Anchor Conference Call

AGENDA

April 11, 2014
9:00 - 10:30 a.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 DSRIP IGT entity to Anchors soon. HHSC may determine that the full $5M is not required for DY3 and will keep you informed once we have a final determination. For the monitoring amount for DY3, HHSC is planning to request all of it in July (this is an update from what we included in the April reporting webinar.)

- We mentioned in the call in response to a question that this July may be the last opportunity for a project to submit a plan modification for DY4 - 5. We are still considering this. We will look at this issue further and provide you with additional information soon.

2. DSRIP Implementation

April DY3 Reporting

- April DY3 reporting instructions and templates, including the QPI template, have been posted on the waiver website. As a reminder, reports will be due to Deloitte by 5:00 p.m. CST on April 30th.
    - We understand that some anchors and providers have had difficulty downloading some of the templates from the website using Internet Explorer. We apologize for the inconvenience; it appears that there are issues using Explorer with the .docx and .xlsx version of templates. Alternate browsers, such as Google Chrome or Firefox, do not pose the same issues with these templates. We are also converting some of the documents to earlier versions of Excel or Word and will repost them to the website.
    - For providers who are having functionality issues with a template, please send to the waiver mailbox as soon as the issue is identified. We are sending the templates to Deloitte to be fixed and returning to providers as soon as possible. This may take a couple of days, so please allow that time before sending follow-up messages after you've requested a template.
    - An updated version of the DY 2 Carryforward Template has also been posted today (noted as updated 4/11/14).
- When reporting, there are separate forms to attach for reporting on QPI metrics (optional pilot version for April), Category 3 Status Reports (DY2 and DY3), and Category 4.
- As a reminder, do not report a Category 1 or 2 metric as completed until it is completed. For any metric/milestone that HHSC does not find sufficient evidence of achievement in the documentation, the provider will only have one opportunity in June to submit additional information. If the provider cannot demonstrate during the June "needs more information" (NMI) period that the metric/milestone was completed by March 31, 2014, the provider will no longer be eligible for payment for that metric/milestone. In addition, if a metric/milestone is reported as completed and is approved by HHSC and CMS, but during the compliance monitoring, it is found that the metric was not completed as reported, the associated DSRIP payment may be subject to recoupment.
- HHSC provided guidance in the webinar regarding metrics that could be reported in April vs. October. Please advise providers to follow the guidance in the webinar and companion. If there is

a question on a certain metric, please send an email to the waiver mailbox and include the Project ID, the metric, the goal and the question on why it is not clear whether the metric is ok to report in April vs. October. HHSC does not have the bandwidth to respond if providers submit all their metrics to ask about whether to report in April. If a provider is uncertain about whether to report in April, we advise you to wait until October. Our goal is that providers are able to earn DSRIP funds for achieved metrics, but if you report them too early, you will forfeit that payment.

- In June, HHSC Rate Analysis will notify IGT Entities of the IGT required for DSRIP payments and DSRIP monitoring. The file will allow IGT Entities to enter the actual IGT amount to transfer and calculate the amounts for DSRIP payments versus DSRIP monitoring. IGT Entities must enter the correct IGT amounts in two separate categories in HSAS by RHP, otherwise payments may be delayed.
- We have been asked if we will expect providers to turn in documentation for core components with their semi-annual reporting.
    - Documentation only needs to be submitted if a core component is also included in a project metric/milestone. In this instance, supporting documentation can be included. Otherwise, core components only need to be reported in the qualitative response in each Project Summary section.
- We discussed on the anchor call in March how to handle individuals with Exchange health insurance coverage in terms of counting them toward the Medicaid/low income uninsured %, including those that use a coverage program (e.g. JPS Connections) as a 2nd payor source because they can't afford deductibles as well as people who had moved to Exchange plans since this was not considered during those percentage estimates.
    - Providers can include low-income individuals that are on Exchange plan when providers have made efforts to move individuals from uninsured to insurance through the Exchange. If a provider has a system to document low-income individuals in the Exchange (such as individuals receiving a subsidy), that is recommended.

New 3-year projects

- HHSC feedback on 3-year projects has been sent to most RHPs (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 reviewed — 5, 8, 17 and 20 — were sent to CMS last week. If metrics are reported and approved in April, payment will be contingent on CMS approval of the project.
    - The final workbooks, projects with revisions and clean versions as submitted to CMS have been forwarded to 5,8,17 and 20 for providers to see any changes that HHSC may have made after receiving them from providers.
- Some providers have expressed concern that Category 3 information is outdated. CMS will not be reviewing Category 3 at this time.
- HHSC will continue to send feedback for other RHPs. Providers should plan to address the HHSC feedback quickly.
- Our goal is to submit all of the projects to CMS by early May, which will mean RHPs will receive CMS feedback by June. CMS prefers that HHSC submit the remaining 3-year projects in either 1 or 2 additional batches (which triggers the CMS 45-day review timeframe).
- 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.
- Many regions are asking for extensions on their responses to HHSC feedback. Please note that this can impact when all projects are submitted to CMS.
- Anchors should send a message to the waiver mailbox informing us when projects have been

submitted to Deloitte so that we can track these closely.

- We have been asked how redistributed Category 3 dollars are factoring into the list for 3 year projects and the funding available per region. Because the Category 3 funding was being redistributed and not decreased, this does not impact availability of funding for new 3-year projects. If a new 3-year project does not get approved and is not replaced, then the associated funding would be available for new 3-year projects. For instance, if a provider opts to withdraw a 3-year project in the near future, HHSC will include those funds in the redistribution calculation. However, at some point HHSC plans to do a final redistribution of funds for new 3-year projects, so if a 3-year project gets disapproved by CMS late in the review process, those funds likely will not be redistributed.

DY 4/5 Valuation

- 14 projects that provided qualitative justification for original DY 4/5 valuation are still under 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).
- HHSC will continue to work with CMS to provide more information to the projects with DY4-5 valuation coversheets to those providers soon.

Category 3

- HHSC will continue Category 3 selection review and will continue with TA as needed to prepare for the next step of establishing baselines for October reporting.
    - The review process has begun and is occurring by region.Feedback will be sent directly to providers to the contact listed in the Category 3 selection tool, with a cc to the Anchor.
    - Initial feedback is scheduled to go out from late April to late May.
    - Providers will have 10 business days to respond to this initial round of feedback, either providing the additional information requested by HHSC -or- confirming HHSC's understanding of the use of the measure**.** (Providers may request extensions due to competing deliverables). **All providers will receive feedback and will be required to respond, even if just to confirm the measure selection**.
    - HHSC will review the provider responses to HHSC feedback and approve the measure or request the provider continue to revise their selection.
    - The timelines are planned for Category 3 review to be finalized by July 1st, 2014.
    - Information will then be provided to CMS and if there are any questions we will follow up as needed.
- Continue to send questions to the waiver mailbox, using the Category 3 designation in the subject heading.
- The final Category 3 compendium versions will be released with the revised RHP Planning Protocol, which is targeted for mid-June.
    - Updates will include benchmarks where possible, shift of measures from QISMC to IOS and minor clarifications to specifications based on the questions we have received.
    - When possible HHSC will provide any updates on if measures are categorized as QISMC or IOS as well as any updates to benchmark values during the review period in the Category 3 feedback to providers.

Category 4

- For Domains 1 & 2 (PPAs and PPRs), HHSC will receive the reports from the 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. Our staff has confirmed contacts for providers and will notify Anchors once the reports are sent. Rather than submitting individual hospital PPE data to CMS, HHSC will submit data to CMS at the RHP level.
- Given the delay in providing PPE data for Cat 4, CMS has agreed for Domains 1 and 2, providers will not be required to include a qualitative report on these domains for April. Reporting for Domain 3 begins in DY 4 (Potentially Preventable Complications).
- The qualitative report will be required in April for Domains 4 and 5, as well as 6, if applicable.
- RD 5: We have received some questions from providers on this measure and have found a discrepancy in the RD 5 measure specifications on the NQF site. The intent of the measure per the measure steward is to find "the median time from admit decision time to time of departure from the emergency department (ED) for ED patients admitted to inpatient status." NQF incorrectly states this measure as having a traditional numerator and denominator, both of which are described as the same continuous variable and, if used as described, would always result in a rate of 100% and not provide any detail about the number of admissions from the ED considered in the calculation. Please see here for the actual measure guidelines. We are posting a revised template and are asking for the following information.
    - Median Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients
    - Number of emergency department (ED) patients seen and used to calculate median time in minutes from admit decision time to time of departure from the ED for admitted patients.
- 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 proposed to CMS that only hospitals that have outpatient clinics would report these measures. CMS is still reviewing this request. HHSC advises that hospitals report on this optional domain in April only if they can report on all the measures. We will continue to work with CMS on this issue. For the HEDIS measures in RD-6, hospitals can modify and report on "patient" rather than "member," given this is hospitals reporting rather than health plans.
- UC hospitals are also required to send Domains 1 & 2 to be eligible for DY 3 UC payments. We will advise the date for those reports to be provided to HHSC.

Anchor Administrative Match Protocol

- HHSC is continuing to work with CMS on the Protocol. HHSC has reviewed all cost allocation methodologies with CMS and has shared a framework that may be workable for all Anchors that is utilized by RHPs 8 & 17. We will send this out with the Anchor notes today to get your feedback as well. It is a "Percent Effort Spreadsheet" that is logged on a monthly basis. Anchors may have varying processes they could use, but the proposal would be that this could be a consistent document for tracking costs.
- The process utilized by RHP 8 & 17 is similar to what they use for other federally sponsored projects, which provides a practical basis for documenting distribution among the 6 CMS-approved anchor administrative functions.
- A spreadsheet is used that documents the percentage of each employee's time that is applied to the anchor administration functions, which is certified for each month.
- We have received feedback on the issue raised by CMS for accounting for 100% of staff time, and we will continue to work with CMS on this issue.

Recent questions from anchors (*HHSC answers follow questions*):

- Is HHSC keeping logs of the questions they received on one-on-one calls with providers? Are these logs inclusive of 'meeting minutes' documenting the questions received and answers given? ***No***
    - If no, do you have any suggestions on how providers should document those calls in case answers provided in them ever need to be referenced to support project decisions, documentation, during an audit, etc.? ***Providers can follow up with HHSC with an e-mail to the mailbox to document their understanding of telephone guidance.***
    - ***HHSC does not have a log of one-on-one calls with providers, though we typically have some email trail from it. It would be fine for providers to follow up with HHSC with an e-mail to the mailbox to document their understanding of the telephone guidance.***

- Full plan submission & mid-point assessment
    - Multiple providers have asked what type of updates will be allowed to take place in the narratives when the full RHP plan is resubmitted.
        - Some providers have detailed information about their Category 3 outcomes, and different implementation efforts within their projects they would do in order to achieve certain outcomes – with the recent Category 3 changes now and some providers changing their outcomes entirely – what is the opportunity for providers to update their narratives to correct outcomes and implementation efforts around them.
            - ***The narrative for Category 3 outcomes will be included with the Category 1 and 2 Project narratives with the full plan submission. Category 3 updates can be made at that time.***
        - In light of the mid-point assessment/ monitoring contracts and evaluating providers based on their documented implementation success and what is written in the submitted plan – what is HHSC going to expect in areas where Category 3 outcomes have changed, or other elements of the project now need updating due to these changes?
            - ***HHSC is working on additional details on mid-point assessment/ monitoring and will communicate more details soon.***
        - If some items of project narratives have to be changed or are now irrelevant due to these changes, how should that be documented and how will that be handled during the mid-point assessment/ continued monitoring?
            - ***Changes that are related to Category 3 or plan modifications that have already been approved would occur. If there are other changes, then a plan modification may be needed.***

Other Information for Anchors

Carryforward and Payment Timing

- Our staff has been discussing carryforward reporting and payment and would like Anchor input We need to check with CMS regarding options for when to "cut off" payments out of the DY2 DSRIP pool, so wanted to run the following scenario by you:
    - A provider carried forward a DY2 milestone, which enables it to report achievement either in April 2014 or October 2014. If it reports achievement in October 2014, but HHSC/CMS need more information to approve the achievement, that payment would not occur until

July 2015, which is late in DY4. CMS may not go for this, so an alternative would be to not have an NMI opportunity for metrics carried forward and then reported in the 2nd reporting period of the subsequent DY (in this example, reporting in October 2014).

- PLEASE LET US KNOW IF YOU HAVE CONCERNS ABOUT THE OPTION ABOVE - ONLY ONE CHANCE TO REPORT DY2 CARRYFORWARD METRICS/MILESTONES IF REPORT IN OCTOBER 2014.

Federal Review of DSRIP (and UC)

- We want to let you know that CMS notified HHSC this week that it will do a financial review of DY2 DSRIP (to date). This is not a surprise as CMS had told HHSC some time back that a financial review was likely early in the waiver. We will provide CMS information about DSRIP providers, IGT entities, and DY2 reporting to facilitate this review.
- HHSC also learned this week that the U.S. General Accounting Office has been asked by members of the Senate Finance Committee to review Medicaid non-DSH supplemental payments (including UPL and supplemental payments through 1115 waivers, so both UC and DSRIP) in a number of states. HHSC will be speaking with GAO about this inquiry soon.

House County Affairs Hearing - April 22nd, 9 am - HHSC will provide a DSRIP update; HHSC understands that some DSRIP anchors/participants also will present

Statewide Learning Collaborative

- The event is scheduled for September 9 & 10 at the AT&T Center in Austin.
- We are planning for 500 participants at the Center and web-streaming for those not attending in person and will work with Anchors on the number of in-person participants that will be invited from each RHP. At this time Anchors and DSRIP providers can plan for 1 in-person participant each, at a minimum.
- A survey is in development for DSRIP participants and other stakeholder feedback for the agenda and look forward to your insights.

HHSC Survey Regarding Certain Expenditures

- On today's anchor call, someone asked about the survey that a number of DSRIP providers have received (both hospitals and non-hospitals). This survey is from the HHSC Rate Analysis area and HHSC is required to collect the survey information per Rider 43 from the FY14-15 General Appropriations Act (see attachment).
- The survey will go to all DSRIP providers (both hospitals and non-hospitals), along with DSH, UC, and Indigent Care providers. Rider 43 is an update to Rider 46 from the 2011 Legislative session, and as noted in the email that went out with the survey, the results of the Rider 46 survey are available on HHSC's website.
- Rider 43 requires that HHSC collect information from providers about DSRIP payments and how those funds were expended. So, if a provider earned $2 million DSRIP in FFY2013 (DY2), the provider would report that $2 million payment and include in the survey how the funds were expended (e.g. patient care, Medicaid healthcare services, etc.). The survey is not asking about the cost of the DSRIP project; rather it's asking about the amount of DSRIP funds earned and how they were expended.
- Non-hospital providers that are getting this survey for the first time may find it helpful to look at the results of the Rider 46 survey on the website to get a sense of how hospitals filled out that survey.

Anchor Conference Call

AGENDA

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.