the Anchoring Entity. In regions without a public hospital, the following entities may serve as anchors: (1) a hospital district; (2) a hospital authority; (3) a county; or (4) a State university with a health science center or medical school. RHP Anchoring Entities shall be responsible for coordinating RHP activities and assisting HHSC perform key oversight and reporting responsibilities.

Anchoring Entities activities shall include:

- Coordinating the development of a community needs assessment for the region;
- Engaging stakeholders in the region, including the public;
- Coordinating the development the 5-year RHP Plan that best meets community needs in collaboration with RHP participants;

- Ensuring that the RHP Plan is consistent with Attachment I, Attachment J, and all other State/waiver requirements;
- Facilitating RHP Plan compliance with the RHP Plan Checklist;
- Transmitting the RHP Plan and any associated plan amendments to HHSC on behalf of the RHP;
- Ongoing monitoring and annual reporting (as required in paragraph 20) on status of projects and performance of Performing Providers in the region; and
- Ongoing communication with HHSC on behalf of the RHP.

6. IGT Entities

Intergovernmental transfer (IGT) Entities are entities that fund the non-federal share of DSRIP payments for an RHP. They include Anchoring Entities, government-owned Performing Providers, community mental health centers (CMHCs), local health departments, academic health science centers, and other government entities such as counties.

An IGT Entity may fund DSRIP, Uncompensated Care (UC), or both DSRIP and UC as long as regional requirements are met, as described in Section VI "Disbursement of DSRIP Funds" and the IGT funding source comports with federal requirements outlined in paragraph 55 of the waiver's special terms and conditions.

IGT Entities may fund DSRIP projects outside of their RHP Region. Such a DSRIP project must be documented in the RHP Plan where the Performing Provider implementing the DSRIP project is physically located, with a few exceptions described in 7 below.

7. Performing Providers

Providers that are responsible for performing a project in an RHP Plan are called "Performing Providers." All Performing Providers must have a current Medicaid provider identification number. Performing Providers that complete RHP project milestones and measures as specified in Attachment I, "RHP Planning Protocol" are the only entities that are eligible to receive DSRIP incentive payments in DYs 2-5. Performing Providers will primarily be hospitals, but CMHCs, local health departments, physician practice plans affiliated with an academic health science center, and other types of providers approved by the State and CMS may also receive DSRIP payments. Physician practices plans not affiliated with an academic health science center may also be eligible as Performing Providers under the "Pass 2" methodology as described in paragraph 25.d.

A Performing Provider may only participate in the RHP Plan where it is physically located except that physician practice plans affiliated with an academic health science center, major cancer hospitals, or children's hospitals may perform projects outside of the region where the Performing Provider's institution is physically located if it receives an allocation from that region in accordance with the process described in paragraph 25. In these cases, the project must be included in the RHP Plan where the DSRIP project is implemented. All related DSRIP payments for the project(s) are counted against the allocation of that RHP Plan as specified in Section VI "Disbursement of DSRIP Funds".

8. DSRIP and Uncompensated Care Pool

a. UC Pool Description

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

b. DSRIP Requirements for UC Pool Program Participants

Hospitals that receive payments from the Uncompensated Care Pool shall participate in the RHP and be required to report on a subset of Category 4 measures from Attachment I, "RHP Planning Protocol". The subset of Category 4 measures fall into 3 domains: (1) Potentially Preventable Admissions (PPAs); (2) Potentially Preventable Readmissions (PPRs) and (3) Potentially Preventable Complications (PPCs). Category 4 reporting shall begin in DY 3 for the PPA and PPR domains, and in DY 4 for the PPC domain and continue through DY 5. Hospitals that only participate in UC shall not be eligible to receive DSRIP funding for required Category 4 reporting. If a hospital fails to report on all required Category 4 measures by the last quarter of the applicable Demonstration Year, the hospital shall forfeit UC payments in that quarter. A hospital may request from HHSC a 6-month extension from the end of the DY to report any outstanding Category 4 measures. The fourth-quarter UC payment will be made upon completion of the outstanding required Category 4 measure reports within the 6-month period. A hospital may receive only one 6-month extension to complete Category 4 reporting for each demonstration year. This requirement shall apply to all UC participating hospitals, including hospital Performing Providers that are fully participating in DSRIP. Hospitals that meet the criteria described in paragraph 11.f below are exempt from this requirement.

UC hospital participants shall also participate in learning collaboratives conducted annually during DYs 3-5 to share learning, experiences, and best practices acquired from the DSRIP program across the State.

III. KEY ELEMENTS OF PROPOSED RHP PLANS

9. RHP Plans

Each RHP must submit an RHP Plan using a State-approved template that identifies the projects, objectives, and specific milestones, metrics, measures, and associated DSRIP values adopted from Attachment I, "RHP Planning Protocol" and meet all requirements pursuant to STCs 45 and 46. The project and DSRIP payments are documented in the RHP Plan where the Performing Provider of the DSRIP project is physically located. An exception applies to projects performed by physician practice plans affiliated with an academic health science center, major cancer hospitals, or children's hospitals in locations outside of the RHP region where these Performing Providers are physically located (as discussed in paragraph 7 above). In these cases, the project must be documented in the RHP Plan where the DSRIP project is implemented.

10. Organization of RHP Plan

a. Executive Summary

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

b. Description of RHP Organization

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

c. Community Needs Assessment

The RHP Plan shall include a community needs assessment for the five-year period that has the following elements for the region:

i. Demographic information (e.g., race/ethnicity, income, education, employment, etc.)
ii. Insurance coverage (e.g., commercial, Medicaid, Medicare, uncompensated care);
iii. Description of the region's current health care infrastructure and environment (e.g., number/types of providers, services, systems, and costs; Health Professional Shortage Area [HPSA]);
iv. Description of any initiatives in which providers in the RHP are participating that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives underway in the RHP region.
v. Description of changes in the above areas, i. – iv., expected to occur during the waiver period of federal fiscal years 2012-16.
vi. Key health challenges specific to the region supported by data (e.g., high diabetes rates, access issues, high emergency department [ED] utilization, etc.)

The RHP's community needs assessment should guide, and be reflected in, the RHP Plan and selection of projects. The community needs assessment may be compiled from existing data sources.

d. Stakeholder Engagement

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

i. Hospitals and other providers in the region.
ii. Public stakeholders and consumers, including processes used to solicit public input into RHP Plan development and opportunities for public discussion and review prior to plan submission.

iii. A plan for ongoing engagement with public stakeholders.

iv. At a minimum, a description of public meetings that were held in different areas of the RHP Region, the public posting of the RHP Plan, and the process for submitting public comment on the RHP Plan.

e. RHP Plan Development

The RHP Plan shall describe the regional approach for addressing the community needs and goals, process for evaluating and selecting projects, and identification of Pass 1 and Pass 2 projects. The RHP Plan shall also include as an appendix a list of projects that were considered but not selected.

11. Number of Projects and Measures

a. General Requirements for Categories 1-4

Pursuant to Attachment I, RHP Planning Protocol, an RHP Plan must meet the following requirements:

i. RHPs must select a minimum number of projects from Categories 1 and 2. The number of minimum projects will differ for RHPs depending on their Tier classification (defined below). An RHP's Tier classification is displayed in Table 1 of Section VI "Disbursement of DSRIP Funds";

ii. Both hospital-based and non-hospital Performing Providers must establish improvement targets for outcomes in Category 3 that tie back to their Category 1 and 2 projects; and

iii. Hospital-based Performing Providers must report on the population-focused improvement measures across five domains identified in Category 4.

Certain hospital Performing Providers defined in 11.f below shall be exempt from selected requirements.

b. RHP Tier Definition

i. Tier 1 RHP

An RHP that contains more than 15 percent share of the statewide population under 200 percent of the federal poverty level (FPL) as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS).

ii. Tier 2 RHP

An RHP that contains at least 7 percent and less than 15 percent share of the statewide population under 200 percent FPL as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS).

iii. Tier 3 RHP

An RHP that contains at least 3 percent and less than 7 percent share of the statewide population under 200 percent FPL as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS).

iv. Tier 4 RHP

An RHP is classified in Tier 4 if one of the following three criteria are met: (1) the RHP contains less than 3 percent share of the statewide population under 200 percent FPL as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS); (2) the RHP does not have a public hospital; or (3) the RHP has public hospitals that provide less than 1 percent of the region's uncompensated care.

c. Categories 1 and 2 Projects

i. Tier 1 RHP

A Tier 1 RHP must select a minimum of 20 projects from Categories 1 and 2 combined, with at least 10 of the 20 projects selected from Category 2, in accordance with Attachment I, "RHP Planning Protocol", which lists the acceptable projects, milestones, metrics, and data sources.

ii. Tier 2 RHP

A Tier 2 RHP must select a minimum of 12 projects from Categories 1 and 2 combined, with at least 6 of the 12 projects selected from Category 2, in accordance with Attachment I, "RHP Planning Protocol", which lists the acceptable projects, milestones, metrics, and data sources.

iii. Tier 3 RHP

A Tier 3 RHP must select a minimum of 8 projects from Categories 1 and 2 combined, with at least 4 of the 8 projects selected from Category 2, in accordance with Attachment I, "RHP Planning Protocol, which lists the acceptable projects, milestones, metrics, and data sources.

iv. Tier 4 RHP

A Tier 4 RHP must select a minimum of 4 projects from Categories 1 and 2 combined, with at least 2 of the 4 projects selected from Category 2, in accordance with Attachment I, "RHP Planning Protocol", which lists the acceptable projects, milestones, metrics, and data sources.

v. Performing Provider Participation in Categories 1 and 2

1. A Performing Provider in an RHP Plan must, at a minimum, participate in a project(s) from either Category 1 or Category 2, and if it chooses to, may participate in projects from both Categories;
2. The RHP Plan must explain how incentive payments to Performing Providers that perform a similar DSRIP project are not duplicative. For example, if two Performing Providers offer diabetes disease management, they must describe how the projects are serving different patients; and
3. The RHP Plan must explain how incentive payments do not duplicate funding for activities of federal initiatives funded by the U.S. Department of Health and Human Services.

d. Category 3: Outcome Reporting and Improvements

i. For each of its Category 1 and 2 projects, every Performing Provider must have a related Category 3 outcome. The outcomes shall assess the results of care experienced by patients, including patients' clinical events, patients' recovery and health status, patients' experiences in the health system, and efficiency/cost. A single Category 3 outcome may tie back to more than one project in Categories 1 or 2 implemented by the Performing Provider. A Performing Provider shall customize an outcome to reflect the patient population targeted in its projects from Categories 1 and 2.

ii. Performing Providers shall establish outcome improvement targets for no later than DY 4 through DY 5. The minimum Category 3 funding percentages specified in paragraph 25.e for DY 4 and DY 5 must go toward outcome improvement targets. In DYs 2 and 3, Performing Providers may undertake actions/steps to establish baselines and prepare for outcome reporting in DYs 4 and 5. These preparatory activities will be reflected as process milestones in the RHP Plan.

a. A hospital Performing Provider shall identify the outcome(s) it has selected for its Category 1 and 2 projects in the RHP Plan. However, it may defer establishing improvement targets until after a baseline is established. Such baselines must be established no later than DY 3.
b. A non-hospital Performing Provider may defer identifying outcomes for its Category 1 and 2 projects until a date defined by HHSC during DY 2, at which point new, approved outcomes shall be added to the RHP Planning Protocol and incorporated into the RHP Plan. A non-hospital Performing Provider must complete establishment of baselines for its selected outcomes and target improvements no later than DY 3.

iii. Performing Providers, HHSC, and CMS shall have an opportunity to re-assess Category 3 outcome improvement targets and revise them based on the following circumstances:

a. A Performing Provider may initiate a review and seek to decrease/increase/revise an improvement target based on experience and circumstances showing that the targets were not set appropriately;
b. CMS may initiate a review to increase an improvement target if a Performing Provider achieves a target two years earlier than projected; and
c. Based on HHSC's annual review of projects and progress by Performing Providers in meeting milestones/measures, HHSC or its external evaluator may identify outcomes that require additional refinements because of data problems or other concerns.

e. Category 4 "Pay for Reporting" Measures

Pursuant to STC 45(d)(ii)(A), all hospital-based Performing Providers in all RHPs must report on all common Category 4 measures. A Performing Provider may also choose to report on additional optional measures. In accordance with this requirement, beginning in

DY 3 (FFY 14) and DY 4 (FFY 15) hospital-based Performing Providers in all RHPs must include reporting of all common domains, pursuant to Attachment I, "RHP Planning Protocol". Hospitals defined under paragraph 11.f are exempt from reporting Category 4 measures. If an exempted hospital elects to report Category 4, then it shall report on all common Category 4 measures and be held to the same requirements as all other Performing Providers participating in Category 4. If a hospital-based Performing Provider's population for a given measure is not sufficiently large to produce statistically valid data, the hospital shall not be required to report the data for that particular Category 4 measure.

f. Hospital Exemption

DSRIP hospitals that meet the criteria below and as approved by the State are exempt from implementing Category 4 reporting in paragraph 11.e of this section.

Definition:
A hospital is not a state-owned hospital or a hospital that is managed or directly or indirectly owned by an individual, association, partnership, corporation, or other legal entity that owns or manages one or more other hospitals and:

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

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

12. Organization of DSRIP Projects

a. Categories 1-4 Descriptions

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

i. Category 1 Infrastructure Development lays the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.
ii. Category 2 Program Innovation and Redesign includes the piloting, testing, and replicating of innovative care models.
iii. Category 3 Quality Improvements includes outcome reporting and improvements in care that can be achieved within four years.
iv. Category 4 Population Focused Improvements is the reporting of measures that demonstrate the impact of delivery system reform investments under the waiver.

b. Categories 1-2 Requirements

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

i. Identifying Information
Identification of the DSRIP Category, name of the project, project element, and RHP Performing Provider name and Texas Provider Identifier (TPI) involved with the project. Each project shall be implemented by one Performing Provider only.

ii. Project Goal
The goal(s) for the project, which describes the challenges or issues of the Performing Provider and brief description of the major delivery system solution identified to address those challenges by implementing the particular project; the starting point of the Performing Provider related to the project and based on that, the 5-year expected outcome for the Performing Provider and the patients.

iii. Rationale
As part of this subsection, each Performing Provider will provide the reasons for selecting the project, milestones, and metrics based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point with available baseline data, as well as a description of how the project represents a new initiative for the Performing Provider or significantly enhances an existing initiative, including any initiatives that may have related activities that are funded by the U.S. Department of Health and Human Services.

iv. Relationship to Other Projects and Measures
A description of how this project supports, reinforces, enables, and is related to other Category 1 and 2 projects, Category 3 outcomes, and Category 4 population-focused improvement measures within the RHP Plan

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

1. For each project from Category 1 and 2, the Performing Provider must include at least 1 milestone based on a Process Milestone and at least 1 milestone based on an Improvement Milestone over the 4-year period in accordance with Attachment I, "RHP Planning Protocol."
2. For each milestone, the estimated DSRIP funding must be identified as the maximum amount that can be received for achieving the milestone. For each year, the estimated available non-federal share must be included and the source (IGT Entity) of non-federal share identified.

c. Category 3 Requirements
This focus area involves outcomes associated with Categories 1 and 2 projects. All Performing Providers (both hospital and non-hospital providers) shall select outcomes and establish improvement targets that tie back to their projects in Categories 1 and 2. RHP Plans must include:

i. Identifying Information
Identification of the Category 3 outcomes and RHP Performing Provider name and Texas Provider Identifier that is reporting the measure.

ii. Narrative Description
Each Performing Provider shall provide a narrative of the Category 3 outcomes.

iii. Outcomes Table
In a table format, the RHP Plan shall include the outcomes selected by each Performing Provider.

1. For each outcome, the RHP Plan may include process milestones described in 11.d.ii above in DY 2-3 that support the development of the outcomes.
2. For each outcome, the RHP Plan shall include improvement targets beginning no later than DY 4.
3. For each milestone or outcome improvement target, the estimated DSRIP funding must be identified as the maximum amount for achieving the milestone or outcome target. For each year, the estimated non-federal share must be included and the source (IGT Entity) of non-federal share identified.

d. Category 4 Requirements
This focus area involves population-focused improvements associated with Categories 1 and 2 projects and Category 3 outcomes. Each hospital-based Performing Provider shall report on all common measures pursuant to Attachment I, "RHP Planning Protocol". RHP Plans must include:

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

ii. Narrative description
A narrative description of the Category 4 measures.

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

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

e. Project Valuation
The RHP Plan shall contain a narrative that describes the overall regional and individual project approach for valuing each project and rationale, including an explanation why a similar project selected by two Performing Providers might have different valuations (e.g., due to project size, provider size, project scope, populations served, community benefit, cost avoidance, and addressing priority community needs). Project valuations must comply with requirements prescribed in Section VI "Disbursement of DSRIP Funds".

In addition, the value of a Category 1 or Category 2 project may not exceed the greater of 10 percent of the Performing Provider's Pass 1 allocation (described in paragraph 25.c) or $20 million in total over DYs 2-5. For projects that represent collaboration across more than one Performing Provider as described in paragraph 25.c.iii and iv, the total maximum value may not exceed the greater of the sum of 10 percent of each Performing Provider's Pass 1 allocation for each Performing Provider that is collaborating in the project or $20 million in total over DYs 2-5.

IV. STATE AND FEDERAL REVIEW PROCESS OF RHP PLANS

13. Review Process

HHSC will review all 5-year RHP Plan proposals prior to submission to CMS for final approval according to the schedule below.

The HHSC and CMS review process for 5-year RHP Plan proposals shall include the following schedule:

14. HHSC Review and Approval Process

a. Pre-Submission Review of RHP Plans
To support HHSC's review process, the RHP Anchoring Entity shall perform an initial review of the RHP Plan to ensure compliance with elements described in b. below and with the RHP Plan Checklist, prior to submitting the Plan to HHSC.

b. HHSC Review of Plans

i. Between September 1, 2012 and October 31, 2012, each RHP identified in paragraph 4 will submit a 5-year RHP Plan to HHSC for review. Submissions received after October 31, 2012 will be prioritized lower in review. HHSC shall review and assess each plan according to the following criteria using the RHP Plan Checklist:
   - The plan is in the format and contains all required elements described herein and is consistent with special terms and conditions, including STCs 45(a), 45(b), 45(c), and 45(d)(iii).
   - The plan conforms to the requirements for Categories 1, 2, 3, and 4, as described in Section III "Key Elements of Proposed RHP Plans", Attachment I, "RHP Planning Protocol", and "RHP Plan Checklist."
   - Category 1 and 2 projects clearly identify goals, milestones, metrics, and expected results. Category 3 clearly identifies the outcomes to be reported. Category 4 clearly identifies the population-focused health improvement measures to be reported.

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

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

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

c. HHSC Approval of Plans

By October 31, 2012, HHSC will submit all received RHP Plans to CMS. No later than November 30, 2012, HHSC will take action on each timely submitted RHP Plan, will approve each plan that it deems meets the criteria outlined in Attachment I, "RHP Planning Protocol", Attachment J, "Program and Funding Protocol", and "RHP Plan Checklist" and submit approved plans to CMS for final review and approval.

15. CMS Review and Approval Process

CMS will review each RHP's 5-year RHP Plan upon receipt of the plan as approved by HHSC. Plans reviewed and approved by HHSC will result in approval by CMS within 45 days of receipt from HHSC, provided the plan(s) meet all criteria outlined in paragraph 14.b.i above.

Within 45 days of receipt of the State-approved RHP Plan and RHP Plan Checklist from HHSC, CMS will complete its review of each plan and will either:

- Approve the plan; or
- Notify HHSC and the Anchoring Entity if approval will not be granted for a component of the RHP Plan. For example, CMS may approve a project in the plan but not approve the project valuation if it does not comport with Section VI "Disbursement of DSRIP Funds". Notice will be in writing and will include any questions, concerns, or issues identified in the application.

RHPs shall develop an acceptable revision to a project for any components of the plan identified by CMS as not approvable. Within 30 days of CMS notification, HHSC shall submit revised RHP Plans to CMS and CMS shall approve or deny the plans in writing to HHSC and the RHP Anchoring Entity by March 1, 2013.

16. Revisions to the RHP Planning Protocol

If the CMS review process of RHP Plans results in the modification of any component of an RHP's plan, including but not limited to projects, milestones, measures, metrics, or data sources,

that was not originally include in the RHP Planning Protocol, Texas may revise the RHP Planning Protocol accordingly. CMS will review and approve these proposed revisions within 30 days of submission by HHSC, provided that the RHP Planning Protocol revisions are in accordance with the final approved RHP Plan(s) prompting the revision(s) and all applicable STC requirements. Such revisions to the RHP Planning Protocol do not require a waiver amendment.

V. RHP AND STATE REPORTING REQUIREMENTS

17. RHP Reporting for Payment in DY 1

a. RHP Plan Submission
Submission of a State-approved RHP Plan to CMS shall serve as the basis for the full DY 1 presumptive payment to that RHP's Performing Providers and Anchoring Entity as prescribed by Section VI "Disbursement of DSRIP Funds".

b. RHP Plans Not Approved by CMS on or after March 1, 2013
All Performing Providers and Anchoring Entities in an RHP whose RHP Plan is not approved in full by CMS shall be at risk for recoupment of their entire DY 1 incentive payment related to plan submission. Within 10 business days of CMS written denial of an RHP Plan, the State shall recoup the DY 1 payment from all eligible entities in the affected RHP and promptly return the associated FFP to CMS. If an RHP deletes a project without a replacement to obtain CMS approval of the RHP Plan, the State shall recoup the DY 1 payment from the entities that received funding for that project and promptly return the associated FFP to CMS.

18. RHP Reporting for Payment in DYs 2-5

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

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

These reports will serve as the basis for authorizing incentive payments to Performing Providers in an RHP for achievement of DSRIP milestones. HHSC and CMS concurrently shall have 30 days to review and approve or request additional information regarding the data reported for each milestone/metric and measure. If additional information is requested, the Performing Provider

shall respond to the request within 15 days and both HHSC and CMS shall have an additional 15 days to review, approve, or deny the request for payment, based on the data provided. HHSC shall schedule the payment transaction for each RHP Performing Provider within 30 days following CMS and HHSC approval of the Performing Provider's RHP report.

19. Intergovernmental Transfer Process

HHSC will calculate the nonfederal share amount to be transferred by an IGT Entity in order to draw the federal funding for the incentive payments related to the milestone achievement that is reported by the Performing Provider in accordance with paragraph 18 and approved by the IGT Entity and the State. Within 14 days after notification by HHSC of the identified nonfederal share amount, the IGT Entity will make an intergovernmental transfer of funds. The State will draw the federal funding and pay both the nonfederal and federal shares of the incentive payment to the Performing Provider. If the IGT is made within the appropriate 14-day timeframe, the incentive payment will be disbursed within 30 days. The total computable incentive payment must remain with the Performing Provider.

20. RHP Annual Year End Report

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

21. Texas Reporting to CMS

a. Quarterly and Annual Reporting

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

i. All DSRIP payments made to Performing Providers that occurred in the quarter as required in the quarterly payment report pursuant to STC 43(b);
ii. Expenditure projections reflecting the expected pace of future disbursements for each RHP and Performing Providers;
iii. A summary assessment of each RHP's DSRIP activities during the given period including progress on milestones; and
iv. Evaluation activities and interim findings for the evaluation design pursuant to STC 68.

b. Claiming Federal Financial Participation

Texas will claim federal financial participation (FFP) for DSRIP incentive payments on the CMS 64.9 waiver form. FFP will be available only for DSRIP payments made in accordance with all pertinent STCs and Attachment I, "RHP Planning Protocol" and Attachment J, "Program Funding and Mechanics Protocol". All RHP Plans are subject to potential audits. The Performing Providers shall have available for review by HHSC and CMS, upon request,

all supporting data and back-up documentation evidencing performance as described under an RHP Plan for DSRIP incentive payments. Failure of the Performing Provider to maintain adequate documentation or inaccurate reporting of data may result in recoupment of DSRIP payments.

VI. DISBURSEMENT OF DSRIP FUNDS

22. DSRIP Allocation Methodology to RHPs in DYs 1-5

a. Initial DSRIP Allocation

For Demonstration Years 1-5, DSRIP funding amounts identified in Table 5 of Waiver STC 46 shall be allocated to RHPs according to a formula that takes into account the RHP's role in the safety net system. RHPs that shoulder a larger burden of Medicaid care and serve a larger share of low-income populations shall be allocated a higher share of DSRIP funds. The goal of this approach is to ensure that delivery system reforms under DSRIP have the greatest impact on Medicaid and low-income populations. The following variables were selected as proxies for measuring an RHP's participation in Medicaid and serving low-income populations:

i. Percent of State population with income below 200% FPL residing in the RHP Region (Source: U.S. Census Bureau: 2006-2010 American Community Survey for Texas). An RHP's percentage was calculated by dividing the number of low-income individuals with income below 200% FPL in the RHP Region by the total number of low-income individuals in the State with income below 200% FPL.

ii. Percent of Texas Medicaid acute care payments in SFY 2011 made in the RHP Region (including fee for service, MCO, vendor drug, and PCCM payments). An RHP's percentage was calculated by dividing SFY 2011 Medicaid acute care payments in the RHP Region by total SFY 2011 State Medicaid acute care payments.

iii. Percent of total SFY 2011 Medicaid supplemental payments (former Upper Payment Limit [UPL] program) made to providers in the RHP. An RHP's percentage was calculated by dividing SFY 2011 Medicaid supplemental payments by total SFY 2011 State Medicaid supplemental payments.

The RHP's percentages for the three variables are weighted equally, and then the individual RHP's percentages are averaged to come up with the RHP's DSRIP Funding Allocation Percentage for each demonstration years 1-5.

An RHP's DSRIP Funding Allocation Percentage shall be multiplied by the statewide DSRIP funding amounts in DYs 1-5 identified in Table 5 of STC 46. The product result of this calculation yields the DSRIP funding allocation amount for an RHP, which is reflected in Table 1 below. This table also displays the Tier Level of an RHP as defined in paragraph 11, Section III "Key Elements of Proposed RHP Plans".

Table 1: DSRIP Allocation (All Funds)

RHP	Tier	Funding Allocation %	DY 1	DY 2	DY 3	DY 4	DY 5	Total
1	3	4.00%	19,978,502	91,901,110	106,525,374	113,957,376	123,866,713	456,229,075
2	3	3.78%	18,880,393	86,849,806	100,670,253	107,693,759	117,058,434	431,152,643
3	1	20.22%	101,101,113	465,065,121	539,071,136	576,680,750	626,826,902	2,308,745,022
4	3	4.23%	21,162,653	97,348,206	112,839,268	120,711,775	131,208,451	483,270,354
5	4	7.02%	35,114,687	161,527,561	187,231,512	200,294,176	217,711,061	801,878,997
6	2	10.15%	50,733,669	233,374,879	270,511,925	289,384,850	314,548,750	1,158,554,074
7	3	6.04%	30,176,126	138,810,179	160,899,104	172,124,622	187,091,981	689,102,012
8	4	1.66%	8,275,517	38,067,378	44,125,056	47,203,548	51,308,205	188,979,704
9	2	14.29%	71,434,099	328,596,853	380,886,614	407,460,098	442,891,411	1,631,269,075
10	2	9.74%	48,707,230	224,053,259	259,706,952	277,826,042	301,984,828	1,112,278,311
11	4	1.16%	5,822,871	26,785,208	31,047,550	33,213,658	36,101,803	132,971,091
12	3	3.56%	17,777,700	81,777,422	94,790,698	101,404,003	110,221,742	405,971,566
13	4	0.67%	3,353,261	15,425,003	17,879,590	19,127,003	20,790,221	76,575,078
14	4	2.29%	11,426,916	52,563,813	60,928,316	65,179,128	70,846,879	260,945,051
15	3	4.41%	22,037,042	101,370,394	117,501,509	125,699,288	136,629,661	503,237,895
16	4	1.30%	6,511,903	29,954,753	34,721,466	37,143,894	40,373,798	148,705,813
17	4	1.89%	9,474,480	43,582,608	50,517,928	54,042,434	58,741,777	216,359,227
18	4	1.22%	6,095,208	28,037,958	32,499,651	34,767,068	37,790,292	139,190,178
19	4	0.95%	4,727,871	21,748,205	25,209,007	26,967,774	29,312,798	107,965,655
20	4	1.44%	7,208,757	33,160,283	38,437,093	41,118,751	44,694,294	164,619,177
		100%	**500,000,000**	**2,300,000,000**	**2,666,000,000**	**2,852,000,000**	**3,100,000,000**	**11,418,000,000**

b. One-time Re-Assessment of DSRIP Allocation to RHPs in DY 2

During DY 2, HHSC shall re-assess DSRIP allocation amounts to RHPs. In the event that the total amount of DSRIP funds included in an RHP Plan for DYs 3-5 is less than the total amount available to the RHP in Table 1, HHSC shall redistribute uncommitted amounts that an RHP does not propose to use for new projects for DYs 3-5 as identified in an approved plan modification request described in paragraph 27 of Section VII. The uncommitted amounts shall be redistributed to RHPs according to a DSRIP funding allocation methodology agreed to by HHSC and CMS. The redistributed funds may be used by RHPs to fund new projects beginning in DY 3 in accordance with Section VII "Plan Modifications".

23. Benchmark Payment Variation between UC and DSRIP

UC payments will be based on each provider's reported UC costs on the UC application and reduced proportionately if the total statewide UC cap is exceeded for a given demonstration year. However, to ensure a robust and meaningful DSRIP program, RHPs are strongly encouraged to submit RHP Plans that in total fund DSRIP projects at no less than the percentages listed in Table 2 below. Table 2 shows the statewide waiver funding allocation schedule for DSRIP and UC described in Table 5 of STC 46.

Table 2: Waiver Funding Allocation between UC Program and DSRIP Programs

	DY 2	DY 3	DY 4	DY 5	Total
% UC	63%	57%	54%	50%	60%
% DSRIP	37%	43%	46%	50%	40%

24. DY 1 RHP DSRIP Allocation Formula

a. Eligible Entities

Anchoring Entities and Performing Providers that begin participation in DSRIP in DY 2 and that have a current Medicaid provider identification number are eligible to receive a DY 1 DSRIP payment according to the requirements in this section. An entity that serves both roles in an RHP is eligible to receive a DY 1 payment under each of the categories described below.

b. Anchoring Entities

The Anchoring Entity of an RHP that is also a Medicaid provider (i.e. it has a current Medicaid provider identification number) shall be allocated 20 percent of the total DY 1 RHP DSRIP funding amount. If an Anchoring Entity is not a Medicaid Provider, then the 20 percent shall be allocated to eligible Performing Providers as described in paragraph 24.c.

c. Performing Providers

Remaining DY 1 RHP DSRIP funding (less the Anchoring Entity DY 1 DSRIP) shall be allocated to Performing Providers based on an allocation formula. The allocation formula divides an RHP Plan's estimated dollar value of a Performing Provider's DSRIP projects in Categories 1-4 over the DYs 2-5 period by the total value of the RHP's DSRIP projects over the DYs 2-5 period. The resulting percentage is then multiplied by the RHP's remaining DY

1 DSRIP amount to determine the DY 1 DSRIP payment for the Performing Provider.

Example:

- An RHP's DY1 DSRIP Allocation is $25 million.
- 20 percent or $5 million is allocated to the Anchoring Entity.
- The remaining amount, $20 million, shall be distributed to Performing Providers according to the following formula:

    1. An RHP Plan reports a total DSRIP valuation of projects in DYs 2-5 equal to $500 million across 10 Performing Providers.
    2. Performing Provider "A's" DSRIP valuation for projects over the 4-year period in the RHP is $100 million, or 20 percent of the total DSRIP valuation.
    3. Based on the formula, Performing Provider "A" would be eligible to receive $4 million or 20 percent of the remaining $20 million DY 1 DSRIP payment amount.

25. DYs 2-5 RHP DSRIP Allocation Formula

a. Eligibility for DSRIP

Performing Providers described in Section II "DSRIP Eligibility Criteria" are eligible to receive RHP DSRIP payments in Demonstration Years 2-5. Each Performing Provider will be individually responsible for progress towards and achievement of its milestone bundles in all categories as defined in the RHP's approved RHP Plan. As outlined in Section V "RHP and State Reporting Requirements", Performing Providers will be eligible to receive DSRIP incentive payments related to achievement of their milestone bundles upon submission and approval of the required reports for payment.

b. "Two-Pass" Process for Allocating DSRIP Funds

DSRIP funding shall be allocated to Performing Providers using a two-stage process. The first stage or "Pass 1" sets an initial allocation to each potential provider who would be eligible to participate in DSRIP as described in paragraph 25.c.i.-ii. The purpose of this step is to encourage broad participation in DSRIP within an RHP. Under Pass 1, the RHP must identify and fund its minimum required number of projects. In addition, in order to access Pass 2 funds, RHPs in each Tier must meet DSRIP participation requirements for major safety net hospitals (described below in paragraph 25.c.v.2) and meet a threshold for DSRIP participation by non-profit and other private hospitals (described below in paragraph 25.c.v.3).

Recognizing that not all potentially eligible Performing Providers will participate in DSRIP, Pass 2 of the DSRIP allocation process permits RHPs to reallocate unused DSRIP funds for new projects in Categories 1, 2, and 3. DSRIP projects funded in the plan must support the RHP's overall goals and be consistent with its community needs assessment. HHSC shall ensure in the RHP Plan submission requirements that the "two-pass" process has been followed.

c. Initial DSRIP Allocation ("Pass 1" Allocation)

i. Hospital Providers

Potentially eligible hospital Performing Providers in an RHP that participated in either the Disproportionate Share Hospital (DSH) program during FFY 2012 or the former Upper Payment Limit (UPL) program during FFY 2011 shall be allocated 75 percent of the RHP's annual DSRIP funds. Of this amount, each hospital shall be assigned a potential DSRIP allocation based on a provider's size and role in serving Medicaid and uninsured patients, as measured by three variables:

1. The hospital's percent share of Medicaid acute care payments in SFY 2011 made to all potentially eligible hospitals in the RHP (including fee for service, MCO, and PCCM payments);
2. The hospital's percent share of total SFY 2011 Medicaid supplemental payments made to all potentially eligible hospital providers in the RHP (former UPL program); and
3. The hospital's percent share of uncompensated care in the RHP. A hospital's uncompensated care is measured by its FFY 2012 Hospital Specific Limit (HSL). For hospitals that do not have a FFY 2012 Hospital Specific Limit, uncompensated care shall be measured by that hospital's charity care costs reported in the 2010 Annual Hospital Survey trended to 2012 by an annual trend rate of approximately 2 percent (4 percent total trend over the two-year period).

The individual hospital's percent share of Medicaid acute care payments shall be weighted 25 percent, percent share of Medicaid supplemental payments shall be weighted 25 percent, and percent share of uncompensated care shall be weighted 50 percent to determine the Hospital DSRIP Funding Allocation Percentage. The Hospital DSRIP Funding Allocation shall be multiplied by the annual RHP DSRIP amount allocated to hospitals in the RHP to come up with the Pass 1 allocation amount for each hospital.

ii. Non-Hospital Providers

Potentially eligible non-hospital Performing Providers in an RHP are allocated a total of 25 percent of the RHP's annual DSRIP funds, to be distributed as follows:

1. Community Mental Health Centers (CMHCs) initially shall be allocated a total of 10 percent of the RHP's annual DSRIP funds;
2. Physician Practices affiliated with an Academic Health Science Center initially shall be allocated a total of 10 percent of the RHP's annual DSRIP funds. Such physician practices outside an RHP as referenced in paragraph 7 may access the 10 percent upon request of the RHP; and
3. Local Health Departments initially shall be allocated a total of 5 percent of the RHP's annual DSRIP funds.

If an RHP does not include one or more of the non-hospital providers listed above, the Pass 1 allocations will be redistributed in "Pass 2" as described in paragraph 25.d.

iii. Option for Smaller Hospitals in Tiers 1 and 2 to Collaborate in Pass 1

1. Hospitals in RHPs categorized in Tiers 1 or 2 whose DSRIP allocation in Pass 1 in DY 2 is less than $2 million are encouraged to work within their RHP to combine their individual DSRIP allocations to implement a robust DSRIP project(s) that will be valuable to the RHP as determined by the RHP Plan and community needs assessment. A single Performing Provider must implement each DSRIP project.
2. Such hospitals can combine their individual DSRIP allocations if there is a signed agreement between the affected parties submitted with the RHP Plan stating that the transaction is entered into freely and that it benefits regional transformation. No hospital is required to combine its individual DSRIP allocation.

iv. Option for Performing Providers in Tiers 3 and 4 to Collaborate in Pass 1

1. Performing Providers in RHPs categorized in Tiers 3 or 4 may combine their individual DSRIP allocations within their RHP to implement a robust DSRIP project(s) considered valuable to the RHP as determined by the RHP Plan and community needs assessment. A single Performing Provider must implement each DSRIP project.
2. Such Performing Providers can combine their individual DSRIP allocations if there is a signed agreement between the affected parties submitted with the RHP Plan stating that the transaction is entered into freely and that it benefits regional transformation. No Performing Provider is required to combine its individual DSRIP allocation.

v. Requirements in Pass 1

1. Minimum Projects
RHP Plans must identify the minimum number of Category 1 and 2 projects the RHP is required to implement according to its Tier Level as outlined in Section III "Key Elements of Proposed RHP Plans" and must show that Performing Providers will meet the funding allocation requirements in each Category as described in paragraph 25.e. If an RHP Plan does not meet these criteria in Pass 1, the RHP Plan will not be approved.

2. DSRIP Participation Target for Major Safety Net Hospitals
An RHP Plan must meet DSRIP participation requirements for major safety net hospitals in order to be eligible to participate in "Pass 2" and to receive any redistributed DSRIP funds in DY 3 (as described in paragraph 22.b). In order to ensure broad participation of safety net hospitals in DSRIP, each RHP will have a minimum number of safety net hospitals participate in DSRIP as Performing Providers. The participation target varies by RHP Tier Level and is presented in Table 3 below.

For the purposes of this requirement, a hospital is defined as a major safety net hospital if it meets either of these two criteria:

a. Criteria 1
   The hospital participated in the Disproportionate Share Hospital (DSH) program in FFY2012 and
   i. The hospital received at least 15 percent of the region's total Medicaid revenue (fee-for-service, managed care, primary care case management [PCCM]) in FFY2011 for Pass 1 hospitals or;
   ii. has a trended 2012 hospital specific limit (HSL) that represents at least 15 percent of the region's total HSL,
   or
b. Criteria 2
   The hospital has a Pass 1 DSRIP allocation for DY 2-5 of greater than $60 million as defined in paragraph 25.c.i above.

Table 3: Major Safety Net Hospital DSRIP Participation Target by RHP Tier Level

RHP Tier	Number of Major Safety Net Hospitals in each RHP that must Participate in DSRIP*	Estimated Number of Safety Net Hospitals Participating in DSRIP
Tier 1	At least 5	5
Tier 2	At least 4	11
Tier 3	At least 2	12
Tier 4	At least 1	10
Total		38

*If there are fewer major safety net hospitals in an RHP than specified for its Tier level, then the RHP Plan must include all the major safety net hospitals as defined above in that RHP as Performing Providers for DSRIP.

3. Broad Hospital Participation Target
   An RHP Plan must meet the broad hospital participation target in order to be eligible to participate in "Pass 2" and to receive any redistributed DSRIP funds in DY 3 (as described in paragraph 22.b). RHPs shall have minimum representation of non-profit and other private hospitals in their RHP plans. An RHP Plan must include projects with values equal to at least a minimum percentage of DSRIP Annual Allocation Amounts assigned to non-profit and other private hospitals as defined in paragraph 25.c.i above. The minimum percentage varies by RHP Tier Level and is presented in Table 4 below.

Table 4: Non-Profit and Other Private Hospital DSRIP Target by RHP Tier Level

RHP Tier	Percent of Total Pass 1 Assigned DSRIP Annual Amounts Aggregated Across all Non-Profit and Other Private Hospitals included in RHP Plan
Tier 1	At least 30%

Tier 2	At least 30%
Tier 3	At least 15%
Tier 4	At least 5%

d. Re-allocation of Unused DSRIP Amounts for New Projects ("Pass 2")
After requirements of Pass 1 are met, as specified in paragraph 25.c.iv, if there are DSRIP allocation amounts that remain unused by potential Performing Providers, the RHP may redirect the unused amounts to fund additional projects by hospital providers and non-hospital providers that support the overall goals and community needs assessment of the RHP. HHSC also strongly encourages broad geographic representation across the region. In "Pass 2", the RHP shall identify the new projects and outcomes from Categories 1-3, the Performing Providers who shall implement the project, and the DSRIP funding amount assigned to the projects and measures.

In addition to the eligible providers identified in paragraph 25, physician practices that are not affiliated with academic science health centers may participate in Categories 1, 2, and 3 DSRIP projects in Pass 2. Hospitals that did not participate in the DSH program in FFY 2012 or the UPL program in FFY 2011 may also participate in DSRIP in Pass 2.

i. Pass 2 - Performing Providers that did not participate in Pass 1:
Potentially eligible Performing Providers in an RHP that did not participate in Pass 1 shall be allocated a total of 25 percent of the RHP's unused Pass 1 DSRIP funds. The Anchor will calculate the following for Pass 2 using the total unused DSRIP from Pass 1 allocations:

1. Hospital Performing Providers that did not participate in the DSH program in FFY 2012 or the UPL program in FFY 2011 shall be allocated a total of 15 percent of the RHP's unused Pass 1 DSRIP funds. Each hospital shall be allocated a proportion of the 15 percent divided by the number of new hospital Performing Providers.
2. Physician practices not affiliated with academic health science centers shall be allocated 10 percent of the RHP's unused Pass 1 DSRIP funds. Each physician practice shall be allocated a proportion of the 10 percent divided by the number of interested physician practices.

ii. Pass 2 - Performing Providers that participated in Pass 1:
Performing Providers in an RHP that participated in Pass 1 shall be allocated a total of 75 percent of the RHP's unused Pass 1 DSRIP funds. The Anchor will calculate the following for Pass 2 using Pass 1 DSRIP project information:

1. Each individual Performing Provider's percent of the total Pass 1 funding for DSRIP projects in Pass 1 in DYs 2-5.
2. The Performing Provider's percent as calculated in 1. above is multiplied by the 75 percent of the RHP's unused Pass 1 DSRIP funds to determine the allocation of DSRIP to each Performing Provider in the RHP for Pass 2.

3. Performing Providers may implement new DSRIP projects that complement the projects from Pass 1 and address outstanding community needs.
4. One Performing Provider must implement each DSRIP project.

iii. Collaboration among Performing Providers in Pass 2
Within each RHP, Performing Providers may combine their individual Pass 2 DSRIP allocations to fund a DSRIP project that is a priority for the RHP if there is a signed agreement between the affected parties submitted with the RHP Plan stating that the transaction is entered into freely and that it benefits regional transformation. No Performing Provider is required to combine its individual DSRIP allocation.

iv. If there are unused funds after Pass 2, the Anchoring Entity may collaborate with RHP Performing Providers to determine which additional DSRIP projects to include in the RHP Plan.

e. Project Valuation
RHP Plans shall include a narrative that describes the approach used for valuing projects and rationale to support the approach. At a minimum, Performing Providers shall ensure that project values comport with the following funding distribution across Categories 1-4 in DYs 2-5. Projects valued at the maximum levels described in paragraph 12.e are expected to support meaningful, large-scale delivery system transformation and must provide sufficient justification of the project value in the RHP Plan.

Hospital Performing Providers: DSRIP Category Funding Distribution

	DY 2	DY 3	DY 4	DY 5
Category 1 & 2	No more than 85%	No more than 80%	No more than 75%	No more than 57%
Category 3	At least 10%	At least 10%	At least 15%	At least 33%
Category 4*	5%	10 - 15%	10 - 15%	10 - 15%

*Hospital providers defined in paragraph 11.f, Section III "Key Elements of Proposed RHP Plans" that elect not to report Category 4 measures shall allocate Category 4 funding to Categories 1 & 2 or 3.

Non-Hospital Performing Providers: DSRIP Category Funding Distribution

	DY 2	DY 3	DY 4	DY 5
Category 1 & 2	95% to 100%	No more than 90%	No more than 90%	No more than 80%
Category 3*	0% to 5%	At least 10%	At least 10%	At least 20%

*Non-hospital Performing Providers are expected to allocate funds for Category 3 in the RHP Plan submission and may submit plan modifications in DY 2 with specific Category 3 outcomes to be eligible for the funding in DYs 3-5.

f. Milestone Valuation
With respect to Categories 1, 2, and 4, milestones for a project within a demonstration year shall be valued equally.

26. Payment Based on Achievement of Milestone Bundles in Categories 1, 2, and 4

a. Definition

With respect to Categories 1-2, a milestone bundle is the compilation of milestones and related metrics associated with a project in a given year. A milestone may have more than one annual metric associated with it. Two or more metrics associated with a milestone shall be assigned equal weighted value for the purpose of calculating incentive payments. With respect to Category 4, a milestone bundle is the compilation of reporting measures within a Category 4 domain. A Category 4 reporting measure within a domain shall be considered a milestone for the purpose of this section and all measures within a domain shall be weighted equally for the purpose of calculating incentive payments.

b. Basis for Calculating Incentive Payment for Categories 1-2

Incentive payments are calculated separately for each project in Categories 1 and 2.The amount of the incentive funding paid to a Performing Provider will be based on the amount of progress made within each specific milestone bundle. For each milestone within the bundle, the Performing Provider will include in the RHP semi-annual report the progress made in completing each metric associated with the milestone. A Performing Provider must fully achieve a Category 1 or 2 metric to include it in the incentive payment calculation.

Based on the progress reported, each milestone will be categorized as follows to determine the total achievement value for the milestone bundle:

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

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

Example of disbursement calculation:

A Category 1 Project in DY 2 is valued at $30 million and has 5 milestones, which make up the Milestone Bundle. Under the payment formula, the 5 milestones represent a maximum achievement value of 5.

The hospital Performing Provider reports the following progress at 6 months:

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

- Metric 1: Fully achieved

- Metric 2: Fully achieved

Milestone 2: 66.7% percent achievement (Achievement value = .5)
- Metric 1: Fully achieved
- Metric 2: Fully achieved
- Metric 3: Not Achieved

Milestone 3: 0 percent achievement (Achievement value = 0)
Metric 1: Not Achieved

Milestone 4: 50 percent achievement (Achievement value = .5)
- Metric 1: Fully Achieved
- Metric 2: Not Achieved

Milestone 5: 40 percent achievement (Achievement value = .25)
- Metric 1: Fully achieved
- Metric 2: Fully Achieved
- Metric 3: Not Achieved
- Metric 4: Not Achieved
- Metric 5: Not Achieved

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

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

Disbursement at 12 months is $30 million - $13.5 million = $16.5 million.

c. Basis for Calculating Incentive Payment for Category 4

i. DY 2 Incentive Payments
In DY 2, a hospital Performing Provider participating in Category 4 reporting shall be eligible to receive an incentive payment equal to 5 percent of its total allocation amount in DY 2 upon submission to HHSC of a status report that describes the system changes the hospital is putting in place to prepare to successfully report Category 4 measures in DYs 3-5.

ii. DYs 3-5 Incentive Payments
The amount of the incentive funding paid to a hospital Performing Provider will be based on the amount of progress made in successfully reporting all measures included in a domain. A hospital must complete reporting on **all** Category 4 measures included in a domain prior to requesting incentive payments. Hospitals shall report progress on completing measure reporting in the semi-annual reports.

Example of disbursement calculation:

A Category 4 Domain includes 5 reporting measures. The hospital Performing Provider completes reports on two measures by March 31 (or by the 6th month of the DY). The hospital reports this achievement in the first semi-annual report; however, an incentive payment is not made because 3 other measures in the domain remaining outstanding. By the 12th month of the DY, the hospital has successfully reported on the remaining 3 measures. At that point, the hospital may request and receive a full incentive payment for the entire domain of measures. If a hospital fails to report on a single measure in a domain, it will forfeit the entire payment for the domain in question.

27. Basis for Payment in Category 3

a. Valuation of Category 3 Outcomes
A Performing Provider shall have flexibility in assigning different values to its Category 3 outcomes and related milestones and outcome improvement targets, as long as total payments meet the annual category allocation amounts defined in 25.e above and the valuations are sufficiently justified.

b. Process Milestones/Metrics
A Performing Provider must fully achieve metrics associated with the process milestones to qualify for a DSRIP payment related to these milestones.

c. Outcome Improvement Targets
Performing Providers may receive partial payment for making progress towards, but not fully achieving, an outcome improvement target. The partial payment would equal 25 percent, 50 percent, or 75 percent of the achievement value of that outcome improvement target. Based on the progress reported, each outcome improvement target will be categorized as follows to determine the total achievement value percentage:

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

Example of disbursement calculation:

A hospital Performing Provider has set outcome improvement targets that would decrease potentially preventable readmissions for a target population with a chronic condition by 2 percent in DY 4 and by 5 percent in DY 5.

In DY 4, the Performing Provider achieved a 1 percent reduction in PPR, short of its goal. Under the partial payment policy, the provider would be reimbursed 50 percent of the incentive payment associated with this outcome improvement target because it achieved 50 percent of the target. The Performing provider may earn the remaining DY 4

incentive payment for the outcome improvement target in the following year (DY 5) under the carry-forward policy outlined in Section VIII: "Carry-forward and Penalties for Missed Milestones."

VII. PLAN MODIFICATIONS

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

28. Plan Modification Process

An RHP may request modifications to an RHP Plan under the following circumstances:

a. Adding New Project for Demonstration Year 3

An RHP may amend its plan to include new projects financed by either new or existing IGT Entities that are implemented by either existing and/or new Performing Providers. These projects shall be 3 years in duration, beginning in Demonstration Year 3. Projects added for DY 3 may be selected from Categories 1, 2, or 3 of Attachment I, "RHP Planning Protocol" and are subject to all requirements described herein and in the STCs. Newly added hospital Performing Providers shall be required to report Category 4 measures according to Section III "Key Elements of Proposed RHP Plans". Plan modifications related to adding new projects must be submitted to HHSC by a date within DY 2 specified by HHSC. The RHP shall ensure that incentive payments for the new project comply with Section VI "Disbursement of DSRIP Funds".

b. Deleting an Existing Project

An RHP may request to delete a project from its RHP plan and forgo replacing it if the RHP continues to meet the minimum project number requirements outlined in Section III "Key Elements of Proposed RHP Plans" and the loss of the project does not jeopardize or dilute the remaining delivery system reforms pursued in the plan. An RHP may not redistribute incentive funding from the deleted project to other existing projects; unless the project is replaced in accordance with subparagraph a. above, the affected Performing Provider and RHP shall forfeit funding associated with the deleted project. The forfeited funding may be available for redistribution to RHPs in accordance with Section VI "Disbursement of DSRIP Funds".

c. Modifying Existing Projects

RHPs may submit requests to HHSC to modify elements of an existing project prospectively, including changes to milestones and metrics with good cause. Such requests must be submitted to HHSC within 90 days of the end of a demonstration year for changes to go into effect the following demonstration year.

d. Plan Modification Review and Approval Process

Plan modifications require both HHSC and CMS approvals. Plan modifications must be submitted in writing to HHSC; HHSC shall take action on the plan modification request

within 30 days and submit recommended requests to CMS. CMS shall take action to approve or disapprove the Plan Modification request within 30 days of receipt from HHSC.

VIII. CARRY-FORWARD AND PENALTIES FOR MISSED MILESTONES

29. Carry-forward Policy

If a Performing Provider does not fully achieve a milestone bundle in Categories 1 or 2, or a Category 3 process milestone or outcome improvement target that was specified in its RHP Plan for completion in a particular demonstration year, it will be able to carry forward the available incentive funding associated with the milestone or outcome improvement target until the end of the following demonstration year during which the Performing Provider may complete the milestone and receive full payment. To effectuate carry-forward policy, a Performing Provider shall provide narrative description on the status of the missed milestones and outcome improvement targets and outline the provider's plan to achieve the missed milestones/targets by the end of the of the following demonstration year.

30. Penalties for Missed Milestones

If a Performing Provider does not complete the missed milestone bundle or measure during the 12-month carry-forward period or the reporting year with respect to Category 4, funding for the incentive payment shall be forfeited and no longer available for use in the DSRIP program.