Anchor Conference Call

AGENDA

January 25, 2013
2:00-3:30 p.m.

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

1. General Anchor Communication

2. Collaborations

Collaborations:

- Last Friday, HHSC sent a notice regarding DSRIP projects that were proposed under the collaboration option. CMS provided guidance that some of these projects may be denied if the collaboration appears to be an impermissible provider-related donation. HHSC offered two options in the notice:
    - One option is to withdraw some or all collaborative projects from the RHP Plan. The funds for the withdrawn projects may be used in Pass 3b to fund the projects withdrawn in Pass 1 or 2, fund other projects that benefit the region, and/or leave some of the funds for plan modifications beginning in DY3.
    - A second option is to leave collaborative projects in Pass 1 or 2 with an explanation of why the project is collaborative and transformative for the region.

- HHSC will be sending a document later today that provides technical guidance for withdrawing collaborative projects, including steps for updating the narrative and workbook.
- Any project identified as a potential collaboration may be withdrawn from Pass 1 or 2 along with the corresponding Category 3 outcome(s). Other projects identified by the provider as a project that may have potential provider-related donation issues based on recent CMS guidance may also be withdrawn.
- Pass 3b
    - Funds for withdrawn projects will flow to Pass 3b. No other funding is available for Pass 3b.
    - Former Pass 1 or 2 projects and the corresponding outcome(s) may be funded in Pass 3b at the same or reduced value.
    - If funding other projects in Pass 3b, only projects that were previously considered but not included prior to the December 31, 2012, full plan submission and that have a funding source may be proposed.
    - Pass 3b DSRIP funds may not be used to increase funding for any Pass 1, 2, or 3 projects or outcomes.
    - Cat. 4 and estimated UC may <u>not</u> be changed.
- If you pull a Pass 1 or 2 project, indicate in the RHP comment column in the valuation feedback worksheet for the project. In the pulled project's row, also indicate if the project is reintroduced in Pass 3b and indicate the new unique ID.
- In the narrative for projects that have moved to Pass 3b, indicate in the heading next to the new unique ID for the project that it is a Pass 3b project and also <u>note the former unique ID number for the project</u>. Ex: *Project Title*, [new unique ID #], Pass 3b, (Former Unique ID: [old unique ID #])

DY1 DSRIP Payments

- HHSC estimates that the first DY 1 DSRIP payments may be made in March for two RHPs (depending on how soon they are submitted to CMS). The remaining RHPs will likely receive DY 1 DSRIP payments in April and May.
- A few RHPs did not enter IGT information for DY 1 DSRIP payments in their Anchor workbooks. The IGT information must be submitted to process DY 1 DSRIP payments. This request will be included in your formal feedback.
- Reminder: HHSC will use the DY 1 DSRIP IGT information entered in the Anchor workbooks to make IGT requests at the time of payment processing. If less IGT is provided than required, than DY 1 DSRIP will be proportionately reduced for the Performing Providers affiliated with the IGT Entity as well as the IGT Entity's DY 1 DSRIP payments if they are also a Performing Provider. The proportionate reduction will not impact the 20 percent DY 1 DSRIP Anchor payment.
- All Performing Providers and IGT Entities must have a TIN at the time of DY 1 DSRIP payment processing to be able to be paid. All Performing Providers must also have an active TPI at the time of payment.

3. Category 3

- HHSC wants to give the RHPs a heads up that CMS has requested a modification to Category 3 achievement targets with the intent to introduce a methodology for calculation. Details still need to be worked out with CMS, but we want to make you aware.
- Current implications for projects: <u>For now, focus on the choice of Cat 3 outcome, not on the achievement level.</u> Partial plan approval initially (for Cat 1, 2, 4 and Cat 3 process milestones) with full approval when benchmarks and associated targets have been established. DY4/5 Cat 3 approval will be pended until targets are finalized during plan modification process.
- Our quality team is in ongoing discussions with CMS and more details will follow.

4. Plan Review and Feedback

Quantifiable patient benefit and milestones:

- Common valuation feedback: "Recommend clarifying in summary estimated patient impact of this project by DY. The quantifiable patient impact also should be reflected in the milestones."
- Providers are STRONGLY encouraged to reflect patient benefit information in their Category 1 and 2 milestones.
- Providers either can add an additional milestone or revise an existing milestone to clearly quantify patient benefit (e.g., in cases that an existing milestone has a baseline of TBD yet a percent improvement is noted for the goal).
- Options to indicate patient benefit in milestones, <u>if no patient benefit is included in current milestones</u>:
  - Review the improvement milestones in the RHP Planning Protocol for your project area and see if any could be used for your project to reflect patient benefit.
  - Create a customized milestone that quantifies major project activities that directly support the project valuation. The customized milestone should reflect either a number of patients served or quantity of services provided.
- Options to indicate patient benefit in an existing milestone, <u>if the existing baseline is TBD and a percent improvement is noted</u>:
  - Modify a TBD baseline for an existing milestone to reflect a hard number to make the percent improvement quantifiable.

- Instead of a percent improvement over a TBD baseline, revise to reflect a hard number goal for patient benefit.
- For projects in which it is more difficult to quantify patient benefit (e.g., continuous process improvement projects):
  - If the provider has identified a quality objective for why they are implementing the project, they can indicate the number of clients impacted by a process change (e.g., if a provider is doing a process improvement project that will result in new protocols for a targeted condition, the provider could indicate how many clients the new protocol will be applied to).
  - If the project is broadly about systemic change, at a minimum, providers can note the number of patients in the system.

Category 1 and 2:

- No TBD should be used for Cat 1 and 2 goals – particularly for DY2, because there will be no basis for payment.

Category 4:

- Category 4 should have a separate narrative for each domain
- Primary expectation of each domain description is describing any tie between Cat 1 and 2 projects and Cat 3 outcomes and their impact on that specific reporting domain. Note unique project ID in parenthesis on first mention. Indicate no impact if none.
- Remember that Cat 4 is about inpatient reporting – it is a common issue for providers to state, for example, that their projects will impact inpatient PPCs in RD 3 when their projects only impact outpatient settings.
- Note that RD 5 on emergency department is not about nonemergent ED utilization – it only addresses admit decision time to ED departure.

5. 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

Responding to feedback:

- 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.
- Do NOT delete any highlights that were included in earlier versions of your plan submissions.
- 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, this is where you should indicate if it is being reintroduced and what the new unique project ID is.

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.

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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 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.