Anchor Conference Call

AGENDA

October 11, 2013
1:30-3:00 p.m.

1. General Anchor Communication

- Thanks for your continued hard work, most recently the submission of the Learning Collaborative Plans and replacement projects. We really appreciate the role you play in helping coordinate all of the information required to keep the waiver moving forward!
- HHSC continues to work on many items as outlined in more detail below.
- We want to announce that effective next Monday, Laela Estus will be moving to another division within HHSC, so you should no longer call Laela for waiver-related issues. We are happy for Laela's promotion, but we will miss her friendly way and know you will too. We will be working to hire a replacement for Laela as soon as possible and will maintain our regular communication channels through the waiver mailbox and the rest of our staff in the meantime.

2. RHP Plan Review

Phase 1 review

- The 48 projects that were not addressed in the CMS letters (22 from Table 5 and 26 from Table 6) are still being evaluated by CMS. HHSC had hoped to receive word from CMS about these projects by today (mid October), but the federal government shutdown has delayed their response further. CMS has indicated that it will provide its feedback on these 48 projects in October, but at this point HHSC believes it likely will be late October (October 21 or later). We will keep you updated as we get more information.

Replacement Projects

- HHSC is currently evaluating the replacement project submitted at the end of September.
- Replacement projects that get approved will be eligible to report late DY2 achievement beginning in April 2014 (first DY3 reporting period).
- Since HHSC is still waiting for CMS feedback on the outstanding 48 Phase 1 projects, we are going ahead and reviewing the replacement projects that were submitted in case a Phase 1 project doesn't get approved.
- HHSC plans to send out feedback on replacement projects early next week. The process will use a cover letter similar to Phase 1, with technical review items in an Excel spreadsheet. HHSC will send out the feedback to the anchors, who will be responsible for sharing the feedback with providers and collecting the responses and revised projects and re-submitting them to HHSC. The action items for the providers will be clear.

DY2 August Reporting Review

- August reporting stats:
  - 600+ Category 1 or 2 projects
  - 700+ Category 3 outcomes
  - 85+ Category 4 hospital reports
- Over 81% of the metrics submitted for the August reporting period were approved.
- If a metric reported in August was not approved, information was included in the October reporting templates for the additional information that is needed to approve the metric in October.

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DY2 August Reporting Payments

- The DSRIP payment dates for approved August reports have changed to the following:
  - 10/28/13 DSRIP IGT Settlement date
  - 11/4/13 DSRIP Payment date for Transferring Hospitals
  - 11/18/13 DSRIP Payment date for all other performing providers

DY 2 October Reporting

- The October reporting templates have been posted to the HHSC website. As with August reporting, each RHP's zip file contains individual provider templates. **Templates are due by October 31, 2013.**
  - Please have your providers carefully review the October templates to identify any issues with the template (e.g. missing projects, missing milestones). **Email the waiver mailbox no later than October 25, 2013, with template issues.** HHSC will not be able to fix template issues after the October report has been submitted.
  - Please carefully review your submissions that all the attachments are included for each metric you are reporting. Please use caution with any internet links you are using. We are allowing links at this time; however in August reporting review not all links were active. An attachment should always be included that clearly states what information is included in the link provided and how the information fulfills the requirement of the metric.
- For those providers who reported in August and have questions about metrics/milestones that were designated as "Needs More Information", providers are encouraged to send an email to the Waiver mailbox (TXHealthcareTransformation@hhsc.state.tx.us). Providers should include such details as RHP #, project ID, metric ID, HHSC comment and specific question being asked. HHSC requests that all questions be received no later than COB on 10/18/2013, to ensure adequate time for HHSC to respond and the provider to prepare for October reporting.
- An updated Companion document for guidance on October reporting has also been posted. Please review the Companion carefully and completely as it has been updated to reflect lessons learned from the August reporting that will help providers to submit documentation in a way that will assist HHSC reviewers to more efficiently and accurately review a project's reported milestones.
- The key differences for October reporting from August reporting include:
  - Required semi-annual reporting for all projects and metrics/milestones, even if those metrics were reported in August; refer to p. 3-4 in the Companion Document.
  - Options for DY2 Category 3 reporting, refer to p. 5-7 in the Companion Document. Any approved Cat 1 or 2 project may opt to use the Cat 3 status update in lieu of reporting on the specific Cat 3 milestones in October. This includes projects that reported in August and had Cat 3 milestones that were not approved for payment and/or for which more information was needed from August reporting.
  - Opportunity to carry forward DY2 Category 1 or 2 metrics and Category 3 milestones for achievement in DY3 by answering the three carry-forward questions for the applicable metric/milestone.
  - One issue HHSC would like to highlight for October reporting is that you should not report a metric/milestone as completed until it is completed. For August reporting ONLY, if a provider reported a milestone as completed that actually has not been completed, there will be a one-time opportunity in October to change the status to “No-Partially Completed” in order to carry forward that metric for late achievement reporting in DY3. If a provider reports a metric/milestone as completed in October and it does not supply adequate supporting documentation either in October or December for HHSC/CMS to approve it, the provider will no longer be eligible for payment for that metric/milestone. This applies to DY3-5 reporting as well. Refer to p. 4-5 in the Companion Document.
- The IGT Entity Feedback form has also been posted. This is an opportunity for IGT entities to provide feedback on their affiliated providers' reported DY2 progress, if they wish. IGT feedback is

due to HHSC by November 15th.

New Cost-Related Questions on the October Reporting Templates

HHSC has received a number of inquiries about the following three new questions added for October reporting for project semi-annual reporting. These questions are on lines 64-66 of the payment reporting workbook in the project specific tabs.

1. What percent and dollar value of your DSRIP payments received to date for this project have been spent on the project?
2. Of the funds not spent on this project, how were they spent or how do you intend to spend them?
3. If the answer to percent of DSRIP payments spent on the project is 100% and additional funds have been spent on the DSRIP project, you may provide information on additional funds spent.

Questions from providers:

- What is the intent of these questions? HHSC added these questions to the report at the request of CMS. While DSRIP valuation is not cost based, CMS is interested in knowing at a high level approximately what portion of each project's DSRIP payments are being used for that project and if not all funds are being used for the project, what they are being spent on.
- Does HHSC expect Providers to detail amounts to the exact dollar or provide a general estimate for these three questions? HHSC expects providers to give good faith estimates for these three questions for each project.
- Regarding Question 1 - what is meant by DSRIP payments received to date? It means any DSRIP funds that provider has received as of the date of the reporting period, which for October reporting would just be the DY1 DSRIP payment (all funds) associated with each project. The RHP Plan data for each RHP located at http://www.hhsc.state.tx.us/1115-RHP-Plans.shtml shows under the Projects tab the Cat 1-3 proposed value for each of a provider's projects at the time HHSC submitted the plan to CMS. Since the DY1 payment was based on the original plan submission, even though some project values have changed in Phase 1, HHSC thinks the best way to estimate how much of its DY1 DSRIP payment was for each project is to use the data in the Projects tab and proportionally split its DY1 payment among all its projects.
- What is meant by dollars spent - is there any definition, may indirect costs be included, etc? HHSC/CMS is not providing a specific definition – the dollars spent should represent a good faith estimate of what has been spent to carry out the approved project plan. The provider may indicate that indirect costs are included, and approximately what % of the spend those costs represent.
- For #2, what is meant by funds not spent on the project? This is the difference between all DSRIP funds received to date and the answer to #1. For example, if the provider has received $100 to date for a DSRIP project, and indicated in question #1 that $75 has been spent on the project, then the funds not spent on the project would be the other $25.
- Should we expect that this information will be subject to audit? HHSC has not finalized any audit plans at this time nor are we aware of any CMS audit plans, however anything related to DSRIP is subject to audit. HHSC's draft plan for the mid-point assessment review, which is under CMS review, is located at http://www.hhsc.state.tx.us/1115-docs/DraftMidPointCriteria.pdf.
- If CMS intends to perform audits on the DSRIP payments, does HHSC have any idea of the frequency/details CMS would look for? HHSC does not have any information from CMS regarding future federal audits of DSRIP.
- How will CMS use the answers to these questions moving forward? HHSC does not have information from CMS regarding how it plans to use the answers to these questions. However, it is possible that in aggregate the information provided in these reports will help inform discussions of waiver extension. As HHSC has consistently conveyed to providers, it is important that Texas

demonstrate results with DSRIP funds, with an emphasis on improving healthcare for the Medicaid and low-income uninsured populations that are the target of the waiver.

- Will the figures entered for these three questions be used as metrics or referred to in future reports? The figures entered for these questions will not be used as metrics. They are instead part of the qualitative reporting for each project. The same three questions will be asked and must be answered for every project during each semi-annual DSRIP reporting period going forward.

IGT Entity Changes

- The IGT Entity changes, either in Entity or proportion of payment among IGT Entities, must be submitted to HHSC no later than October 31, 2013 for October DY2 DSRIP payment processing using the *IGT Entity Change Form* located on the waiver website at: http://www.hhsc.state.tx.us/1115-docs/RHP/Plans/IGT-Change.xlsx.
- Any changes received after October 31 will go into effect for the April DY3 DSRIP reporting and payment for the impacted projects will be delayed until that time.

New 3-year projects

- The prioritized list of new 3-year projects is due to HHSC from each RHP by October 31, 2013. This will enable 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.
- Please see the Anchor update email sent September 27th for the instructions and template for submitting the prioritized list of new 3-year projects.
- HHSC has received some stakeholder questions regarding the rule language that requires the prioritized list alternate by IGT entity, so the following is a clarification of how the process works per the rule:
    - All projects submitted to the anchor must go through the public input and scoring process (based on community need) regardless of whether they have an IGT source.
    - Once that scoring process is done, the prioritized list submitted to HHSC should be based on community need except that it must alternate by IGT entity, i.e. two projects supported by the same IGT entity aren't consecutively listed unless there is no other IGT seeking to fund projects that meet a community need (and other waiver requirements) in that RHP.
    - Projects that were submitted but are not on the prioritized list (including due to no IGT or scoring poorly for community need) should also be submitted to HHSC in the second tab.
    - An RHP may opt to customize its process if there is consensus in the region and as long as it fits within the confines of the rule. The RHP should clearly explain the process it followed with its 10/31/13 submission. Examples:
        - If there are four IGT entities in the region supporting projects that meet a community need, the RHP could opt to rotate the prioritized list through all four entities before the first entity gets another project on the list.
        - One of the scoring criteria a region may use is whether the project is performed from a major safety net hospital or other key stakeholder (such as the Medical Society) that wasn't able to do a DSRIP project in the original plan submission.
        - If an RHP has 10 providers with strong projects and $50 million DSRIP allocation left, the participants could agree to a $5 million cap per project over the three years.

DY4-5 Valuation Review Update

- HHSC expects to receive soon from CMS the results of its regression analysis of DY4-5 project valuation, and we will advise as soon as possible which projects' valuations have been approved for DY4-5. The federal shutdown may delay CMS' DY4-5 valuation feedback.

- 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.

Category 3

- HHSC is continuing to work with CMS on the new measures proposed for the Category 3 menu.
- For now, we want to reiterate that for all Cat 3 measures (approved or not), there will be an option to earn DY2 Category 3 funds in the October reporting period based on a status update regarding Category 3. As mentioned previously, the reporting Companion document contains details about Cat 3 October reporting.
- A key theme in discussions with CMS 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 to both the allowable measures on the menu and how the denominator is defined for each measure.
- CMS has indicated it will approve many of the measures proposed in the revised Cat 3 menu (including some modified/custom measures).
- There are two issues that HHSC laid out at the Executive Waiver Committee meeting last week and on which we also welcome your feedback:
    - Using a denominator for Category 3 that is broader than the population served by the project. (or put another way, a denominator that does not change based on the # enrolled in the project)
    - Using a combination of pay for reporting and pay for performance in Category 3.
- At this time, addressing Category 3 milestones is scheduled for Phase 4, but this may be delayed, due in part again to the partial federal government shutdown. We will let you know as soon as we can about the timing of Category 3 changes.

Denominator

- There is a strong CMS preference that Cat 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.
- 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 who 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.

Combination of Pay for Reporting and Pay for Performance

- CMS and HHSC are discussing a Category 3 framework in which Category 3 payments for DY4-5 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.
- Under discussion is that at least the amount of funds required to be allocated to Category 3 in DY3

(10% of total DSRIP) would be earned based on pay for reporting in DY4-5.

Provider Type	DY3	DY4	DY5
Hospitals	10%	15% (at least 10% pay for reporting)	33% (at least 10% pay for reporting
Non-hospitals	10%	10% (at least 10% pay for reporting)	20% (at least 10% pay for reporting)

Anchor Administrative Match Protocol

- Thank you for your narrative and budget/cost projection information.
- A draft protocol has been completed and is under internal review. We are communicating with anchors as needed when additional information or clarification is needed.
- A question has been raised as to whether anchors can include activities for the RHP Plan submission that occurred during DY 2. The anchor payment for DY 1 that was 20% of the regional allocation was specific to successful submission of the RHP Plan to CMS, and is not included in the allowable administrative activities for DY 2 – DY 5. Anchor activities from October 1, 2012 through February 2013 (when RHP Plan submission to CMS that occurred) may be included as applicable to the six allowable areas. If anchors have included information in the narrative specific to RHP Plan submission we will provide feedback to adjust.
- Some anchors have requested HHSC to pursue a method of anchor administrative cost similar to DY 1. The DY 1 payment mechanism was a one-time event and CMS is not allowing in DY 2 – DY 5. Anchors are not required to participate in administrative match and some have elected not to. Anchors may use other DSRIP project funds, such as those for Learning Collaboratives, to cover administrative costs.
- CMS is allowing the protocol to be submitted after Oct 1st.

State Initiatives

- HHSC has received many inquiries about state DSRIP initiatives.
- HHSC has requested from CMS that the unused money from DY2 be allowed to be used for state priority projects in DY3-5. This would require a waiver amendment. CMS appears open to this if they like the projects, but the waiver amendment would not be approved until early 2014.
- There is over $250 million DSRIP allocation that didn't get spent in DY2 that may go toward such state initiatives. The other remaining funds, over $1 billion, sits in the 20 RHPs for your use to propose new three-year projects.
- HHSC is working with the Department of State Health Services on how funds it was appropriated for FY14-15 may be leveraged for state initiatives, including related to behavioral health, primary care, adult immunizations and tobacco cessation.
- There will be a public process if the State decides to pursue any initiatives, but we are not yet at a point to share details. It's likely such initiatives would be carried out through existing DSHS contracts in order to be implemented quickly.

Key Dates for RHP Plans through March 2014

- Submit prioritized list of new three-year projects by October 31, 2013.
- Make any necessary revisions to DY4-5, in light of anticipated CMS feedback regarding valuation,

which is targeted for October 2013.

- Phase 4 –
    - Submit priority technical corrections, Category 3 improvement target achievement levels, corrections to non-quantifiable/TBD goals, and requests for plan modifications by a date being negotiated with CMS (no later than Dec 1, 2013). Submit new three-year projects – exact date TBD, likely early December 2013.
- Through March 31, 2014, HHSC will work with the RHPs to clean up any outstanding issues from Phase 4 and the CMS valuation review.
- The full plan will not need to be resubmitted as a single document until March 2014.

3. Other Information for Anchors

- **Stephen Palmer, Director, Office of e-Health Coordination, HHSC**
    - Health Information Exchange (HIE) in Texas
    - HIE and DSRIP

- Note, please do not send us secure emails unless there is a compelling reason such as sensitive PHI information. There may be delays in responses if secure emails are sent due to access issues.

For waiver questions, email waiver staff: TXHealthcareTransformation@hhsc.state.tx.us.
Include "Anchor:" followed by the subject in the subject line of your email so staff can identify your request.