Anchor Conference Call

AGENDA

October 24, 2014
1:30 - 3:00 p.m. CST

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

1. General Anchor Communication

- Thank you for all of your continued work!
- RHPs 10 (http://www.rhp10txwaiver.com/) and 12 (http://texasrhp12.com/index.php/news/141-hhsc-summit-sept-9-10th) are both hosting the videos from the SLC Summit on September 9-10, 2014. Thanks to you both!

2. DSRIP Implementation

Category 3

- All regions have received their Category 3 baseline templates. These templates are also posted to the Waiver website here: (Category 3 Baseline Reporting Templates). Earning payment for the DY 3 process milestone is based on successful completion of the template.
- Since providers from the following RHPs had delays in receiving their templates, we are providing the following extension dates only for the submission of the Category 3 baseline templates. This will occur outside of the automated reporting system:
  - RHPs 9 & 10: Nov. 7
  - RHPs 12, 14, 15, 17 & 18: Nov. 12
  - RHPs 16, 18, 19 & 20: Nov. 13
- Category 3 baseline templates for all other RHPs will be due through the automated reporting system by Nov. 5th, along with all other DSRIP reporting for all 20 regions.
- Many providers have reached out for technical assistance with baselines for those projects with less than 6 months' worth of baseline data by the end of DY3. In the reporting companion document, HHSC described a baseline policy exemption form that providers could submit with their baseline templates. In the last several weeks we received a high volume of providers requesting this TA and we have prioritized these discussions and are determining appropriate resolutions for these requests. Please encourage providers **not** to delay reporting while waiting for exemption forms. HHSC does have a record of these conversations that we will refer to during reporting review, so providers should stay on track with reporting deadlines. We are still continuing to work through the list of providers who have requested TA.
- Explanation of the Category 3 baseline exemption process:
  If providers do not have 6 months' worth data by the end of DY3, they are required to have approval for an exemption from our baseline policies. Below is a description of the triage process. We have a record of all provider stated issues (at the project level) as well as approved HHSC resolution.
  - Shorter measurement period
    - If the provider has any baseline data collected by the end of DY3 but it is less than 6 months, we discussed with provider the volume and length of the measurement period. If at least one month and 30 cases provider is approved to use a shorter measurement period to include the maximum amount of data available.
    - In the baseline template, provider indicates 'No' do not have at least 6 months' worth of data and enters the date range in the next field in mm/dd/yy – mm/dd/yy format.
  - Proxy populations
    - IF provider does not have data on the approved measure specifications (including

subsets) but does have a like population in which historical data is available. Often times this is for a provider who establishing an existing service line in a new location. As such, they cannot report on the approved subset (e.g., new clinic) but they do have data from existing clinics. This is an appropriate proxy for baseline and to indicate improvement in the new location in DY4 and DY5.

- In the baseline template, provider indicates they are using a proxy population and describe the similarities/differences between proxy cohort and DY4/DY5 cohort.

- Carry forward baseline measurement period (measure shifts to P4R structure)
  - Provider has no baseline data by the end of DY3 or a very small sample (< 1 month, 15 cases). Often times this is due to delayed approval for Cat 3 outcomes and requires tool/survey implementation OR this is a 3 year project with a new service line (no historical data) in which per the approved plan is not implemented until DY4.
  - In the baseline template provider will indicate that milestone is carried forward. Below are the mechanics of payment and reporting in DY4 and DY5.
    - Oct DY3: provider carries forward baseline reporting milestone
    - April DY4: report 6 months' worth of data (10/1/14-3/31/14) and receive DY3 baseline submission payment for reporting the rate. **This is when we will "officially" change the measure to P4R**
    - Oct DY4: report 12 months' worth of data (10/1/14-10/1/15) and receive 100% of DY 4 allocation for reporting the rate (no improvement needed)
    - October DY5: report 12 months' worth of data (10/1/5-10/1/16)
      - 50% DY5 allocation for reporting the measure
      - 50% DY5 allocation for improving over the rate reported in Oct DY4 at the same threshold that would have been in place for the measure had it remained a P4R measure, i.e., 10% for IOS measure or 20% for QISMC measure. Partial payment and carry forward applies here.

Category 4 Update

- Providers reporting Category 4 optional Reporting Domain 6 were sent a crosswalk of measure descriptions last Friday. This document contains additional guidance for reporting measures that have changed in the 2014 CMS Core Set. If you did not receive this excel document, please send an email to the box.

Change Request Process (Plan Modification Requests and Technical Change Requests)

- We estimate we will provide comments/preliminary determinations to the anchors in early to mid-November. Providers will be asked to respond to HHSC comments on change requests in late November to early December. We understand that providers would like information as soon as possible and so we are prioritizing the plan modifications over the technical changes.

October Reporting

- The recordings from the 3 webinars related to October DY3 Reporting have been posted on the waiver website (Recorded Webinars/Conference Calls page).
- We've heard that in rare cases the completed QPI template may be larger than 30 megabytes, even when zipped. Files larger than 30 MB cannot be uploaded into the online reporting system. HHSC will either implement a change to allow larger file sizes to be uploaded, or will provide an alternate method for submitting QPI templates that are larger than 30 MB.

- We are getting questions from providers on QPI for projects that are expanding on existing services. The goal with the QPI webinar and template is to make QPI reporting as clear as possible. With that goal, we introduced the term "pre-DSRIP baseline." This is not a new concept or requirement, but simply a different term. During Phase 2 during the summer of 2013, when providers were asked to confirm QPI targets, HHSC provided the following guidance in the Instructions tab in the Phase 2 workbook. This specifies that the QPI number, by DY, should exceed the baseline prior to the start of a project. The baseline in this guidance is the same as the term "pre-DSRIP" baseline. For expansion projects, the QPI should represent the number served that is above this baseline. Providers are also strongly encouraged to read the QPI Companion.

  From the Phase 2 workbook:

  > **Only Include Project-Specific Impact**: Please confirm that the QPI targets for each DY reflect the increase in patients served/ encounters provided in that year that is due to the project (i.e. the number exceeding the baseline prior to the start of the project). For example, if the intervention is a new project that will serve a total of 100 patients in DY4 and 200 patients in DY5, those are the figures to include in the QPI spreadsheet (as opposed to 100 patients in DY4 and 100 more in DY5). If the project expands an existing initiative that currently serves 200 people, but will serve 300 by DY4 and 400 by DY5, then the provider would reflect that due to the project, 100 additional patients will be served in DY4 and 200 additional patients will be served in DY5. The number reported in each DY should show what patient impact (workload) occurred that DY that would not have occurred if they project had not been undertaken.

- Given the complexity and volume of the October reporting, we want to remind you and your providers to NOT report achievement unless you're confident you've achieved a metric by September 30, 2014. In past reporting periods, due to the newness of a number of issues (e.g. annual metrics), HHSC in certain circumstances changed a status to "Did Not Report" so that the provider wouldn't lose the chance to earn payment. HHSC will **not** do this for October reporting or going forward, so if a provider reports achievement that can't be proven during the NMI period, the payment for that metric will no longer be earnable.
- Given all the questions HHSC is getting about QPI metrics, HHSC recommends that if a provider isn't clear that it met its QPI goals as defined above (the DY3 QPI workload of individuals/encounters that is over and above the pre-DSRIP baseline amount), then the provider should request to carry forward its QPI metric to DY4.

Anchor Administrative Costs

- The formal anchor contracts for administrative costs have been sent out. Our goal was to execute the contracts by September 30, 2014. We realize that the process for obtaining contract approval/signature may take longer for some entities, but we encourage everyone to return their signed contracts as soon as possible.
- The due date for the DY2 anchor cost claiming report is November 30, 2014. Anchors can also submit their DY3 costs with this initial invoice, but will have the option to carry-forward DY3 costs to the next invoice period.
- The cost template for administrative cost claiming was posted on the waiver website today. The primary revisions made to the document include:
  - expanding the number of pre-populated staffing slots in most of the tasks;
  - the application of a separate overhead (indirect) rate to non-staff costs;
  - allowing separate benefit calculations for contractor vs employee staff (i.e., subject to

benefits vs not subject to benefits);
- the addition of instructions for the signature page; and,
- an additional error check section added at the bottom of each task tab, to check that the detail input ties to the summary amounts at the top.

CMS DY2 DSRIP Financial Management Review

- As discussed previously, CMS is reviewing RHPs 4, 7, 9 and 10.
- The goal is for CMS to provide HHSC a draft report by late October/November. HHSC will have the opportunity to comment on the draft report, and then it will continue through the CMS approval process. (Based on the timing of the site visits, HHSC wouldn't be surprised if this date slips a little, though CMS hasn't indicated that yet.)
- HHSC has gotten clarification from CMS on an issue that was raised by CMS regional reviewers during some site visits - whether there is authority in the waiver for providers to get paid for DY5 metrics that are carried forward and achieved the year after DY5. CMS has confirmed that based on the language included in the PFM Protocol, providers will have the ability to earn these funds for achievement in the year following DY5.

DSRIP Mid-Point Assessment

- Communication regarding mid-point assessment is coming from a new mailbox: TXHealthcareTransformationDSRIP_Compliance@hhsc.state.tx.us.
- HHSC has sent out emails with letters for the mid-point assessment review to providers in all RHPs.
- HHSC notified anchors about projects selected in their regions for the Mid-Point Assessment review prior to the Summit. At this time we are not copying anchors on the letters, since providers are receiving information specific to their project (the reason why the project was selected). It is up to providers to share this information with anchors.
- The summary will be sent to each anchor informing them about what was sent to providers.
- Myers and Stauffer is conducting a detailed desk review of the projects in the first regions and will be contacting selected providers about site visits. Prior to on-site visits, Myers and Stauffer will give each region an option to meet for an entrance conference to provide an overview of the reviews on site, explain what supporting documentation may be required, and to answer questions related to site reviews. The entrance conference may be conducted at the anchor site and have teleconference capabilities for providers who cannot join in person.

3. Other Information for Anchors

Update on Unspent DY2 DSRIP Funds

- HHSC has submitted the public notice for the waiver amendment, and it will publish in the Texas Register next Friday, October 31, 2014. HHSC will be discussing the amendment with CMS next week and plans to submit the amendment by December 1, 2014. The public notice reflects the framework we've previously discussed (projects in good standing can add metrics in DY5). HHSC wants to point out that the public notice states that HHSC may prioritize the DY2 funds for projects related to primary and preventive care, BH care, and chronic care management, and in particular may prioritize the funding for 58 DSRIP providers who also are DSHS contractors for primary health care or BH care. This is to build on the GR investments Texas has made in these areas. HHSC will use the information submitted through the spreadsheet to help determine next steps in how to distribute the funds once they're secured through the amendment. At this stage, HHSC is requesting information for all projects other those in 1.10, 2.4, 2.5 and 2.8 regarding interest in adding on to projects to earn a portion of the remaining DY2 funds.

- Please see the attached request for the providers in your RHP to fill to indicate which projects are interested in adding certain metrics in DY5 and whether they have a confirmed funding source to do so. HHSC is requesting that providers return this information through the anchors by **November 21st**.

UC Deferral

- HHSC has set up standing meetings every other Friday at 1 pm to discuss (as needed) with the anchors, EWC members, and hospital associations for any updates on the CMS UC deferral.
- HHSC also is working directly with the affected regions and providers.
- CMS has removed 9 hospitals from the deferral letter (8 private hospitals not in RHPs 4, 9, or 10 and 1 public hospital), which reduces the deferral amount by $11.7 million. HHSC plans to submit a response to CMS in November and also will be working to meet with CMS to work to resolve this issue by December prior to January DSRIP payment.

2014 (DY3) UC Update

- 2014 UC payments will not be made until 2014 DSH payments are made.
- 2014 DSH payments are delayed due to issues surrounding the procurement of the non-federal share of the payments; once those issues are resolved, HHSC will process the first two quarters of 2014 DSH payments as a single payment and follow-up with the first two quarters of 2014 UC payments one month after the DSH payments are processed, assuming there are no conflicts on the payment calendar (for example, as long as DSRIP payments are not scheduled for that same month).
- 2014 DSH/UC tools are currently being audited and processed by HHSC staff; processing is expected to be completed by January 2015. If we are able to make DSH payments earlier than January 2015, we will use 2013 HSLs and days as proxies for 2014 data for these payments, with a reconciliation to 2014 HSLs and days when final 2014 DSH payments are made. UC payments for the first two quarters of 2014 will be calculated using the advance payment methodology which allows HHSC to make advance UC payments based on a percentage of payments made in the preceding year.