April DY4 Reporting – Companion Document

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Key Points for April 2015 Reporting

Each DSRIP provider should review this entire Companion document to understand the guidelines for how to report DSRIP achievement for the April DY4 reporting period. The Companion Document includes important information about changes to required documentation compared to what was required for DY 3 reporting.

Below are several critical points HHSC wants to highlight from the document.

- **Metrics/milestones should only be reported in April if a provider is confident that the metric/milestone was fully achieved by March 31, 2015, and can be clearly demonstrated. For any metric/milestone that HHSC does not find sufficient evidence of achievement in the documentation, the provider will only have one opportunity in June/July to submit additional information. If the provider cannot demonstrate during the June/July "needs more information" (NMI) period that the metric/milestone was completed by March 31, 2015, the provider will no longer be eligible for payment for that metric/milestone.**
- A *Coversheet* is required for each Category 1 or 2 project for the provider to clearly outline metric achievement and to assist HHSC reviewers in understanding the documentation submitted by the provider. Please download the *Coversheet* from the Waiver website. To allow providers to access all of the features of the *Coversheet* form, providers should confirm that they are running a recent version of Adobe Acrobat or Adobe Reader. HHSC also encourages providers to save the *Coversheet* as a pdf and then complete the form in their Adobe software rather than completing the form in the browser.
- Separate forms are required for QPI reporting, Category 3 DY3 baseline reporting, Category 3 DY4 achievement reporting, and Category 4 reporting. The format of the *QPI Reporting Template* has changed from October DY3 reporting. Please be sure to download the new version from the Waiver website.
- There is a separate User Guide for the DSRIP Online Reporting System and a Companion Document for completing the *QPI Template*.
- **All providers are required to provide semi-annual reporting information regardless of whether the provider is reporting for payment in April. DSRIP payments may be withheld until the complete report is submitted. (p. 7)**
    - The "Provider Summary Report" must be completed as part of the provider-level Semi-Annual Reporting requirement.
    - For each project, the provider should complete:
        - the "Project Summary" tab – all questions must be answered for each Category 1 or Category 2 DSRIP project.
        - the "Progress Update" field – must be completed for each Category 1 or Category 2 metric and each Category 3 milestone.

April Reporting Checklist

Please review this checklist to ensure you have completed all items for April reporting. This checklist is for informational purposes only and does not need to be submitted with April reporting materials.

- ☐ April DY4 Reporting information entered into the online system – "Reporting Status" tab indicates "Ready to Submit" or "Report Submitted" for all sections. (As long as the completed reports and supporting attachments have been **saved** by the reporting deadline, they will be considered officially submitted.)
- ☐ Semi-annual reporting requirements met:
    - ☐ "Provider Summary Report" completed in the online reporting system.
      For each project:
        - ☐ "Project Summary" tab – all questions answered online for each Category 1 or Category 2 DSRIP project.
        - ☐ "Progress Update" field – completed online for each Category 1 or Category 2 metric and each Category 3 milestone.
- ☐ (If applicable) DY3 Carryforward Reporting information entered into the online system. Carryforward milestones appear with an asterisk on the current year's Project Reporting page.
- ☐ *Coversheet*(s) completed and uploaded. (1 *Coversheet* per Category 1 or 2 project - *Coversheets* include boxes for 9 metrics. If a provider is reporting on more than 9 metrics for a given project in DY4, they will need to submit an additional *Coversheet* for that project.)
- ☐ Supporting documentation submitted – all documents are uploaded to the DSRIP Online Reporting System under "Supporting Attachments", file names reference Project IDs, and date ranges that show when the metric was completed are included within each document. (Minimum of 1 supporting document uploaded for each Category 1 or 2 metric, but the same document may be used to demonstrate achievement for multiple metrics if appropriate).
- ☐ *Category 3 DY4 Performance Reporting Template* completed and uploaded to report achievement of DY4 milestones (1 template per provider).
- ☐ (If applicable) *Carryforward Category 3 Baseline Template* completed and uploaded to report DY3 carried forward achievement of PM-9: Successful reporting and validation of baseline rates. (1 template per provider).
- ☐ (If applicable) *Category 4 Reporting Template* completed and uploaded. (1 template per hospital provider participating in Category 4, 1 tab per Reporting Domain if reporting in April).
- ☐ All items listed above submitted through the DSRIP Online Reporting System no later than 11:59 p.m. on **April 30, 2015.**

☐ (If applicable) IGT changes in entities or proportion of IGT among entities submitted to HHSC (TXHealthcareTransformation@hhsc.state.tx.us) using the *IGT Entity Change Form* by **April 30, 2015, 11:59 p.m.** (1 IGT Entity Change Form per provider)

Overview

This document includes information on reporting during the first DY 4 reporting period in April DY4 including timelines, DY3 carryforward instructions, use of *Coversheets* and other HHSC reporting templates, QPI guidance, guidance on supporting documentation, and an overview of payment and IGT processing.

For technical instructions on using the DSRIP Online Reporting System, please refer to the *DSRIP Online Reporting System presentation* and *DSRIP Online Reporting System User Guide* posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under **April DY4 Reporting.** Note that the reporting system refers to April reporting as Round 1 and October reporting as Round 2.

Supporting documentation submitted in previous reporting periods outside of the DSRIP Online Reporting System (August DY2, October DY2, April DY3, and October DY3 provisional NMI period) is not available on the online reporting system.

As HHSC addresses technical errors with how historical DSRIP payments are shown in the online reporting system, please refer to the payment summary posted on the HHSC website under Tools and Guidelines for Regional Healthcare Partnership Participants for actual payments made for DY2 August reporting, DY2 October reporting, and DY3 April reporting. Please check with your Anchor for the summary file of actual payments made for DY3 October reporting.

There are two opportunities to report achievement of milestones and metrics in DY 4: April and October 2015.

- Milestones and metrics achieved by March 31, 2015 may be reported in April.
- Milestones and metrics achieved by September 30, 2015 may be reported in October.
- The DY3 milestones and metrics approved for carryforward may be reported in April or October 2015.
- Changes submitted through the Change Requests (Plan Modification and Technical Change Requests) process in August 2014 for DY 4 and DY 5 are completed and no further changes will be considered unless requested by HHSC. If there are variations in baselines or previously reported achievement, please address it in reporting as outlined in this companion document under "Guidance for Category 1 and 2 Metrics Reporting" on p. 10.

April Reporting Timeline

- **April 1, 2015** – The DSRIP Online Reporting System will open for providers to begin April reporting. The templates for *Coversheets*, QPI reporting, Category 3, and Category 4 will be posted to the waiver website.
    - Some providers have difficulty downloading files from the waiver website using Internet Explorer. We suggest downloading files using Chrome or another browser if possible.
- **April 24, 2015** – Final date to submit questions regarding April reporting and inform HHSC of any issues with DY4 data in the reporting system.
- **April 30, 2015, 11:59pm**
    - Due date for providers' submission of April DY4 DSRIP reporting using the DSRIP Online Reporting System and upload of applicable *Coversheets*, supporting documentation, and QPI, Category 3 and Category 4 templates. Late submissions will not be accepted.
    - Due date for submission of any IGT changes in entities or proportion of IGT among entities submitted to HHSC (TXHealthcareTransformation@hhsc.state.tx.us) using the IGT Entity Change Form located at: http://www.hhsc.state.tx.us/1115-docs/DY3-Templates/April2014/IGT-Entity-Change-Form.xlsx.
- **May 1, 2015** – HHSC will begin review of the April reports and supporting documentation.
- **May 20, 2015, 5:00pm** – Due date for IGT Entities to approve and comment on their affiliated providers' April reported progress on metrics using the "IGT Info" tab for each project. The tab is not an opportunity to identify technical errors entered in the reporting system. Examples of issues to include are reported progress that was not actually achieved, changes in project scope that were not reported by the provider, and risks to the project that were not reported by the provider. If there are no issues, comments do not need to be submitted and HHSC will assume the IGT Entity has approved the reported information. **If there is a need to identify any technical errors in the reporting system please use the Waiver mailbox to communicate those errors by April 24, 2015 as stated above.**
- **June 10, 2015** – HHSC and CMS will complete their review and approval of April reports or request additional information (referred to as NMI) regarding the data reported. Note that HHSC completes multiple levels of review prior to determining that a milestone/metric requires additional information.
    - If additional information is requested, the DSRIP payment related to the milestone/metric will not be included with July DSRIP payments.
- **July 2, 2015, 11:59pm** – Due date for providers to submit responses to HHSC requests for additional information (NMI requests) on April reported Category 1-4 milestone/metric achievement and Semi-Annual Reporting requirements. Please include "NMI" in the file name when uploading documentation in response to NMI requests.

- **July 8, 2015** – IGT due for April reporting DSRIP payments.
- **July 21, 2015** – April reporting **DY4 DSRIP payments** processed for transferring hospitals and top 14 IGT Entities.
- **July 31, 2015** - April reporting **DY2 and DY3 DSRIP payments** processed for all providers and **DY4 DSRIP payments** processed for remaining providers that were not paid on July 21, 2015. Note that there are separate transactions for each payment for each DY.
- **August 7 2015** – HHSC and CMS will approve or deny the additional information submitted in response to HHSC comments on April reported milestone/metric achievement. Approved reports will be included for payment in the next DSRIP payment period, estimated for January 2016.

Required Semi-annual Progress Reports

According to the Program Funding and Mechanics Protocol, paragraph 16 (on page 351 of the waiver amendment approved May 21, 2014 although dated March 6, 2014), semi-annual progress reports must be submitted to HHSC and CMS. DSRIP payments may be withheld until the complete report is submitted. To meet this requirement, **all providers are required to complete the items below for April DY4 Reporting for every project regardless of whether the milestone/metric is reported for payment in April**. All information will be entered into the online reporting system.

- "Provider Summary Report."
- For each project:
    - "Project Summary" tab – all questions must be answered for each Category 1 or Category 2 DSRIP project. You may enter "NA" for some of the questions, but there must be an explanation of why the response is "NA" (e.g. NA – no patient impact in DY4 because all project milestones were focused on implementing project. Patient impact will be reported beginning in DY5.)
        - If there were any variations from the project narrative and metrics that have already been reported as achieved, please provide this information under "Project Overview: Challenges" (e.g. We hired two nurses to meet a DY3 metric, but one of them moved out of the area and we've been unable to refill that position. This may impact our ability to achieve our QPI metrics.).
        - Under "Patient Impact for Medicaid/Low-Income Uninsured Population," please identify the patient impact in DY4 and specify the Medicaid/low-income uninsured percentage that was served, including the split percentages if available.
        - Under "Progress on Core Components," please list and describe progress on each required core component through March 31, 2015.

- "Progress Update" field – **must be completed for each Category 1 or Category 2 metric and each Category 3 milestone**. This should be a succinct summary (one to several sentences as needed), e.g.:
  - (If completed) - Two pediatricians were hired in February 2015 and they have begun to serve patients at the neighborhood clinic.
  - (If in progress) – One pediatrician was hired in December 2014. We continue to advertise for the second pediatrician and hope to have them hired by the end of 2015.
  - (If not completed yet) – We began to advertise to hire the two pediatricians in January 2015. We are interviewing now, but have not yet hired either pediatrician. The goal is to have both of them hired and serving patients by the first quarter of 2016.

DY3 Carryforward Reporting

The carried forward DY3 milestones and metrics are included in the online system under DY4 Round 1 along with the DY4 milestones and metrics and are identified with an asterisk. For Category 1 and 2 carried forward milestones and metrics, please follow the same guidance included in "Guidance for Category 1 and 2 Metrics Reporting" starting on p. 10.

Note that if you are reporting on a carried forward percentage improvement metric that is included in DY3 and DY4, then the DY3 carried forward metric must be demonstrated prior to the DY4 metric. For example, a project includes a DY3 goal: 10% decrease in no-show rates from DY2 baseline and DY4 goal: 15% decrease in no-show rates from DY2 baseline. The provider requested carryforward because the DY2 no-show baseline rate was not determined until DY3 - June 2014. To report achievement of the DY3 goal, a minimum of six months of data must be used to demonstrate 10% decrease from the baseline. The DY3 carried forward metric may be reported in April or October 2015. Because this is an annual metric, the DY4 achievement of 15% decrease from the baseline may only be reported in October and use a 12 month period. The DY4 12 month period may overlap with the period used for reporting DY3 carryforward.

For achievement of Category 3 carried forward milestones:

PM-8: Submission of Category 3 DY3 Status Report- please complete the Category 3 DY3 Status Update Template posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under **April DY4 Reporting.**

PM-9: Successful reporting and validation of baseline rates), please complete the *Carryforward Category 3 Baseline Reporting Template* posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under **April DY4 Reporting.**

**Note that the option to carryforward DY4 milestones and metrics will be available in October reporting. Category 3 DY4 achievement milestones (e.g., AM-1.1) that are partially achieved in April reporting may also be carried forward for remaining achievement. See "Category 3 Payment Calculations, Partial Achievement" on p. 37.

Guidance for Category 1 and 2 Metrics Reporting

When determining whether a metric was achieved, HHSC reviews the specific metric description language, baseline/ goal language, numeric goal (if applicable) and data source. HHSC also references the project narrative when clarification of the metric intent or target population is needed. Providers should be sure that the documentation they are submitting in support of a metric is in line with this information and that any information not included in these sources or that requires clarification is included in the supporting documents and/ or *Coversheet*.

Milestones with Multiple Metrics: For milestones with multiple metrics, each metric may be reported in separate reporting periods based on when it is achieved (e.g. P-12.1 and P-12.2 do not need to be reported at the same time to be eligible for payment).

Metrics with Multiple Parts: All metric goals must be fully achieved to report "Yes-Completed" under "Achieved by March 31" and be eligible for DSRIP payment (e.g., if a goal has two parts of expanding by 4 hours a week and adding one new exam room, both the expanded hours and new exam room would need to be completed).

Non-QPI Metrics with Percentage Goals: For metrics that include percentage goals, whether a metric may be reported in April depends on the specific metric language and whether the provider can demonstrate by April that the metric was fully achieved for DY4. Examples:

- May be reported in April if achieved by March 31, 2015: Metric P-4.1 (Project Option 1.3.1) - Implement/expand a functional disease management registry. Baseline/Goal: To implement a functional registry in 30% of identified sites as calculated by number of sites with registry functionality out of total number of sites. If the provider has implemented the functional registry in 30% of the identified sites by the end of March, it may report achievement in April.
- May be reported in April if achieved by March 31, 2015: Metric I-11.1 (Project Option 1.1.2) - Patient Satisfaction with primary care services. Goal: Improve patient satisfaction by 10% over baseline as calculated by numerator sum of all survey scores and denominator number of surveys completed. If the provider has improved patient satisfaction by 10% over baseline using the appropriate measure specifications, it may report achievement in April. HHSC isn't prescribing a specific baseline timeframe but

each measurement period (baseline and achievement) should be at least six months and the 10% improvement should be demonstrated some time in DY4.

- Should not be reported in April: Metric I-11.1 (Project Option 2.10.1) - Pain screening (NQF-1634) Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter. Goal: Provide screening to at least 50% of palliative care patients (319). In this case, metric 1-11.1 is not a QPI metric, so the primary goal is to screen at least 50% of palliative care patients in DY4. Since DY4 will only be halfway completed by March 2015, this metric should be reported in October (or carried forward if needed).
- Should not be reported in April: Metric P-4.1 (Project Option 2.4.1) - Percent of new employees who received patient experience training as part of their new employee orientation. Baseline: 0. Goal: to have 85% of new employees receive patient experience training as part of their new employee orientation. Numerator: Number of new employees receiving patient experience training. Denominator: Total number of new employees. Since DY4 will only be halfway completed by March 2015, this metric should be reported in October (or carried forward if needed).
- Other metrics that generally should not be reported in April: Metric I-15.1 *Usual source of care*, Metric I-17.1 *Reminders for patient preventive services* (Project Area 2.1), Metric P-2.3 *Frequency of contact with care navigators for high risk patients* (Project Area 2.9), Metric I-6.2 *Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED* (Project Area 2.9), and Metric I-18.1 *Increase the number of computerized provider order entries* (Project Area 2.11). However, the determination about whether a metric may be reported in April may vary depending on the specific language of the goal or if it is a QPI goal.

Since a provider will only have two opportunities to demonstrate whether it successfully met a metric (which will be April and June if the provider reports in April), HHSC strongly encourages providers to ask for technical assistance prior to submitting April reporting if you have any questions about whether a metric with a percentage should be reported in April.

Providers Performing Projects in Multiple Regions: If a provider has similar projects in more than one region and the supporting documentation is also the same, then the provider must include an explanation that the documentation is the same, include the other project's(s') applicable IDs for the documentation, and explain how this documentation meets the metric goals for both projects. HHSC will review on a case-by-case basis. This may be allowable for process metrics when consistent with the approved project. For metrics that report number of patients served, documentation must be provided specific to the patients served in the region.

General Guidance for Supporting Documentation Used for Multiple Metrics: If the same or similar documentation is used to support multiple metrics, clearly differentiate how each metric was met with similar documentation (e.g., if a metric is using the same curriculum across multiple clinics or for two different chronic care management programs, then demonstrate how different staff were trained on the same curriculum).

Providers Hiring Staff for Multiple Projects: For Categories 1 and 2, providers should not report the same achievement for multiple projects unless it is clear from the approved projects that is the case. For example, if a provider reports under two different projects that the provider is hiring one physician and one office manager, the provider should clearly explain if the physician and office manager are the same for both projects and how their time is divided among the projects or if there are two of each. Overlap between projects will be closely reviewed and may not be approved.

Providers Establishing Additional Clinics Providing Multiple Types of Services: For providers establishing additional clinics, expanding existing clinics, or relocating clinics (Project Option 1.1, Milestone P-1), if the clinic will be used for multiple types of services (e.g., OB/GYN and primary care), the provider should clearly explain how the clinic is utilized for the different services. Providers should also be sure to only include data for the type of service that is targeted by their project in their metric calculations.

Providers Using Same Needs Assessment for Multiple Projects: Providers may submit the same community needs assessment as applicable for multiple projects. However, providers will be expected to clearly highlight and distinguish where (page numbers) and how the needs assessment addresses each specific project being discussed.

Providers Establishing a Care Transitions Protocol for Multiple Projects: For providers developing a care transitions protocol (Project Option 2.12) for multiple projects, the provider should clearly explain how the protocols are different for each project based on the population served, setting, etc.

Early Metric Achievement: DY3 achievement (October 1, 2013 – September 30, 2014) of non-QPI metrics may be allowable for DY4 metrics, if the State deems appropriate (such as if staff were able to be hired early or a clinic opened a little earlier than expected); however, providers also should be aware that early achievement of metrics is a criterion that will be looked at in compliance monitoring. QPI metrics may be achieved in the subsequent demonstration year, but not in an earlier demonstration year. For example, if a new project stated it would serve 200 in DY4 and 300 in DY5, it would need to serve 200 people in DY4 in order to achieve the DY4 metric. Early achievement of QPI metrics is not being allowed to ensure that projects' impact on patients continues to grow throughout the demonstration period.

Deviation from a Metric: If a provider is deviating from a metric, then an explanation is required in the "Progress Update" field (e.g. Project Area 1.3, Metric P-1.1 requires number of patients entered in the registry; provider requests that metric be met with number of patients identified in target population to be entered in the registry, not those actually entered). The provider should also reference the progress update information in their *Coversheet*. HHSC will review the request using both the approved project language and the RHP Planning Protocol and submit the request to CMS for approval if deemed appropriate or request additional information. If approved, payment for the requested deviation may be made in the following reporting period depending on approval date (e.g. requested in April 2015, payment would be made with October 2015 reporting period if approval was obtained in July 2015, payment estimated to be in January 2016). If the requested deviation is not approved after HHSC has requested additional information, the provider will no longer be eligible for payment for that metric.

DY4 Reported Achievement is less than DY3 Reported Achievement: If a provider is reporting on the same metric from DY3 but has a lower achievement in DY4, then an explanation should be provided in the "Progress Update" field. For example, the metric goal describes that the provider will demonstrate an 8% improvement in patients' average reported functional status using a standardized instrument (e.g., PROMIS) in DY3 and a 16% improvement in DY4 relative to the average score reported in DY2 (baseline). In DY3 the provider meets (and exceeds) the metric goal by demonstrating 10% improvement in the average score reported. In DY4 provider reports a 3% improvement in average reported score relative to DY2 baseline, demonstrating less of an improvement in DY4 than was recognized in DY3. In "Progress Update" field, provider explains that the smaller improvement in DY4 was due to implementation of an online assessment that was emailed to patients and this resulted in a much lower response rate. Whereas in DY3, a paper assessment was administered to patients in the office immediately post-visit following their resulting in a higher response rate and potentially creating a respondent bias.

DY2 or DY3 Reported Achievement has Changed: If the reported and approved achievement of a DY2 or DY3 metric has changed, please provide an explanation in the Project Summary section under "Project Overview: Challenges" (e.g. Location of DSRIP project has changed from Clinic A to Clinic B due to flooding and water damage at Clinic A. DSRIP services and QPI goals remain unchanged.).

Baseline has Changed: If the baseline reported in DY2 or DY3 has changed, please provide an explanation in the "Progress Update" field for the metric. The stated DY4 goals must still be achieved. If the DY4 goal is an improvement over baseline, HHSC will review in context of the entire project to determine appropriateness.

Reporting on QPI

For projects with DY4 QPI metrics (metrics marked "Yes" for QPI), the *QPI Template* must be completed for each project if the QPI metric is being reported as achieved by March 31, 2015.. The same template is used for DY3 carried forward QPI metrics being reported for payment.

If a provider is reporting achievement of a QPI metric in April for payment, it must demonstrate in the *QPI Template* that the QPI goal was achieved between October 1, 2014 and March 31, 2015.

Providers should only submit one *QPI Template* per project per reporting period.

Please read the *QPI Reporting Companion Document* carefully before entering any information and refer to Instructions included in the first tab of the *QPI Template* workbook for general guidance.

Supporting Documentation

Please refer to the RHP Planning Protocols for Categories 1 and 2 and your project specific information for guidance regarding types of supporting documentation and data sources for each metric. The planning protocols are available at the following link: http://www.hhsc.state.tx.us/1115-docs/DSRIP-Protocols.pdf.

General Documentation Guidance:

- Providers must include a *Coversheet* for each project for which they are reporting metric achievement, describing how supporting documents demonstrate achievement of each metric on which they are reporting. The *Coversheet* template is posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under **April DY4 Reporting.**
    - *Coversheets* include boxes for 9 metrics. If a provider is reporting on more than 9 metrics for a given project in DY4, they will need to submit an additional *Coversheet* for that project.
    - If you are reporting a metric as "No-Partially Achieved" or "No-Not Started", then that metric should not be included in the *Coversheet* and supporting documentation should not be submitted for the metric. For these metrics, enter "NA" in the "Supporting Attachments" field and complete the "Progress Update" field as required by semi-annual reporting.
- Providers should submit documentation in common file formats (e.g., pdf, Microsoft Word, Microsoft Excel, Microsoft PowerPoint, zip files) that are allowed by the reporting system.
- Providers are strongly encouraged to submit data in an Excel spreadsheet rather than in a document table (e.g., pdf, Word), as this is more conducive to efficient review of your metric. If submitting data in a document, providers should include column totals.
- Providers should rotate document pages using landscape and/ or portrait settings as appropriate, so that pages are not upside down or sideways.
- **All documentation must demonstrate baseline information as well as the increase or total achievement stated in the goal.** For example, a metric includes a baseline of 2 physicians and a goal that states 5 physicians providing services by DY4. Documentation must include identification of the 2 original physicians as well as the total of 5 physicians on staff (3 new physicians with hire dates in DY4). The metric may be marked by HHSC as "Needs More Information" if only documentation of 3 new physicians is provided. Please refer to the *QPI Reporting Companion Document* for guidance specific to QPI baselines.
- Highlight relevant information within the supporting documentation where the support for achieving a particular metric is one section in a larger document. Be sure to include pages numbers for the relevant information in the *Coversheet*.

- **Providers must include dates in supporting documentation to demonstrate achievement occurred by March 31, 2015** (e.g. date a community assessment was completed, date of hire, date a plan was approved). The date should not just be a date reflecting when the supporting documentation was prepared.
- The related Project ID should be included in the file name of supporting documentation.
- Links will not be accepted as supporting documentation due to broken links provided in previous reporting periods.
- Handwritten notes or photos of handwritten notes will not be accepted as supporting documentation (other than for sign-in sheets from meetings).
- Providers should review supporting documentation carefully to ensure no Protected Health Information (PHI) is included. (Additional information on PHI is included in the Warning Notice at the end of this document.) Providers should confirm that confidential information is not visible or accessible before submitting documentation to HHSC. If, for example, the provider redacts (i.e., blacks out) information on a document and scans it, they should confirm that information is not visible on the scanned copy. When submitting data in a spreadsheet, providers should be sure that fields containing confidential information are de-identified or deleted. Providers should not rely on hiding columns in a spreadsheet to protect confidential information, because columns can easily be unhidden.
- Sensitive information such as salaries may be redacted.
- Staff names should not be redacted (e.g. hiring forms, training logs).
- If HHSC has provided a response regarding reporting of a milestone/metric, please attach it to the applicable metric when reporting for payment.

Additional guidance is provided below for many of the most commonly selected milestones and metrics.

- Increased Staff Metrics: For metrics that involve hiring of additional staff to increase care capacity, the goal is that there is an increase in the total number of staff to care for patients due to the DSRIP project and associated funding. HHSC will consider the specific language of the metric and the project when reviewing metrics around increased staff, but the provider should demonstrate as clearly as possible that the staff changes are different than business as usual. For example, business as usual would be "two staff quit on August 31, so we filled those two vacancies within our existing clinic budget." To demonstrate DSRIP achievement, the provider should explain how positions were created or specifically filled to document expansion related to the DSRIP project.
    - Staff must have begun employment and not only signed a contract/agreement to be counted towards increased staff/hiring metrics. (For example, if an employment contract was signed on January 31, 2015, but the physician's start date is April 1, 2015, this metric should be reported in October 2015.)

- For Project Area 1.9 projects, mid-level providers may not be counted towards achieving I-22.1 (increase in number of specialist providers) unless they were explicitly stated in the goal as the providers to be hired.

- Expanded Hours Metrics: If a goal specifies when the expanded hours are to occur and the expanded hours are changed (e.g., had planned to expand from 5-6 p.m. Monday through Thursday, but instead expanded 5-7 p.m. on Monday and Wednesday), then it will be acceptable as long as the total number of expanded hours remains the same as originally stated and the change makes sense within the context of the project narrative. The documentation must clearly show what the previous hours were (and that they have continued) and that there are additional hours in which appointments are offered.
- Metrics Involving Improvement Over Baseline: HHSC may refer to baseline periods specified in the custom milestone/metric description or "Baseline/Goal" field. If a baseline period is not specified and is cited as a point of improvement for a subsequent goal, a 12-month baseline period should be provided. A minimum six-month baseline period may be allowed due to delayed project implementation with sufficient provider explanation. If a DY4 metric goal is to demonstrate improvement over DY3 performance, there should no gaps in DY3 and DY4 measurement periods without explanation. For example, if intervention activities began in January 2014 and DY4 achievement is being reported, then the baseline measurement period should be January 2014 - September 2014 (intervention start to end of DY3) and the DY4 achievement measurement period could be October 2014 - March 2015 and be eligible to report in April of DY4.
- Percent Improvement Metrics: In those situations where Metric achievement is stated as a percentage increase over prior performance and the language could represent a flat increase in the percentage or an increase relative to prior performance (i.e., X% + prior performance vs. X% * prior performance), HHSC may accept either method of measuring percentage improvement if it is not clearly specified in the baseline/goal language or in the narrative. For example, a 15% improvement may be reported as 50% + 15% = 65% or (50% * 15%) + 50% = 57.5%. Within the reporting coversheet, provider should clarify how these types of calculations were made and how the calculation aligns with the intention of the goal and where that is supported in the project narrative.
- Learning Collaborative Metrics: For metrics involving learning collaboratives (including regional learning collaboratives), documentation must include the date, agenda, sign in sheet, and a summary of topics discussed and *lessons learned relevant to the project to demonstrate participation.* The provider is not required to make a presentation at the learning collaborative event to demonstrate achievement of the metric. Providers from other regions and non-DSRIP providers may be included in the regional learning collaborative meetings.

- Statewide Learning Collaborative: Providers who plan to use the Summit to meet metrics related to learning collaborative participation should submit documentation of who from the organization attended or viewed the webcast, what sessions they attended/viewed, what they learned from the event and how they plan to apply the information gained to their DSRIP projects. Please provide information on all sessions attended or viewed via webcast, with a minimum of ½ day or 3 sessions. HHSC will provide a template you may use, but this is not required. If you do not use the template, please be sure all elements as described here are included.

- Metrics Involving Meetings: For metrics involving meetings, all meetings must be scheduled and completed as stated in goals to be eligible for April reporting. Dates, agendas and minutes or summaries of meetings must be submitted as supporting documentation.
- "Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions" Metrics: This metric may only be reported in October 2015 or carried forward to DY5 since it is a weekly DY4 metric. For metrics requiring the number of new ideas, tools, or solutions, for each idea, tool, or solution provide documentation of the Plan-Do-Study-Act (PDSA) concepts as well as the ideas, dates, staff involved, and action taken. Another option is to submit a PDSA document for each idea, tool, or solution. A sample template is available on the Institute for Healthcare Improvement (IHI) website at http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx. This site does require registration (at no cost). This site is an excellent resource for providers. A provider may continue to test one or more ideas throughout the year; however, activity must occur weekly.
- "Implement the "raise the floor" improvement initiatives established at the semiannual meeting" Metrics: For metrics requiring implementing "raise the floor" improvement initiatives, the documentation should include a list of ideas that came up during the semiannual meeting that would apply to the project, a description of the provider's agreement to implement at least one idea and rationale for the selection, a description of the status of implementation, and any details related to the impact of the idea on the project (e.g., improvement on project uptake, outcomes, or spread). Providers with similar projects do not need to select the same "raise the floor" initiative.
- Training metrics: For metrics that involve training, the documentation should include the training materials and training logs/sign-in sheets. Training logs/sign-in sheets should clearly identify staff being trained, organizations represented, number of people trained, when the training occurred, and where the training took place. For example, stating that "Andy, Mary, and Julie met with Alex and Nancy on the phone to provide diabetes training on 11/2/14" is unclear as to whether 2, 3, or 5 people were trained.

- Clinical collaborations: Clinical collaboration agreements being used for supporting documentation should be signed by all parties in order to be accepted for metric achievement.
- Gap Assessment Metrics: For any metrics requiring completion of a gap assessment, please include additional information to address the following questions:
    - Is the selected project in an area of high need for the Medicaid/uninsured population?
    - How would the selected project impact/benefit the Medicaid/uninsured population?
    - Does the gap assessment include a clear description of what the initiative is going to focus on to address gaps?
- Establishing a plan metrics:
    - For metrics that require an implementation plan, the following should be included:
        - Roles and responsibilities of those involved in implementation (providers, partner agencies, working group, etc.).
        - Timeline, including:
            - List of tasks to be completed (e.g., development of policies, procedures, or protocols, staff training, steps to address software needs, etc.).
            - Status of each task (e.g., Not started, In progress, Completed).
            - Scheduled start and completion dates for tasks.
            - Actual start and completion dates for tasks.
            - Name(s) of those responsible for completing tasks.
    - For metrics that require an evaluation plan, the following should be addressed:
        - Type of evaluation implementing (e.g., process and/or outcome evaluation).
        - Evaluation questions and measurable outcomes (outputs and outcomes).
        - Resources required (funds, partnerships, staff, technology, survey tools, etc.).
        - Major activities (including timeline and who is responsible).
        - Method for data collection.
        - Method for data analysis.
        - Plan for communicating and reporting results.
- Metrics Involving Disseminating Findings: If a milestone or metric requires "disseminate findings," if the approved project narrative specified any partnerships or collaborations, the findings should be disseminated to those entities. If the project does not specify any relationships, then the type of information collected would guide to whom the findings should be disseminated. Another option is to disseminate findings with providers with similar projects or reaching similar populations within the RHP.
- Sample Size: For milestones or metrics that require a sample size, HHSC suggests use of a sample size calculator like the one available here:

http://www.raosoft.com/samplesize.html. Assume a confidence level of 95 percent and margin error of 5 percent.

CATEGORY 1

Project Option: 1.1

Milestone: P-1 Establish additional/expand existing/relocate primary care clinics

Metric P-1.1: Number of additional clinics or expanded hours or space.

- Additional Guidance:
    - For additional, expanded, or relocated primary care clinics, provide documentation such as blueprints or design plans, lease/contract, picture of facility with address, new primary care schedule, floor plans, etc., as applicable. Please include clear evidence that the construction/remodel/expansion is complete, the date of completion, and the date the location opened.
    - For new primary care providers and staff (if applicable), provide signed contract(s) or other documentation for new providers and staff with starting dates, new primary care schedule, etc. Sensitive information such as salaries may be redacted. Staff names should NOT be redacted.

Milestone: P-4 Expand the hours of a primary care clinic, including evening and/or weekend hours

Metric P-4.1: Increased number of hours at primary care clinic over baseline.

- Additional Guidance:
    - For expanded hours at existing clinics, provide documentation of previous schedule and new schedule such as brochures or advertisements showing hours before and after expansion, screen shots from a clinic scheduling system clearly showing hours before and after expansion, or other official documents such as letters, memoranda, or meeting minutes describing hours before and after expansion.
    - For new primary care providers and staff (if applicable), provide signed contract(s) or other documentation for new providers and staff with starting dates, new primary care schedule, etc. Sensitive information such as salaries may be redacted. Staff names should NOT be redacted.

Milestone: P-5 Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers

Metric P-5.1.: Documentation of increased number of providers and staff and/or clinic sites.

- Additional Guidance:

- For new primary care providers and staff (if applicable), provide signed contract(s) or other documentation for new providers and staff with starting dates, position hired for, new primary care schedule, etc. Sensitive information such as salaries may be redacted. Staff names should NOT be redacted.
- For training, provide documentation of who attended training and when.
- For increased number of primary care clinics, provide documentation such as blueprints or design plans, lease/contract, picture of facility with address, new primary care schedule, etc., as applicable. Also include narrative description in metric reporting or attach separately.

Project Option: 1.2

Milestone: P-2 Expand primary care training for primary care providers, including physicians, physician assistants, nurse practitioners, registered nurses, certified midwives, case managers, pharmacists, dentists

Metric P-2.2: Hire additional precepting primary care faculty members. Demonstrate improvement over prior reporting period (baseline for DY2).

- Additional Guidance:
  - For new primary care faculty members, provide signed contract(s) or other documentation with starting dates and positions.

Milestone: I-11 Increase primary care training and/or rotations.

Metric I-11.7: Improvement in number of primary care practitioners that went on to practice primary care after graduating from primary care training/residency.

- Additional Guidance:
  - HHSC does not consider students practicing in the ER and other hospital-based scenarios to be practicing primary care.

Project Option: 1.9

Milestone: P-1 Conduct specialty care gap assessment based on community need

Metric P-1.1: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2).

- Additional Guidance:
  - In the gap assessment, the questions outlined in Appendix C of the *CMS Initial Review Findings: Companion Instructions for Resubmission to CMS* should also be addressed: http://www.hhsc.state.tx.us/1115-docs/RHP/Plans/companion.pdf

Milestone: P-11 Launch/expand a specialty care clinic (e.g., pain management clinic)

Metric P-11.1: Establish/expand specialty care clinics.

- Additional Guidance:
    - For additional or expanded specialty care clinics, provide documentation such as blueprints or design plans, lease/contract, picture of facility with address, new specialty care schedule, etc. Also include narrative description in metric reporting or attach separately.
    - For new specialty care providers and staff (if applicable), provide signed contract(s) or other documentation for new providers and staff with starting dates, new primary care schedule, etc. Sensitive information such as salaries may be redacted. Staff names should NOT be redacted.
    - For number of patients served, provide narrative description with data reports to show previous number of patients and expanded number of patients.

Project Option: 1.12

Milestone: P-3 Develop administrative protocols and clinical guidelines for projects selected (i.e., protocols for a mobile clinic or guidelines for a transportation program).

Metric P-3.1: Manual of operations for the project detailing administrative protocols and clinical guidelines

- Additional Guidance:
    - Provide administrative protocols and clinical guidelines for individual projects based on protocols and guidelines offered by professional associations relevant to the project option domain or based on protocols or guidelines adapted from other states, etc. As applicable, manual of operations should clearly outline the process related to the services provided, including:
        - who is eligible for services
        - when, how and by whom services will be provided
        - processes around project documentation
        - procedures related to patient follow-up

CATEGORY 2

Project Option: 2.1

Milestone: P-1 Implement the medical home model in primary care clinics.

Metric P-1.1: Increase number of primary care clinics using medical home model.

- Additional Guidance:
    - PCMH recognition is not required under P-1.1 unless stated in the metric goal or project narrative. The provider must show how the medical home model has been implemented (via readiness survey and other documents) and describe the

standards that are met as work is continued toward full PCMH recognition. There are several key 'pillars' that represent the medical home model and it would be helpful if these themes are used to describe the steps to implementation, next steps on each theme, and any barriers to implementing fully. The pillars of successful PCMH implementation as well as assessment guides may be found here: http://pcmh.ahrq.gov/sites/default/files/attachments/Strategies%20to%20Put%20Patients%20at%20the%20Center%20of%20Primary%20Care.pdf http://www.coachmedicalhome.org/sites/default/files/coachmedicalhome.org/key-activities-checklist.xls

Milestone: P-6 Establish criteria for medical home assignment.

Metric P-6.1: Medical home assignment criteria.

- Additional Guidance:
    - This link may be helpful around "assigning" patients. It outlines what the policies could look like and the procedures for proper medical home empanelment. http://www.safetynetmedicalhome.org/change-concepts/empanelment

Milestone: P-11 Identify current utilization rates of preventive services and implement a system to improve rates among targeted population.

Metric P-11.1: Implement a patient registry that captures preventive services utilization.

- Additional Guidance:
    - HHSC does not have a template or a set criterion to be used by providers. However, the registry should be designed to allow for the tracking of patient interactions and clinical studies (e.g. lab reports, patient histories) as necessary and pertinent to the DSRIP project.
    - Helpful references from the American Academy of Family Physicians regarding the development and role of patient disease registries:
        - http://www.aafp.org/fpm/2006/0400/p47.html
        - http://www.aafp.org/practice-management/pcmh/quality-care/patient-reg.html

Project Option: 2.2

Milestone: P-3 Develop a comprehensive care management program

Metric P-3.2: Increase the number of patients enrolled in a care management program over baseline.

- Additional Guidance:

- Describe what services are provided in the comprehensive care management program, which patients are eligible, how patients are identified and processes around patient enrollment in the care management program.
- For number of patients enrolled, provide narrative description with data reports to show baseline number of patients receiving care management services and expanded number of patients receiving care management services. When possible, provide detail around frequency of services used and other relevant trends in utilization. (If this metric is designated as QPI, use the *QPI Template*.)

Project Option: 2.4

Milestone: P-6 Include specific patient and/or employee experience objectives into employee job descriptions and work plans.

Metric P-6.1: % employees who have specific patient and/or employee experience objectives in their job description and/or work plan.

- Additional Guidance:
  - One example of an updated job description may be provided along with either 1) a list of all employees including confirmation that their job descriptions have specific patient and/or employee experience objectives with a date of the updates or 2) other documentation such as an official memo or report stating the number of employees and affirming that all employees' job descriptions have been updated as of a certain date with a general explanation of what was added to the job descriptions and the process that was followed.
  - It is not necessary to provide all job descriptions, but the job descriptions should be available for audit purposes.

Project Option: 2.6

Milestone: P-2 Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community.

Metric P-2.1: Document innovational strategy and plan.

- Additional Guidance:
  - Also provide narrative description of how priority interventions were identified, including how the selected priority intervention(s) address the needs assessment and the anticipated impact of the interventions on the target population.

Project Option: 2.7

Milestone: P-1 Development of innovative evidence-based project for targeted population

Metric P-1.1: Document innovational strategy and plan.

- Additional Guidance:
  - Also provide narrative description of how target population was identified, including a description of how evidence based guidelines or interventions have been adapted to fit the target population.

Project Option: 2.8

Milestone: P-1 Target specific workflows, processes and/or clinical areas to improve

Metric P-1.1: Performing Provider review and prioritization of areas or processes to improve upon.

- Additional Guidance:
  - Provide narrative description of methods used to identify specific workflows, processes, and/or clinical areas were selected for improvement, e.g., Process mapping, root cause analysis, fishbone diagrams, Pareto Analysis, Force field analysis, etc.
  - Provide narrative description of activities and what will be achieved.

Project Option: 2.11

Milestone: I-8: Identify patients with chronic disease who receive medication management in their discharge instructions appropriate for their chronic disease.

Metric I-8.1: X percent increase of patients with chronic disease who receive appropriate disease specific medication management.

- Additional Guidance:
  - "Discharge" is considered a discharge from an acute care setting (typically a hospital) to an ambulatory care setting.
  - Medication management instruction documentation would generally include medication schedules or charts in combination with teaching or counseling documentation. Documented activities may include providing and discussing written materials related to medications with patients to ensure that they understand the purpose of various medications, when they should be taken, consequences of drug omission, precautions related to over-the-counter drugs, toxic side effects, etc.

Project Option: 2.12

Milestone: P-4 Conduct an assessment and establish linkages with community-based organizations to create a support network for targeted patients post-discharge.

Metric P-4.1: Care transitions assessment.

- Additional Guidance:

- When determining if the goal has been met, HHSC would expect to review the care transitions assessment and resource planning documents, including the description of partnerships. The types of community-based organizations could be determined through the assessment. Linkages with nursing homes and home health agencies would be relevant, as would any other linkages that are established.

Project Option: 2.13

Milestone: P-2 Design community-based specialized interventions for target populations.

Metric P-2.1: Project plans which are based on evidence / experience and which address the project goals.

- Additional Guidance:
  - In project documentation, provide narrative description of how target population was identified, including a description of how evidence based guidelines or interventions have been adapted to fit the target population.

Milestone: I-5 Functional Status.

Metric I-5.1: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.)

- Additional Guidance:
  - If this metric is also being used as a QPI metric, then the QPI Template must be submitted along with results of improved functional status.

Project Option: 2.15

Milestone: P-2 Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both in new settings or for physicians to share their office space with behavioral health practitioners.

Metric P-2.1: Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations.

- Additional Guidance:
  - Provide list of interviews and analysis of interview results.

Milestone: P-3 Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa

Metric P-3.1: Provide documentation of number and types of referrals that are made between providers at the location.

- Additional Guidance:
    - Also submit standards that were developed and implemented.
    - A referral for a service would count only once during the initial period in which the person was referred. The same person could not be counted towards P-3.1 in subsequent DYs.

Milestone: P-6 Develop integrated behavioral health and primary care services within co-located sites.

Metric P-6.1: Number of providers achieving Level 4 of interaction.

- Additional Guidance:
    - Documentation would need to demonstrate that the client/patient is coming to a single facility and receiving a set of integrated services. This could include a "scheduler" or calendar that shows both primary care and behavioral health providers sharing the same client/patient in the same facility on a shared record (EHR). Documentation could also describe how the providers are interacting. (e.g., case conferences).

CATEGORY 3

This section of the DY4 reporting companion describes, at a high level, the structure of DY4 and DY5 milestones that appear in Category 3, methodologies used to establish performance goals, and achievement thresholds required to earn incentive payments.

Providers submitting **Category 3 baselines in April of DY4 (Carryforward from DY3) will submit a *Carryforward DY3 Baseline Reporting Template*, which is a modified version of the DY3 reporting template and will allow providers to report baselines for outcomes that indicated Carryforward in DY3. Providers should refer to the separate Category 3 template instructions posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under **April DY4 Reporting** for detailed instruction on how to complete the Category 3 baseline template. Baseline templates not populated correctly may result in a Need More Information status during this reporting period, which will result in delays in incentive payments.

** Providers submitting **Category 3 performance results in April of DY4** will submit a *DY4 Performance Reporting Template*. HHSC has created detailed instructions for using the *DY4 Performance Reporting Template*, posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under April DY4 Reporting. DY4 performance templates not populated correctly may result in a Need More Information status during this reporting period, which will result in delays in incentive payments.

** Providers with a Population Focused Priority Measure (PFP) who intend to submit a baseline during the DY4 reporting period will do so using the *PFP Baseline Reporting Form,* posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under April DY4 Reporting.

For historical information regarding the Category 3 framework and the process of outcome selection, providers should refer to the *Category 3 (Selection) Companion* posted on the HHSC website here: http://www.hhsc.state.tx.us/1115-docs/Cat3-companion.pdf.

Overview of Category 3 Milestones that appear in DY4 Reporting

- Milestone PM-8: Submission of Category 3 DY3 Status report
    - Carryforward from DY3. October DY4 is the last opportunity to report PM-8.
    - Providers earn 50% of their DY3 allocation for each Category 3 project with the submission of the Category 3 DY3 Status Update which is posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under April DY4 Reporting.
    - The intention of this status report is for providers to describe their understanding of the measure specifications, denominator populations, planning for the Alternate Improvement Activities and any technical assistance needs.
    - In order to successfully achieve this milestone, the provider must ensure that the Category 3 project ID (TPI.3.#) entered into the Status Update template matches the

currently approved project ID AND that all required fields include an informative response.

- Milestone PM-9: Validation and submission of baseline performance (i.e., submission of baseline template) (for all provider reporting carried forward baseline rates in DY4)
    - Carryforward from DY3. As Cat 3 baselines must be reviewed by HHSC before DY4 and DY5 performance targets can be confirmed, PM-9 cannot be reported in the same reporting period as DY4 PM-10/AM-1 for a given Cat 3 outcome (. Providers cannot report Cat 3 baseline and DY4 performance for the same Cat 3 outcome in the same reporting period).
    - Providers earn 50% of their DY3 allocation for each Category 3 project with the submission of baseline performance through the *Carryforward Category 3 Baseline Template*. The *Carryforward Category 3 Baseline Template* is posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under April DY4 Reporting.
    - **Please upload one Category 3 baseline reporting template per provider** to the first Category 3 ID and PM-9 milestone that is being reported as carried forward achieved. For the remaining Category 3 PM-9 carried forward milestones, please indicate in the "Progress Update" field the Category 3 outcome ID where the baseline template may be found, e.g. "Category 3 Baseline Template is uploaded to 111111111.3.200 Milestone PM-9."

- Milestone PM-10: Successful reporting to measure specifications
    - Providers earn either 50% (P4P outcomes) or 100% (P4R outcomes) of their DY4 allocation for each Category 3 project with the submission of the *DY4 Category 3 Reporting Template* posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under April DY4 Reporting.

- Milestone AM-1.x: Achievement of DY4 performance goal for each outcome component
    - Providers earn 50% (P4P outcomes) of their DY4 allocation for each Category 3 project with the submission of the achievement reported in the *DY4 Category 3 Reporting Template* posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under April DY4 Reporting
    - Most outcomes have a single component/rate and this will be designated as AM-1.1, representing Achievement Milestone (AM) for DY4 (-1) and first component (.1). For those outcomes with multiple components (e.g., IT-1.18: Follow-Up After Hospitalization for Mental Illness- 7 and 30 day follow-up the 2 components are designated as AM-1.1: 7 day follow-up and AM-1.2: 30 day follow-up).

Achieving DY4 and DY5 Performance Goals

For those outcomes where the measure type is P4P and baseline performance was submitted in DY3 HHSC has determined/will determine the DY4 and DY5 performance goals relative to the reported baseline using one of two standard goal setting approaches described below.

Quality Improvement System for Managed Care (QISMC): For those P4P outcomes where the improvement methodology is designated as QISMC, providers will receive incentive payments for closing the gap between their baseline performance and a benchmark performance.

- The achievement level goal for DY4 will be determined as follows:
    - IF a provider's reported baseline rate falls below the low performance benchmark (also called minimum performance level or MPL) the DY4 Achievement Target is equal to the rate listed for the MPL.
    - IF a provider's reported baseline rate falls above the MPL but below the high performance level (HPL) benchmark, the provider must close the gap between baseline performance and the HPL rate by 10%.
- The achievement level goal for DY5 will be determined as follows.
    - IF a provider's reported baseline rate falls below the low performance benchmark (also called minimum performance level or MPL) the DY5 Achievement Target is equal to a 10% gap reduction between the MPL and HPL.
    - IF a provider's reported baseline rate falls above the MPL but below the high performance level (HPL) benchmark providers must close the gap between baseline performance and the HPL rate by 20%.

Improvement Over Self (IOS): There are some P4P measures where QISMC appropriate benchmarks (HPL and MPL) are not available. For these P4P measures, the improvement methodology is designated as "IOS", or Improvement over Self and providers earn incentive payments for demonstrating improvement over baseline performance. The achievement level goals will be determined as follows:

- DY4 achievement level goal is equal to a 5% gap reduction between baseline and optimal performance.
- DY5 achievement level goal is equal to 10% gap reduction between baseline and optimal performance.

Measurement periods

DY4 and DY5 measurement periods for Category 3 outcomes are predetermined by the measurement period used to establish baseline performance. The DY4 measurement period is established as the 12 months immediately following the end of baseline period and the DY5 measurement period as the 12 months immediately following the end of DY4 measurement period.

As the DY4 and DY5 measurement periods are anchored around the baseline, HHSC is asking providers to ensure that the correct measurement period is used to report DY4 performance for both P4P and P4R outcomes and to indicate the beginning and the end of the measurement period within the *DY4 Performance Reporting Template*

Supporting Documentation for Category 3 Milestones that appear in DY4 Reporting

Beyond the Baseline and DY4 Reporting Templates, which should be referenced as supporting documents for milestone achievement in the reporting system, most providers will not need to submit any additional documentation during the reporting period.

All providers should maintain records (internally) of the reports used to abstract the numerator and denominator: a.) To ensure that the same abstraction method is used from baseline to DY5, and b.) Should HHSC or the compliance monitor ask to see these details.

CATEGORY 4 Instructions

Providers may report DY4 Category 4 Reporting Domains in April 2015 if eligible, based on the measurement periods used for DY3 reporting or in October 2015. There is no carry forward for Category 4. Providers who do not meet reporting standards may be subject to need more information (NMI) requests from HHSC.

Providers who are exempt from Category 4 reporting do not need to submit a *Category 4 DY4 Reporting Template* but may receive Medicaid Potentially Preventable Events reports from HHSC for informational purposes.

Category 4 has six Reporting Domains (RDs), and all RDs should be reported in a single template. Providers should note that the Category 4 reporting template has been updated for DY4, and providers should not submit the DY3 reporting template.

- RDs 1, 2, & 3:
    - The Institute for Child Health Policy (ICHP), which is Texas' Medicaid External Quality Review Organization (EQRO), prepared reports based on Calendar Year 2013 Medicaid and CHIP data for hospitals for reporting domains RD-1 – Potentially Preventable Admissions, RD-2 – 30-day Readmissions, and RD-3 – Potentially Preventable Complications. HHSC will provide the individual reports on RD-1, RD-2, and RD-3 to hospitals by email by April 3, 2015. This data will not be re-sent for October 2015 reporting. If an individual report needs to be re-sent to a provider, please contact HHSC at TXHealthcareTransformation@hhsc.state.tx.us.
    - In DY4, providers are required to submit responses to qualitative questions regarding provider specific RDs 1-3 PPA, PPR and PPC results.
    - RDs 1, 2, & 3 are compiled using Medicaid/CHIP data.
    - The DY4 measurement period for DY4 is calendar year 2013 and RDs 1-3 may all be reported in April or October 2015.

- RDs 4, 5, & 6:
    - Hospitals will also report the RD-4 – Patient Centered Healthcare, RD – 5 Emergency Department measures, and optional RD – 6 Initial Core Set of Health Care Quality Measures if indicated in the RHP Plan, based on all-payer data submitted by the individual provider.
    - Providers will have the option of reporting RDs 4, 5, and 6 for Medicaid only data if available. In DY4, providers will report this in a structured field designated for Medicaid only data, and not in the qualitative response section.

- The DY4 measurement period for RDs 4, 5, & 6 is determined by the DY3 measurement period. In DY3, providers selected a 12-month measurement period of their choosing, and DY4 measurement periods will be the 12 months immediately following the end of the measurement period reported in DY3. Providers will be eligible to report RD-4, RD-5, and RD-6 in April only if their DY4 measurement period as determined by their DY3 measurement period ends no later than March 31st, 2015. Reporting domains not eligible for reporting in April because of their DY4 measurement period will report in October 2015.
- HHSC will not accept measurement periods of less than 12 months.
- Responses to qualitative questions must be included for RDs 4 & 5 and optional RD-6 if applicable.
- Providers are not required to submit additional documentation beyond the *Category 4 Reporting Template.* However, providers are subject to additional monitoring at any time and should maintain the documentation for their Category 4 data.

Reporting Domains 1, 2, & 3:

For Reporting Domains 1 – 3, in DY4 providers will confirm that they received the relevant reports or that they did not have sufficient eligible admissions/readmissions to receive a given report, and respond to qualitative questions for each domain reporting. Providers that do not receive a report because of low volume are still required to respond to qualitative questions.

The EQRO has compiled data and reports for Potentially Preventable Admissions, and providers will use data from the first template section "PPA Rates" and the fifth section "PPA Results by Category." Please copy the data from the EQRO report into the RD-1 tab of the *Category 4 Reporting Template*.

Reporting Domain 4:

Component 1: Patient Satisfaction

For RD-4 Component 1, providers will report the percentage of survey respondents who choose the most positive, or "top-box" response for the following measures, displayed below.

For additional information, visit:
http://www.hcahpsonline.org/files/HCAHPS%20Fact%20Sheet%20May%202012.pdf and

Data is publicly reported and available on Hospital Compare:
https://data.medicare.gov/data/hospital-compare/Patient%20Survey%20Results

- HCAHPS Reporting Measures:
    - Percent of patients who reported that their doctors "Always" communicated well
    - Percent of patients who reported that their nurses "Always" communicated well
    - Percent of patients who reported that they "Always" received help as soon as they wanted
    - Percent of patients who reported that their pain was "Always" well controlled
    - Percent of patients who reported that staff "Always" explained about medicines before giving it to them
    - Percent of patients who reported that YES, they were given information about what to do during their recovery at home.
    - Percent of patients who reported that their room and bathroom were "Always" clean
    - Percent of patients who reported that the area around their room was "Always" quiet at night
    - Percent of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).
    - Percent of patients who reported YES, they would definitely recommend the hospital.

HHSC is unable to grant exceptions to the use of HCAHPS unless there is a reason that using HCAHPS would be inappropriate for the population served.

Component 2: Medication Management

For RD-4 Component 2, providers will report on NQF measure 0646. The measure specifications can be found on the NQF website here, and in the Category 4 section of the RHP planning protocol.

If manual chart review is required, please use the following sampling guidelines.

- For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
- For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
- For a measurement period where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.

Instructions to hospitals reporting alternate Medication Reconciliation for RD-4 Component 2
Several hospitals have communicated that they have a comprehensive medication reconciliation process, but it deviates from the NQF 0646 measure because they do not provide patients a list of "do not take" medications on discharge. In these limited cases only, providers may report their medication reconciliation for RD-4 as follows:

- Select "No" in response to the question "Are you reporting in compliance with NQF 0646".
- In the quantitative field, include the numerator, denominator, and resulting rate relevant to your medication reconciliation process.
- In the qualitative field, explain 1) what the quantitative measurement represents; 2) that you have a comprehensive reconciliation process; 3) why you have opted to use this process; and 4) what information you have to show that the process is effective.
- Providers that deviate from NQF 0646 will be subject to compliance monitoring for this measure.

Reporting Domain 5:

RD-5 (Admit decision time to ED departure time for admitted patients) specifications are defined in National Quality Forum Measure 0497. The specifications are available here. Note: "Time" and "Provider Time" in the numerator and denominator are used interchangeably. The numbers entered should be all-payer data. Please also include the ED admit decision time to ED departure time for admitted patients information for DSRIP eligible patients in the qualitative response section if available.

If manual chart review is required, please use the following sampling guidelines.

- For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
- For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
- For a measurement period where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.

Reporting Domain 6:

Providers must report on all of the listed measures; however, for measures that cannot be reported, providers may provide a justification to explain why a measure cannot be reported.

Possible acceptable rationales for not reporting on a measure include:

- The hospital does not serve the population that is being measured.
- The hospital does not provide outpatient services that are being measured.
- There is not a statistically significant population to report the measure – defined as at least 30 cases included in the denominator.
- The hospital's current data systems do not allow for the measure to be reported; if so, include information about what the hospital is doing to be able to report it in later years.
- The identical data is being reported as a Category 3 outcome (including same denominator as Category 3).

Many of the measures are not hospital-focused, and measures marked with an asterisk (*) in the reporting template are only applicable to providers with outpatient services.

Measures marked with a double asterisk (**) have been modified to be specific to DSRIP providers, similarly to the changes made in Category 3 measures (e.g. "member" modified to "patient"). Please see the corresponding Category 3 compendium document for these specifics.

Please see the links below to the technical specifications and resource manuals for detailed measure guidelines.

Child Set of Core Measures

Adult Set of Core Measures

April Payment and IGT Processing

Categories 1 and 2 Payment Calculations

The amount of the incentive funding paid to a Performing Provider will be based on the amount of progress made and approved within each specific milestone. A milestone may consist of one or more metrics. 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 and approved, each milestone will be categorized as follows:

If consisting of one metric:

- Full achievement (achievement value = 1)
- Less than full achievement (achievement value = 0)

If consisting of more than one metric:

- 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 Performing Provider is eligible to receive an amount of incentive funding for that milestone determined by multiplying the total amount of funding related to that milestone by the reported achievement value. If a Performing Provider has previously reported progress on a milestone with multiple metrics and received partial funding, only the additional amount it is eligible for will be disbursed.

Example of Category 1 or 2 disbursement calculation:

A Category 1 Project in DY 3 is valued at $4 million and has one milestone with two metrics and one milestone with three metrics.

The Performing Provider reports the following progress in April and has been approved by HHSC and CMS:

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

Disbursement for April reporting: Milestone 1 ($2 million *1 = $2 million) + Milestone 2 ($2 Million *0.5 = $1 Million) = $3 Million

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

Disbursement for October reporting is $4 million - $3 million = $1 million.

Note that DSRIP funds are Medicaid incentive payments that are earned for achieving approved metrics at agreed upon values. Once those funds are earned, neither HHSC nor CMS is prescribing how they are to be spent, but we certainly encourage providers to spend them to improve healthcare delivery, particularly for the Medicaid and low-income uninsured populations.

Category 3 Payment Calculations

April DY4 Category 3 payments are based on performance reported in the *DY4 Category 3 Performance Reporting Template, completion of the DY3 Category 3 Baseline Template, completion of the Category 3 DY3 Status Update Template,* and approval of the submission by HHSC and CMS.

For P4R Category 3 outcomes, 100 percent of DY4 funding is for reporting to approved measure specifications (PM-10).

For process milestones, a Performing Provider must fully achieve to qualify for the DSRIP payment related to these milestones.

For P4P Category 3 outcomes with a standard baseline (using DY3 or prior historical data) and standard achievement type, 50 percent of DY4 funding is for PM-10, reporting to approved measure specifications (process milestone) and 50 percent is for AM-1, achievement of DY4 performance goals (achievement milestone). For outcomes with multiple components/rates the 50% allocation toward achievement (AM-1) is split evenly between the number of components/rates (e.g. AM-1.1 and AM-1.2) and these achievement milestones can be achieved or partially achieved independently.

Example milestone structure for outcomes with a single component/rate

P4P outcome selected is IT-1.7 Controlling high blood pressure. This outcome has a single component or part with a DY4 value of $200K and DY5 value of $300K the following is a description of the milestone structure and payment allocation by milestone.

- DY4 Milestones
    - PM-10: Successful reporting to specs $100K—carry forward eligible, not eligible for partial payment.

- AM-1.1: Achievement of DY4 performance goal $100K—partial achievement and carryforward eligible.

- DY5 Milestone
  - AM-2.1: Achievement of DY5 performance goal $300K—partial achievement and carryforward eligible.

Example milestone structure for outcomes with multiple components/rates

P4P outcome selected is IT-4.19 Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls. This outcome has 3 components or parts (screening, risk assessment and plan of care) with a DY4 value of $200K and DY5 value of $300K. The following is a description of the milestone structure and payment allocation by milestone.

- DY4 Milestones
  - PM-10 Successful reporting to specs (for all components) $100K—carry forward eligible, not eligible for partial payment.
  - AM-1.1: Achievement of DY4 goal for component 1 (screening)- $33K- partial achievement and carryforward eligible.
  - AM-1.2: Achievement of DY4 goal for component 2 (risk assessment)- $33K- partial achievement and carryforward eligible.
  - AM-1.3: Achievement of DY4 goal for component 3 (plan of care)- $33K- partial achievement and carryforward eligible.
- DY5 Milestones
  - AM-2.1: Achievement of DY5 goal for component 1 (screening)- $100K- partial achievement and carryforward eligible.
  - AM-2.2: Achievement of DY5 goal for component 2 (risk assessment)- $100K- partial achievement and carryforward eligible.
  - AM-2.3: Achievement of DY5 goal for component 3 (plan of care)- $100K- partial achievement available.

Partial Achievement: In all Category 3 P4P achievement milestones there are 8 quartiles of eligible achievement between baseline and the DY5 performance goal. Any achievement not earned during the DY4 measurement period may be carried forward to the next measurement period. A Performing Provider may receive partial payment for making progress towards, but not fully achieving, the predetermined performance goal. Partial payment is available in DY4 in four quartiles, based on the percent of goal achieved.

DY4 goal				DY5 goal			
25% of AM-1.1 allocation	50% of AM-1.1 allocation	75% of AM-1.1 allocation	100% of AM-1.1 allocation	25% of AM-2.1 allocation	50% of AM-2.1 allocation	75% of AM-2.1 allocation	100% of AM-2.1 allocation

Full achievement (achievement value = 1, equal to 100% of funds available)

Partial Achievement:

- 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 Performing Provider has a DY4 achievement target that would decrease the percentage of patients with diabetes with poor HbA1c control (IT-1.10). The provider reported a baseline of 45% in DY3, which resulted in a DY4 performance goal of 43.4%, and a DY5 performance goal of 41.79%.

In DY 4, the Performing Provider reduced their rate of HbA1c poor control to 44.1%, short of their DY4 goal of 43.4%, which is equal to 56.25% of goal achieved.

Baseline: 45%
DY4 Performance Goal: 43.4%
DY4 Achievement: 44.1%

Percent of goal achieved for a negative directionality outcome (i.e., lower performance represents improvement in the outcome)
Percent of goal Achieved = (Baseline – DY4 Achievement) / (Baseline – DY4 Performance Goal)
= (45% - 44.1%) / (45% - 43.4%) = 56.25% of goal achieved

Under the partial payment policy, the provider would be reimbursed 50 percent of the incentive payment associated with this achievement milestone because it achieved 50 percent of the target. The Performing provider may earn the remaining DY 4 incentive payment if the DY4 performance goal is met in the full 12 month DY5 measurement period under the carry-forward policy. Carryforward for Category 3 means moving the unachieved portion of the milestone to the next full twelve month measurement period. In this example, in DY4 the provider earned 50% of total DY4 dollars for reporting the measure to specifications (i.e., PM-10 is fully achieved) and 25% of the total DY4 dollars for partially achieving the DY4 performance goal (i.e., AM-1.1 is partially achieved with 50% of total DY4 dollars * 50% of goal achieved). The remaining 50% of the DY4 goal for AM-1.1 will be carried forward to DY5 which dictates that this remaining 50% will fall into outcome's specified DY5 measurement period.

Category 4 Payment Calculations

A hospital Performing Provider will be eligible for a Category 4 DSRIP payment for each Reporting Domain within the *Category 4 Template* completed and approved by HHSC and CMS.

Partial payments do not apply to Category 4.

Approved October 2014 Needs More Information (NMI) milestones and metrics

In February 2015, HHSC completed review of October 2014 reporting submissions in response to HHSC requests for more information. Approved Needs More Information (NMI) milestones and metrics will be included in the July 2015 payment processing of April reports. NMI milestones and metrics that were not approved will no longer have access to the associated DSRIP funds.

Not Approved October 2014 Provisional Review milestones and metrics

In March 2015, HHSC completed review of October 2014 provisionally approved milestones and metrics. Provisionally approved milestones and metrics that were changed to Not Approved will be notified of the associated DSRIP recoupment amount in April 2015. The provider will have 30 days from receipt of the letter from HHSC Rate Analysis to send in the DSRIP All Funds amount. Once HHSC has received a report confirming receipt of the returned funds, the IGT refund will be processed within approximately two weeks. If the recoupment amount is not submitted, future DSRIP payments may be delayed.

IGT Processing

In July 2015, HHSC Rate Analysis will notify IGT Entities and Anchors of the IGT amounts by affiliation and IGT Entity by RHP for July 2015 payment processing of approved April reports. The IGT amounts for October 2014 approved NMI milestones and metrics, DY3 carry forward achievement, DY4 achievement, and DY4 monitoring will be indicated as well as a total IGT amount.

Per Texas Administrative Code §355.8204, HHSC may collect up to $5 million per demonstration year from DSRIP IGT entities to serve as the non-federal share (50 percent IGT/50 percent federal funds) for DSRIP monitoring contracts. For DY4, HHSC plans to collect $3 million in Monitoring IGT. The monitoring amount for each IGT Entity is a portion of the $3 million based on the January 1, 2015 value of the IGT Entity's funded DY4 Category 1-4 DSRIP projects out of all DY4 Category 1-4 DSRIP projects in the state. Based on projects withdrawn by May 1, 2015, HHSC will decrease the Monitoring IGT due for the associated IGT Entities. The difference will not be redistributed among remaining IGT Entities.

HHSC will request 100 percent of the DY4 IGT monitoring amount with July 2015 payment processing of April reports. If the full DY4 IGT monitoring amount is not submitted by an IGT Entity in July 2015, it will be requested with January 2016 payment processing of October

reports. If the full DY4 IGT monitoring amount is not submitted by an IGT Entity by January 2016, then it will be carried forward and due with DY5 payment processing.

An IGT Entity may either transfer the total IGT amount due for DY2 DSRIP, DY3 DSRIP, DY4 DSRIP, and monitoring or an amount less than the total IGT due. If less than the total IGT amount is transferred, then HHSC will account for the IGT monitoring amount first and the remaining IGT will be proportionately used to fund DY2, DY3, and DY4 approved DSRIP payments. If an IGT entity does not fully fund its DSRIP payments in July, the remaining IGT amount due for its' affiliated projects' achievement may be transferred with January 2016 payment processing of October reports or for DY4 carried forward achievement, with DY5 payment processing. **Please note that for DY2 metrics/milestones achievement, the last payment opportunity will be July 2015.**

DSRIP payments are made using the Federal Medical Assistance Percentage (FMAP) for the federal fiscal year (October 1 – September 30) during which the DSRIP payment is issued and is not based on the demonstration year FMAP of the achieved milestone or metric. The FMAP for FFY2015 and used for July DSRIP payment processing of April reports is 58.05. The FMAP for FFY2016 and used for January 2016 DSRIP payment processing of October reports is estimated at 57.13.

IGT Entity Changes

The IGT Entity(ies) for each project/outcome is listed under "IGT Funding" on the Project Details page. If you have changes to the IGT Entity, either in Entity or proportion of payment among IGT Entities, listed in the reporting system, please complete the *IGT Entity Change Form* available at http://www.hhsc.state.tx.us/1115-docs/DY3-Templates/April2014/IGT-Entity-Change-Form.xlsx. IGT Entity changes must be received no later than **April 30, 2015, 11:59 p.m.** for April reporting DSRIP payment processing. Any changes received after April 30, 2015, will go into effect for the October DY4 DSRIP reporting and payments will be delayed until that time. Note that IGT Entity changes submitted for April reporting will not impact the IGT monitoring amounts since monitoring contract amounts due for DY4 are based on each IGT entity's proportional share of DY4 Category 1-4 DSRIP projects as of January 1, 2015.

WARNING NOTICE Regarding Submission of Supporting Documentation

All information submitted for DSRIP reporting by Texas Healthcare Transformation and Quality Improvement Program §1115 Waiver participants is subject to the Public Information Act ("Act"), Chapter 552 of the Government Code. Certain information, such as commercial or financial information the disclosure of which would cause significant competitive harm, is excepted from public disclosure according to the Act. If you believe that the documentation submitted through this system is excepted from the Act, please note that belief at the beginning of your submission, including the particular exception you would claim.

Providers are required by the HHSC Medicaid Provider Agreement, as well as state and federal law to adequately safeguard individually identifiable Client Information. The transmission you are about to make is unsecure and will not be confidential. As such, Providers are prohibited from submitting Personally Identifiable Information about clients, HIPAA Protected Health Information or Sensitive Personal Information in connection with submittal of meeting the metric. Providers are required to only submit De-identified information [as evidence of meeting a metric]. If Provider inadvertently uploads individually identifiable client information or following discovery of an Event or Breach, the Provider should report this to HHSC Waiver Staff and the Provider's designated privacy official or legal counsel to determine whether or not this is a privacy breach which requires notice to your patients. Provider will cooperate fully with HHSC in investigating, mitigating to the extent practicable and issuing notifications directed by HHSC, for any event or breach of confidential information to the extent and in the manner determined by HHSC. Provider's obligation begins at the discovery of an event or data breach and continues as long as related activity continues, until all effects of the event are mitigated to HHSC's satisfaction.

Definitions

"**Breach**" means any unauthorized acquisition, access, use, or disclosure of confidential Client Information in a manner not permitted by [this incentive program] or applicable law. Additionally:

(1) HIPAA Breach of PHI. With respect to Protected Health Information ("PHI") pursuant to HIPAA regulations and guidance, any unauthorized acquisition, access, use, or disclosure of PHI in a manner not permitted by the HIPAA Privacy Regulations is presumed to be a Breach unless Provider, as applicable, demonstrates that there is a low probability that the PHI has been compromised. Compromise will be determined by a documented Risk Assessment including at least the following factors:

i. The nature and extent of the Confidential Information involved, including the types of identifiers and the likelihood of re-identification of PHI;
ii. The unauthorized person who used or to whom PHI was disclosed;
iii. Whether the Confidential Information was actually acquired or viewed; and

iv. The extent to which the risk to PHI has been mitigated.

With respect to PHI, a "breach," pursuant to HIPAA Breach Regulations and regulatory guidance excludes:

(A) Any unintentional acquisition, access or use of PHI by a workforce member or person acting under the authority of HHSC or Provider if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the HIPAA Privacy Regulations.

(B) Any inadvertent disclosure by a person who is authorized to access PHI at HHSC or Provider to another person authorized to access PHI at the same HHSC or Provider location, or organized health care arrangement as defined by HIPAA in which HHSC participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the HIPAA Privacy Regulations.

(C) A disclosure of PHI where Provider demonstrates a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information, pursuant to HIPAA Breach Regulations and regulatory guidance.

(2) Texas Breach of SPI. Breach means "Breach of System Security," applicable to electronic Sensitive Personal Information (SPI) as defined by the Texas Breach Law. The currently undefined phrase in the Texas Breach Law, "compromises the security, confidentiality, or integrity of sensitive personal information," will be interpreted in HHSC's sole discretion, including without limitation, directing Provider to document a Risk Assessment of any reasonably likelihood of harm or loss to an individual, taking into consideration relevant fact-specific information about the breach, including without limitation, any legal requirements the unauthorized person is subject to regarding confidential Client Information to protect and further safeguard the data from unauthorized use or disclosure, or the receipt of satisfactory assurance from the person that the person agrees to further protect and safeguard, return and/or destroy the data to the satisfaction of HHSC. Breached SPI that is also PHI will be considered a HIPAA breach, to the extent applicable.

(3) Any unauthorized use or disclosure as defined by any other law and any regulations adopted there under regarding Confidential Information.

"Client Information" means Personally Identifiable Information about or concerning recipients of benefits under one or more public assistance programs administered by HHSC.

"De-Identified Information" means health information, as defined in the HIPAA privacy regulations as not Protected Health Information, regarding which there is no reasonable basis to believe that the information can be used to identify an Individual. HHSC has determined that health information is not individually identifiable and there is no reasonable basis to believe that the information can be used to identify an Individual only if:

(1) The following identifiers of the Individual or of relatives, employers, or household members of the individual, are removed from the information:

(A) Names;

(B) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

(i) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(ii) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

(C) All elements of dates (except year) for dates directly related to an Individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

(D) Telephone numbers;

(E) Fax numbers;

(F) Electronic mail addresses;

(G) Social security numbers;

(H) Medical record numbers (including without limitation, Medicaid Identification Number);

(I) Health plan beneficiary numbers;

(J) Account numbers;

(K) Certificate/license numbers;

(L) Vehicle identifiers and serial numbers, including license plate numbers;

(M) Device identifiers and serial numbers;

(N) Web Universal Resource Locators (URLs);

(O) Internet Protocol (IP) address numbers;

(P) Biometric identifiers, including finger and voice prints;

(Q) Full face photographic images and any comparable images; and

(R) Any other unique identifying number, characteristic, or code, except as permitted by paragraph (C) of this section; and

(2) Neither HHSC nor Provider has actual knowledge that the information could be used alone or in combination with other information to identify an Individual who is a subject of the information."

"Discovery" means the first day on which an Event or Breach becomes known to Provider, or, by exercising reasonable diligence would have been known to Provider and includes Events or Breaches discovered by or reported to Provider, its officers, directors, partners, employees, agents, work force members, subcontractors or third-parties (such as legal authorities and/or Individuals).

"Encryption" of confidential information means, as described in 45 C.F.R. §164.304, the HIPAA Security Regulations, the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without the use of a confidential process or key and such confidential process or key that might enable decryption has not been breached. To avoid a breach of the confidential process or key, these decryption tools will be stored on a device or at a location separate from the data they are used to encrypt or decrypt.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended by the HITECH ACT and regulations thereunder including without limitation HIPAA Omnibus Rules, in 45 CFR Parts 160 and 164. Public Law 104-191 (42 U.S.C. §1320d, *et seq.*); Public Law 111-5 (42 U.S.C. §13001 *et. seq.*).

"HIPAA Privacy Regulations" means the HIPAA Privacy Regulations codified at 45 C.F.R. Part 160 and 45 C.F.R. Part 164, Subpart A, Subpart D and Subpart E.

"HIPAA Security Regulations" means the HIPAA Security Regulations codified at 45 C.F.R. Part 160 and 45 C.F.R. Part 164 Subpart A and Subpart C, and Subpart D.

"HITECH Act" means the Health Information Technology for Economic and Clinical Health Act (P.L. 111-5), and regulations adopted under that act.

"Individual" means the subject of confidential information, including without limitation Protected Health Information, and who will include the subject's Legally authorized representative who qualifies under the HIPAA privacy regulation as a Legally authorized representative of the Individual wherein HIPAA defers to Texas law for determination, for example, without limitation as provided in Tex. Occ. Code § 151.002(6); Tex. H. & S. Code §166.164; and Texas Prob. Code § 3. "Legally authorized representative" of the Individual, as defined by Texas law, for example, without limitation as provided in Tex. Occ. Code § 151.002(6); Tex. H. & S. Code §166.164; and Texas Prob. Code § 3, includes:

(1) a parent or legal guardian if the Individual is a minor;

(2) a legal guardian if the Individual has been adjudicated incompetent to manage the Individual's personal affairs;

(3) an agent of the Individual authorized under a durable power of attorney for health care;

(4) an attorney ad litem appointed for the Individual;

(5) a guardian ad litem appointed for the Individual;

(6) a personal representative or statutory beneficiary if the Individual is deceased;

(7) an attorney retained by the Individual or by another person listed herein; or

(8) If an individual is deceased, their personal representative must be the executor, independent executor, administrator, independent administrator, or temporary administrator of the estate.

"Personally Identifiable Information" or "PII" means information that can be used to uniquely identify, contact, or locate a single Individual or can be used with other sources to uniquely identify a single Individual.

"Protected Health Information" or "PHI" means individually identifiable health information in any form that is created or received by a HIPAA covered entity, and relates to the Individual's healthcare condition, provision of healthcare, or payment for the provision of healthcare, as further described and defined in the HIPAA. PHI includes demographic information unless such information is De-identified, as defined above. PHI includes without limitation, electronic PHI, and unsecure PHI. PHI includes PHI of a deceased individual within 50 years of the date of death.

"Unsecured Protected Health Information" means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized Persons through the use of a technology or methodology specified by the HITECH Act regulations and HIPAA Security Regulations. Unsecured PHI does not include secure PHI, which is:

(1) Encrypted electronic Protected Health Information; or

(2) Destruction of the media on which the Protected Health Information is stored.