Anchor Conference Call

AGENDA

March 7, 2014 **1:30 - 3:00 p.m. CST**

1. General Anchor Communication

Thank you for the work you continue to do for health care transformation in Texas.

2. RHP Plan Review

Replacement Projects

- CMS results are expected soon.
- CMS has indicated that all the replacement projects will be approved; they are getting the final formal signoff for the letter(s).

DY2 October Reporting Review

- All providers should now have final results of October reporting NMI review.

April DY3 Reporting

- HHSC is currently finalizing the April DY3 reporting templates and updating the Companion document that contains instructions and examples.
- Providers will also be able to report on DY2 metrics that were carried forward for late achievement.
- There will be separate forms to attach for reporting on QPI metrics, Category 3, and Category 4.
- We will use the same reporting process that we've used in the past: Reporting templates and other materials will be posted on the waiver website, and reports will be due to Deloitte by April 30.
- Since the reporting process will be the same as before, HHSC will make minor updates to its PowerPoint with instructions and examples. Because changes are minimal, we are thinking of posting the PowerPoint, possibly with recorded audio, rather than conducting a live webinar. Specific questions about reporting should be submitted to the waiver mailbox.

Phase 4

- HHSC plans to provide results of Phase 4 NMIs in mid/late-March along with the final milestones and metrics tables for each region. Note that HHSC did not approve changes to QPI goals without a Plan Modification request. If a provider indicated that they will submit a Plan Modification at a later time, then HHSC changed the QPI goals backs to what was originally submitted in Phase 2 – QPI.
- HHSC approved most plan modification requests. In some cases, HHSC made approval contingent on changes made by HHSC. In these cases, providers cannot submit reporting in April unless the HHSC changes were accepted. CMS may still review certain plan modification requests and add additional projects to the midpoint assessment review.
- Additional plan modifications for DY4-5 will be accepted in June/July 2014, including for Category 3 if needed.

New 3-year projects

- HHSC feedback on 3-year projects has been sent to RHPs 5, 8, 17, 20, 11 and 13 (the workbooks are posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under **New 3-Year DSRIP Projects**).

- HHSC's goal is that many projects from these four RHPs will be able to report achievement in April 2014. Payment will be contingent on CMS approval of the project.
- **HHSC plans to send feedback for other RHPs over the next month. Providers should plan to address the HHSC feedback in April.**
- We have gotten some questions from providers regarding when CMS will approve 3-year projects. While we don't have firm dates yet, we believe that June is a good estimate.
- HHSC is conducting a detailed review of all 3-year projects so that there is not the need for additional follow up activities (the 4 phases we have needed to use for initial projects submitted). To streamline feedback, HHSC is also updating narratives and workbooks for provider review and acceptance of changes.
- Category 3 outcome measures and funding included for new 3-year projects will be replaced by the information submitted in March in the Category 3 selection tool.
- It does not look like CMS will be approving the waiver amendment to allow state retention of the unused DY 2 DSRIP funds for statewide priority initiatives.

Funds available for 3-year projects

- HHSC will send you updated 3-year project available funds information today by RHP that reflects additional withdrawn projects for your RHP, any DY4-5 valuation reductions that your providers accepted in the DY4-5 valuation review and a PRELIMINARY redistribution of funds not used by other regions.
- The redistributed funds are still preliminary as some providers submitted lower project values (for various reasons) than what was submitted with the prioritized lists. The preliminary redistribution information used in what you get today is based on the prioritized list amounts.
- The #s do not include:
    - Additional funds that may become available to your RHP once HHSC/CMS decide on the 14 projects under DY4-5 valuation review that sought to justify their original valuation.

DY 4/5 Valuation

- Projects that provided qualitative justification for original DY 4/5 valuation are still under review. A formal CMS decision on these 14 projects is expected in March, and HHSC has sent those CMS outlier projects that sought to justify their original valuation to CMS for review.

Category 3

- The Category 3 selection tool, companion and compendium information on the measures has been sent to Anchors and posted on HHSC website. ODs 7 and 15 are next and will be completed by Monday. OD-14 is the one remaining (workforce), which will not have very much additional detail given the type of measures. The workforce measures have been changed to P4R for this reason and are designated P4R in the selection tool.
- The recording of the Category 3 webinar is posted on the HHSC waiver website.
- The date for providers to submit their selected Category 3 selections is **March 10, 2014 for providers that plan to report status update milestone in April. If there is clarification still needed on certain measures, please include this information in your selection tool and we will continue to follow up to provide TA as needed.**
- For providers that are conducting projects in more than one RHP, an RHP # can be added to the naming convention of the file.
- Providers can opt to submit by March 31, 2014 if they plan to report status update milestone in the October reporting period.
- HHSC conducted TA sessions with many RHPs and providers this week. Given these sessions and continuing to release compendium information, the mailbox responses have been delayed at times.

- Questions can be sent to the waiver mailbox. Please continue to use the Category 3 designation. We will prioritize e-mails on any issues on the selection tool. We have some staff that will be out for some of spring break, and some Category 3 questions will continue to be addressed, but some may be delayed until the week of March 17. We are asking that Category 3 specific questions include additional detail in the subject line so we can triage as follows: Category 3-selecting measure(s) to fit Category 1 or 2 project; Category 3 – selection tool; Category 3 – population-focused priority measures; Category 3-stretch activities; Category 3 – achievement methodology; Category 3 – data collection processes; Category 3 – tools/surveys; Category 3 – Other.
    - We are asking that questions related to measure specifications be held until we release the compendium. Helpful information can currently be found in the Category 3 spreadsheet that will assist providers until the companion and compendium are released. Specifically, where applicable, the Category 3 spreadsheet references a National Quality Forum (NQF) ID number and providers can visit the NQF website to get a better understanding of the measure specifications. The spreadsheet also contains details as to any modifications we are approved to make to these measures.

Category 3 next steps

- HHSC will provide a status to Anchors next week on Category 3 submissions received from providers on March 10th. Please reconcile the list with your tracking and let us know if you see any discrepancies. We will have a narrow period of time to assure that providers are included in April reporting.
- HHSC will review Category 3 measures that require prior authorization and will target feedback before April 1. However, if a provider has prior auth measure and does not receive confirmation of selection before April, they can still submit a status report to earn process milestone payment. (Timeline is dependent on how many measures require review).
- HHSC will continue review and will continue with TA as needed to prepare for next step of baseline for October reporting.

Category 3 guidance from TA calls

- For QISMC measures, if a provider's baseline is significantly under MPL, HHSC will work with CMS to allow an alternative achievement level in the October timeframe (such as 5% IOS).
- For QISMC measures, if, once a provider has baseline data to report in October and the baseline is at HPL or above, CMS has stated that the provider can earn incentive payment for maintaining performance. However, a provider would select an additional measure for P4P to report in DY 5. HHSC may also work with CMS if a provider thinks they can improve over the 90th percentile in lieu of adding a new measure.
- For some provider types, namely local health departments and other community based projects, reporting measures to specifications will result in a denominator that is equal to the intervention population (such as if a particular type of screening is only occurring at the LHD through a DSRIP project). This may occur for P4P or P4R measures.
- For some measures, HPV vaccinations (IT-12.11) for example, providers have approved projects where a measure is the best fit but the specification detail an age group that does not fit the project. In these cases, we are asking providers to propose a denominator subset for age and include the age they wish to capture (including the evidence base and rationale for why these ages are within guidelines.) In the HPV example, the measure specs go to age 13yo, however the project and the evidence is around vaccinating high risk males up to age 26yo. Our general guidance is that providers may propose subsets that fall outside the range of the specifications, with sufficient justification and rationale, and these proposals will be reviewed in the context of the measure specification and the approved Cat 1 or 2 project.
- For projects that can only identify one non-standalone measure specific to the project, this will be

allowable for local health departments.

- Defining facility denominator subset: Currently the guidance for facility subset is to allow providers to specify a denominator to the location services are delivered. In some cases, this may be less a physical entity and more a structural or organizational entity. For example, we have providers who would like to use the facility subset to reflect services delivered by a specific community based organization. If we do not allow this we have providers that have limitations to the data that is available to them. To be clear, providers would still be reporting all cases that fit the specifications, just specific to the organization. We propose that the facility population could reflect where or by whom services are delivered (at an organization level, not specific practitioner level).
- In some cases, providers are requesting to exclude certain exclusion criteria to ensure that they have a reportable denominator size. HHSC is asking providers to propose that during the selection process with justification, and will come back to CMS with examples when available.
- In general, additional tools are not being added to the menu, with limited exceptions when no other tool will work for project, such as Autism Spectrum projects.
- Some measure specifications do not include specific codes for inclusion or exclusion. In those cases we are allowing providers to define this, ensuring that the intention of the measure is still met and that the included codes are comprehensive. The guidance we have provided to the field is that providers should do their due diligence to adhere to measure specifications. An example of this can be found in the ED-Utilization- LWBS rate (IT-9.6) and the dental measures around determining "risk". Providers will specify the codes they wish to include in the selection tool or April reporting as well as the rationale for how the codes were identified.
- Providers have had lots of questions around what is allowable for risk adjusting of the PPAs and PPRs. Our general message to providers has been that this should be a methodological sound manner of risk adjusting, using a case mix adjusted approach. We have not been too prescriptive of what is required, besides to say that provider may use their internal software (for those who have purchases risk adjusting software), a third party vendor or the Category 4 3M rates.
- In some cases, the minimum valuation rules that we outlined (50% of average distribution across projects) conflict with the initial guidance to providers to align the Cat 3 valuation proportionally to the Category 1 or 2 projects. This is an issue for some providers when there are large variances between Category 1 and project values (e.g. $200K and $20M). We are allowing providers to request a different minimum for specific projects based on their proportionality to Cat 1 or 2 value. This will be reflected in the revised PFM Protocol that HHSC is working to send to CMS for review.
- For the measures in OD-9 and OD-2 based on regional populations (census like data), we are allowing providers to report at the facility level using the facility subset, capturing only those admissions and ED visits that occur at their hospital per 100K population. In terms of benchmarking that, we are hoping to receive QISMC appropriate rates from our EQRO, however these will be based on much larger populations than a provider population, so we will need to scale up the provider rates or scale down the benchmarks to make them comparable and fit within the QISMC framework. We can revisit this when we see how the benchmarks will be reported from the EQRO.

Category 4

- HHSC is working on templates and additional guidance for Category 4 reporting for April 2014 on domains 1, 2, 4, 5 and 6, if applicable.
- For Domains 1 & 2 (PPAs and PPRs), HHSC will receive the reports from Texas EQRO (ICHP) by April 15 and we will send individually to providers to the email we have on file for you as soon as possible after that date. The data will include all Medicaid (FFS and managed care) and CHIP.

- Given the delay in providing data CMS has agreed for domains 1 and 2, providers will not be required to include a qualitative report. Reporting for Domain 3 begins DY 4. (Potentially Preventable Complications).
- The qualitative report will be required for Domains 4 and 5; as well as 6, if applicable.
- For Domains 1 & 2, providers will use the same reports provided by HHSC to upload for Category 4 payment for these 2 domains. HHSC is checking with legal to determine if this information will become public information once reported by providers.
- For domains 4-6, where providers are supplying their own data, providers will be required to report the numeric metric and include a qualitative assessment.
- UC hospitals are also required to send Domains 1 & 2 to be eligible for DY 3 UC payments. We will advise the date for the reports to be provided to HHSC.

3. Other Information for Anchors

Anchor Administrative Match Protocol

- HHSC received feedback from CMS on the Protocol this week. Based on the questions, the protocol will not be approved for anchors to submit costs in April as planned.
- CMS is committed to working through to approval and we plan for anchors to report in October.
- Most of the questions are specific to the cost allocation methodology. Most anchors are using a process using timesheets. Our plan is to find a consistent language that fits what most Anchors are using. It would be helpful to have specific examples from Anchors that represent a timesheet or report that you are using specific to staff conducting anchor functions. ***Please submit to the waiver mailbox by next Friday, March 14, so we can include with follow up questions from CMS.***

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.