Changes to the Program Funding and Mechanics (PFM) Protocol for Demonstration Years (DY) 9-10
Summary of Stakeholder Feedback and HHSC Responses

On January 3, 2019, HHSC released the draft changes to the DSRIP Program Funding and Mechanics (PFM) Protocol for Demonstration Years (DY) 9-10 for stakeholder feedback. The PFM Protocol was updated to describe the methodology for Performing Providers' valuation reductions to account for the lower DY9-10 DSRIP pools, the RHP Plan Update for DY9-10 process, Performing Provider requirements to continue DY9-10 DSRIP participation, and changes to reporting requirements. HHSC hosted a webinar on January 10, 2019 to provide an overview of the DY9-10 PFM proposed changes and answer questions. Stakeholders submitted feedback through an online survey that closed on January 31, 2019.

This document summarizes the stakeholder feedback HHSC received through the forty-seven respondents to the survey. The DSRIP team reviewed stakeholder comments, grouped similar comments together, drafted responses, and determined PFM changes through multiple team meetings and a discussion with leadership. Changes made to the PFM Protocol as a result of stakeholder feedback and leadership direction are reflected in the updated PFM Protocol and are noted in the responses herein.

HHSC submitted the updated PFM Protocol to the Centers for Medicare & Medicaid Services (CMS) on March 31, 2019 for review and feedback. All DY9-10 requirements are subject to CMS approval and HHSC will continue to work with CMS to achieve timely approval. HHSC may further update the PFM Protocol based on changes and feedback on the Measure Bundle Protocol (MBP). The MBP is estimated to be shared for stakeholder feedback in June 2019. HHSC is targeting September 2019 for CMS approval of the DSRIP protocols.

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A. RHP Plan Update for DY9-10 (paragraph 11)

1. A stakeholder asked what the format and deadline is for the RHP Plan Update for DY9-10. Ten stakeholders requested that providers be able to indicate in the RHP Plan Update for DY9-10 that they are continuing as-is from DY7-8.

   HHSC Response: HHSC has not yet developed the templates for the RHP Plan Update for DY9-10, but HHSC expects to have provider templates and an Anchor template in Microsoft Excel, similar to the RHP Plan Updates for DY7-8. Data from DY7-8 will be pre-populated in the templates (including the most recent Core Activities, Medicaid and low-income or uninsured (MLIU) Patient Population by Provider (PPP), and Category C selections), and providers may make changes for DY9-10 if needed.

   The only new information required for DY9-10 is the estimated break out of Medicaid and low-income or uninsured individuals and dropdown responses to Related Strategies for each selected Measure Bundle.

   The target due date for the RHP Plan Update for DY9-10 is November 30, 2019, pending CMS approval of the DSRIP protocols.

2. A stakeholder asked if each provider needs to complete a community needs assessment.

   HHSC Response: No, each provider does not need to complete a community needs assessment. The community needs assessment was previously completed by the Anchor and may be updated in the RHP Plan Update for DY9-10 if needed.

Category B in RHP Plan Update for DY9-10

3. Several stakeholders requested clarification on how to calculate their DY9-10 estimates of their breakout of Medicaid and LIU individuals.

   HHSC Response: Providers will use their DY7-8 MLIU PPP historical data to forecast their DY9-10 Medicaid and LIU breakout numbers. Providers will enter and submit their DY7-8 MLIU numbers in the DY9-10 RHP Plan Update template.

4. Stakeholders asked for clarification of the Category B goal due to the addition of the Medicaid and LIU breakout numbers. Will the Category B goals still be based on the aggregate MLIU PPP goal, or will providers also be held to their Medicaid and LIU breakout estimates for DY9-10? Will additional funding be attached for the Medicaid and LIU breakout?

   HHSC Response: Achievement of Category B will continue to be based on the MLIU PPP numeric goal. Providers will be reporting the breakout of Medicaid and LIU individuals for informational purposes only and will not be held to their DY9-10 Medicaid and LIU breakout

estimates. No additional funding is attached to reporting the Medicaid and LIU breakout for Category B.

5. Stakeholders asked if HHSC will reconcile the Medicaid and LIU definitions between Category B and Category C, and if there will be additional guidance to providers who find themselves unable to differentiate Medicaid and LIU populations.

   HHSC Response: HHSC will reconcile the definition of Medicaid and LIU between Category B and Category C. The Category B definition of Medicaid, as defined in PFM paragraph 4.j.i, will now include individuals who are enrolled in CHIP. Additional guidance will be provided through an updated Category B FAQ document.

6. A stakeholder asked if new baseline data would need to be submitted during the DY9-10 RHP Plan Update and what the timeframe of submission would be.

   HHSC Response: Providers will not be required to reset baselines for Total and MLIU PPP during the RHP Plan Update process for DY9-10. Providers will continue to maintain their MLIU service levels using their MLIU PPP numeric goals that were established in the RHP Plan Update for DY7-8. However, if a provider has had a significant change to its system definition and needs to update its baseline(s), the provider can make adjustments during the RHP Plan Update process for DY9-10. The tentative submission date for the RHP Plan Update for DY9-10 is November 30, 2019.

Category C - Optional Addition or Discontinuation of Measure Bundles and Optional Discontinuation of Certain Non-clinical Measures

7. Eleven stakeholders advocated for partial Measure Bundle selection for hospitals and physician practices to accommodate a change in the DY9-10 minimum point threshold (MPT).

   HHSC Response: CMS has expressed strong opposition to optional measures within a Measure Bundle when similar proposals were made in past program negotiations. Additionally, the MBP states “Bundling measures… increases standardization of measures across the state for hospitals and physician practices with similar activities, facilitates the use of regional networks to identify best practices and share innovative ideas, and continues to build on the foundation set in the initial waiver period while providing additional opportunities for transforming the healthcare system and bending the cost curve.” Measure Bundles provide a framework for reporting, point valuation, and achievement valuation, without which it would be difficult to move forward into Performance Years. At this time, HHSC believes the DSRIP structure is well-established using a system dependent on Measure Bundling and would not advise dismantling that system in the final years of the program.

8. Ten stakeholders advocated for allowing certain providers to report non-clinical measures that can be discontinued as pay-for-reporting (P4R) instead of pay-for-performance (P4P) without a reduction in the valuation of the measure being reported (the achievement milestone valuation for a P4R measure is currently redistributed to other P4P measures in the bundle). This was often suggested as an alternative to partial Measure Bundle selection.

   HHSC Response: If providers have previously selected measures in DY7-8 that may be discontinued in DY9-10, they will be eligible to keep the achievement milestone payment if they choose to continue to report those measures as P4P. CMS has historically discouraged valuing P4R measures equally as P4P measures.

9. Many providers sought more information on the discontinuation/graduation of certain measures for hospitals and physician practices and how that will affect their retention or removal of different Measure Bundles. Particularly, providers want to have input regarding which measures are graduated and the ability to choose to drop graduated measures or maintain some kind of 'grandfathered' status.

   HHSC Response: Hospitals and physician practices will have the ***option*** to discontinue certain non-clinical DY7-8 measures indicated in the Measure Bundle Protocol (MBP). Providers may choose to continue all measures from DY7-8 in DY9-10.

   Choosing to discontinue those non-clinical measures ***will not*** impact the Measure Bundle's point value.

   This allows providers to increase the valuation of clinical outcomes after the aim of process-focused measures has been accomplished. Per the DY9-10 PFM Webinar released on January 10, 2019, factors that will be evaluated in proposing measures for discontinuation to CMS may include:
   1) consistently high baselines reported in DY7;
   2) consistently low volume for baselines reported in DY7; and
   3) measures with high rates of reported improvement in DY2-6.

   The MBP will define which measures can be discontinued. Providers can give input on the MBP changes and individual measures during the open comment period.

10. One stakeholder asked how Measure Bundle valuations will be impacted for Measure Bundles that include DY9-10 "graduated"/discontinued non-clinical measures.

    HHSC Response: Since Measure Bundle point values in DY9-10 will not be impacted by the discontinuation of certain non-clinical measures, HHSC does not expect Measure Bundle valuations to be impacted by the discontinuation of these measures.

11. One stakeholder asked if providers adding new Measure Bundles may opt out of reporting on the discontinued non-clinical measures.

HHSC Response: No, if a provider newly selects a Measure Bundle, then it must report on all required measures in the bundle. The reasoning behind the optional discontinuation of certain non-clinical measures is that they were process-type measures achieved in DY7-8 and the changes implemented in DY7 have been accomplished.

Category C - Related Strategies

12. About half of commenting stakeholders did not express any concerns or leave a comment about reporting on Related Strategies in the RHP Plan Update for DY9-10. However, several stakeholders wanted clarification about Related Strategies in the RHP Plan Update for DY9-10.

    HHSC Response: In the DY9-10 RHP Plan Update, providers will indicate the Related Strategies that were implemented in DY7-8 and planned for in DY9. A checklist of Related Strategies will be associated per Measure Bundle for hospitals and physician practices and per measure or group of measures for CMHCs and LHDs.

B. RHP Plan Update for DY9-10 Review and Approval Process (paragraph 13)

13. Five stakeholders requested that the RHP Plan Updates be approved prior to DY9 (October 1, 2019 - September 30, 2020), before PY3 (Calendar Year 2020), or before October reporting. Three stakeholders expressed general concern about providers completing the RHP Plan Updates during October 2019 reporting. One stakeholder requested a longer submission window from the current 60 days due to the overlap with October 2019 reporting. Another stakeholder requested more time to complete measure selections.

    HHSC Response: HHSC is targeting September 30, 2019 for CMS approval of the DSRIP protocols. CMS has indicated they will aim to approve the protocols by this date; however, they are unable to guarantee the timing. If CMS approval is delayed, the timeline for RHP Plan Updates for DY9-10 will be subsequently delayed. RHP Plan Update templates may not be released or submitted prior to CMS approval of the protocols.

    Time is also required for providers and Anchors to complete the templates and HHSC to review and provide feedback on submissions.

    October 2019 reporting is expected to be lighter than April 2019 reporting. The majority of providers will likely report PY1 achievement and Category D in April 2019 while October 2019 reporting will be focused on Category A, Category B, and any remaining PY1 achievement that was not ready to report in April.

    Given some stakeholder requests to approve before DY9 or PY3 begins and other stakeholder requests for more time to complete the templates, and the unpredictable timing of CMS approval, HHSC has determined the estimated RHP Plan Update timeline with final approval targeted by February 28, 2020.

14. Three stakeholders expressed concern regarding the regional steps and due dates, particularly for providers withdrawing from DSRIP, prior to the RHP Plan Update for DY9-10 submission to HHSC.

    HHSC Response: RHPs may set internal timelines for providers to submit continued or discontinued participation in DSRIP in DY9-10. HHSC has not determined the format of the RHP Plan Update templates; however, HHSC expects that the templates will allow for an initial step whereby a provider indicates if it is continuing to participate in DSRIP in DY9-10 or withdrawing and whether the provider will accept additional funding. Providers will submit their responses to the Anchors for compilation in the Anchor template, the Anchor template will calculate additional funds (if any) and updated MPTs, and the providers will complete the remaining provider templates for Categories A-D.

    Anchors may also determine regional deadlines for providers to submit completed templates for their review prior to HHSC submission.

15. A stakeholder requested that webinars be allowed for the public meeting requirement prior to submitting the RHP Plan Update for DY9-10.

    HHSC Response: HHSC prefers in-person meetings for the public meeting requirement; however, any group meeting such as a webinar or conference call wherein stakeholders may ask questions and provide feedback is acceptable. Anchors should also accept questions and feedback on the RHP Plan Update through email if using a webinar or conference call. Individual calls to stakeholders would not meet the requirement.

C. RHP Plan Update Modification Process (paragraph 14)

16. A stakeholder requested clarification on the deadlines for plan modifications and how these requests may be submitted.

    HHSC Response: For DY9-10, providers must submit plan modification requests for Category B or Category C at least 30 days prior to the start of the semi-annual reporting period. This means that for adjustments that impact the April reporting period, the deadline is March 2nd, and for the October reporting period, the deadline is September 1st. Plan modification requests may be submitted using a plan modification form (if available) or emailing the request to HHSC at TXHealthcareTransformation@hhsc.state.tx.us. Forms and other resources can be found on the DSRIP Online Reporting System's Bulletin Board.

D. Provider Valuation for DY9-10 (paragraph 16)

17. The majority of stakeholders supported the proportional valuation reduction for providers with a DY8 valuation greater than $1 million or did not provide comments on the proposal. However, nine stakeholders requested that all providers have their valuations reduced

regardless of their DY8 valuation. One stakeholder requested that its rural RHP not be subject to any valuation reductions. One stakeholder proposed that the valuation reduction be tiered based on DY8 valuation given that providers with lower valuations are more impacted by the reduction than providers with higher valuations. One stakeholder preferred a valuation reduction based on the percentage of Medicaid and low-income or uninsured (MLIU) individuals served.

HHSC Response: HHSC values the stability of the rural healthcare safety net that tends to include DSRIP providers with a DY8 valuation of less than $1 million. To lower the chances of these providers withdrawing, their valuations are not reduced for DY9-10. Given that these providers represent less than 1.5% of the DY8 total valuation, there is minimal impact to other providers. A proportional reduction across all providers with a DY8 valuation above $1 million is more straightforward than creating tiers of valuation reduction or targeting specific RHPs.

HHSC considered reducing provider valuation based on a provider's percentage of MLIU served; however, such a methodology may cause considerable disruption for providers when there are only two remaining years of DSRIP and most providers expected a proportional reduction.

18. One stakeholder asked if the draft provider DY9-10 valuations posted already accounted for providers with less than $1 million not receiving a valuation reduction.

    HHSC Response: Yes, the posted valuations include valuation reductions for providers with a DY8 valuation greater than $1 million and no reductions for providers with a DY8 valuation less than $1 million.

19. One stakeholder asked what happens to DSRIP funds that are not achieved by the end of the carryforward measurement periods.

    HHSC Response: The final opportunity to earn DY10 payments is during DY12 April 2023 reporting with payments in July 2023. Given the late timing of determining unearned DSRIP funds and that payments may only be paid out within two demonstration years after the end of a demonstration year (e.g. DY10 may only be paid as late as the end of DY12 - September 30, 2023), HHSC currently has no plans to distribute remaining DSRIP funds.

Funding from Withdrawn Providers

20. The majority of stakeholders supported the proportional redistribution of funding from withdrawn providers or did not submit comments on the proposal. Three stakeholders requested that providers be able to refuse additional funding. One stakeholder requested that if a provider receives additional funding, then its MPT should not increase above its DY7-8 MPT. One stakeholder wanted clarification on whether there would be a cap on increasing valuation.

HHSC Response: Providers will be able to choose whether to accept the additional funding from withdrawn providers in the RHP Plan Update for DY9-10. If providers refuse the additional funding, then the funding may be redistributed to other providers in the RHP in the RHP Plan Update for DY9-10.

If a provider accepts the additional funding, then its DY9-10 MPT will be recalculated. Providers may refuse additional funding if it increases their DY9-10 MPT beyond their DY7-8 MPT.

There is no cap on the amount of additional funding a provider may receive from withdrawn providers.

21. One stakeholder requested that the redistribution of funding from withdrawn providers be based on meeting metrics rather than a proportional redistribution.

HHSC Response: Providers will still be reporting on DY7 Category C milestones in October 2019 which overlaps with the completion of the RHP Plan Update for DY9-10. In addition, providers may carryforward DY7 Category C achievement milestones to report in April 2020. Category B and C milestones are eligible for partial achievement which may have different interpretations of being met. Due to the difficulty of defining which metrics have been met and the timing of reporting with the RHP Plan Update for DY9-10, HHSC is unable to redistribute these funds based on metric achievement.

22. Five stakeholders requested clarification on how a proportional redistribution would impact providers and whether all Categories would have additional funding.

HHSC Response: The withdrawn providers' valuation would be proportionately distributed among the remaining providers in the RHP based on their share of DY8 valuation in the RHP. The provider's total valuation would be increased so the additional funds would be distributed among the Categories as indicated in PFM paragraph 16.c.

Example:
There are seven providers in one RHP. Provider 6 withdraws.

A provider's percentage of DY8 RHP Valuation is calculated as the provider's DY8 Valuation ÷ (total RHP's DY8 valuation of $39,183,000 - Provider 6's DY8 valuation of $3,792,000).

Provider 1 "% of DY8 Valuation" = $5,809,000 / ($39,183,000 - $3,792,000) = 16.41%

The updated DY9-10 valuations are based on the provider's initial DY9-10 valuations added to the percentage of DY8 RHP Valuation multiplied by Provider 6's DY9 and DY10 valuations.

Provider 1 "Updated DY9 Valuation" = $5,463,000 + (16.41% * 3,566,000) = $6,048,315

Provider 1 "Updated DY10 Valuation" = $4,660,000 + (16.41% * 3,042,000) = $5,159,307

	DY8 Valuation	Initial DY9 Valuation	Initial DY10 Valuation	% of DY8 RHP Valuation	Updated DY9 Valuation	Updated DY10 Valuation
Provider 1	$5,809,000	$5,463,000	$4,660,000	16.41%	$6,048,315	$5,159,307
Provider 2	$3,123,000	$2,937,000	$2,505,000	8.82%	$3,251,674	$2,773,435
Provider 3	$12,155,000	$11,431,000	$9,751,000	34.34%	$12,655,739	$10,795,772
Provider 4	$12,131,000	$11,407,000	$9,731,000	34.28%	$12,629,321	$10,773,709
Provider 5	$1,560,000	$1,467,000	$1,251,000	4.41%	$1,624,186	$1,385,088
Provider 6	$3,792,000	$3,566,000	$3,042,000	NA	NA	NA
Provider 7	$613,000	$613,000	$613,000	**1.73%**	**$674,766**	**$665,690**
	$39,183,000	**$36,884,000**	**$31,553,000**		**$36,884,000**	**$31,553,000**

DSRIP Category Valuation

23. Most stakeholders agreed with or did not have comments on the DY9-10 DSRIP funding across Categories. There were 13 stakeholders that requested a **portion of DY9 valuation be applied for RHP Plan Update submission**. Stakeholders suggested a range of 1-20% of total DY9 valuation for the RHP Plan Update submission. Some stakeholders were concerned that there may be a delay in CMS approval of the protocols that may impact April DY9 reporting and payments while others noted that the RHP Plan Update requires a substantial amount of effort.

    HHSC Response: The only new information required for the RHP Plan Update for DY9-10 is the estimated break out of Medicaid and low-income or uninsured individuals and Yes/No responses to Related Strategies for each selected Measure Bundle. Providers may make changes for DY9-10 if needed, otherwise data from DY7-8 will be pre-populated for continuation in DY9-10. The level of effort to complete the RHP Plan Update for DY9-10 should be less than what was required for the RHP Plan Update for DY7-8.

    The DY7-8 payment for RHP Plan Update submission was included due to the major changes from DY2-6 to DY7-8 and the CMS delay in approving the DSRIP Protocols. The proposed DY9-10 requirements build upon and are similar to DY7-8. HHSC is targeting September 30, 2019 for CMS approval of the DSRIP protocols. CMS has indicated they will aim to approve the protocols by this date; however, they are unable to guarantee the timing. If CMS approval is not obtained by mid-November 2019, then HHSC will negotiate with CMS on potential changes to the PFM.

24. Seven stakeholders requested that **Category A be allocated a valuation**. Three stakeholders mentioned 5 percent while one requested 20 percent of a provider's total valuation for Category A. Two stakeholders proposed that the Category A valuation be limited to DSRIP providers that serve as IGT Entities for other DSRIP providers or provide another incentive to continue providing IGT for other DSRIP providers.

HHSC Response: Although Category A requires reporting on Core Activities, alternative payment models, costs and savings, and collaborative activities, Category A is focused on reporting activities and allowing changes as determined by the provider rather than requiring demonstrated improvement in the activities. Category A will remain as required reporting to be eligible for any payments in Categories B-D. This maintains the focus on measure reporting and achievement.

Less than a quarter of the over 200 DSRIP IGT Entities are DSRIP providers providing IGT for other DSRIP providers. To ensure fairness, there cannot be different valuations across Categories for different DSRIP providers.

E. Category A - Costs and Savings (paragraph 17.c.)

25. Multiple stakeholders requested clarification or expressed concern about the draft PFM language requiring that "the Core Activity selected for DY9-10 must be different from the Core Activity selected for DY7-8."
    a. Two providers are seeking clarification on the draft PFM requirement that "the Core Activity selected for DY9-10 must be different from the Core Activity selected for DY7-8," and two providers recommended removing this requirement.
    b. One Provider believes that it would be premature to abandon analysis of a Core Activity that has recently been implemented in order to select a different Core Activity for analysis, and one stakeholder stated that the delays in finalizing the DY7-8 protocols did not provide sufficient time to evaluate the effectiveness of the existing Core Activities.
    c. One stakeholder suggested that providers be allowed to do a Cost and Savings analysis on one of the related strategies associated with Measure Bundles.

HHSC Response: HHSC asked for comments on the following draft PFM language: "The Core Activity selected for DY9-10 must be different from the Core Activity selected for DY7-8, or if a Performing Provider has only one Core Activity in DY7-10, then the Performing Provider must analyze different aspects of the Core Activity, must analyze different time periods for DY7-8 and DY9-10, or must analyze the same aspects of the Core Activity for the same time period in order to compare the costs and the forecasted savings to the costs and the generated savings."

Based on providers feedback, HHSC will edit the draft PFM language to read as follows: "Performing Providers must analyze a different Core Activity for the Costs and Savings analysis in DY9-10 than was used for the Costs and Savings analysis in DY7-8, or Performing Providers must analyze a different aspect of the same Core Activity for the Costs and Savings analysis in DY9-10 than was used for the Costs and Savings analysis in DY7-8." This will allow providers with broad Core Activities to continue analysis of different aspects without adding new Core Activities.

Providers may incorporate a Related Strategy into a Core Activity or as a new Core Activity that is used for the Costs and Savings analysis.

HHSC encourages providers to continue analyzing the costs and savings of quality initiatives regardless of DSRIP requirements. Providers will not submit their first Cost and Savings analysis for the DY7-8 PFM requirements until October of 2019, and the Costs and Savings analysis for the DY9-10 draft PFM requirements will be due in October of 2021.

26. One provider stated that adding the Costs and Savings analysis requirement after the fact leads to more work for smaller providers and the results of the analysis are something that is limited in scope and sample size, which has limited use to HHSC, CMS, or regional providers.

    HHSC Response: For the Costs and Savings analysis, providers should, at a minimum, include costs and savings specific to their organization and other contracted providers if that information is available and related to the intervention being examined. Providers are not required, but are encouraged to include costs and/or savings outside of their organization. In this sense, the Costs and Savings guidance is flexible by allowing providers to scale the scope of the analysis so that the analysis is beneficial to providers outside of DSRIP. For example, in addition to using the Costs and Savings analysis for DSRIP reporting requirements, providers can also use this analysis as a case study of quality improvement projects for upper management, in working with MCOs to establish an APM, as a justification for sustaining quality initiative post-DSRIP, as a means to analyze lessons learned, etc. HHSC also hopes that this analysis will assist providers in deciding which initiatives to continue in their current form and which initiatives to further refine.

    The Costs and Savings analysis portion of Category A has been a PFM requirement since DY7 and is not a new requirement in DY9-10. The requirement to perform the analysis again in DY9-10 allows providers to analyze the cost effectiveness of multiple quality initiatives. Furthermore, only providers who have a total valuation of one million dollars or more per DY are required to submit the Costs and Savings analysis. The Cost and Savings analysis can be used by the State and CMS in evaluating successful DSRIP initiatives. HHSC has also received questions from State leadership regarding the cost effectiveness of quality initiatives.

27. One stakeholder stated that the recommended tools for the Costs and Savings analysis are built for managed care providers and are not useful to other providers; some providers do not end up with a tool that demonstrates or matches the reality of their world.

    HHSC Response: Providers are allowed to request an alternative tool to complete their analysis per the Costs and Savings guidance document. This was allowed in DY7-8 and will continue to be allowed in DY9-10. The Cost and Savings analysis allows providers to analyze the costs and savings of a quality initiative(s) for a target population. The Costs and Savings analysis should not be limited to only Medicaid clients, unless the target population for the

analysis is comprised of only Medicaid clients as indicated in one of the provider's Core Activities. Providers only have to complete the recommended tools or an approved alternative tool with data relevant to the intervention being examined. Based on the scope of the provider's analysis, the provider might not need to use all data points requested in one of the recommended tools or an approved alternative tool. Providers should, at a minimum, use cost data from their entity and any contracted providers, if that information is available and relevant to the initiative being examined.

28. Multiple providers requested clarification on the expectations for the Costs and Savings analysis on DY9-10. Three providers wanted clarification if there will be the same expectation for the Costs and Savings analysis in DY9-10 as there are for the Costs and Savings analysis in DY7-8. One provider also asked if HHSC will propose the same recommended tools to complete the analysis in DY9-10.

    HHSC Response: HHSC will have the same expectation for the Costs and Savings analysis in DY9-10 as it did for the Costs and Savings analysis in DY7-8 with minimal updates needed due to changes in the DY9-10 PFM requirements. HHSC may also add questions to the narrative template for DY9-10. Providers will give an update in October DY9 and the analysis and narrative will be due in DY10. HHSC will propose the same recommended tools to complete the analysis in DY9-10, and providers will have the option to request to use alternative tools.

29. One stakeholder requested that HHSC host webinars on the Costs and Savings analysis.

    HHSC Response: HHSC will consider hosting a webinar or providing additional guidance for the Costs and Savings analysis. In addition, both of HHSC's recommended tools for the Costs and Savings analysis have corresponding user guides, which are available online. Providers are also encouraged to collaborate with other providers in their region and/or at events such as learning collaboratives.

F. Other Category A Comments

30. Eleven stakeholders suggested that HHSC establish a new category of incentives for providers to work on value-based purchasing arrangements and alternative payment methodology arrangements with MCOs.

    HHSC Response: Overall, the valuation distribution across different Categories will be similar to DY7-8 with Category A remaining at 0 percent (see response #24). Providers will continue reporting in October of each year on the progress made with alternative payment methodologies (APM). During transition planning in DY9-10, HHSC staff will research the issues leading to barriers for APM arrangements. DSRIP staff will coordinate its research and planning efforts with other HHSC departments to determine how providers, including rural providers, can overcome these barriers.

G. Category B - breakout of MLIU (paragraph 18.b. and d.)

31. A stakeholder suggested that HHSC should enforce a MLIU percentage goal to encourage DSRIP providers to increase the pool of MLIU patients served by their system in order to continue receiving DSRIP funds.

    HHSC Response: HHSC has previously considered MLIU percentage goals. However, a MLIU numeric goal is more consistent. A percentage goal has the potential to reduce a provider's MLIU PPP numeric goal if the provider saw a decrease in Total PPP when the provider should be maintaining or expanding its MLIU population. A provider's MLIU percentage is also taken into consideration in other ways, such as in the calculation of MLIU PPP's allowable variation.

    As far as increasing the MLIU PPP numeric goal by a certain percentage over the course of DY7-10, HHSC does not want to dictate what a provider's patient population should be if the provider acquires new or additional system components. Those are business decisions that should be left to the provider and can be dependent on many other external factors. DY7-10 waiver activities are not intended to fund infrastructure development and measure increased capacity, like some of the projects that were completed during DY2-6.

    It is also important to note that if a provider wants to increase its goal due to a significant change in its system definition or in its patient population, the provider has the option of making this request through a Category B Plan Modification.

32. A few stakeholders requested the purpose of reporting separate Medicaid and LIU PPP numbers for Category B.

    HHSC Response: HHSC is requiring providers to report separate Medicaid and LIU PPP numbers to help inform DSRIP transition activities and other Medicaid waiver initiatives, and for other requests for information (agency, stakeholder, legislative, etc.).

H. Category C - Requirements for Hospitals and Physician Practices (paragraph 19)

33. Three stakeholders proposed maintaining a valuation threshold for hospitals and physician practices of greater than $2,500,000 per DY in DY7-8 or greater than $2,500,000 per DY in DY9-10 for the Measure Bundle requirement related to 3-point measures.

    HHSC Response: HHSC aims to minimize changes in requirements for providers from DY7-8 to DY9-10. Based on the proportional reduction in valuation across providers in DY9-10, the requirement related to 3-point measures was intended for hospitals and physician practices with a valuation greater than $2,000,000 in DY10 *only* rather than DY9-10. Barring any provider withdrawals and associated valuation redistribution among providers in the RHP, which may impact a provider's valuation in DY9-10, HHSC expects only one provider to be impacted by this requirement in DY9-10. The impact is expected to be minimal since this

provider has already met the requirement by selecting a Measure Bundle with one required 3-point measure in DY7-8. HHSC will also change the requirement to greater than $2,000,000 in DY10 only for CMHCs and LHDs; however, it does not have any impact on these providers.

34. Two stakeholders wanted clarification about the definition of "significant volume" for the Measure Bundle requirement for hospitals and physician practices related to 3-point measures.

    HHSC Response: The definition of "significant volume" will be included in the DY9-10 Measure Bundle Protocol (MBP), which will be available for stakeholder feedback in June 2019. HHSC does not intend to change the definition of "significant volume" as described in paragraph 4.a.i. of the DY7-8 MBP; "significant volume" is defined, for most outcome measures, as an MLIU denominator for the measurement period that is greater than or equal to 30, unless an exception has been granted by HHSC to use an all-payer denominator as defined in the PFM.

35. One stakeholder proposed requiring only one population-based clinical measure as P4P for hospitals and physician practices with an MPT of 75 in DY9-10.

    HHSC Response: CMS strongly encourages demonstrated progress towards reporting measures as pay-for-performance (P4P). Furthermore, since all 15 hospitals and physician practices with an MPT of 75 in DY7-8 reported at least two population-based clinical outcomes as P4P and since no new providers will have an MPT of 75 in DY9-10, HHSC will maintain the requirement of hospitals and physician practices with an MPT of 75 to report at least two population-based clinical outcomes as P4P in DY9-10.

36. One stakeholder suggested decreasing the MPT threshold in order to include more hospitals, particularly large, private, and urban hospitals, in the Measure Bundle requirement for hospitals and physician practices related to reporting at least two population-based clinical measures as P4P.

    HHSC Response: Hospitals and physician practices that do not have an MPT of 75 in DY9-10 may still report population-based clinical outcomes as P4P and are, in fact, highly encouraged by CMS and HHSC to do so. However, HHSC is not considering decreasing the MPT threshold for this requirement in DY9-10 since the MPT alone does not necessarily correspond to a hospital's size, urban location, or status as a private or public entity.

37. Seven stakeholders proposed HHSC allow modification requests for DY9-10 Measure Bundle valuations, specifically suggesting there be a set maximum valuation percentage with a compelling justification.

    HHSC Response: CMS strongly encourages predetermined Measure Bundle valuations that allow for performance-based funding to be distributed within a bundle proportionately

across all required measures. Furthermore, in consideration of the proportional reduction in valuation across all providers with a DY8 valuation greater than $1 million in DY9-10 and in order to promote standardization, HHSC will maintain the same Measure Bundle valuation methodology from DY7-8 into DY9-10 without allowing Measure Bundle valuation modification requests in DY9-10. Only a few hospitals and physician practices will be impacted by maintaining the Measure Bundle valuation methodology without allowing Measure Bundle valuation modification requests.

38. One stakeholder wanted clarification about the minimum and maximum valuations per Measure Bundle.

    HHSC Response: HHSC does not intend to change the DY9-10 Measure Bundle valuation methodology from that described in paragraph 19.p. of the PFM. Paragraph 19.o. includes the minimum and maximum Measure Bundle valuations with example calculations that applied to DY7-8.

I. Category C - Requirements for Community Mental Health Centers (CMHCs) and Local Health Departments (LHDs) (paragraph 20)

39. One stakeholder requested that CMHC/LHD valuation be tied to a measure's point value so that 3-point measures are more highly valued.

    HHSC Response: HHSC intends to maintain consistent and equal valuation across measures for DY9-10. HHSC believes that this promotes standardization across providers and reduces the amount of payment at risk depending on a provider's ability to achieve.

40. Four CMHCs/LHDs requested additional 3-point measure options from other menus.

    HHSC Response: Providers will have the opportunity to comment on measures for CMHCs and LHDs as part of the MBP feedback. HHSC will consider adding certain CMHC measures to the menu for LHDs.

J. Category C - Reporting Related Strategies

41. More than half of commenting stakeholders did not address reporting on Related Strategies in DY9-10 Category C reporting milestones. Several stakeholders wanted clarification about Related Strategies reporting.
    a. Points of clarification included the development and format of the Related Strategies reporting checklists, whether there would be flexibility to change Related Strategies selections over time, and if HHSC will be sharing the data on Related Strategies with providers.
    b. Some stakeholders expressed concerns about potential reporting duplication between Category C Related Strategies and Category A Core Activities and the additional reporting burden on rural and/or small volume providers.

c. Ten stakeholders recommended Related Strategies reporting be moved from Category C to Category A.

HHSC Response: As part of DY9-10 Category C reporting milestones, providers will indicate the Related Strategies that were implemented during the associated performance year and planned for in the following performance year. A checklist of Related Strategies will be associated per Measure Bundle for hospitals and physician practices and per measure or group of measures for CMHCs and LHDs. Examples of Related Strategies checklists will be included in the MBP, which will be available for stakeholder feedback.

Related Strategies represent the strategies across providers that may be linked to higher Category C achievement and may inform planning for DY11 onward. HHSC will analyze Core Activities (Category A) to inform the development of the Related Strategies checklists (Category C), but reporting on Related Strategies will be distinct from reporting on Core Activities. Related Strategies are intended to capture the delivery system changes that a provider has made, even apart from DSRIP, which may not be included in Core Activities reporting.

Since a checklist of Related Strategies will be associated per Category C Measure Bundle for hospitals and physician practices and per measure or group of measures for CMHCs and LHDs, HHSC will not be moving Related Strategies reporting from Category C to Category A in DY9-10. HHSC does not consider this as duplicative reporting, since providers submit detailed updates under Category A. Moving reporting on Related Strategies to Category A would increase the amount of details required for Related Strategies reporting.

Since there will not be a qualitative reporting component for Related Strategies, HHSC does not expect Related Strategies reporting to disproportionately increase administrative burden on providers. However, pending CMS approval, HHSC has increased the Category C reporting milestone valuation from the proposed 25% to 33% of a P4P measure's total valuation in DY9-10 to acknowledge the effort of reporting Related Strategies.

HHSC will be able to share data collected on Related Strategies with providers.

K. Category C - Goal and Achievement Calculations

42. Some respondents indicated that the proposed goals are too high for measures continuing in DY9-10. Ten respondents requested that goals for DY9-10 be set as equal to the DY8 goal for continuing measures. One respondent requested lower goals for DY9-10 as compared to DY7-8 goals and to eliminate the use of national benchmarks so that goals for all measures are determined as an improvement over self. One provider requested benchmarks be removed for measure D1-237 Well Child Visits in the in the first 15 months of life and goals be set using the IOS methodology. Two respondents indicated that goals generally are too difficult. One respondent indicated that measures are subject to influencing factors that are outside of the provider's control. Five respondents agreed with the proposed goals, and 19

respondents had no comments.

HHSC Response: HHSC declines to lower the goals proposed for Category C measures in DY9-10. The proposed PFM maintains the allowance for partial payment if a goal is partially achieved, and carryforward of achievement if a goal is not met in its first associated performance year. HHSC acknowledges the difficulty some providers may face in fully achieving all goals for their selected measures and does not expect the incentive payment for Category C achievement to be fully earned. The goals proposed for DY10 are equal to the goals approved for DY6 of the program. In DY2-6 of the demonstration, 79% of pay-for-performance measures reported full achievement of their DY6 milestones, and 5% reported partial achievement. Non-standalone measures, which are typically process-type measures, reported higher levels of full achievement than standalone measures, which are typically clinical measures. Eight-four percent of non-standalone measures and 77% of standalone measures reported full achievement. HHSC will continue to monitor performance year data to identify any needs to request potential changes to proposed goals for certain measures. While providers are encouraged to continue demonstrating improvement of their currently-selected Measure Bundles, the proposed PFM allows hospitals and physician practices to select different Measure Bundles, and allows CMHCs and LHDs to select new measures for DY9-10.

43. Some respondents requested a provision for earning payment for measures that are high performing at baseline that have a small decrease in their performance years. Five respondents requested payments for maintenance of high performance. One provider suggested two methods of achieving goals for measures with a high performing baseline (both an IOS goal and a maintenance of a benchmark goal), similar to the QIPP program.

    HHSC Response: HHSC has modified the PFM to request from CMS an allowance for partial payment for providers with high performing baselines that demonstrate statistically significant maintenance of high performance.

44. One respondent requested that for measures with a very low baseline, goals for DY9 and DY10 be based of something other than the reported baseline.

    HHSC Response: HHSC has considered using internally-developed benchmarks for certain process measures without a national benchmark, but has not opted to use this methodology due to a lack of immediate validation and the frequency of corrections to previously reported data. HHSC will continue to work with providers that have baselines that are very low due to late implementation of measurement processes to identify allowable resolutions (approximate baseline specifications, delayed baselines) that result in meaningful performance year goals.

45. One respondent requested benchmarks for measures within the D3 pediatric hospital safety bundle.

HHSC Response: Providers will be able to make comments on the MBP at a later date. Currently, no benchmarks are known to HHSC for the measures within the D3 bundle. As few providers are reporting the D3 measures, and data are reported by provider self-report without a timely external validation, using DSRIP-specific benchmarks would be challenging. HHSC has modified the PFM to request from CMS an allowance for partial payment for providers with high performing baselines that demonstrate statistically significant maintenance of high performance.

46. Two respondents indicated that the improvement floor goal in the draft PFM is identical in DY9 and DY10.

    HHSC Response: HHSC will amend the DY9 improvement floor goal so that it is set as a 9% difference between the High Performance Level (HPL) and the Minimum Performance Level (MPL).

47. One provider requested clarification on the impact to reporting milestone payment if a provider does not achieve its goal.

    HHSC Response: Reporting milestones are not impacted by goal achievement. Providers will be eligible to earn reporting milestones by submitting the associated data year reporting and completing the related qualitative reporting and Related Strategies reporting.

L. Category C - Other Comments

48. Multiple stakeholders provided comments that were related to the MBP. One provider requested allowing providers to suggest measures from a list of approved measure stewards. Two providers expressed concern with denominator exclusions for the measure L1-347 Latent Tuberculosis Infection (LTBI) treatment rate. One provider requested that the value sets for PQIs and PDIs be updated. One provider recommended eliminating measures that may be duplicative in nature.

    HHSC Response: Providers will be able to make comments on the MBP at a later date. HHSC does not intend to propose significant changes to the MBP or the currently approved measures for DY7-8.

49. One provider requested that the all-payer population be reported and used for goal setting and achievement calculations.

    HHSC Response: Providers report all-payer data for most measures in DY7-8, and will continue to report all-payer data for most measures in DY9-10 as outlined in the MBP. Achievement goals are determined for most measures based on the MLIU population, which is the target population of the DSRIP program.

50. One provider requested clarification about Minimum Point Thresholds (MPTs) and how they are calculated.

HHSC Response: Paragraphs 17.r.,17.s., and 18.l. (pgs. 17-19, 20-21) of the current PFM Protocol (dated 6/1/18 https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/AttachmentJ-PFM-DY7-8-05.21.18.pdf) outline the calculations that determine the MPT for each provider type. MPTs are also posted to the waiver website under Waiver Renewal https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/draft-provider-dy9-10-valuations-mpts.xlsx.

51. One provider expressed concern whether it would be able to maintain its limited scope of practice status into DY10.

HHSC Response: Yes, providers approved for a limited scope of practice in DY7-8 will be able to maintain their limited scope of practice designation in DY9-10.

M. Category D Reporting

52. One provider requested clarification regarding the structure of Category D reporting to determine if it remains similar to DY7-8 reporting or if there will be any adjustments to Category D reporting.

HHSC Response: The overall Category D reporting structure will be similar to DY8-9. HHSC may adjust certain questions as needed, but the overall reporting approach will remain the same. HHSC is not planning to change Category D measures to pay-for-performance.

53. Many providers requested that HHSC provide data that can be used to complete Category D reporting and allow providers to report what they can for Category D in April of 2020, regardless of the approval status of the RHP Plan Updates.

HHSC Response: HHSC currently does not anticipate delays in providing data for Category D reporting. However, HHSC cannot guarantee that providers will be able to report prior to the RHP Plan Update approval. HHSC is targeting RHP Plan Update approval prior to April reporting.

N. Private Hospital Participation Incentive

54. The majority of commenting stakeholders (40) did not provide ideas to encourage continued private hospital participation in DY9-10. Seven stakeholders proposed setting a minimum private hospital participation threshold for each RHP based on the level of private hospital participation in DY7-8. If an RHP does not meet the private hospital participation threshold, either the DSRIP valuations for withdrawing providers would be proportionately redistributed to all remaining RHPs meeting the private hospital participation threshold or

the providers in the RHP would not be eligible for 15-20% of their valuation for submission of the RHP Plan Update for DY9-10, with the valuation being placed in Category C.

HHSC Response: Redistributing withdrawn funds among RHPs that meet a private hospital participation threshold may delay RHP Plan Update submission and require multiple rounds of redistributing funds, especially if providers opt out of increasing their valuation. Several stakeholders have expressed concerns about delays in RHP Plan Update approvals and an uncertain MPT if there are multiple changes in valuation. Stakeholders argue that redistributing funds for withdrawn providers encourages IGT Entities to discontinue providing IGT for private hospitals. However, of the nearly 80 IGT Entities that currently fund DY8 private hospitals, less than half are DSRIP Performing Providers.

The only new information required for the RHP Plan Update for DY9-10 is the estimated break out of Medicaid and low-income or uninsured individuals and Yes/No responses to Related Strategies for each selected Measure Bundle. Providers may make changes for DY9-10 if needed, otherwise data from DY7-8 will be pre-populated for continuation in DY9-10. The level of effort to complete the RHP Plan Update for DY9-10 should be less than what was required for the RHP Plan Update for DY7-8. The RHP Plan Update payment for DY7-8 was due to the major changes from DY2-6 to DY7-8 and delay in CMS approval of the DSRIP protocols. The proposed DY9-10 requirements build upon and are similar to DY7-8. HHSC is targeting CMS approval by September 30, 2019, and CMS has agreed that it will aim for timely approval. HHSC does not plan to provide payment for RHP Plan Update submission.

There are 134 private hospitals participating in DY8, so seven stakeholders represent just 5 percent of private hospitals. Given that the majority of stakeholders did not provide feedback on this issue and the challenges noted above, HHSC is unable to implement a private hospital incentive as proposed by stakeholders.

O. Other General Comments

55. Many stakeholders sought more information about the MBP for DY9-10, what changes will be proposed, and when it would be available for comment.

HHSC Response: HHSC plans to release a draft of the updated MBP for DY9-10 in late spring (late May/June 2019) which will be open for review and public comment thereafter (June/July 2019). The updated MBP will reflect all changes to individual measures, Measure Bundle inclusions, and measure menus by provider type. HHSC plans to review data from the April reporting period to inform any changes; accordingly, the timeline for releasing the updated MBP unfortunately cannot be pushed to an earlier date.

56. Several providers wanted to know the status of and timelines for compliance monitoring since it will impact their workload and impact activities in other Categories, including Category A.

HHSC Response: Providers should expect continuation of compliance monitoring during DY9 and 10. HHSC will inform providers when monitoring services will resume once the procurement process is completed.