Anchor Conference Call

AGENDA

March 21, 2014
1:30 - 3:00 p.m. CST

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

1. General Anchor Communication

- Thank you for the work you continue to do for health care transformation in Texas.
- HHSC plans to send DY3 monitoring amounts by IGT entity to Anchors in early April.

2. RHP Plan Review

Replacement Projects

- CMS results have been received and were forwarded to anchors last week (Tues 3/11/14).
- As noted, the letters were for DY 2-3 initial approval. DY 4/5 will be included with the existing 4-year project notifications from CMS.

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. Providers that have carryforward metrics from DY2 will report that on a separate reporting template from the DY3 reporting template. Both templates will be provided in the coming weeks.
- There will be separate forms to attach for reporting on QPI metrics, Category 3 Status reports (DY2 and DY3), 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.
- HHSC plans a webinar for early April (likely Tuesday, April 8th) to specifically focus on reporting of carry-forward, QPI metrics, Category 4, and Category 3 status update. The webinar will not include information on documentation for specific metrics. We ask that providers send these types of questions to the waiver mailbox.

Phase 4

- HHSC plans to provide results of Phase 4 NMIs in 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 back 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 July 2014, including for Category 3 if needed.
- HHSC has also updated the Phase 4 QPI metrics to include the increased Medicaid/low income

uninsured percentage that was included in the DY4-5 valuation coversheets. During DY4-5 reporting, the QPI goal as well as the Medicaid/low income uninsured percentage must be met for the metric to be eligible for payment.

New 3-year projects

- HHSC feedback on 3-year projects has been sent to RHPs 5, 8, 17, 20, 11, 13, 4 and 19 (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**).
- Most projects from the first four RHPs (5, 8, 17 and 20) 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 March - April.**
- We've gotten some questions from providers regarding when CMS will approve 3-year projects. All RHPs will receive CMS feedback by June if HHSC is able to submit them by early May, which is our goal. CMS prefers that HHSC submit all the 3-year projects in either 2 or 3 batches (which triggers the CMS 45-day review timeframe). HHSC plans to submit the projects for the first 4 RHPs to CMS next week.
    - HHSC believes that most projects will receive CMS approval (as was the case for replacement projects and also initial projects), but it's up to each provider to decide whether to begin implementation prior to formal CMS approval.
- 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.
- If an RHP returns a project to HHSC with significant changes (not requested by HHSC) or without addressing the issues raised by HHSC, that project's CMS approval likely will be delayed as HHSC works with the provider to further explain and clean up the project.
- 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.
- HHSC sent out the anchors two weeks ago an updated estimate of how much each RHP has for new 3-year projects. We've gotten some questions since then so want to clarify a few points.
    - Some providers submitted project valuations for 3-year projects below the amount noted for the project on the prioritized list.
    - In these cases, for the purpose of the redistribution, HHSC assumed (other than for RHPs that had extra funds) that each project may seek to use the full amount from the prioritized list.
    - When HHSC returns 3-year projects to RHPs for clean up, HHSC will ask those projects that submitted lower values whether they would seek additional valuation if more funds are available to the RHP (up to the amounts on the prioritized list).
    - HHSC will continue to follow the order of each RHP's prioritized list, so if the first 5 projects are fully funded up to their originally proposed level (and seek to keep those levels), and the 6th is partially funded, the 6th project will decide whether to move forward based on the available funds.
    - Most submitted 3-year projects will get funded based on the remaining funds.
    - (HHSC also is aware of an issue with the workbooks where the summary tabs with the milestone tables don't total up valuation correctly. HHSC is using the amounts in the individual DY tabs as the formal valuation submission.)

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.
- HHSC just learned from CMS that CMS may not issue formal valuation approvals for DY4-5 until after the mid-point assessment (in case the mid-point assessment leads to valuation changes). However, CMS has indicated that unless something is found to warrant changing a project's valuation in the mid-point assessment, then most projects' DY4-5 valuation looks fine (apart from those that received coversheets and still are under valuation review).

Category 3

- Thank you and your providers for submission of Category 3 selections by March 10th.
- HHSC provided a status to Anchors on March 14th of the Category 3 submissions received on March 10th in order for Anchors to note any discrepancies, and responses were received by March 18th. This group of providers is eligible for Category 3 reporting in April.
- Given the volume of Category 3 measures that require prior authorization, HHSC will not be able to review by April 1st as planned. HHSC will review Category 3 measures over the next several months and will provide feedback to providers either confirming selection or requesting additional information. During this feedback period, providers may make changes to their Category 3 selections at the request of HHSC.
- Those providers who did not submit by the 3/10 deadline will submit by March 31st to report status in the October reporting period.
- HHSC will continue review and will continue with TA as needed to prepare for next step of baseline for October reporting.
- HHSC also will have updated benchmarks for some measures, updates to measure specifications "clean-up," and guidance on improvement over self (IOS) methodology.
- Continue to send questions to the waiver mailbox, using the Category 3 designation in the subject heading.
- HHSC has received a lot of questions for measurement periods and has the following initial guidance. CMS has also indicated that this approach will work. HHSC will include measurement information based on preliminary baseline information that was included in the selection tool as part of the feedback process:

  In the Category 3 selection tool providers were asked to select a proposed baseline period from the below options:
  - 12 months - DY3 (10/1/13 – 09/30/14) or SFY 2014 (9/1/13 - 8/31/14)
  - 6 months (1) - DY3 (10/1/13 – 03/31/14) or SFY 2014 (9/1/13 - 2/28/14)
  - 6 months (2) - DY3 (4/1/14 – 09/30/14) or SFY 2014 (3/1/13 - 8/31/14)
  - 12 months - CY 2013 (1/1/2013-12/31/2013)
  - 6 months (1) - CY 2013 (1/1/2013-6/30/2013)
  - 6 months (2) - CY 2013 (7/1/2013-12/31/2013)
  - 12 months - DY2 (10/1/12 – 9/30/13) or SFY 2013 (9/1/12 - 8/31/13)

  We stated that a 12 month baseline period was preferred, but we understand in some cases 6 months may be all a provider has. We also stated that if a provider wanted to propose a baseline period different than those above, it could do so for review and approval.

  The measurement period to earn DY4 funds is the year following the end of the baseline period, and the measurement period to earn DY5 funds is the year right after the DY4 measurement period. (Carry forward will still apply for late achievement if needed.)

So, for example, from the options above, if a provider selects DY3 as their baseline period, then the measurement periods would be DY4 and DY5. If a provider selects the first six months of DY3 as the baseline period (ending 3/31/14), then the measurement period to earn DY4 funds would be 4/1/14-3/31/15 and the measurement period to earn DY5 funds would be 4/1/15-3/31/16.

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 submit as supporting documentation for Category 4 payment for these 2 domains. HHSC has discussed with CMS state statutes around confidentiality of Medicaid PPE reports (at the hospital level), and we think we have a good plan for maintaining confidentiality. Providers will submit their Cat 4 data for these two domains to HHSC (which HHSC must keep confidential), and HHSC will certify to CMS that each hospital met its Cat 4 reporting requirement. Rather than submitting individual hospital PPE data to CMS, HHSC will submit data to CMS at the RHP level. We believe this addresses confidentiality concerns at the individual hospital level. As a reminder, some hospitals are exempt from Cat 4 reporting and for hospitals for which the data isn't statistically significant, the Domain 1 & 2 reports that hospitals receive from HHSC will show zeroes rather than actual numbers to indicate the data wasn't statistically significant.
- 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.
- HHSC has received questions on the optional RD 6, given that many of the measures are ambulatory and hospitals may not be collecting this data. We have designated which are ambulatory and plan to propose to CMS that only hospitals that have outpatient clinics would report these measures.
- 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.

Other Information for Anchors

Anchor Administrative Match Protocol

- Thank you for sending us your examples of the timesheets you are using for anchor cost allocation. If you have not sent us one yet, we would still like to receive them. We are including this information with follow-up to CMS on their questions about anchor cost allocation methodologies. Looking at what you are using to allocate time will help us find a consistent strategy that fits with what most Anchors are using and that will be sufficient for CMS.

HCBS Final Rule Publication

- CMS has announced the publication of an important final rule about home and community-based services (HCBS) provided through Medicaid's 1915(c) HCBS Waiver program, 1915(i) HCBS State

Plan Option, and 1915(k) Community First Choice. The rule is on display today at the Federal Register, see https://www.federalregister.gov/articles/2014/01/16/2014-00487/state-plan-home-and-community-based-services-5-year-period-for-waivers-provider-payment-reassignment. The rule enhances the quality of HCBS, provides additional protections to HCBS program participants, and ensures that individuals receiving services through HCBS programs have full access to the benefits of community living.

- The final rule and a set of fact sheets are available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html.

Key Upcoming Waiver Dates

- **By March 28, 2014** – HHSC submits New 3-Year Projects to CMS (those that will be eligible for April reporting).
- **April 2014** – First DY3 (or carry forward DY2) reporting opportunity.
- **April 30, 2014** – April DY3 milestone/metric achievement (or carry forward DY2) reporting and Semi-Annual Progress Reports due from providers. IGT Entity Change Forms for July DSRIP payments due from providers.
- **May 16, 2014** – Due date for IGT entities to notify HHSC of any issues with affiliated providers' reports.
- **By mid-May 2014** - HHSC submits last batch of 3-year projects to CMS for review.
- **Early June 2014** – HHSC approves April reports or requests additional information from providers.
- **By June 2014** - CMS approves 3-year projects.
- **July 2014** – RHPs submit plan modifications for DY4-5.
- **TBD** – Full RHP Plan submission to HHSC (July 2014 or later).
- **July 9, 2014** – Estimated IGT due date for approved April milestone/metric achievement and DY3 monitoring.
- **Mid-July 2014** – Providers supply additional information if necessary following April reporting.
- **July 31, 2014** – Estimated payment date for April reporting.
- **Mid-August 2014** – HHSC reviews and approves or disapproves additional information submitted by providers following April reporting.
- **September 9-10, 2014** - Tentative dates for annual statewide learning collaborative in Austin.
- **October 31, 2014** – Anchors submit administrative costs for DY 2 and DY 3 (target pending CMS approval of Anchor Administrative Costs Protocol).
- **January 2015** – Estimated payment date for Anchor Administrative Costs.