TACHC

The Heartbeat of Texas Community Health Centers | **Weekly Wrap-up - June 28, 2012**

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Staff at
Legacy Community Health Services, Houston, TX

Upcoming Events

July CPI Webcast: Meaningful Use (MU) of the Health Center Electronic Health Record (EHR)

July 20, 2012, 9:00am to 11:00am CST

Eligible healthcare professionals can receive as much as $63,750 over a six-year period through the MU incentive program. Established under the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, the Texas Medicaid EHR Incentive Program started in 2011. It offers incentive payments to eligible professionals at health centers as they adopt, implement, or upgrade (AIU) certified EHR technology in their first year

of participation and demonstrate meaningful use for up to five remaining participation years. Learn more about the program background, eligibility, and how to participate over the next several years. Learn also how meaningfully using your EHR can help you achieve Patient Centered Medical Home recognition.

NOTE: Registration for all CPI Webcast Trainings is for two webcasts, Parts 1 and 2, at once. Thus, please register for July **and** August 2012 CPI Webcasts by logging in on the TACHC website **Events** page, clicking the Register button, and paying for one registration covering both months.

TACHC Clinical Director Institute

July 27-28, 2012, in Austin, TX

Attention all Chief Medical Officers, Chief Dental Directors, and Behavioral Health Directors: please join your colleagues this year for an interactive 2-day session that will help you prepare for the upcoming challenges at your community health center. The Institute will be held at the Intercontinental Stephen F. Austin Hotel, 701 Congress Avenue, Austin, TX 788701. Presentations include, but not limited to: "Accountable Care, the Sustainability Model", "How to Spread the Knowledge or Proper Coding and Improve the Skills of CHC Providers", "ICD-10 Coding for Clinicians", "Peer Review" and "How to Manage Physicians in Good Times and Bad". To download a registration form, click **HERE**. For more information, contact Davelyn Eaves Hood, MD, Director of Clinical Affairs at TACHC, 512-329-5959, Ext. 2130.

Information regarding all upcoming events hosted by TACHC can be found **HERE**.

Governance and Finance

1. HHSC Webinars and Planning Summit for 1115 Transformation Waiver: Right now, HHSC is negotiating with the Centers for Medicare and Medicaid Services (CMS) on the Program Funding and Mechanics Protocol (PFM) and the Delivery System Reform Incentive Payment (DSRIP) Planning Protocol. There are two webinars scheduled for next week that will provide updates on the negotiations with CMS. HHSC is also accepting comments on the current draft of the PFM protocol. Finally, HHSC will host a Regional Healthcare Partnership (RHP) Planning Summit in Austin on August 7 and 8. See below for details on the webinars and the planning summit. For questions related to the 1115 Waiver, please contact Laura Martin.

- ***Tuesday, July 10th from 10 to 11:30am* – PFM Webinar:** You can log in online to view the slides and listen to the audio conference through computer speakers OR call in for the audio portion. If you dial in, you should do so 15 minutes prior to the start of the webinar. You will be automatically connected to the meeting room and will hear music until the webinar starts.

  To access the webinar, on July 10th at 10 a.m.**:**
  1) Go to www.webex.com
  2) Click on Attend Meeting
  3) Enter Meeting Number: 802 994 356 (no password necessary)
  4) Call 1-800-396-3172 (no password necessary)

- ***Wednesday, July 11th from 10 to 11:30am* – DSRIP Planning Protocol Webinar:** You can log in online to view the slides and listen to the audio conference through computer speakers OR call in for the audio portion. If you dial in, you should do so 15 minutes prior to the start of the webinar. You will be automatically connected to the meeting room and will hear music until the webinar starts.

  To access the webinar, on July 11th at 10 a.m.**:**
  1) Go to www.webex.com
  2) Click on Attend Meeting
  3) Enter Meeting Number: 805 776 476 (no password necessary)
  4) Call 1-800-396-3172 (no password necessary)

- ***August 7-8* – Regional Healthcare Partnership (RHP) Planning Summit:** On Tuesday, August 7th and Wednesday, August 8th, HHSC will host an RHP Planning Summit at the Hilton in downtown Austin. Broad stakeholder input is needed for the success of each RHP plan.

Due to limited space, in-person attendance will be capped at approximately 250 attendees. Each RHP will have a minimum of seven in-person slots for the summit, so the anchor entity, along with key inter-governmental transfer (IGT) entities and performing providers will be able to attend to receive information on how to complete and submit the RHP plan. As the coordinating entity for each RHP, anchors should identify the appropriate people from their region that need to attend the planning summit, and no more than 50 percent of attendees allotted to each RHP may be from the anchor organization. HHSC also invited Executive Waiver Committee members and other organizations directly involved in the implementation of the 1115 Transformation waiver. Only those who have registered can attend the meeting in person.

2. TACHC Innovations in Leadership Conference: On August 24 – 25, 2012, TACHC will convene a two day advanced leadership training for community health center executive leadership staff at the lovely San Luis Resort, Spa and Conference Center in Galveston. During this training, participants will gain the skills and competencies necessary to shift away from focusing on "individual experts" and departments to

develop a culture in your health center that leverages cross-boundary groups and teams and spans disciplines, levels, functions, generations and professions. Both an internal and external focus in this training will allow participants to better understand how to improve overall leadership team functioning, staff productivity and workforce retention as well as how to more effectively collaborate with other community providers and stakeholders. This session will also showcase best practices in health centers across the state to highlight successful community partnerships, innovations in service delivery, service excellence, workforce recruitment and retention, and performance management. We have limited space available, so register today! Click **HERE** for more information or see the attached registration form to register for this event.

3. TACHC 29th Annual & Clinical Conference: October 14-17, 2012, TACHC will host its 29th Annual & Clinical Conference at The Worthington Renaissance Hotel, 200 Main Street in Fort Worth, TX. For reservations, call 1-800-433-5677 and reference the group name (TACHC) or click **HERE** to book rooms online.

Clinical Affairs

IAATP Infant Adoption Awareness Training: This training by IAATP is designed for medical, clinical and educational professionals who could be working with a teen or woman experiencing an unplanned pregnancy as she is trying to decide which of the three options is best for her. The training provides participants with opportunities for self-reflection and open discussion about the issues that women facing unintended pregnancies experience. Hope Cottage Pregnancy and Adoption Center is the lead partner agency in Texas to receive federal funding to provide this training. Nurses, Social Workers, and Licensed Mental Health Counselors receive 4.5 CEU's for attending. The training can be provided at your agency or your staff can attend training at another site. For more information contact Julie Hames at NETX@hopecottage.org

Other News

TACHC Member News: To learn what your fellow health centers are involved in or read news that may affect your health center, click **HERE** for news coverage. We also encourage you to post your news, questions and comments to each other on the TACHC members listserv (members@tachc.org), where only TACHC executives or their designees are recipients.

Innovations in Leadership Conference
August 24-25, 2012
The San Luis Resort, Spa & Conference Center
5222 Seawall Blvd.
Galveston, TX 77551

Registration Form (Please send ALL team members forms at the same time)

Name_____
Agency_____
Title_____
Mailing Address_____
City_____, **State** _____ **Zip** _____
Phone ( ) _____-_____ **Fax ( )** _____-_____
Email Address_____
Special Needs _____
Vegetarian ❍ I will attend need a vegetarian food option

	Member	
Registration Fees	**By August 10**	**After August 10**
1st and 2nd Registrant from same center	$350	$400
3rd Registrant from same center plus more	$200	$250

Total $ _____

Payment
❍ Check (Payable to TACHC) ❍ Visa ❍ MasterCard ❍ American Express *(If paying by credit card, all fields are required)*

Cardholder Name _____

Cardholder Phone_____

Card Number_____Sec. code (required)_____Exp.Date_____

Signature_____

Confirmation of registration payment will be forwarded by email or fax upon receipt of payment. Please call the TACHC office with your credit card information. Also bring a copy of your written confirmation to the conference. Please mail, fax or email form to:

Texas Association of Community Health Centers,
ATTN: TaSheena Mitchell, Meeting Planner,
5900 Southwest Parkway, Building 3, Austin, Texas 78735

Fax: (512) 329-9189, Tel: (512) 329-5959, Email: tmitchell@tachc.org

Cancellation Policy: Written cancellation notice must be received via email by August 10, 2012. There is a $150 processing fee for refunds. There will be no refunds given after this date or for No-Shows.

Please Note: It is very hard to regulate the temperature in hotel meeting space so please bring a jacket or sweater!

Hotel Information

The San Luis Resort, Spa & Conference Center
5222 Seawall Blvd, Galveston, TX 77551

To make reservations, call 1-800-392-5937 and mention **Texas Association of Community Health Centers** to receive the special conference rate. Reservations must be guaranteed with a major credit card. Hotel's cancellation policy is three days (72 hours) prior to arrival, to avoid charge. Hotel check-in is 4:00 pm and checkout is 11:00 am. Rates are good for reservations made by **July 24, 2010 at 5:00pm!**

Room Type	Single/Double Occupancy
Run of House	$189.00

Parking
Complimentary self-parking
Valet $15 Overnight
Valet $7 Short-Term Parking

General Directions to the Hotel
An easy-to-reach destination, The San Luis Resort, Spa & Conference Center on Galveston Island is less than an hour's drive from Houston, three hours from Austin and five hours from Dallas/Ft. Worth.

From Houston
Take Interstate 45 South to Galveston. Take the 61st Street exit and turn right (south). Stay on 61st Street to Seawall Boulevard. Turn left (east) at Seawall Boulevard. The San Luis Resort is located past 53rd Street and Seawall Boulevard on the left (north) side.

Transportation
Airports
William P. Hobby Airport (HOU) (recommended)
George Bush Intercontinental Airport (IAH)
Scholes International Airport at Galveston

Ground
Transportation directly to The San Luis from both Houston airports is available through http://www.galvestonlimousineservice.com/

In addition, The San Luis Resort is conveniently located just minutes from the Galveston Airport and Interstate 45.

Local
Transportation around Galveston Island is available by taxi service. Please contact our Concierge and they will be happy to assist with arrangements

Texas Transformation and Quality Improvement Program 1115 Waiver
Program Funding and Mechanics Protocol Feedback Form

Name: _____ **Date:** _____

Organization: _____

Type of Organization (e.g. public hospital, private hospital, professional organization, academic health science center, county agency)**:**

_____

County where organization is located: _____

Complete the following table to submit comments regarding Section VI of the updated Program Funding and Mechanics (PFM) Protocol (dated June 29, 2012) for the Texas Transformation and Quality Improvement Program 1115 Waiver. Please add rows as needed. The other sections of the PFM Protocol were updated based on stakeholder, state, and federal feedback received in May and June 2012. However, if you have additional comments on these other sections, please include them in the second section of the table below. Comments will only be considered if submitted to the Texas Health and Human Services Commission (HHSC) using this form by **Friday, July 13, 2012**.

Please save the feedback form as a Microsoft Word file and email to TXHealthcareTransformation@hhsc.state.tx.us. HHSC prefers to receive feedback in a Microsoft Word file sent to the waiver email box; however, if you are unable to access email, please fax to ATTN: Donna Miles at 512-491-1971.

Note: The protocol is HHSC's draft proposed approach; however, many items are under negotiation with the Centers for Medicare & Medicaid Services (CMS), including Delivery System Reform Incentive Payment (DSRIP) requirements to be eligible for uncompensated care (UC) payments; UC and DSRIP allocation methodology; the methodology for allocating funding among DSRIP Categories; the minimum number of projects; valuation of projects; and variation of requirements across regions.

#	Section VI	Comment/Issue	Proposed Change
Example	*VI(22)(a)*	*HHSC is using Medicaid MCO amount paid in the variables for DSRIP allocation to regions.*	*This should not be used as a factor given that not all regions had Medicaid managed care in SFY2011.*
1			
2			

Comments on other sections:

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 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, 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
IV. State and Federal Review Process of RHP Plans

II. DSRIP ELIGIBILITY CRITERIA

4. RHP Regions

Texas has approved the following 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.

RHPs may vary in size, demographics, number and types of providers, and by available financing. 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, 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, Denton, 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

Each RHP shall have one Anchoring Entity that coordinates the development of the RHP Plan for that region. In RHP regions that have a public hospital, a public hospital shall serve as the Anchoring Entity. In regions without a public hospital, the following entities may serve as anchors: (1) a hospital district; (2) a hospital authority; (3) a county; or (4) a State university with a health science center or medical school. An Anchoring Entity may not control another entity's IGT funding.

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

- Developing a community needs assessment for the region;
- Engaging stakeholders in the region, including the public;
- Developing the 4-year RHP Plan that best meets community needs in collaboration with local IGT Entities and Performing Providers;
- Ongoing communication with HHSC;

- Ongoing communication with IGT Entities financing the non-federal share of DSRIP payments in the region and Performing Providers;
- Ongoing monitoring and reporting to HHSC on status of projects and performance of Performing Providers in the region;
- Ensuring the number of projects from each Category as required by region is met;
- Ensuring that the RHP's Plan is consistent with all other protocol requirements; and
- Facilitating compliance with the RHP Plan Checklist.

6. IGT Entities

a. Description

Intergovernmental transfer (IGT) Entities are entities that fund the non-federal share of DSRIP payments for an RHP. They include Anchoring Entities, government-owned Performing Providers, local mental health authorities (LMHAs), 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".

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

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

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 as specified in this protocol are the only entities that are eligible to receive DSRIP incentive payments in DYs 2-5. Performing Providers will primarily be hospitals, but LMHAs, 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. A Performing Provider may only participate in the RHP Plan where it is physically located.

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 participate and receive payments from the Uncompensated Care Pool shall be required to report on a subset of Category 4 measures. The subset of Category 4 measures fall into 3 domains: (1) Potentially Preventable Admissions (PPA's); (2) Potentially Preventable Readmissions (PPR's) and (3) Potentially Preventable Conditions (PPC's). Beginning in Demonstration Year 3, if a hospital fails to report on all required Category 4 measures by the last quarter of each DYs 3-5, 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. 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.e below are exempt from this requirement.

III. KEY ELEMENTS OF PROPOSED RHP PLANS

9. RHP Specific 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.

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 projects including project titles, brief descriptions of the projects, and the four-year goals. The Executive Summary shall also include a description of key challenges facing the RHP and how the four-year 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 that has the following elements for the region:

i. Demographic information (e.g., race/ethnicity, income, education, employment, etc.)
ii. Insurance coverage (e.g., commercial, Medicaid, Medicare, uncompensated care);
iii. Description of the region's current health care infrastructure and environment (e.g., number/types of providers, services, systems, and costs; Health Professional Shortage Area [HPSA]);

iv. Description of changes in the above areas, i. – iii, expected to occur during the waiver period of federal fiscal years 2012 – 16.
v. Key health challenges specific to the region (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, 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.

11. Number of Projects

RHPs must select a minimum number of projects from Categories 1, 2, and 3, and reporting measures from Category 4 pursuant to Attachment I, "RHP Planning Protocol". The number of minimum projects will differ for RHPs depending on their Tier classification. An RHP's Tier classification is displayed in Table 2 of Section VI "Disbursement of DSRIP Funds".

a. Definitions

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).
vi. 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 one public hospital that provides less than 1 percent of the region's charity care.

b. Categories 1 and 2 Projects

i. Tier 1 RHP
A Tier 1 RHP must select a minimum of 10 projects from Categories 1 and 2 combined, with at least 5 of the 10 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 6 projects from Categories 1 and 2 combined, with at least 3 of the 6 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 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.

iv. Tier 4 RHP
A Tier 4 RHP must select a minimum of 2 projects from Categories 1 and 2 combined, with at least 1 of the 2 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; and
2) Performing Providers in the same RHP may not adopt the same project that serves the same patients. The RHP Plan must assure that the incentive payments are in no way duplicative. For example, if two Performing Providers offer diabetes disease management, they must describe how the projects are serving different populations.

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

i. Implement 1 common Category 3 intervention identified in Attachment I, "RHP Planning Protocol".

ii. Select 1 additional Category 3 intervention from within the optional Category 3 interventions in the RHP Planning Protocol. For its 1 additional intervention, a hospital-based Performing Provider is precluded from choosing an intervention for which it has achieved top performance for at least 4 consecutive quarters prior to approval of the waiver on December 12, 2011, as defined by Category 3 in the RHP Planning Protocol.

d. Category 4
Pursuant to STC 45(d)(ii)(A), all hospital-based Performing Providers must report on all Category 4 measures. In accordance with this requirement, beginning in DY 3 (FFY 13) hospital-based Performing Providers in all RHPs must include reporting of all core measures, pursuant to Attachment I, "RHP Planning Protocol". Hospitals defined under paragraph 11.e are exempt from reporting Category 4 measures. If an exempted hospital elects to report Category 4, then it shall report on Category 4 measures and be held to the same requirements as all other Performing Providers participating in Category 4.

e. Hospital Exemption
DSRIP hospitals that meet the criteria below and as approved by the State are exempt from implementing the additional Category 3 intervention in paragraph 11.c.ii and Category 4 reporting in paragraph 11.d 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 four-year plan will include sections on each of the 4 categories as specified in the RHP Planning Protocol. They include:

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

ii. Category 2 Program Innovation and Redesign includes the piloting, testing, and replicating of innovative care models.
iii. Category 3 Quality Improvements is broad dissemination of a set of interventions in which major improvements in care can be achieved within 4 years.
iv. Category 4 Population Focused Improvements is the reporting of measures that demonstrate the impact of delivery system reform investments under the waiver.

b. Categories 1-3 Requirements

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

i. Identifying information
Identification of the DSRIP Category, name of the project/intervention, and RHP Performing Provider name and Texas Provider Identifier (TPI) involved with the project. 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 or intervention; the starting point of the Performing Provider related to the project or intervention and based on that, the 4-year expected outcome for the Performing Provider and the patients.
iii. Rationale
As part of this subsection, each Performing Provider will provide the reasons for selecting the project or intervention, milestones, and metrics based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point.
iv. Relationship to Other Projects
A description of how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP Plan. Non-hospital Performing Providers shall include a description of how the Category 1 or Category 2 project supports, reinforces, enables, and is related to Category 3 interventions and/or Category 4 reporting measures of hospitals in their region. At a minimum, a non-hospital Performing Provider's project must tie to certain Category 4 reporting measures.
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.

a) For each project from Category 1 and 2, the Performing Provider must include at least 1 milestone based on a Process Measure and at least 1 milestone based on an Improvement Measure over the 4-year period in accordance with Attachment I, "RHP Planning Protocol."
b) For each intervention from Category 3, a Performing Provider shall establish improvement targets to be achieved over the DYs 2-5 period.

c) For each milestone, the estimated DSRIP funding must be identified as the maximum amount that can be received for achieving the milestone.
d) For each year, the estimated available non-federal share must be included and the source of non-federal share identified.

c. Category 4 Requirements

This focus area involves population-focused improvements associated with Categories 1, 2, and 3 projects. Each 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 and how the measures relate to project(s) and interventions in Categories 1, 2, or 3 within the RHP's Plan.

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.
3. For each year, the estimated available non-federal share must be included and the source of non-federal share identified.

d. Project Valuation

The RHP Plan shall contain a narrative that describes overall 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, etc.).

IV. STATE AND FEDERAL REVIEW PROCESS OF RHP PLANS

13. Review Process

The Texas Health and Human Services Commission (HHSC) will review all 4-year RHP Plan proposals prior to submission to CMS for final approval according to the schedule below. The schedule is based on CMS approval of the State's RHP Planning Protocol (Attachment I) and Program Funding and Mechanics Protocol (Attachment J) by July 31, 2012.

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

14. HHSC Review and Approval Process

a. HHSC Review of Plans

i. By September 1, 2012, each RHP identified in paragraph 4 will submit a 4-year RHP Plan proposal to HHSC for review. HHSC shall review and assess each plan according to the following criteria:
- The plan is in the format and contains all required elements described herein and is consistent with special terms and conditions, including STCs 45(a), 45(b), 45(c), and 45(d)(iii).
- The plan conforms to the requirements for Categories 1, 2, 3, and 4, as described in Section III "Key Elements of Proposed RHP Plans", Attachment I, "RHP Planning Protocol", and "RHP Plan Checklist."
- Category 1, 2, and 3 projects clearly identify goals, milestones, metrics, and expected results. Category 4 clearly identifies the population-focused health improvement measures to be reported.
- The amount and distribution of funding is in accordance with the stipulations of STC 46 and Section VI "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. By September 30, 2012, 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 RHP Anchoring Entity shall respond in writing to any notification by HHSC of questions or concerns. The RHP's responses must be received by the date specified in the aforementioned notification. The RHP Anchoring Entity's initial response may consist of a request for additional time to address HHSC's comments provided that the RHP's revised plan addresses HHSC's comments and is submitted to HHSC by October 15, 2012.

b. HHSC Approval of Plans

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

15. CMS Review and Approval Process

CMS will review each RHP's 4-year 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 DSRIP requirements as outlined in Section III "Key Elements of Proposed RHP Plans" and Attachment I, "RHP Planning Protocol."

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

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

RHPs shall develop an acceptable revision to a project for any components of the plan identified by CMS as not approvable. By January 15, 2013, HHSC shall submit revised RHP Plans to CMS and CMS shall approve or deny the plans in writing to HHSC and the RHP Anchoring Entity by February 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, 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 Plan 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 an RHP Plan to CMS by October 31, 2012, shall serve as the basis for the full DY 1 payment to Performing Providers, Anchoring Entities, and IGT Entities, as prescribed by Section VI "Disbursement of DSRIP Funds".

b. RHP Plans Not Approved by CMS on or after February 1, 2013

All Performing Providers, Anchoring Entities, and IGT 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 take steps to recoup the DY 1 payment from all eligible entities in the affected RHP. If an RHP deletes a project without a replacement to obtain CMS approval of the RHP Plan, the State shall take steps to recoup the DY 1 payment from the entities that received funding for that project.

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 certify 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 shall schedule the payment transaction for each RHP Performing Provider within 30 days following HHSC approval of the RHP report.

19. Intergovernmental Transfer Process

Within 14 days after notification by HHSC of the required nonfederal share amount, the IGT Entity will make an intergovernmental transfer of funds equal to the nonfederal share (as determined by HHSC) that is necessary to draw the federal funding for the incentive payments related to the milestone achievement that is reported by the Performing Provider in accordance with paragraph 18 and approved by the IGT Entity and the State. The State will draw the federal funding and pay both the nonfederal and federal shares of the incentive payment to the Performing Provider. If the IGT is made within the appropriate 14 day timeframe, the incentive payment will be disbursed within 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. The Performing Providers shall have available for review by HHSC and CMS, upon request, all supporting data and back-up documentation. All RHP Plans are subject to potential audits. Failure of the Performing Provider to maintain adequate documentation may result in recoupment of DSRIP payments.

21. Texas Reporting to CMS

a. Quarterly and Annual Reporting

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

i. All DSRIP payments made to Performing Providers that occurred in the quarter;
ii. Expenditure projections reflecting the expected pace of future disbursements for each RHP and Performing Providers;
iii. A summary assessment of each RHP's DSRIP activities during the given period; 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". Texas and the Performing Providers shall have available for review by CMS, upon request, all supporting data and back-up documentation.

VI. DISBURSEMENT OF DSRIP FUNDS

22. 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 Standard Term and Condition 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 allotted 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 (Source: U.S. Census Bureau: 2006-2010 American Community Survey for Texas).
ii. Percent of Texas Medicaid acute care payments in SFY 2011 made in the RHP (including fee for service, MCO, vendor drug, and PCCM payments).
iii. Percent of total SFY 2011 Medicaid supplemental payments made to providers in the RHP.

The simple average of the three variables (low income population (<200% FPL), Medicaid supplemental payments, and Medicaid acute care medical payments) is the basis for allocating DSRIP Pool funds to each RHP. For two variables, (i.e., low income population and Medicaid supplemental payments), the percent of the region's performance on the variable to the total amount of the variable at the state level (e.g., region's number of low income individuals / state's low income population) was calculated. The third variable, Medicaid acute care medical payments, is a composite variable, composed of FFS, PCCM, MCO and vendor drug payments. These four service payments were summed and the RHP's percent of the state's total amount was calculated. Once the percentages for each region for these three variables were calculated, they were averaged and it is this average that is used to allocate the DSRIP Pool to each RHP for each DY.

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 2 below. This table also displays the Tier Level of an RHP as defined in paragraph 11, Section III "Key Elements of Proposed RHP Plans".

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 2, the uncommitted amounts shall be redistributed to RHPs according to the DSRIP funding allocation methodology described in a. above, subject to plan modification requests. The redistributed funds may be used by RHPs to fund new projects beginning in DY 3 in accordance with Section VII "Plan Modifications".

23. Uncompensated Care Allocation and Benchmark Payment Variation between UC and DSRIP

RHPs shall be allocated Uncompensated Care funds using the same DSRIP funding allocation methodology described in paragraph 22.a. The UC funding amounts allotted to each RHP in DYs 2-5 are displayed in Table 3 below.

An RHP's funding allocation amounts between UC and DSRIP as shown in Table 1 below are consistent with the allocation schedule described in Table 5, paragraph 46 of the waiver's standard terms and conditions. Table 1 shall serve as a benchmark for UC payments and DSRIP payments in an RHP. RHPs are strongly encouraged to adhere to this benchmark to ensure a robust and meaningful DSRIP program.

Table 1: 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%

Table 2: DSRIP Allocation ($ in millions)

RHP	Tier	Funding Allocation %	DY 1	DY 2	DY 3	DY 4	DY 5	Total
1	3	4.00%	19.98	91.90	106.53	113.96	123.87	456.23
2	3	3.78%	18.88	86.85	100.67	107.69	117.06	431.15
3	1	20.22%	101.10	465.07	539.07	576.68	626.83	2,308.75
4	3	4.23%	21.16	97.35	112.84	120.71	131.21	483.27
5	4	7.02%	35.11	161.53	187.23	200.29	217.71	801.88
6	2	10.15%	50.73	233.37	270.51	289.38	314.55	1,158.55
7	3	6.04%	30.18	138.81	160.90	172.12	187.09	689.10
8	4	1.66%	8.28	38.07	44.13	47.20	51.31	188.98
9	2	13.45%	67.23	309.27	358.48	383.49	416.84	1,535.30
10	2	9.74%	48.71	224.05	259.71	277.83	301.98	1,112.28
11	4	1.16%	5.82	26.79	31.05	33.21	36.10	132.97
12	3	3.56%	17.78	81.78	94.79	101.40	110.22	405.97
13	4	0.67%	3.35	15.43	17.88	19.13	20.79	76.58
14	4	2.29%	11.43	52.56	60.93	65.18	70.85	260.95
15	3	4.41%	22.04	101.37	117.50	125.70	136.63	503.24
16	4	1.30%	6.51	29.95	34.72	37.14	40.37	148.71
17	4	1.89%	9.47	43.58	50.52	54.04	58.74	216.36
18	4	2.06%	10.30	47.37	54.91	58.74	63.85	235.16
19	4	0.95%	4.73	21.75	25.21	26.97	29.31	107.97
20	4	1.44%	7.21	33.16	38.44	41.12	44.69	164.62
		100.0%	**500**	**2,300**	**2,666**	**2,852**	**3,100**	**11,418**

Table 3: Uncompensated Care Allocation ($ in millions)

RHP	Funding Allocation %	DY 2	DY 3	DY 4	DY 5	Total
1	4.00%	155.83	141.21	133.78	123.87	554.68
2	3.78%	147.27	133.45	126.42	117.06	524.20
3	20.22%	788.59	714.58	676.97	626.83	2,806.97
4	4.23%	165.07	149.58	141.71	131.21	587.56
5	7.02%	273.89	248.19	235.13	217.71	974.92
6	10.15%	395.72	358.59	339.71	314.55	1,408.57
7	6.04%	235.37	213.28	202.06	187.09	837.81
8	1.66%	64.55	58.49	55.41	51.31	229.76
9	13.45%	524.41	475.19	450.18	416.84	1,866.62
10	9.74%	379.92	344.26	326.14	301.98	1,352.31
11	1.16%	45.42	41.16	38.99	36.10	161.67
12	3.56%	138.67	125.65	119.04	110.22	493.58
13	0.67%	26.16	23.70	22.45	20.79	93.10
14	2.29%	89.13	80.77	76.51	70.85	317.26
15	4.41%	171.89	155.76	147.56	136.63	611.84
16	1.30%	50.79	46.03	43.60	40.37	180.80
17	1.89%	73.90	66.97	63.44	58.74	263.05
18	2.06%	80.32	72.78	68.95	63.85	285.90
19	0.95%	36.88	33.42	31.66	29.31	131.26
20	1.44%	56.23	50.95	48.27	44.69	200.14
	100.0%	**3,900**	**3,534**	**3,348**	**3,100**	**13,882**

24. DY 1 RHP DSRIP Allocation Formula

a. Eligible Entities

Anchoring Entities, IGT 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 multiple 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 shall be allocated 10 percent of the total DY 1 RHP DSRIP funding amount.

c. IGT Entities and Performing Providers

Remaining DY 1 RHP DSRIP funding (90 percent) shall be allocated to Performing Providers and eligible IGT Entities 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 and IGT entities. The Performing Provider shall retain 50 percent of the resulting payment and the remaining 50 percent shall be shared proportionally among the IGT Entities (inside and outside the RHP Region) that are funding the Performing Provider's projects.

Example:

- An RHP's DY1 DSRIP Allocation is $25 million.
- 10 percent or $2.5 million is allocated to the Anchoring Entity.
- The remaining amount, $22.5 million, shall be distributed to Performing Providers and eligible IGT Entities according to the following formula:

    1. An RHP Plan reports a total DSRIP valuation of projects in DY 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. The RHP's remaining DY 1 DSRIP amount after funds are allocated to the Anchoring Entity is $22.5 million. Based on the formula, Performing Provider "A" and the IGT Entities that are slated to fund Provider A's projects would be eligible to receive $4.5 million or 20 percent of the total DY 1 DSRIP payment amount.
    4. Fifty percent of the DY 1 payment, or $2.25 million shall be paid to Performing Provider A and the remaining 50 percent ($2.25 million) shall be shared proportionally among the IGT Entities (inside and outside the RHP Region) that are funding the non-federal share of Performing Provider A's projects.

25. DYs 2-5 RHP DSRIP Allocation Formula

a. Eligibility for DSRIP Incentive Payments

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 for each potential provider who would be eligible to participate in DSRIP. The purpose of this step is to encourage broad participation in DSRIP in an RHP. Under Pass 1, the RHP must identify and fund its minimum required number of projects and meet a threshold for DSRIP participation by non-profit and private hospitals (described below).

Recognizing that not all potentially eligible Performing Providers will participate in DSRIP, stage 2 of the DSRIP allocation process permits RHPs to reallocate unused DSRIP funds for new projects in Categories 1, 2, and 3. The RHP has discretion in selecting projects that support the RHP's overall goals and are 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 shall be initially 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 patients, as measured by two 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, vendor drug, and PCCM payments); and
2. The hospital's percent share of total SFY 2011 Medicaid supplemental payments made to potentially eligible hospital providers in the RHP.

The two variables shall be weighted equally and added together to produce a Hospital DSRIP Allocation percentage. The resulting percentage shall be multiplied by the annual RHP DSRIP amount allocated to hospitals to come up with the potential allocation amount for each hospital.

ii. Non-Hospital Providers

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

1. Local Mental Health Authorities initially shall be allocated a total of 10 percent of the RHP's annual DSRIP funds;
2. Physician Practices associated with an Academic Health Science Center initially shall be allocated a total of 10 percent of the RHP's annual DSRIP funds;
3. Local Health Districts initially shall be allocated a total of 5 percent of the RHP's annual DSRIP funds.

iii. Requirements in Pass 1

1. Minimum Projects
RHP Plans must identify 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".

2. Broad Hospital Participation
RHPs classified in Tier 1, Tier 2, or Tier 3 in Section III "Key Elements of Proposed RHP Plans" shall have minimum representation of non-profit and private hospitals in their RHP plans. Minimum representation is defined as a RHP Plan that reflects at least X percent of the assigned DSRIP annual amount allocated to non-profit and private hospitals identified in paragraph 25.c.i above.

d. Re-allocation of Unused DSRIP Amounts for New Projects
After requirements of Pass 1 are met, 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. In this second pass, the RHP shall identify the new projects from Categories 1-3, the Performing Providers who shall implement the project, and the DSRIP funding amount assigned to the projects. The value of a project adopted by a Performing Provider in the second pass shall not exceed the highest value of any individual project adopted by the Performing Provider in Pass 1.

In addition to the eligible providers identified in paragraph 25, physician practices that are not affiliated with academic science health centers may also participate in Categories 1 and 2 DSRIP projects.

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, hospital Performing Providers shall ensure that project values comport with the following funding distribution across Categories 1-4 in DYs 2-5.

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 80%	No more than 75%
Category 3	At least 10 %	At least 10%	At least 10%	At least 15%
Category 4*	5%	At least 10%	At least 10%	At least 10%

*Hospital providers defined in paragraph 11.e, 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.

26. Payment Based on Achievement of Milestone Bundles in Categories 1-4

a. Definition

With respect to Categories 1-3, 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 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 1-3

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 1-3 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 total possible achievement value by the reported achievement value. If a Performing Provider has previously reported progress in a bundle and received partial funding, only the additional amount it is eligible for will be disbursed. 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.

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.

27. 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 June 1, 2013. 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

28. Carry-forward Policy

If a Performing Provider does not fully achieve a milestone bundle in Categories 1-3 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 bundle until the end of the following demonstration year during which the Performing Provider may complete the milestone and receive full payment. Carry-forward shall not be available for Category 4 measures; if a hospital performing provider fails to report a Category 4 measure in a demonstration year it shall forfeit incentive payment for that measure.

29. 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.

TX Infant Adoption Awareness Training

This training is designed for medical, clinical and educational professionals who could be working with a teen or woman experiencing an unplanned pregnancy as she is trying to decide which of the three options is best for her. The training provides participants with opportunities for self-reflection and open discussion about the issues that women facing unintended pregnancies experience.

Hope Cottage Pregnancy and Adoption Center is the lead partner agency in Texas to receive federal funding to provide this training. Nurses, Social Workers, and Licensed Mental Health Counselors receive 4.5 CEU's for attending. The training can be provided at your agency or your staff can attend training at another site.

The goals of the program are to help participants:

- Develop an understanding of the Texas infant adoption process and how it has changed in the past several years
- Understand state and federal laws that govern infant adoption
- Recognize how social, cultural, and personal issues impact decision making
- Understand the birth father's role and rights
- Understand adolescent development and attitudes toward pregnancy
- Learn concrete non-directive, non-coercive counseling techniques to use in your practice with patients or clients

The content addresses questions that typically arise when a clinician is providing counseling to a woman or teen with an unplanned pregnancy.

Participants receive an Adoption Manual and a TX Resource Guide. The program is highly interactive. Case examples, videos, small and large group discussion will be used to answer participant's questions about common, yet complex, situations they encounter in their practice.

If you have any additional questions, please contact Julie Hames at 903-816-4322 or at netx@hopecottage.org. To register for training online, go to www.iaatp.com and click on Texas.

The following have participated in the TX Infant Adoption Training:

Family Planning Clinics

Brazos Valley Community Action Agency – College Station
Family Healthcare Inc – Denton
Longview Wellness Center – Longview
Parkland Family Planning Clinics (Dallas County hospital District) – Dallas
Planned Parenthood – Abilene
Planned Parenthood – Lubbock
Planned Parenthood – McAllen
Planned Parenthood – Odessa
Planned Parenthood of Hidalgo County – McAllen
Planned Parenthood of South Texas – Corpus Christi
Project Vida – El Paso
University Health System – San Antonio
University Medical Center – El Paso
Wilson Family Planning Clinic – Wichita Falls

Federally Qualified Health Centers

Brownsville Community Health Clinic – Brownsville
Centro de Salud Familiar La Fe – El Paso
Centro San Vicente – El Paso
Community Health Center of Lubbock – Lubbock
Gateway Community Health Center – Laredo
South Plains Rural Health Services – Levelland

Public Health Departments

Bell County Public Health District – Temple
Cameron County Department of Health and Human Services - Harlingen
Dallas County WIC - Dallas
Harris County Public Health and Environmental Services – Houston
Hays County Health Department – San Marcos
Jasper Newton County Public Health – Jasper
Texas Department of State Health Services – San Antonio
Wichita Falls Health Department – Wichita Falls