Anchor Conference Call

AGENDA

June 7, 2013
1:30-3:00 p.m.

Call-in: 877-226-9790
Access Code: 3702236

1. General Anchor Communication

- **Waiver team staffing** – Amanda Broden has joined the waiver team and will soon be playing a significant role in anchor communications.

- **Monitoring** – Staff is continuing to work with state leadership and CMS on monitoring that would occur through an independent entity. HHSC sent all the anchors the draft proposed rule that would allow HHSC to retain up to 1% of DSRIP IGT for monitoring. This rule will go to the HHSC advisory committees (HPAC, MCAC, and HHSC Council) between June 11-14 and will be published as proposed in the Texas Register on June 28th, to be expedited for adoption by August 31, 2013.

- **Category 3**
  - If providers have any suggestions for Category 3 measures to add to the RHP Planning Protocol, please send suggested measures to waiver mailbox (subject: Category 3) by Monday, June 17. If a provider already submitted an "other" outcome, HHSC is already working with CMS to attempt to get many of these on the menu.

- **QPI – Phase 2**
  - You will be receiving these spreadsheets sometime after June 20 to return sometime in July (providers will have at least two weeks, if not longer). Detailed instructions will accompany QPI, because this process is complicated, and we will work out an appropriate way to have technical assistance for QPI.

- **Learning Collaboratives**
  - CMS will develop a template for inclusion in the RHP Plan on learning collaboratives
  - After the template is developed, CMS will host a webinar in July on learning collaboratives

- **New 3-year projects -**
  - We may push back the full project submission date a little bit, even though the prioritized list still will be due by August 31.
  - CMS is open to accepting the milestones and metrics table in Excel instead of embedded in the Word documents. We may talk to RHPs further about this process. It would be applied to both new projects and Phase IV revisions to existing projects.

- **Phase 1 review process and coversheets**
  - Sending first batch of projects to CMS on Monday, June 10, with weekly batches thereafter.
  - Please encourage providers to read the companion!
  - Make sure all changes are clear – don't insert new information or delete information (particularly milestones) without identifying the change.
  - Providers should not be weakening metrics or the narrative as part of the project revisions. Major substantive project changes should be made in response to CMS and HHSC feedback only.
  - In the "CMS Comments" section of the cover sheet, all CMS comments were included, even if they appeared in the section about technical corrections that need to occur by October 2013. We want to emphasize that those technical comments for October 2013 do not need to be addressed at this stage and will not be reviewed at this time. For Phase 1, providers are responsible for correcting the issues that appear in the tables on the cover sheet and that are identified in the *HHSC Comments* as directly affecting project approvability, valuation, or overlap of improvement milestones and improvement targets.

- When addressing duplications between improvement milestones and improvement targets, providers should consider whether the change they are making will impact the way quantifiable patient impact is reflected in their project. Try to replace rather than completely remove any milestones if they were the only ones that represented the project's QPI.
- Common reasons for which HHSC is returning projects to RHPs:
  - Providers did not fill out a required appendix: When responding to Appendix questions, do so in a Question and Answer format in which the provider states the question followed immediately by the answer to that question. CMS has specifically asked for these Appendix questions to be answered in certain circumstances, and this format will best facilitate efficient CMS project review. Use the companion to determine if appendix is required.
  - Providers did not submit changes in the proper format: Start from the clean version of the project as initially submitted to CMS. Strike through deletions. Highlight additions. These revisions SHOULD be made using the font strikethrough and font highlight functions in Word. Projects should NOT include any track changes. Submit documents to HHSC in Word format (not PDF).
  - For 6D projects not initially approved due to the provider needing to further define specialists – providers must include Appendix C and should define the TYPE of specialists being hired, including in milestones. At a minimum, if the type is not finalized, the provider should note all specialist types that may be considered.

Phase 3:

- All regions have received their Phase 3 Provider Correction Templates. Please work with your providers to submit corrections by the due date indicated in the email. HHSC is not providing extensions for more than 2 days due to the timing of August reporting.

- Phase 3, providers should focus:
  - Responding to HHSC comments
  - Updating milestone/metric goals that are TBD or non-quantifiable or metrics with missing data sources that HHSC may have missed
  - Correcting data entry errors

- The main items that need to be updated regarding goals and data sources can be found in the columns in the Category 1 and 2 tabs referring to "Metric #X Baseline/Goal (DY2)", "Metric #X Type", "Numeric Goal", "Metric #X Data Source (DY2)" and "Data Source Provider Manual Desc (if needed)".

- Under Category 3, the columns to focus on for changes include "Target (DY2)", "Target Type", "Numeric Goal", "Process Milestone #X Data Source (DY2)", "Process Milestone Data Source Provider Manual Desc (if needed)", and if the provider is completing an improvement target in DY2, this may also include numerator and denominator.

- Any changes should be aligned with the elements described in the project narrative. During the mid-point assessment, HHSC will review projects for compliance with the narrative as well as the reported achievement on milestones and metrics. (For instance, if the narrative states the project will hire a physician in DY2, and the original metric was "hire staff," if the provider changes that metric to "hire one nurse," instead of the physician reflected in the narrative, this may be require the project's value to be re-evaluated during the mid-point assessment.)

- Bugs in the Provider Correction Template
  - Please ignore the summary tabs if they are not working properly. These were provided for informational purposes only as a summary of the Category 1-3 tabs; however, later regions

did not receive the summary tabs due to the bugs identified. All changes should be made in the Category 1-4 tabs and IGT tabs.
  - Miscalculation of "IGT Needed for Milestone #X (DY2)" – for earlier regions that received their Provider Correction Templates, this column miscalculates the IGT Needed and instead provides the federal share. Please refer to the IGT tab for a better estimate of IGT needed. Note: FMAP is 59.3 for DY2 and 58.69 for DY3. However, because DY2 payments are estimated to be paid in DY3 (November 2013 and January 2014), the DY3 FMAP of 58.69 will be used.

- The Phase 3 Guidance and Overview has been updated to reflect the items above. It is attached for your reference and will be posted on the website next week.