Anchor Conference Call

AGENDA

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

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

1. General Anchor Communication

- Thank you for submitting your plans. All were received by December 31.
- 1,341 projects received and plan review is under way.
- Discussion of collaborations

2. IGT for UC payments

- Determining IGTs for final DY1 UC payments – currently scheduled for March.
- Anchors will be asked to obtain IGT commitments for all hospitals and physician groups in their RHP for the final DY1 UC payment. A standardized format will be sent to the Anchors for reporting the IGT commitments.
- The IGT commitments will be used to determine if any reduction to the maximum payments (reductions from the caps – also known as a haircut) is needed to remain within the waiver maximum funding.
- Actual IGT payments will occur after the IGT commitments are received, and the determination of compliance with the waiver maximum funding has been determined.

3. Plan Review and Feedback

Demonstrating patient benefit:

- Common issues from feedback – not providing sufficient information to justify valuation. Need to be able to quantify patient benefit – volume of services or number of clients served – particularly in DY 5. If this issue has been highlighted in your region's feedback, the provider should be sure to update the project to include at least one of these data points. The milestones should reflect the stated patient benefit.
- CMS has requested annual information on patient impact (workload) of a Cat 1 or 2 project (e.g., X,XXX services provided in DY 3, X,XXX services provided in DY 4, and X,XXX services provided in DY 5).
- The provider can update patient benefit information by revising the summary and/or narrative, and providers are strongly encouraged to reflect this patient benefit information in their Category 1 and 2 milestones and/or Category 3 outcomes.
- The valuation feedback was based on the plan including project summaries. If a provider received feedback that the patient benefit, estimated number of patients, or estimated number of services needed further clarification, then this indicates HHSC is requesting more information than what was included in the project summaries.

Technical Feedback:

- Regions will receive spreadsheets with data related to project findings from technical review. Major issues will be highlighted and summary comments for project issues are included.
- The technical review process for projects was extensive, and reviewers may not have identified all issues that may eventually need to be addressed for final plan approval.

Valuation feedback – looking at patient benefit, strength of outcome, relevance of milestones to narrative:

- Valuation feedback will highlight the valuations for projects that have been flagged because HHSC's assessment is the project needs additional work to justify the proposed valuation.
- Providers may do several things to better justify the valuation:
  - improve the project summary, narrative, and tables to better explain the patient benefit;
  - increase the patient benefit (providers can demonstrate patient benefit through their Category 1 or 2 milestones and/or select stronger Category 3 outcome(s) to support the proposed value);
  - reduce the proposed valuation; and/or
  - replace the project with another project.
- When regions resubmit plans, HHSC will review the changes made to projects to better justify the proposed valuation. Depending on the extent of the changes, HHSC still may flag the project as a valuation outlier when the RHP plan goes to CMS, or may remove the flag.

Workbooks:

- Unless your region has specifically been contacted about submitting another anchor workbook, you do not need to submit another anchor workbook.
- A blank workbook will be provided with your formal feedback that providers can use if your region needs to replace a project
- An IMD workbook with UC data can be provided, if requested by DSHS.
- Only hospitals, physician practices that participated in the former physician UPL program, governmental dental providers, and governmental ambulance providers are eligible for UC. Other providers that indicated UC estimates will be noted in the formal feedback.

4. Timelines and Next Steps

- HHSC plans for all regions to receive feedback by early February.
- Your feedback includes a note indicating the 15-day response deadline to address HHSC's concerns.
- You may request up to an additional 15 days if you need more time. Email extension requests to txhealthcaretransformation@hhsc.state.tx.us
- Please note that any additional time it takes your region to address the feedback may delay DY 1 payments.

Responding to feedback:

- Please work with the providers of the projects identified to make changes. The performing providers for identified projects will be informed that you have received feedback about their projects.
- Plans should highlight substantive changes made in response to HHSC feedback in yellow. Substantive changes not in response to HHSC feedback should be highlighted in gray.
- There will be a place in the feedback documents you receive in which HHSC asks you to affirm if the issues have been resolved and to indicate how the issues were addressed.

If a project is pulled, the money for that project cannot be distributed to other projects. You can either:

- Replace the project now with one or more new projects valued up to but not exceeding the original project amount; or
- Do not replace the project now, but the funds for that project will be available to the region for projects approved for DY 3.

If your region is replacing any projects, please submit the *DSRIP Feedback Changes Electronic Workbook* for the particular Performing Provider. The Anchor Workbook does not need to be resubmitted.

Format of revised plan submission:

- Send one CD and one hard copy.
- The CD should include one "clean" copy of the plan and one version that includes changes highlighted as directed in the feedback.
- The electronic version of the document should not include any track changes.
- The hard copy also should highlight changes as specified in the feedback.

HHSC review of revised plan submissions:

- Any critical changes that providers do not make in response to feedback could risk that HHSC will not move the plan or a particular project forward to CMS. Examples of critical issues: IGT not identified, plan not signed, project does not serve Medicaid/indigent, no patient benefit.
- HHSC will flag items in projects for which regions have not responded to feedback.
- For plans that can move forward, HHSC will submit the clean version of the RHP Plan to CMS with presumptive state approval.
- HHSC will inform the RHP when the plan is submitted to CMS or will provide additional feedback if the RHP has not adequately addressed HHSC's feedback.
- Expect that there will be questions and feedback from CMS.

For DY1 DSRIP payments, a couple of regions may receive DY1 DSRIP in March depending on when their plans are submitted to CMS, but HHSC expects most regions will receive DY1 DSRIP payments in April-May. HHSC is working to put out a draft timeline for all waiver payments.

Semi-annual reporting

- HHSC will prescribe the format for reporting. For DYs 3-5, HHSC is in the process of procuring a vendor to develop a web-based application to enter progress on milestones, outcomes, and reporting domains as well as uploading supporting documentations. This will also be the system for IGT Entities to report available IGT for DSRIP. RHPs may use other systems for project management; however, HHSC expects Performing Providers to enter DSRIP data for payment in the HHSC application.
- For DY 2, HHSC is developing a more manual reporting system using the workbooks as the basis. HHSC has discussed with CMS the opportunity for RHPs to provide the first report in June or August 2013 while the second reporting period will remain October 31, 2013.