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Health and Human
Services Commission

Executive Waiver Committee

October 3, 2013

10:00 a.m. – 12:00 p.m.

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Waiver Updates

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Discussion Items

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October 3, 2013

Use of IGT for Monitoring – Revised Proposed Rule

- When HHSC proposed the original rule in June, many IGT entities and DSRIP providers requested that the monitoring funds be allowed to be on top of the 100% DSRIP payment. CMS has agreed to this.
- A waiver amendment was approved by CMS as of September 6, 2013, that notes in the PFM Protocol that IGT may be used for the non-federal share of the waiver monitoring contract(s).
- HHSC also is changing the maximum total IGT amount for monitoring from $10 million/year to $5 million/year.

Use of IGT for Monitoring – Revised Proposed Rule, continued

- HHSC will withdraw and re-propose the monitoring rule to reflect these changes and to include more details about how HHSC will calculate what each DSRIP IGT entity will pay for monitoring.
- Assessing IGT for monitoring will begin with demonstration year (DY) 3 payments for the April 2014 reporting period.
- HHSC has not issued an RFP for monitoring yet, and plans to do so through the TXMAS pre-approved vendors list.

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DY2 Reporting Review

- August 2013 was the first opportunity to report DY 2 DSRIP achievement for payment.
- HHSC reviewed August reports through a multi-level process.
  - Provider reports were reviewed to confirm that goals were met and that supporting documentation was sufficient.
  - Metrics that did not appear to have sufficient documentation were reviewed by second and in some cases third reviewers.
  - For metrics with insufficient documentation, providers will be asked to submit additional information during the October DY 2 reporting period.

DY2 Reporting Review, continued

- August reporting stats:
  - 600+ Category 1 or 2 projects
  - 700+ Category 3 outcomes
  - 85+ Category 4 hospital reports
- Most metrics (over 81 percent) were approved for the August reporting period. HHSC based the review on the level of guidance that was provided at this early stage of the waiver.
- October is the next opportunity to report DY 2 achievement with payment in January 2014.

DY2 Reporting Review, continued

- If a metric reported in August was not approved, information will be included in the October reporting templates for the additional information that is needed to approve the metric to submit in October.
- HHSC plans to post the October templates on the waiver website as early as possible the week of October 7.
- An updated reporting guidance "Companion" document will be posted based on the lessons learned from the August reporting. The Companion will also give information on Category 3 reporting options for October.

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Valuation Review Update

- HHSC expects to receive soon from CMS the results of its regression analysis of DY4-5 project valuation.
- This valuation review included the quantifiable patient impact of each project, including for Medicaid and low-income uninsured individuals.
- HHSC will advise as soon as possible which projects' valuation have been approved for DY4-5.
- For DY4-5 valuation outliers that appear to be overvalued, HHSC will have an opportunity to explain to CMS why it believes the valuation is supported. Otherwise, providers will have the option to take the lower CMS alternate value if they wish to move forward with the project.

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Category 3 Update

- HHSC is continuing to work with CMS on the new measures proposed for Category 3 menu.
- Given the delay in finalizing the revised Category 3 menu, providers were not required to select or confirm their Category 3 measure(s) by October 1, 2013 as planned.
- For all Category 3 measures (approved or not), there will be an option to earn DY 2 Category 3 funds in the October reporting period based on a status update regarding Category 3. Details will be in the Companion document to come out next week.

Category 3 Update

- It has been a challenge to arrive at an appropriate Category 3 menu and achievement methodology given the variety of Texas DSRIP providers and projects.
- A key theme in discussions is that CMS wants to ensure Category 3 data reported is valid and reliable, and does not lead to adverse selection or unintended consequences for patients. This applies both to the allowable measures on the menu and how the denominator is defined for each measure.
- There are two issues about which HHSC seeks stakeholder feedback:
  - Using a denominator for Category 3 that is broader than the population served by the project.
  - Using a combination of pay for reporting and pay for performance in Category 3.

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Category 3 Update

- CMS has indicated it will approve many of the measures proposed in the revised Category 3 menu (including some modified/custom measures).
- There is a strong CMS preference that Category 3 measures use a facility-level denominator or appropriate subset that would stay more or less the same year to year.
- Concerns regarding using a denominator that reflects only those served by the project:
  - Could penalize providers if they continue to serve/enroll high needs patients.
  - Could lead to adverse selection in the project in order to perform better for Category 3 payment purposes.

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Category 3 Update

Examples of possible appropriate "facility level" populations or subsets to be used as the denominator include:

- Medicaid and/or low-income uninsured patients
- Patients with specific conditions such as diabetes or congestive heart failure
- Patients that may be targeted by a project focused on disparities, such as Hispanic adults with diabetes
- Patients under age 21
- Patients at the provider's two clinics where the intervention is taking place

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Category 3 Update

- CMS and HHSC are discussing a Category 3 framework in which Category 3 payments for DY 4-5 will be based on a combination of pay for reporting and pay for performance.
- The PFM Protocol requires that a minimum percent of each providers' DSRIP funds be allocated to Category 3.

Provider Type	DY3	DY4	DY5
Hospitals	10%	15%	33%
Non-hospitals	10%	10%	20%

- Under discussion is that at least the amount of funds required to be allocated to Category 3 in DY 3 (10% of total DSRIP) would be earned based on pay for reporting in DY 4-5.

Unspent DSRIP Funds – Process for 3-Year Projects

- Each RHP will be required to submit a prioritized list of 3-year projects to HHSC by **October 31, 2013**, in order for HHSC to assess whether there will be any DSRIP funds to be redistributed before full 3-year projects are submitted in early December.
- HHSC does not intend to review and give feedback on project content based on the prioritized list.
- An RHP must hold a public meeting to consider the list of three-year DSRIP projects prior to submitting the list to HHSC.

Unspent DSRIP Funds – Process for 3-Year Projects, continued

- When submitting the list to HHSC, the RHP must also submit:
  - A description of the processes used to engage potential performers, public stakeholders, and consumers.
  - A description of the regional approach for evaluating and prioritizing DSRIP projects.
  - A list of DSRIP projects that were considered by the RHP but not included on the list, regardless of whether or not those DSRIP projects had an identified source of IGT.
- The template for the prioritized list of projects and more detailed instructions were distributed to anchors earlier this week. Guidelines are also available in rule and on the website.

Upcoming Waiver Amendment

- In October, HHSC will submit a waiver amendment to CMS for the managed care expansion to take place in September 2014. Some of the major changes include:
  - Expand STAR+PLUS to the Medicaid Rural Service Areas.
  - Add nursing facility services, mental health targeted case management and mental health rehabilitation, employment assistance, and supported employment as benefits that will be delivered by managed care organizations.
  - Move individuals with intellectual disabilities or a related condition in Medicaid who are enrolled in certain 1915(c) waiver programs into STAR+PLUS for acute care services.

Upcoming Waiver Amendment

- HHSC will implement an Upper Payment Limit (UPL) program for public, non-state owned nursing facilities on October 1, 2013.
- Since nursing facility services are being carved into STAR+PLUS effective September 1, 2014, HHSC will request that the funds for the nursing facility UPL program be moved into the waiver. This likely will take the form of a separate quality/transformation pool for nursing facilities.
- In October, with the managed care waiver amendment, HHSC will submit to CMS a concept paper regarding the transition of nursing facility UPL into the waiver.