Category A
Costs and Savings
DY9-10 Guidance Document

Contents

Definitions 2

Introduction 3

Financial Analysis Overview 3

Purpose 3

Costs and Savings Analysis Requirements 4

1. Analyze a different intervention in DY10 than was used in DY8 4
2. Intervention is a Component of a DY9-10 Core Activity 7
3. Intervention Initiated between December 2011 and September 2021 7
4. Cost Data for Program Costs 7
5. Cost Data for Financial Outcomes 8
6. Analysis Period 9
7. Data Sources 10
8. Discount Rate 10
9. Costs and Savings Template Questions 10

Scoping the Costs and Savings Analysis 10

DY10 Round 2 Submission 12

Questions 13

Definitions

Below is a list of unique terms defined in this document:

- **Costs and Savings Analysis:** The analysis that includes the costs of at least one Core Activity of choice and the forecasted or generated savings of that Core Activity.
- **Costs and Savings Template:** The reporting template developed by the Health and Human Services Commission (HHSC) that providers must use to report the Costs and Savings Analysis.
- **Intervention:** A systematic, continuous, and deliberate action(s) intended to improve the quality of healthcare services and outcomes of the Patient Population.
- **Patient Population:** Individuals who received the intervention or are expected to receive the intervention.
- **Initiated:** Interventions are initiated once the majority of the intervention has been developed and is operational, and the intervention can affect the Patient Population.
- **Analysis Period:** The timeframe of the Costs and Savings Analysis, which includes the Startup Period and the Operating Period.
- **Startup Period:** The day the provider began developing the intervention through the day before the intervention is initiated.
- **Operating Period:** The day the intervention is initiated through, at least, three (3) consecutive years after initiation and through the end of DY9 for interventions initiated before DY10.

Introduction

During DY9 Round 2 reporting (October 2020), providers with a total valuation of $1 million or more per DY were required to submit an update on progress made towards the final report of costs and savings that is due during DY10 Round 2 reporting (October 2021) by responding to questions in the DSRIP Online Reporting System under the Category A tab.

During DY10 Round 2 reporting, providers with a total valuation of $1 million or more per DY are required to submit the costs of at least one Core Activity of choice and the forecasted or generated savings of that Core Activity (the "Costs and Savings Analysis") on the template developed by HHSC (the "Costs and Savings Template").

Providers with a total valuation of less than $1 million per DY will have the opportunity to answer optional questions in the DSRIP Online Reporting System under the Category A tab during DY9 and DY10 Round 2 reporting and will have the opportunity to submit an optional Costs and Savings Analysis during DY10 Round 2 reporting.

Financial Analysis Overview

Financial analyses, like the kind used for the Costs and Savings Analysis, can illustrate to stakeholders (e.g., payers, managed care organizations, community partners, health systems, etc.) that an intervention could be or is a worthwhile investment by showing the potential or generated financial outcomes associated with an intervention before undertaking the intervention or after the intervention has been initiated.

A financial analysis can also demonstrate to payers the potential for a value-based payment arrangement. The goal of a value-based payment arrangement is to pay for value instead of volume. Value-based purchasing has the potential to direct clinical services in the most appropriate manner. Over time, linking healthcare payments to value or quality should result in improved patient outcomes and greater efficiencies in the system of care.

For some interventions, providers can incur significant costs to develop the intervention before it is initiated, and it can therefore take a longer period to see the net benefits or return from this initial investment. Other factors such as a long ramp-up period, or the time it takes to reach full enrollment in the intervention, can affect how long it takes to see the net benefits or return from the intervention. If a financial analysis is calculated early in the intervention, then the results are more likely to be negative. If a financial analysis is calculated in the long-run, then the likelihood of having positive results will increase.

Purpose

The purpose of the Costs and Savings Analysis is for providers to analyze the financial outcomes of the intervention on the system of care and other stakeholders. The Costs and Savings Analysis can be used by providers to work

with Medicaid managed care organizations and other payers on alternative payment models, for sustainability of interventions post-DSRIP, to evaluate the financial outcomes of the intervention on different stakeholders, to identify lessons learned, etc.

Providers do not need to reach a specific result to receive credit for the Costs and Savings Analysis (i.e., the Costs and Savings Analysis does not need to show a savings).

HHSC plans to use providers' Costs and Savings Analyses for various purposes, including identification of interventions that may be financially sustainable and/or beneficial to populations and/or other stakeholders. The Costs and Savings Analyses could also be used to inform future policy.

Costs and Savings Analysis Requirements

Below is a list of requirements for the Costs and Savings Analysis. The Costs and Savings Template and/or review criteria will account for these requirements.

1. Analyze a different intervention in DY10 than was used in DY8

The Program Funding and Mechanics Protocol requires that providers with a total valuation of $1 million or more per DY analyze: 1) a different Core Activity for the Costs and Savings Analysis due during DY10 Round 2 reporting than was used for the Costs and Savings Analysis that was due during DY8 Round 2 reporting; or 2) a different aspect of the same Core Activity for the Costs and Savings Analysis due during DY10 Round 2 reporting than was used for the Costs and Savings Analysis that was due during DY8 Round 2 reporting.

This means that providers are required to analyze a different intervention or a different scope of the same intervention for the Costs and Savings Analysis due during DY10 Round 2 reporting than was used for the analysis that was due during DY8 Round 2 reporting.

An intervention is considered different if it targets a different Patient Population or if it targets the same Patient Population, but the specific action/changes implemented as part of the intervention are different and are expected to result in different outcomes. Below are examples of how interventions can be different:

- *Targets a different Patient Population:*
  - An intervention offering healthy lifestyle classes to Diabetes patients is now being offered to Heart Disease patients. In this example, the intervention could be the same for Diabetes and Heart Disease patients (i.e., offering healthy lifestyle classes), but the outcomes could be different for Heart Disease and Diabetes patients.
- *Specific actions/changes implemented as part of the intervention are expected to result in different outcomes:*

- An intervention that offers free healthy cooking classes to Diabetes patients is now offering free exercise classes to these same Diabetes patients in addition to the healthy cooking classes. In this example, the same Diabetes patients are receiving the intervention, but the inclusion of free exercise classes is expected to further improve outcomes. In this example, if the same Diabetes patients are being used, the outcomes expected by adding the healthy cooking classes is being analyzed (i.e., pre-initiation of the intervention, the Diabetes patients are receiving free healthy cooking classes; post-initiation of the intervention, the Diabetes patients is receiving free healthy cooking classes and free exercise classes).

An intervention is also considered different if the scope of the intervention being analyzed for the Costs and Savings Analysis due during DY10 Round 2 reporting is a subset of the intervention that was analyzed for the Costs and Savings Analysis that was due during DY8 Round 2 reporting. Providers submitting an analysis during DY10 Round 2 reporting that is a subset of a prior analysis will be required to provide justification in the Costs and Savings Template explaining the merit of analyzing a subset of a prior analysis. Below are examples of how interventions can have a different scope that is a subset of a prior analysis and examples of justifications:

- Provider already analyzed the outcomes of an intervention that offered healthy cooking classes, exercise classes, and digital glucose monitoring devices to Diabetes patients, but provider wants to analyze the outcomes associated with only offering digital glucose monitoring devices to these same Diabetes patients. In this example, the outcomes of the intervention could be different when isolating the digital glucose monitoring device intervention, and the cost to provide just the digital glucose monitoring device intervention would be different.
    - Example Justification: With limited funding available, provider wants to see if the Diabetes management program which includes the free cooking classes, exercise classes, and digital glucose monitoring devices is viable if only the digital glucose monitoring devices intervention is continued.

- Provider already analyzed the outcomes of an intervention offering healthy lifestyle classes to Diabetes and Heart Disease patients, but provider wants to analyze the outcomes associated with providing the healthy lifestyle classes to Heart Disease patients only. In this example, the outcomes could be different for Heart Disease patients versus Diabetes patients, and the cost to provide the intervention to Heart Disease patients only would be different.
    - Example Justification: The intervention was more effective for Heart Disease patients in terms of outcomes, and provider wants to analyze the associated cost savings to the

system of care based on the outcomes of the intervention for Heart Disease patients only.

- Provider already analyzed the outcomes of an intervention offering healthy lifestyle classes to all Diabetes patients, but provider wants to analyze the outcomes associated with providing the healthy lifestyle classes to Diabetes patients with high ED utilization only. In this example, the outcomes of the intervention on the Diabetes patients with high ED utilization could be different than all Diabetes patients, and the cost to provide the intervention to Diabetes patients with high ED utilization only would be different.
  - Example Justification: Provider believes that there is more opportunity for cost savings if high ED utilizers with Diabetes are targeted with the intervention instead of all Diabetes patients, and provider wants to see if the intervention is viable post-DSRIP if offered only to high ED utilizers with Diabetes. Provider also believes patients with high ED utilization would benefit the most from the intervention.

- Provider already analyzed the outcomes of an intervention offering digital glucose monitoring devices to all Diabetes patients, but provider wants to analyze the outcomes associated with providing digital glucose monitoring devices to Diabetes patients that are uninsured only. In this example, the outcomes of the intervention on the uninsured Diabetes patients could be different for uninsured Diabetes patients versus all Diabetes patients, and the cost to provide the intervention to uninsured Diabetes patients only would be different.
  - Example Justification: With limited funding available, provider wants to see if the intervention is viable if offered only to Diabetes patients that are uninsured as provider believes the targeting the uninsured would maximize cost savings, and there is the greatest room to improve outcomes for these individuals.

Providers cannot complete the Costs and Savings Analysis over the same scope of the same intervention but analyze additional years. For example, providers that analyzed the first three years after the intervention was initiated for the analysis due during October DY8 Round 2 reporting cannot submit an analysis over the first four years after the intervention was initiated for the analysis due during DY10 Round 2 reporting if the intervention being used for the analysis due during DY10 Round 2 reporting is over the same scope of the same intervention that was used for the analysis that was due during DY8 Round 2 reporting.

Additionally, providers cannot analyze the latest years of an intervention for the analysis due during DY10 Round 2 reporting if provider analyzed prior years of the same scope of the same intervention for the analysis due during

DY8 Round 2 reporting. For example, a provider that analyzed the first two years (DY7-8) after the intervention was initiated for the analysis due during DY8 Round 2 reporting cannot analyze the latest three years (DY9-11) of the same scope of the same intervention for the Costs and Savings Analysis due during DY10 Round 2 reporting. Providers should note that the Operating Period starts once the intervention is initiated and requires that consecutive years be analyzed.

Providers should also note that the requirement to analyze a different intervention or a different scope of the same intervention does not allow providers that did a forecasting model for the analysis due during DY8 Round 2 reporting to submit the analysis due during DY10 Round 2 reporting in the new Costs and Savings Template from a retrospective perspective without any changes to the scope of the intervention being analyzed.

2. Intervention is a Component of a DY9-10 Core Activity

Interventions chosen for the Costs and Savings Analysis must be a component of a Core Activity that is active in DY9-10, assuming the provider did not already analyze the intervention or the same scope of the same intervention for the Costs and Savings Analysis that was submitted during DY8 Round 2 reporting.

Providers have structured their Core Activities in different ways: some Core Activities may represent a singular intervention while other Core Activities may include several interventions in multiple Secondary Drivers and Change Ideas. Because of the differences in the scope of providers' Core Activities, the Costs and Savings Analysis due during DY10 Round 2 reporting requires providers to analyze an intervention that is a component of one of their Core Activities. An intervention could represent the entire Core Activity or a portion of the Core Activity, and a portion of the Core Activity could include some of the Core Activity's Secondary Drivers and Change Ideas.

3. Intervention Initiated between December 2011 and September 2021

The intervention chosen for the Costs and Savings Analysis must be initiated between the start of the DSRIP Program (December 2011) and the end of DY10 (September 2021) to be eligible for reporting.

Providers can analyze interventions that were initiated in DY7-8 or in earlier DYs if the intervention is still a component of a Core Activity that is active in DY9-10.

4. Cost Data for Program Costs

Providers should ensure they can collect and maintain or estimate program costs to develop and operate the intervention for the Startup Period and the Operating Period.

The Costs and Savings Template will require the provider to enter both direct and indirect costs to develop and operate the intervention, including costs for

existing personnel or resources that might otherwise be allocated for other purposes.

Direct costs are costs that are only attributable to the intervention and may or may not have existed before the intervention was developed and initiated. Some examples of direct costs are as follows: contractual costs if providers are contracting with vendors to provide some or all of the intervention; salary costs; costs for additional space, supplies, etc.; costs of E.H.R. changes or process changes; etc.

Indirect costs are costs that are necessary for the intervention but are generally shared among other activities and may have already existed before the intervention was developed and initiated. Some examples of indirect costs could include: overhead for rent, utilities, general office supplies, etc. for provider's organization; accounting department or human resources department costs for provider's organization, etc.

Providers should not include program cost categories such as intergovernmental transfers, the administrative cost to complete DSRIP reporting on metrics and milestones, etc. in program costs as these are not costs to develop and operate the intervention.

Please see item 7 below in this list regarding data sources.

5. Cost Data for Financial Outcomes

Providers should ensure they can collect and maintain or estimate the financial outcomes of the intervention in terms of costs to the system of care and/or other stakeholders as a result of better health outcomes, reduced operating expenses, avoided costs, decreased utilization, etc. for the Operating Period.

Cost data for financial outcomes should be appropriate for the Patient Population and the intervention being analyzed. For example, if the intervention did not affect and/or is not expected to affect Inpatient services, then Inpatient services would not be included in the analysis.

Providers should not include health outcomes or other benefits that cannot be expressed in financial terms such as quality adjusted life years.

Providers should include cost data specific to their organization and specific to other contracted providers, if that information is available. If that information is not available, providers may estimate cost data for outcomes from research and/or data from the industry, state, academia, and/or another reputable source.

To demonstrate intervention outcomes, providers may need to collect and maintain or estimate cost data prior to implementation as well as over the length of the Operating Period. These providers should be prepared to submit data on the Patient Population's healthcare utilization and incurred costs for one year immediately before the intervention was initiated.

Providers are encouraged to include all actual or estimated cost data for financial outcomes generated and/or expected to be generated by the intervention under examination, even if the provider does not offer the services expected to be affected by the intervention. This includes cost data for financial impacts to other providers, stakeholders, etc. For example, a CMHC may offer a jail diversion program for patients in mental health crisis, which keeps the patient out of the Emergency Department and the criminal justice system. In this example, the CMHC does not operate an Emergency Department or the criminal justice system, but the financial outcomes of their intervention affect and/or is likely to affect the stakeholders providing these services.

The Costs and Savings Template will require providers to know and/or estimate the size of the Patient Population.

The template will also require providers to use cost data, not charges. For providers who do not have access to cost information from other providers, only charges, a ratio may be used to reduce charges to cost estimates. The provider may choose a reasonable ratio and may be required to explain their basis for the ratio in the template.

Please see item 7 below in this list regarding data sources.

6. Analysis Period

There will not be separate templates for retrospective and forecasting analyses. Providers will be asked to provide the date range for the Startup Period in the Costs and Saving Template, and the template will calculate the Operating Period based on the minimum requirements with options for providers to analyze more time after the required minimum.

Depending on when the intervention was initiated, the Analysis Periods could span past and future dates.

The Operating Period must be whole years, but the Startup Period can be any length of time.

The date range of the Analysis Period will vary among providers based on when the intervention was initiated. The Analysis Period will not necessarily follow DYs or calendar years.

Below is a visual representation of the Analysis Period with example dates.

Analysis Period			
Startup Period Start Date	**Startup Period** End Date	**Operating Period** Start Date (Date Intervention Initiated)	**Operating Period** End Date
4/1/2020	10/31/2020	11/1/2020	10/31/2023
5/31/2017	7/31/2017	8/1/2017	7/31/2021

7. Data Sources

Providers should use the best data available and reasonable methodologies and assumptions to complete the Costs and Savings Analysis.

Data used to complete the Costs and Savings Analysis can be actual or estimated. Actual data, based upon the provider's experience/records, and estimated data, based upon the most appropriate and relevant up-to-date research, would be acceptable to use for both past and future periods if it represents the best data available.

Providers will be expected to explain all assumptions made and methodologies used in detail in the Costs and Savings Template.

8. Discount Rate

Providers will have the option to use a discount rate in the Costs and Savings Template. If using a discount rate, providers may be required to explain how the discount rate was determined.

9. Costs and Savings Template Questions

Providers will be required to respond to different types of questions in the Costs and Savings Template. This could include providing responses to qualitative questions, drop-down questions, etc. These questions will be used to collect information about the intervention and can require providers to summarize the results of the analysis, provide information on the benefits of the intervention that are hard to quantify, provide information to qualify the data input into the template, etc.

Scoping the Costs and Savings Analysis

The steps below outline the general approach to scoping the Costs and Savings Analysis. These steps can help providers identify cost data for financial outcomes and program costs.

1. Determine the intervention that will be used for the Costs and Savings Analysis. Below are items to consider when selecting an intervention.
    a. The intervention selected must be a different intervention or a different scope of the same intervention than was used for the analysis submitted during DY8 Round 2 reporting.
        i. Interventions can be different if it targets a different Patient Population or if it targets the same Patient Population, but the specific actions/changes implemented as part of the intervention are different and are expected to result in different outcomes.
        ii. An intervention is also considered different if the scope of the intervention being analyzed for the Costs and Savings Analysis due during DY10 Round 2 reporting is a subset of the intervention that was analyzed for the Costs and Savings Analysis that was due during DY8 Round 2 reporting. Providers submitting an analysis during DY10 Round 2 reporting that is a

subset of a prior analysis will be required to provide justification in the Costs and Savings Template explaining the merit of analyzing a subset of a prior analysis.

   b. The intervention selected must be a component of a Core Activity that is active in DY9-10.

   c. The intervention selected must be initiated between December 2011 and September 2020.

2. Determine the intervention's Patient Population. Below are items to consider when determining the Patient Population.

   a. Some interventions may target patients with a specific disease or condition, receiving certain healthcare services, or who share some other risk factor, such as homelessness, etc.

   b. If the Patient Population is estimated, providers should consider likely enrollment in the intervention. Enrollment in the intervention can be affected by factors such as the provider's capacity to offer the intervention (e.g., an intervention may only offer 30 beds to patients in mental health crisis), the patient's refusal to participate, lack of contact information/outreach, the amount of time it could take to reach full enrollment/capacity (e.g., full enrollment may not be reached in the first year the intervention is operational), etc.

   c. The Patient Population used for the Costs and Savings Analysis should reflect the Patient Population that was known to receive the intervention and/or is expected to receive the intervention, or a combination of known and expected patients for providers whose Analysis Period spans past and future dates.

3. Determine the program costs to develop and operate the intervention. Below are some items to consider when determining the program costs.

   a. Provider should include both direct and indirect program costs, including costs for existing personnel or resources that might otherwise be allocated for other purposes.

   b. Providers should include program costs for the length of the Analysis Period, which includes the Startup Period and the Operating Period.

   c. Program costs can be known actuals and/or estimates, and providers should use reasonable methodologies and assumptions to allocate program costs.

4. Determine the financial outcomes of the intervention in terms of costs to the system of care and/or other stakeholders as a result of better health outcomes, reduced operating expenses, avoided costs, decreased utilization, etc. Below are some items to consider when determining the scope of the cost data for financial outcomes.

a. Providers should include cost data for financial outcomes for the length of the Operating Period.

b. Providers must include costs specific to their organization and specific to other contracted providers, if that information is available. If that information is not available, providers may estimate cost data for financial outcomes from research and/or data from the industry, state, academia, and/or another reputable source.

    i. Providers are encouraged to use estimated data for past or future dates, if needed, to make their Costs and Savings Analysis more inclusive of the financial outcomes of the intervention in terms of costs to the system of care and/or other stakeholders.

c. Cost data for financial outcomes should be appropriate for the Patient Population and the intervention being analyzed.

d. Cost data for financial outcomes can be actuals and/or estimates, and providers should use reasonable methodologies and assumptions to determine financial outcomes.

DY10 Round 2 Submission

Providers will use the Costs and Savings Template to report the Costs and Savings Analysis to HHSC. During DY10 Round 2 reporting (October 2021), providers will be required to submit the Costs and Savings Template to HHSC by uploading the template to the Category A tab on the DSRIP Online Reporting System. Providers may also be required to respond to questions in the system at this time.

Providers should keep supporting documentation related to the information and data reported in the Costs and Savings Template, including supporting documentation related to methodologies used and assumptions made to complete the analysis. Providers may be required to upload supporting documentation to the Category A tab on the DSRIP Online Reporting System during DY10 Round 2 reporting.

HHSC will not be approving requests to use alternative templates to submit the Costs and Savings Analysis during DY10 Round 2 reporting as HHSC needs standard data for review and analysis, including the ability to complete reviews timely. Providers may use their own tools and/or methods to calculate data needed to complete the Costs and Savings Template.

Each provider is required to submit one complete Costs and Savings Analysis and comply with all reporting requirements. Providers wishing to analyze more than one intervention must complete one Costs and Savings Template per intervention analyzed.

Multiple providers should not submit identical Costs and Savings Analyses. Providers completing the analysis over similar interventions that serve separate DSRIP systems and multiple providers completing the analysis on one intervention

that serves multiple DSRIP systems should still submit a unique analysis per provider. Below is additional guidance related to these scenarios.

- If multiple providers collaborate to provide a single intervention serving multiple unique DSRIP systems in close geographic proximity, then each provider should submit their own analysis that is unique in terms of the provider's DSRIP system. The Patient Population used in the analysis should be unique to the provider's system in terms of the number of individuals receiving or expected to receive the intervention and outcomes appropriate for those unique individuals. Likewise, the program costs should reflect the portion of the intervention's total program costs needed to supply the intervention to the number of individuals receiving or expected to receive the intervention from the provider's DSRIP system. Qualitative responses should be unique as well.
- If multiple providers that are not in close geographic proximity provide or expect to provide similar interventions to individuals in their own unique DSRIP system, then each provider should submit their own analysis that is unique in terms of the intervention being provided at those separate locations. The Patient Population used in the analysis should be unique to the intervention being provided in the unique location in terms of the number of individuals receiving or expected to receive the intervention and outcomes appropriate for those unique individuals. Additionally, the program costs should reflect the program costs needed to provide the intervention at provider's specific location. Additional items such as when the intervention was initiated, which would affect the Analysis Period, may vary between locations. Qualitative responses should be unique as well.

Additional details regarding DY10 Round 2 submission requirements will be outlined in the October DY10 Reporting Companion document.

Questions

Providers should email the waiver team at TXHealthcareTransformation@hhsc.state.tx.us if they have any provider-specific questions or questions about the Costs and Savings Analysis or the contents of this document.

HHSC will not be approving providers' selected interventions prior to DY10 Round 2 reporting, but providers are welcome to email HHSC if they need guidance.