

October DY4 Reporting – Companion Document

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Key Points for October 2015 Reporting

Each DSRIP provider should review this entire Companion document to understand the guidelines for how to report DSRIP achievement for the October DY4 reporting period. The Companion Document includes important information about changes to required documentation compared to what was required for DY3 reporting.

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

- The reporting deadline is **11:59 p.m. on October 31, 2015**, using the DSRIP Online Reporting System: <https://dsrip.hhsc.texas.gov/dsrip/login>.
- Reporting materials (companion documents and reporting templates) can be found on the main HHSC waiver website (<http://www.hhsc.state.tx.us/1115-waiver.shtml>) on the “Tools and Guidelines for Regional Healthcare Partnership Participants” page under **October DY4 Reporting**. Please note that Separate forms are required for QPI reporting, Category 3 reporting, and Category 4 reporting.
 - User Guide for the DSRIP Online Reporting System
 - DY3-DY5 Reporting Coversheet
 - Learning Collaborative Participation Template – This template is not required, but includes suggested elements for Lessons Learned documentation for Learning Collaborative metrics.
 - QPI Reporting
 - October DY4 QPI Reporting Companion
 - October DY4 QPI Template - Please be sure to download the new QPI Reporting Template from the Waiver website as data has been updated and pre-seeded in the template.
 - Category 3 Reporting
 - Category 3 October DY4 Reporting Template - Combined Baseline and Performance Reporting Template
 - Category 3 DY3 Status Report Template
 - Category 3 DY4 Reporting FAQ
 - Category 4 Template
- Metrics/milestones should only be reported in October if a provider is confident that the metric/milestone was fully achieved by **September 30, 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 December/January to submit additional information. If the provider cannot demonstrate during the December/January "needs more information" (NMI) period that the metric/milestone was completed by **September 30, 2015**, the provider will no longer be eligible for payment for that metric/milestone.
- All providers are required to provide semi-annual reporting information regardless of whether the provider is reporting achievement of metrics/milestones for payment in

October. Future DSRIP payments may be withheld until the complete report is submitted. (p. 7)

- The “Provider Summary Report” must be completed by all providers as part of the provider-level Semi-Annual Reporting requirement.
- For each project, all providers 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.
 - The QPI Reporting Template for DY4 QPI metrics, even if not reporting for achievement.
- 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 on the “Tools and Guidelines for Regional Healthcare Partnership Participants” page under **October DY4 Reporting**. 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.
- Please send reporting questions to the HHSC waiver mailbox at TXHealthcareTransformation@hhsc.state.tx.us. Please remember to include your RHP, Project ID, and Metric ID when submitting your questions.

October Reporting Checklist

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

- October 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.
 - QPI Reporting Template – for **ALL** DY4 QPI metrics, even if the provider is not reporting for achievement.
- (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. (One *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 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).
- QPI Reporting Template completed and uploaded for **ALL** DY4 QPI metrics and to report achievement for DY3 carry forward QPI metrics.
 - Save as: RHPXX_ProjectID_QPIOctDY4 (RHP01_123456789.1.1_QPI_OctDY4)
- Category 3 October DY4 Reporting Template* completed and uploaded to report achievement of DY4 milestones (1 template per provider).
 - Save as: RHPXX_TPIXXXXXX_Cat3OctDY4 (RHP01_123456789_Cat3_OctDY4)
- (If applicable) *Category 4 Reporting Template* completed and uploaded. (One template per hospital provider participating in Category 4, one tab per Reporting Domain if reporting in October).
 - Save as: RHPXX_TPIXXXXXX_Cat4OctDY4 (RHP01_123456789_Cat4_OctDY4)
- All items listed above submitted through the DSRIP Online Reporting System no later than 11:59 p.m. on **October 31, 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 **November 20, 2015, 5:00 p.m.** (One IGT Entity Change Form per provider).

Overview

This document includes information on reporting during the second DY4 reporting period in October 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 waiver website on the "[Tools and Guidelines for Regional Healthcare Partnership Participants](#)" page under **October 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 summaries 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, DY3 April reporting, DY3 October reporting, and DY4 April 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. October 2015 is the final opportunity to report achievement of DY3 carryforward milestones and metrics.
- 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.

October Reporting Timeline

- **October 1, 2015** – The DSRIP Online Reporting System will open for providers to begin October 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.
- **October 8, 2015** – HHSC will be holding an October DY4 Reporting Webinar from **10:00–11:30am** which will cover General Reporting, Quantifiable Patient Impact (QPI), and Category 3 guidance.
- **October 23, 2015** – Final date to submit questions regarding October reporting and inform HHSC of any issues with DY4 data in the reporting system.
- **October 31, 2015, 11:59pm**
 - Due date for providers' submission of October 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.
- **November 1, 2015** – HHSC will begin review of the October reports and supporting documentation.
- **November 6, 2015** - HHSC will post the estimated IGT due for October reporting based on milestones and metrics reported as achieved. Final IGT due will be based on HHSC review and approval.
- **November 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 October 23, 2015, as stated above.**
 - 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/092515/IGTEntityChangeForm.xlsx>.
- **December 9, 2015** – HHSC and CMS will complete their review and approval of October 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 January DSRIP payments.

- **January 15, 2016, 11:59pm** – Due date for providers to submit responses to HHSC requests for additional information (NMI requests) on October 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.
- **January 4, 2016** – IGT due for October reporting DSRIP payments.
- **January 15, 2016** – October reporting **DY4 DSRIP payments** processed for transferring hospitals and top 14 IGT Entities.
- **January 29, 2016** - October reporting **DY3 DSRIP payments** processed for all providers and **DY4 DSRIP payments** processed for remaining providers that were not paid on January 15, 2016. Note that there are separate transactions for each payment for each DY.
- **February 17, 2016** – HHSC and CMS will approve or deny the additional information submitted in response to HHSC comments on October reported milestone/metric achievement. Approved reports will be included for payment in the next DSRIP payment period, estimated for July 2016.
- **February 19, 2016** – HHSC and CMS will complete their review and approval of provisionally approved October reports or request additional information (referred to as NMI) regarding the data reported (if applicable).
- **March 9, 2016** – Due date for providers to submit responses to HHSC requests for additional information on provisionally approved October reported milestone/metric achievement and incomplete semi-annual progress reports (if applicable).
- **March 30, 2016** – HHSC and CMS will approve or deny the additional information submitted in response to HHSC comments on provisionally approved October reported milestone/metric achievement and semi-annual progress reports (if applicable).

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 October DY4 Reporting for every project regardless of whether the milestone/metric is reported for payment in October**. All information will be entered into the online reporting system.

- “Provider Summary Report” - This is a brief overview of your project/s current progress, activities conducted, findings, and outcomes achieved. Providers with multiple projects may submit an executive summary overview of all of their projects in the Provider Summary. Responses should be succinct and provide brief relevant detail.
- 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.)
 - Under “Accomplishments,” describe positive change, forward progression with overall project success (e.g., We have hired a new clinician which will allow us to extend our clinic hours soon.)
 - If there were any variations (difficulties and how they were addressed/plans to address) 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 “Lessons Learned” describe what worked well, what could be improved, and how it can aid progress (e.g., Incorporating our new patient navigator into the ED team has helped us lower the rate of episodic care in the ED, but we realize that the workload may require additional staff. Patient navigation services could be improved by increasing navigation staff and cultural competency).
 - 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 September 30, 2015.
 - Under “Continuous Quality Improvement Activities,” if not already described under "Progress on Core Components," describe consistently done actions that are devoted to pushing quality improvement forward (i.e., How the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement).
- “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

- Reporting Achievement of DY3 Carryforward Metrics for Category 1-2
 - October 2015 is the last time to report for completion Category 1 and 2 carried forward metrics. The carried forward DY3 milestones and metrics are included in the online system under DY4 Round 2 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 (July 1, 2014-December 30, 2014 in this example) must be used to demonstrate 10% decrease from the baseline. The DY3 carried forward metric could be reported in April or October 2015. Because this is an annual metric, the DY4 achievement of 15% decrease from the baseline should only be reported in October and use a 12-month period (Oct. 1, 2014-Sept. 30, 2015 in this example). Because this percentage improvement metric is not a QPI metric, the DY4 12-month period may overlap with the period used for reporting DY3 carryforward. Overlapping measurement periods are not allowed for QPI metrics.
- Reporting Achievement of DY3 Carryforward Milestones for Category 3
 - 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 **October DY4 Reporting**.

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

Requesting Carryforward for DY4 Milestones and Metrics

The option to carryforward DY4 milestones and metrics is available in October reporting.

If a milestone or metric will not be achieved by September 30, 2015, under "Achieved by Sept 30?" please select "Partially Completed" or "No-Not Started." To request carryforward, answer the "Carryforward Questions" for each Category 1 or 2 metric or Category 3 milestone on the Round 2 milestone tab:

- Enter a response for "If applicable, please explain why your achievement is less than expected."
- Select "Yes" for "Do you want to carry this metric into the next demonstration year?"
- Enter a response for "What is your plan to improve performance by the end of the following DY?"

For Category 1-2 metrics that are not QPI metrics, you do not need to submit supporting documentation if requesting carryforward.

For Category 1-2 QPI metrics, the completed QPI template must be submitted along with the carryforward request.

For Category 3 DY4 achievement milestones (e.g., AM-1.1) that were partially achieved by September 30, 2015, you may request carryforward 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 September 30” 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).

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 the overlap makes sense. 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 not count individuals or encounters in an earlier demonstration year. For example, if a project's QPI goal was 200 in DY3 and 300 in DY4, and the DY3 goal was achieved before the end of DY3, the project could not start counting DY4 achievement until the start of DY4 (October 1, 2014). Early achievement of QPI metrics is not 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., if a significant variance is requested in October 2015 and HHSC requests additional information, the variance could possibly be approved in January 2016; payment would be made following the April 2016 reporting period, estimated to be in July 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, resulting in a higher response rate and potentially creating a respondent bias.

DY2, DY3, or DY4 Reported Achievement has Changed: If the reported and approved achievement of a DY2, DY3 or DY4 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 as part of the semi-annual reporting requirement.

If a provider is reporting achievement of a DY3 QPI carry forward metric in October for payment, it must demonstrate in the *QPI Template* that the QPI goal was achieved between October 1, 2013 and September 30, 2015. If a provider is reporting achievement of a DY4 QPI metric in October for payment, it must demonstrate in the *QPI Template* that the QPI goal was achieved between October 1, 2014 and September 30, 2015. There cannot be an overlap of the demonstration year dates used to count achievement for different years. In other words, once the DY3 QPI carry forward metric is met, counting toward the DY4 metric achievement can begin.

Providers should only submit one *QPI Template* per project per reporting period. The same template is used for DY3 carry forward QPI metrics and DY4 QPI metrics.

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 **October 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.
 - A coversheet should provide more information than just stating that the provider achieved the metric during the demonstration year. Below please find examples of helpful coversheets.

Metric 1:		
1	Metric ID (e.g., P-1.1):	P-5.1
2	Reporting type (select one):	Reporting current DY (not carryforward)
3	File name(s) for supporting documentation:	123456789.1.1_J.Doe_Provider_Contract_DY4_20150419.pdf 123456789.1.1_J.Smith Contract_DY4_20150419.pdf 123456789.1.1_Primary_Care_Encounter Summary_DY4__20150419.pdf
4	Page #s demonstrating achievement:	For Contracts = Page 1; for Encounters - only one page
5	Describe how the documentation supports achievement of this metric:	123456789.1.1_J.Doe_Provider_Contract_DY4_20150419.pdf - contract on one primary care provider - shows employment as of February 2015. 123456789.1.1_J.Smith Contract_DY4_20150419.pdf - contract on second primary care provider - show employment as of November 2014. This provider is actually at a new location for pediatric patients. 123456789.1.1_Primary_Care_Encounter Summary_DY4__20150419.pdf - one page summary table pulled from patient financial system that shows that both providers are not only employed but currently seeing patients in the first six months of DY4. Our goal for this year is to see 40,144 visits by the end of DY4. Through March 2015, we are at 24,629 and expect to achieve our goal by the end of the measurement year.

Metric 2:		
1	Metric ID (e.g., P-1.1):	P-110.1
2	Reporting type (select one):	Reporting current DY (not carryforward) <input type="text"/>
3	File name(s) for supporting documentation:	RHP3_123456789.2.1_DY3_Agendas RHP3_123456789.2.1_DY3_SLCReporting
4	Page #s demonstrating achievement:	All
5	Describe how the documentation supports achievement of this metric:	The agendas are for each of 20 IDD Crisis Learning Collaborative meetings attended by our Staff. This Learning Collaborative was created in April 2013 and consists of approximately 10 organizations with similar projects across the state. The Learning Collaborative conducted conference calls approximately every two weeks in addition to face to face meetings as scheduled among individual members. The Statewide Learning Collaborative Reporting document shows that our IDD Crisis project Director, Jane Doe attended the face to face statewide RHP Learning Collaboratives on DSRIP projects.

- 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 see the chart below as an example of what may be submitted to demonstrate baseline. Please refer to the *QPI Reporting Companion Document* for guidance specific to QPI baselines.

Employee Name	Position #	Position Name	FTE	Hire Date	Baseline/Goal Notes
Fran Gomez	1116	Physician	1.00	1/2/2003	Pre-DSRIP
George Powell	1117	Physician	1.00	11/28/2007	Pre-DSRIP

Henry Richards	1118	Physician	1.00	10/28/2014	Hired for DY4 Metric Achievement See attached contract.
Ilene Anderson	1119	Physician	1.00	1/5/2015	Hired for DY4 Metric Achievement See attached contract.
Jennifer Bonds	1120	Physician	1.00	5/3/2015	Hired for DY4 Metric Achievement See attached contract.

- 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 page numbers for the relevant information in the *Coversheet*.
- **Providers must include dates in supporting documentation to demonstrate achievement occurred by September 30, 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 by September 30, 2015, and not only signed a contract/agreement to be counted towards increased staff/hiring metrics. (For example, if an employment contract was signed on August 31, 2015, but the physician's start date is October 1, 2015, this metric should be carried forward to April 2016.)
 - 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.
- **Non-QPI 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 be 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 could be January 2014 - September 2014 (intervention start to end of DY3) and the DY4 achievement measurement period could be October 1, 2014 – September 30, 2015, and be eligible to report in October 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., $X\% + \text{prior performance}$ vs. $X\% * \text{prior performance}$), 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 $\frac{1}{2}$ 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.ihl.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 semi-annual meeting” Metrics: For metrics requiring implementing “raise the floor” improvement initiatives, the documentation should include a list of ideas that came up during the semi-annual 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)/letter(s) of position acceptance 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-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.

Milestone: I-22 Increase the number of specialist providers, for the high impact/most impacted medical specialties

Metric I-22.1: Increase number of specialist providers in targeted specialties

- Additional Guidance:
 - To show an increase in specialist providers, provide documentation such as signed contract(s) or other documentation for new providers and staff with starting dates, new specialty care schedule, etc. Sensitive information such as salaries may be redacted. Staff names should NOT be redacted.
 - Baseline information should be included to show the increase in staff. This could be as simple as a staff roster that includes staff names, position titles, and if they are a part of the baseline or hired as part of the DSRIP project.

Project Option: 1.12

Milestone: P-4 Increase primary care clinic volume of visits and evidence of improved

Metric P-4.1: Number of staff secured and trained

- 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, 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. Documentation could include training materials such as sign-in sheets (including the dates of the training sessions), presentations, handouts, an HR report showing training sessions and dates, etc..

Milestone: P-6 Establish behavioral health services in new community-based settings in underserved areas.

Metric P-6.1: Number of new community-based settings where behavioral health services are delivered

- Additional Guidance:
 - Please include clear evidence that the settings are new locations for this provider, with documentation such as blueprints or design plans, lease/contract, memorandum of understanding with another provider for use of space, picture of facility with address, new behavioral health schedule or advertisement with new locations listed, floor plans, etc. as applicable.
 - The documentation should clearly show that the number of new community-based settings matches the number of new settings in the goal, and that those settings differ from and are in addition to the providers' previously existing locations. Provider should provide evidence of behavioral health settings utilized prior to DSRIP project implementation for comparison to show that the number of community-based settings has increased.
 - For providers spanning multiple RHPs, the documentation should clearly evidence that the new community-based settings are in the relevant RHP for the project being reported.

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-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-2 Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care.

Metric P-2.1: Increase percent of staff trained

- Additional Guidance:
 - The provider should clearly note how the percentage was calculated in the Goal Calculation field on the milestone/metric's reporting tab.
 - Documentation should be included for both the numerator and denominator. For example, a staff roster could be used to document the denominator, while the numerator could use an HR report showing training sessions and dates.
 - Please also include training materials such as sign-in sheets (including the dates of the training sessions), presentations, handouts, etc.

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: 2.7

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: 2.11

Milestone: P-9 Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement.

Metric P-9.1: Description and number of new ideas, practices, tools, or solutions tested by each provider.

- Additional Guidance:
 - This metric should only be reported in Round 2 (October) since data collection would occur throughout the demonstration year on a weekly basis.
 - Documentation of the Plan-Do-Study-Act (PDSA) concepts as well as the ideas, dates, staff involved, and action taken should be provided. Another option is to submit a PDSA document for each idea, tool, or solution.

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: 2.13

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:
 - The numerator and denominator used for goal calculation should be included.
 - 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-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

Category 3 Milestones Appearing in DY4:

- PM-10 Successful reporting to approved measure specifications
- AM-1.x Achievement of DY4 Performance Goal (P4P outcomes only)**
- PM-12 Maintenance of High Performance (Maintenance outcomes only)
- PM-8 Submission of Cat 3 DY3 Status Report*
- PM-9 Validation and submission of baseline performance*

**Carried forward from DY3. October DY4 is the last opportunity to report DY3 milestones*

*** Most outcomes have a single component/rate and these are designated as AM-1.1, representing the first and only achievement milestone in DY4. For outcomes with multiple components (IT-1.18: Follow Up After Hospitalization for Mental Illness 7 and 30 days) the two components are represented as AM-1.1 for 7 day follow up and AM-1.2 for 30 day follow up. Baseline, goals, and achievement for multiple components are independent of the other components under a single IT selection.*

Category 3 Reporting Templates:

Category 3 reporting templates can be found on the [Tools and Guidelines for Regional Healthcare Partnership Participants](#) page under **October DY4 Reporting**.

- Category 3 October DY4 Reporting Template (Combined Baseline & Performance Reporting Template):
 - Submitted for reporting of PM-9, PM-10, AM-1.x, and PM-12
 - Providers will submit one Category 3 reporting template in DY4. The Category 3 reporting template contains all projects associated with a given provider in one region including outcomes reporting baseline and outcomes reporting DY4 performance.
 - Category 3 Reporting Template should be attached only once to the first Category 3 outcome associated with the first Category 1 or 2 project in the online reporting system. For all other Category 3 milestones, Providers should indicate in the semi-annual reporting field where the Category 3 reporting template is uploaded, if outcome is being reported in October DY4.
 - Requires Certification by Chief Quality Officer or executive responsible for validating the accuracy of Category 3 reporting. The certifier should print out the certification page and reporting summary of the October DY4 reporting template, sign, and upload a copy of the signed certification along with the October DY4 reporting template.
 - Save file as: *RHPXX_TPIXXXXXXXXX_Cat3_OctDY4 (RHP01_123456789_Cat3_OctDY4)*

- Category 3 DY3 Status Report Template:
 - Submitted to report PM-8
 - Uploaded to the PM-8 Milestone

Category 3 Measurement Periods & October DY4 Reporting Eligibility

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 the 12 months immediately following the end of the DY3 baseline period and the DY5 measurement period is the 12 months immediately following the end of DY4 measurement period.

If a provider received approval to report with a proxy population for baseline, the DY4 and DY5 measurement periods may be non-consecutive from the baseline measurement period. For example, if a provider used a comparable clinic to determine a baseline rate for an outcome using a CY2013 measurement period because the DSRIP project clinic was not open until October 1st, 2014 the provider may begin their DY4 measurement period on October 1st 2014. Providers reporting with a proxy baseline reporting with a non-consecutive DY4 measurement period should include justification for the non-consecutive measurement period in the October DY4 reporting template in the qualitative field for additional information.

Outcomes not approved to report with a proxy baseline who report a non-consecutive DY4 measurement period will result in an NMI determination.

Standard Baseline Measurement Period & October DY4 Reporting:

Category 3 outcomes are required to submit a baseline with 6 - 12 months of baseline data (with few exceptions), with measurement periods that start as early as 01/01/2012 and end no later than 09/30/2014. Baselines that end by 09/30/2014 (the end of DY3) are considered standard baselines for Category 3 milestone and reporting purposes. Outcomes with a standard baseline that reported their baseline in either October DY3 or April DY4 are eligible to report DY4 performance in October DY4. Outcomes with a standard baseline measurement period that have not yet reported a Category 3 baseline and received payment for PM-9 will report their baseline in October DY4, and are not eligible to report DY4 performance in October DY4. For outcomes with a standard baseline, baseline and performance cannot be reported in the same reporting period.

DY4 Baseline Measurement Period & October DY4 Reporting:

In cases where a provider has no or inadequate data to establish a baseline that ends by 09/30/2014 (the end of DY3), DY4 data may be used to establish a baseline and this results in a change to the Category 3 milestone structure. Outcomes approved to report with a DY4 baseline must report a baseline with 12 months of data, and the 12-month period should be as early as possible and end no later than the end of DY4. The DY5 measurement period for outcomes approved to use the DY4 Baseline payment structure will be the 12 months immediately following the baseline measurement period.

Outcomes approved to use a DY4 Baseline are eligible to report their full DY4 baseline in October DY4 in fulfillment of milestone PM-10. Outcomes approved to use a DY4 baseline that have not yet received payment for PM-9 may report PM-9 and PM-10 in the same measurement period.

Calculating DY4 and DY5 Performance Goals

For those outcomes where the measure type is P4P, DY4 and DY5 performance goals are determined by the reported baseline using one of three standard goal setting approaches described below, based on the selected improvement target. Outcomes with a standard baseline measurement period will have a DY4 and a DY5 goal. Outcomes with a DY4 baseline will have a DY5 goal only.

Performance goals for P4P outcomes with a Quality Improvement System for Managed Care (QISMC) improvement type are calculated based on where a provider's baseline falls relative to nationally set benchmarks (Minimum Performance Level (MPL) and High Performance Level (HPL)). The Category 3 Compendium includes details on the HPL and MPL for each QISMC P4P outcome measure.

P4P measures where QISMC appropriate benchmarks (HPL and MPL) are not available are designated as Improvement over Self (IOS) measures. In these scenarios, a provider must improve an outcome over the baseline performance.

The table below outlines how performance goals are calculated for non-survey P4P outcomes.

Improvement Type			DY4 Goal	DY5 Goal
QISMC	Negative Directionality (improvement is a decrease over baseline)	Below MPL	MPL	MPL - .10(MPL - HPL)
		Between MPL & HPL	Baseline - .10(Baseline - HPL)	Baseline - .20 (Baseline - HPL)
		Above HPL	TA Needed - change to IOS, or maintenance	
	Positive Directionality (improvement is an increase over baseline)	Below MPL	MPL	MPL + .10(HPL - MPL)
		Between MPL & HPL	Baseline + .10(HPL - Baseline)	Baseline + .20(HPL - Baseline)
		Above HPL	TA Needed - change to IOS, or maintenance	
IOS	Negative	Baseline - .05(Baseline)		Baseline - .10(Baseline)
	Positive	Baseline + .05(1 - Baseline)		Baseline +.10(1 - Baseline)

The table below shows the performance goals for survey-based P4P measures in ODs 10 and 11. DY4 and DY 5 performance goals are set based on various scenarios selected by the provider at the time of baseline reporting. In Scenario 1, DY4 and DY5 goals are determined by the change in average pretest and posttest scores observed during the baseline measurement period. In Scenario 2 and 3, DY4 and DY5 goals are determined by a fixed improvement set relative to the minimum possible score and the maximum possible score for a given survey/tool.

Improvement Type			DY4	DY5
IOS - Survey	Negative	Scenario 1 DY3 = Pretest & Posttest DY4&DY5 = Posttest Only	DY4 Posttest Goal= Posttest - .05(Pretest - Posttest)	DY5 Posttest Goal= Posttest - .10(Pretest - Posttest)
		Scenario 2 DY3 = Pretests Only DY4/DY5 = Posttest Only	DY4 Posttest Goal = Pretest - .05(Max Score - Min Score)	DY5 Posttest Goal: Pretest - .10(Max Score - Min Score)
		Scenario 3 DY3-5 = Average Score	DY4 Average Score Goal: Baseline - .05(Max Score - Min Score)	DY4 Average Score Goal: Baseline - .10(Max Score - Min Score)
	Positive	Scenario 1 DY3 = Pretest & Posttest DY4&DY5 = Posttest Only	DY4 Posttest Goal= DY3 Posttest + .05(DY3 Posttest - DY3 Pretest)	DY5 Posttest Goal= DY3 Posttest + .10(DY3 Posttest - DY3 Pretest)
		Scenario 2 DY3 = Pretests Only DY4/DY5 = Posttest Only	DY4 Posttest Goal = DY3 Pretest + .05(Max Score - Min Score)	DY5 Posttest Goal: DY3 Pretest + .10(Max Score - Min Score)
		Scenario 3 DY3-5 = Average Score	DY4 Average Score Goal: DY3 Baseline + .05(Max Score - Min Score)	DY5 Average Score Goal: DY3 Baseline + .10(Max Score - Min Score)

Category 3 Milestone Structures October DY4

Category 3 includes four different payment structures for DY4. Payment structures vary based on whether a baseline measurement period is **standard** (baseline ending by DY3, 9/30/2014) or **DY4**, and whether an outcome measure is P4R or P4P or maintenance.

Standard Baseline Milestones Period:

The tables below reflect the payment structures for outcome measures with a **standard (DY3) baseline**. The highlighted text shows the milestone and payment descriptions for DY4 reporting.

Figure X. Payment Structures for Outcomes with a Standard (DY3) Baseline

Standard P4P Payment Structure (baseline ending by 09/30/2014)			
Year	Milestone	Milestone Description	Payment
DY3	PM-8	Submission of Category 3 DY3 Status Report	50% of Cat 3 DY3 Allocation
	PM-9	Validation and submission of baseline performance	50% of Cat 3 DY3 Allocation
DY4	PM-10	Successful reporting to approved measure specifications	50% of Cat 3 DY4 Allocation
	AM-1.x*	Achievement of DY4 performance goal	50% of Cat 3 DY4 Allocation
DY5	AM-2.x*	Achievement of DY5 performance goal	100% of Cat 3 DY5 Allocation

For outcome measures that are standard P4P, providers will report the PM-10 milestone, or successful reporting to approved measure specifications, and the AM-1.x* milestone, or achievement of the DY4 performance goal. Providers will receive 50 percent of Cat 3 DY4 allocations for the PM-10 milestone and 50 percent of Cat 3 DY4 allocations for achieving the DY4 performance goal.

Standard P4R Payment Structure (baseline ending by 09/30/2014)			
Year	Milestone	Milestone Description	Payment
DY3	PM-8	Submission of Category 3 DY3 Status Report	50% of Cat 3 DY3 Allocation
	PM-9	Validation and submission of baseline performance	50% of Cat 3 DY3 Allocation
DY4	PM-10	Successful reporting to approved measure specifications	100% of Cat 3 DY4 Allocation

DY5	PM-10	Successful reporting to approved measure specifications	50% of Cat 3 DY5 Allocation
	AM-3.1* Or PM-11	Achievement of DY5 performance goal for Population Focused Priority (PFP)measure	50% of Cat 3 DY5 Allocation
		Successful Achievement of Stretch Activity	

For outcome measures that are standard P4R, providers will report the PM-10 milestone, or successful reporting to approved measure specifications as outlined in the Cat 3 Compendium. Providers successfully reporting this milestone will receive 100% of their Cat 3 DY4 allocations.

Non-Standard P4P Payment Structure - Maintenance Mode			
Year	Milestone	Milestone Description	Payment
DY3	PM-8	Submission of Category 3 DY3 Status Report	50% of Cat 3 DY3 Allocation
	PM-9	Validation and submission of baseline performance	50% of Cat 3 DY3 Allocation
DY4	PM-10	Successful reporting to approved measure specifications	50% of Cat 3 DY4 Allocation
	AM-1.x* PM-12	Achievement of DY4 performance goal Maintain high performance level	50% of Cat 3 DY4 Allocation
DY5	AM-2.x* PM-12	Achievement of DY5 performance goal Maintain high performance level	100% of Cat 3 DY5 Allocation 50% of Cat 3 DY5 Allocation
	AM-3.1* Or PM-11	Achievement of DY5 performance goal for Population Focused Priority (PFP) measure	50% of Cat 3 DY5 Allocation
		Successful Achievement of Stretch Activity 3	
<p>- Alternate pay for performance measure to be from Cat 3 menu or PFP menu. Baseline is DY3 or DY4. If no alternate measure is possible, SA-3 may be considered.</p> <ul style="list-style-type: none"> - Providers will maintain statistically significant maintenance of high performance, defined as two proportion z-test with a significance level of .10 (calculator available here: http://www.socscistatistics.com/tests/ztest/Default2.aspx). Providers whose DY4 performance stays above their baseline rate do not need to demonstrate statistically significant maintenance. - Providers who do not maintain high performance in DY4 will be eligible to carryforward the DY4 PM-12 milestone for possible achievement in the Category 3 DY5 measurement period. 			

Providers who have a non-standard (DY4 baseline) P4P outcome measure and who have opted to maintain high performance/achievement will receive 50 percent of the Cat 3 DY4 allocations for successful reporting to approved measures specifications and 50 percent of DY4 allocations for maintaining a high performance level.

DY4 Baseline Milestones:

The next tables reflect the payment structures for outcome measures with a **non-standard (DY4) baseline**. The highlighted text shows the milestone and payment descriptions for DY4 reporting.

Non-Standard P4P Payment Structure - DY4 Baseline (baseline established with DY4 data)			
Year	Milestone	Milestone Description	Payment
DY3	PM-8	Submission of Category 3 DY3 Status Report	50% of Cat 3 DY3 Allocation
	PM-9	Validation and submission of baseline performance (<i>functions as a status update</i>)	50% of Cat 3 DY3 Allocation
DY4	PM-10	Successful reporting to approved measure specifications (<i>functions as a final baseline</i>)	50% of Cat 3 DY4 Allocation 100% of Cat 3 DY4 Allocation
	AM 1.x*	Achievement of DY4 performance goal	50% of Cat 3 DY4 Allocation
DY5	AM-2.x*	Achievement of DY5 performance goal	100% of Cat 3 DY5 Allocation

- If not already achieved, PM-9 can be achieved by submitting all baseline information collected to date as a status update through. If already achieved, PM-9 doesn't change.

- DY4 baseline should be 12 months of data set as early as possible and ending no later than 09/30/2015. If 12 months of data are not available by 09/30/2015 provider may be approved to report all data available through 09/30/2015. If no or insignificant data is available by 09/30/2015 provider will carryforward reporting of PM-10.

- DY5 Goal is set as 20% QISMC improvement or 10% IOS improvement over the baseline submitted for PM-10 in DY4.

Providers who have P4P outcome measures with a baseline established using DY4 data will report the PM-10 milestone for DY4, or successful reporting to approved measure specifications. Providers successfully reporting this milestone will receive 100% of their Cat 3 DY4 allocations.

Partial Payment & Carryforward in DY4

Providers may receive partial payment for making progress towards an eligible P4P outcome improvement target (AM-1.x). Partial payment is available in quartiles, with unearned funds carried forward into the next Category 3 12 month measurement period.

Achievement Reported	DY4 Payment
100% Achievement	100% of funds for AM-1.x in DY4
At least 75 % achievement	75% of funds for AM-1.x in DY4
At least 50% achievement	50% of funds for AM-1.x in DY4
At least 25% achievement	25% of funds for AM-1.x in DY4
Less than 25% achievement	No Payment for AM-1.x in DY4

DY4 percentage of goal achieved is determined using the following formula:
(DY4 Performance – Baseline) / (DY4 Improvement Target – Baseline)

Example:

Baseline: .50

DY4 Improvement Target: .5250

DY4 Performance: .5150

$$DY4 \% \text{ of goal achieved} = (.5150 - .50) / (.5250 - .5150) = 60\%$$

In this example, the provider is eligible to receive 50% of funds associated with this AM-1.x milestone, and will carryforward the unearned 50% into the DY5 reporting period.

Providers reporting DY4 performance in October DY4 will report the numerator and denominator for their 12 month DY4 measurement period in the October DY4 reporting template. The template will calculate the DY4 percentage of goal achieved, and indicate how achievement should be reported in the online reporting system.

Carrying forward due to partial achievement of carrying forward the reporting of Category 3 DY4 milestones in October DY4 does not result in a change to the Category 3 DY4 measurement period, which is the 12 months immediately following the end of the baseline measurement period.

Additional examples of Category 3 Partial Payment & Carryforward are available in the payment calculation portion of this reporting companion and the October DY4 Webinar Presentation.

Baseline Corrections in the October DY4 Reporting Template:

If a standard baseline reported in either October DY3 or April DY4 needs to be corrected due to errors in abstraction or understanding of measure interpretation (including outcomes currently under review by Myers and Stauffer (MSLC)), and the provider is reporting DY4 performance in

October DY4, updates can be made through the October DY4 reporting template at the time DY4 performance is reported. For outcomes that are not reporting DY4 performance in October DY4, no baseline corrections can be made through the October DY4 reporting template.

Most P4P & P4R outcomes will be eligible to correct their reported baseline numerator and denominator through the reporting template. Providers will not be able to change the outcome selection, baseline measurement period, or currently approved subsets through the October DY4 reporting template. Providers needing to make changes to the

The following situations will NOT be eligible to correct the baseline numerator and denominator through the reporting template, and will need to contact HHSC prior to October 23rd if a currently reported baseline needs to be corrected:

- Surveys/Tools in OD10 & OD11 using Scenario 1
- Outcomes previously approved for Maintenance due to high performance at baseline
- Outcomes previously approved to use an Alternate Achievement goal calculation

Category 3 & Compliance Monitoring:

Providers with Category 3 outcomes under review by the independent assessor, Myers and Stauffer LLC (MSLC), will receive preliminary notifications and corrective action plans if needed by September 30th 2014. MSLC will begin working with providers to complete corrective action plans and finalize baseline corrections beginning in October, with HHSC scheduled to receive a final revised baseline from MSLC in December 2015.

HHSC will not be removing performance reporting eligibility for October DY4 reporting based on Myers and Stauffer findings and providers reporting performance may correct their currently reported baseline in the October DY4 reporting template to correct errors in data collection or adherence to measure specifications identified by MSLC. Baselines corrected through the October DY4 reporting template will be submitted to MSLC and reviewed for consistency with the final MSLC approved baseline. If the baseline submitted through the October DY4 reporting template does not align with the final baseline approved by MSLC, DY4 performance will also be reviewed by MSLC.

All reporting is subject to compliance monitoring. In cases where compliance monitoring determines that actual achievement is less than reported achievement, payments above actual achievement will be recouped. For example, if a provider reported 100% achievement of their DY4 goal and a compliance monitoring review determined that DY4 achievement was 75% of the DY4 goal, HHSC would recoup 25% of the funds associated with the DY4 achievement milestone. Recoupment due to corrected achievement will apply to P4P Achievement Milestones only. Providers who are subject to recoupment due to correction of DY4

achievement will be eligible to re-earn funds associated with DY4 achievement in their DY5 measurement period through carryforward of partial achievement. **Providers uncertain of their baseline are strongly encouraged to carry forward reporting of their DY4 performance.**

Providers who have received corrective action plans that include instruction to request approval from HHSC for a change to subset or measurement period, or to use modified measure specifications, and who intend to report DY4 performance in October DY4 reflecting these approvals should contact HHSC prior to October 23rd by sending an e-mail to the Waiver mailbox, if the change in subset or measurement period is not currently reflected in the October DY4 reporting template, or the provider has not received written confirmation of approval from HHSC.

If a provider is not reporting an outcome under review by MSLC for performance in October DY4 reporting, there is no need to correct the baseline through the reporting process. MSLC will share their findings with HHSC once the review process is completed, and any required changes will be made to the online reporting system at that time.

Stretch Activities and Population Focused Priority Measures

Providers with DY5 Population Focused Priority Measure milestones (AM-3.x) or Stretch Activity milestones (PM-11) will not provide any additional information or documentation in the October DY4 reporting period. PFP milestones are eligible to be reported beginning in April DY5, pending submission and review of baseline. Stretch Activity milestones are eligible to be reported in October DY5.

Supporting Documentation for Category 3 Milestones that appear in DY4 Reporting

Beyond the reporting template and signed certification page, most providers will not need to submit any additional documentation during the reporting period.

Providers should maintain internal records of the reports used to abstract the numerator and denominator to ensure that the same abstraction method is used across measurement periods, and should HHSC or the compliance monitor ask to see additional details.

Additional Resources

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

For details on measure specifications, providers should refer to the Category 3 Compendium their selected improvement target:
<http://www.hhsc.state.tx.us/1115-docs/Cat3-companion.pdf>

CATEGORY 4

Providers will report DY4 Category 4 Reporting Domains in October 2015 if not reported in April DY4. 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.

Category 4 has six Reporting Domains (RDs), and all RDs should be reported in a single DY4 Category 4 template. Responses to qualitative questions must be included for all applicable submitted RDs.

Save file as: *RHPXX_TPIXXXXXXXXX_Cat4_OctDY4 (RHP01_123456789_Cat4_OctDY4)*

- RDs 1, 2, & 3:
 - The Institute for Child Health Policy (IHP), 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 provided 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.
 - **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 were eligible to report RD-4, RD-5, and RD-6 in April 2015 only if their DY4 measurement period as determined by their DY3 measurement period ended no later than March 31, 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.
- 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.

Category 4 Template Instructions

Reporting Domains 1, 2, & 3:

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 reporting domain. 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*.

- Responses to qualitative questions must be included for all applicable submitted RDs. Example responses below may be brief statements that would need elaboration.
 1. **How does the currently documented number of [PPAs, PPRs, or PPCs] represent an increase or a decrease over the last reporting period? What factors have contributed to any increase or decrease?** (e.g., We had a 35% decrease in readmissions from last year and we feel this is due to an increase in patient navigator retention. Patients that were previously frequent readmits are now receiving disease management in outpatient clinics as a result of navigator services.)
 2. **How is this information used to inform any changes to your current processes and procedures?** (e.g., We use the data in our quarterly Quality Committee, where leadership from all departments attend as a means of increasing organizational data transparency, demonstrating interdisciplinary collaboration, and supporting discord for evidence-based patient care. As a result, leaders are able to disseminate the information to their staff and exchange feedback on processes and procedures. When necessary, those communications are fielded to the Quality department for collaboration in formal performance improvement.
 3. **How does this Medicaid only rate compare to [PPAs, PPRs, or PPCs] rates for your broader population?** (e.g., The Medicaid-only rate is higher than the Non-

Medicaid rate because most of the patients we serve are Medicaid; e.g. We are unable to compare due to system limitations; e.g. We estimate that the Medicaid-only rate is lower than the Non-Medicaid rate because our payer mix shows that we served more Non-Medicaid patients).

4. **Do you track PPA/PPC/PPR rates for your broader all-payer population? And if so, what trends are observed?** (e.g., Yes, it seems the [PPA/PPC/PPR] rates are higher for our Medicaid population because most of the patients we serve are Medicaid. The data collected by our quality department and lead patient navigator also seems to suggest the same as many readmissions and complications are Medicaid-derived. Like last year, top likely Medicaid-derived, DRGs were associated with conditions such as CHF, PNE, and COPD. We are hopeful that we can improve patient outcomes with our new outpatient clinic that focuses on internal medicine and the recruitment of a second interventional cardiologist).
5. **If PPAs/PPCs/PPRs are zero, is it because of a low Medicaid service volume, or processes/procedures in place that are effectively addressing potentially preventable events amongst all patient served in your facility?** (e.g., PPAs/PPCs/PPRs are zero/are low because we are a small provider and service a smaller population. When PPAs/PPCs/PPRs are increased during a particular quarter, we review cases with the appropriate performance improvement teams and take action as necessary).
6. **Describe any established processes/policies/procedures in place to identify and address PPAs/PPCs/PPRs in your facility.**

Responses of "NA" should include an explanation.

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](#)

October 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 ($\$2 \text{ million} * 1 = \2 million) + Milestone 2 ($\$2 \text{ 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

October DY4 Category 3 payments are based on performance reported in the *DY4 Category 3 Combined Baseline and Performance Reporting 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 April 2015 Needs More Information (NMI) milestones and metrics

In August 2015, HHSC completed review of April 2015 reporting submissions in response to HHSC requests for more information. Approved Needs More Information (NMI) milestones and metrics will be included in the January 2016 payment processing of October reports. NMI milestones and metrics that were not approved will no longer have access to the associated DSRIP funds.

IGT Processing

In December 2015, HHSC Rate Analysis will notify IGT Entities and Anchors of the IGT amounts by affiliation and IGT Entity by RHP for January 2016 payment processing of approved October reports. The IGT amounts for April 2015 approved NMI milestones and metrics, DY3 carry forward achievement, DY4 achievement, and any remaining 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 decreased the Monitoring IGT due for the associated IGT Entities. The difference was not redistributed among remaining IGT Entities.

HHSC requested 100 percent of the DY4 IGT monitoring amount with July 2015 payment processing of April reports. If the full DY4 IGT monitoring amount was 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 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 DY3 and DY4 approved DSRIP payments. If an IGT entity does not fully fund its DSRIP payments in January, the remaining IGT amount due for its affiliated projects' achievement may be transferred with July 2016 payment processing of April DY5 reports or for DY4 carried forward achievement, with DY5 payment processing.

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 FFY2016 and used for January 2016 DSRIP payment processing of October reports is 57.13. The FMAP of 57.13 will also be used for July 2016 DSRIP payment processing of April DY5 reports.

IGT Entity Changes

The IGT Entity(ies) and proportion of funding for each project/outcome are listed on the HHSC website on the [Tools and Guidelines for Regional Healthcare Partnership Participants](#) page under **October DY4 Reporting**. By November 6, 2015, HHSC will post the estimated IGT due for October reporting based on milestones and metrics reported as achieved to inform any needed IGT changes. Final IGT due will be based on HHSC review and approval. 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 **November 20, 2015, 5:00 p.m.** for April reporting DSRIP payment processing. Any changes received after November 20, 2015, will

go into effect for the April DY5 DSRIP reporting and payments will be delayed until that time. Note that IGT Entity changes submitted for October reporting will not impact the remaining 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. While the DSRIP online reporting system is secure, and access is limited to HHSC program auditors, protected health information (PHI) is not required by HHSC and should not be transmitted. 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. HHSC will remove the PHI-containing files as necessary, but requests that providers submit de-identified versions of the original documentation and description of corrective actions for auditing and recordkeeping purposes. 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 reasonable 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.