



1115 Transformation Waiver Extension and DSRIP Protocols

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1115 Transformation Waiver

- Three major components:
 - Statewide Medicaid managed care through the STAR, STAR+PLUS, and Children's Medicaid Dental Services programs (including carve in of inpatient hospital, pharmacy and children's dental services).
 - Provider reimbursement to offset uncompensated care costs (Uncompensated Care [UC] Pool)
 - Incentive payments for hospitals and other providers for healthcare infrastructure and innovation through 20 Regional Healthcare Partnerships (Delivery System Reform Incentive Payment [DSRIP] Pool)

1115 Transformation Waiver

- Expand Medicaid managed care statewide
- Develop and maintain a coordinated care delivery system
- Improve health outcomes while containing costs
- Protect and leverage federal match dollars to improve the healthcare infrastructure
- Transition to quality-based payment systems across managed care and hospitals

Extension Request

- By September 30, 2015, HHSC must submit to the federal Centers for Medicare and Medicaid Services (CMS) a request to extend the waiver.
- In September, HHSC plans to request to continue all three components of the waiver for another five years:
 - Statewide managed care
 - UC pool
 - DSRIP pool
- Texas has made progress related to all five waiver goals, and will propose program improvements toward those goals to support and strengthen the healthcare delivery system for low-income Texans.

Extension Request for the Pools

- The extension request on the funding pools:
 - To continue the DY 5 funding level for DSRIP (\$3.1 billion annually)
 - A UC pool equal to the unmet need in Texas, adjusted to remain within budget neutrality each year
- CMS will require that Texas submit a report next year prior to waiver extension related to how the two pools in the waiver interact with the Medicaid shortfall and what uncompensated care would be if Texas opted to expand Medicaid.
- HHSC anticipates a negotiation period with CMS and will plan for a transition period with interim reporting, if necessary.

Waiver Extension Public Comments

- HHSC received over 180 public comments from the eight stakeholder meetings, webinar, and through written submissions. The majority of public comments were in support of continuing the waiver.
- Suggested changes for waiver extension included:
 - Increasing collaboration with community physicians, FQHCs, health information exchanges, and cross-regional providers
 - Implementing additional targeted projects for areas such as pediatric care, behavioral health, and rural regions
 - Changes in UC/DSRIP pool allocations among providers
- HHSC received many comments in support of coverage expansion in the state. Texas has not opted to proceed with a Medicaid coverage expansion, so HHSC does not plan to include a request for coverage expansion in the extension request.

Texas DSRIP

Extension Principles

- Further incentivize transformation and **strengthen healthcare systems** across the state by building on the RHP structure.
- Maintain **program flexibility** to reflect the diversity of Texas' 254 counties, 20 RHPs, and almost 300 DSRIP providers.
- Further **integrate with Texas Medicaid managed care** quality strategy and value based payment efforts.
- **Streamline** to lesson administrative burden on providers while focusing on collecting the most important information.
- Improve project-level evaluation to **identify the best practices** to be sustained and replicated.
- Continue to **support the healthcare safety net** for Medicaid and low income uninsured Texans.

Themes from CMS Based on 2014 Summit

- DSRIP is a substantial federal investment – Texas needs to demonstrate the value of the investment
- Need to continue to strengthen healthcare systems – a community of providers coordinating across the care continuum
- Outcomes measurement is important, including shared outcomes
- Sustainability is the goal – how to take what’s being learned through DSRIP, sustain/replicate best practices, and embed these practices into everyday Medicaid business?

Evolution of DSRIP Based on Recent Waivers

- Recent DSRIP programs are more standardized, increasing accountability by incorporating more outcomes-based payments, and operating through community partnerships.
- While each state's DSRIP is different, more recently approved DSRIP programs:
 - More narrowly defined project menu - more prescriptive about project goals and reporting measures
 - Have larger proportions of total DSRIP funding dedicated toward reporting and results.
 - More closely align pay-for-performance (P4P) metrics with their projects.
 - Base project valuation and total per-provider funding allocations on standardized formulas.

Evolution of DSRIP

Based on Recent Waivers (cont.)

More recently approved DSRIP programs:

- Have all-or-nothing payment (instead of partial payment).
- Have high performance funds (instead of carry forward).
- Require participating providers to submit project budgets.
- May require providers to report at a high level how incentive payments are spent.
- Use attribution models to assign a large portion of the state's low-income patients to specific participating providers.
- Emphasize the importance of sustainability after quality improvements are achieved.

Source: NASHP report for MACPAC, March 2015

DSRIP Extension Request

- The DSRIP program took years to develop and implement – most projects were approved mid-2013 through mid-2014, about halfway through years 2 and 3 of the demonstration.
 - There have been many program changes during the demonstration.
- Due to changes to the framework and measures for Category 3 outcomes related to each project, outcomes baseline information began to be reported in October 2014.
- The interim waiver evaluation supports that one of the strengths of the program is increased connections and collaboration within RHPs.
 - Collaboration for project implementation
 - Learning collaborative activities

DSRIP Extension Request (cont.)

- Continue the existing DSRIP program administrative structure including the 20 RHPs and the role of Anchors.
- The majority of the active DSRIP projects will be eligible to continue to give more time to demonstrate outcomes.
- Some projects will not be eligible to continue.
- Work to strengthen DSRIP and the Medicaid program
 - Incorporate DSRIP into a comprehensive Medicaid quality strategy, aligning as much as possible with managed care
 - Use DSRIP lessons learned to inform Medicaid benefits and value based purchasing
 - Regional performance bonus pools – shared pay for performance
 - Additional program improvements under consideration: collect Medicaid patient IDs from DSRIP, require participation in emergency department admit, discharge, and transfer (ADT) data exchange

- The details of the DSRIP program in the extension period will be outlined in the revised DSRIP protocols, the Program Funding and Mechanics Protocol (PFM) and the RHP Planning Protocol (DSRIP menu).
- HHSC is providing initial information today on proposed changes to the protocols for the extension period.
- Additional details on the protocols will be shared in a webinar planned for late September (date TBD).
- HHSC will consider stakeholder feedback from now through this fall as we work to finalize the protocols for submission to CMS in early 2016.

Initial proposals provided today for feedback:

- Metrics for continuing Category 1 & 2 projects
- Extension menu and metrics for Category 1 & 2 replacement projects
- Parameters for combining projects
- Uses for funds not allocated to active projects
- Regional shared bonus pools
- Statewide analysis plan

Continuing Category 1 & 2 Projects

All projects from areas included on the 3-year menu may be eligible to continue pending HHSC review of higher risk projects.

- There are many promising projects that need more time to demonstrate outcomes and evaluate best practices.
- Some projects may be required to take a next step and HHSC may propose further standardization of continuing projects (including related to QPI and project intensity).
 - The goal is to further transformation in the extension, including by serving additional Medicaid and low-income individuals where feasible and/or taking next steps on initial projects (e.g., a project established a primary clinic, and now will become a patient centered medical home).
 - HHSC will balance this goal with allowing projects that are on track to further progress and to account for projects that initially set overly aggressive goals.

Continuing Category 1 & 2 Projects (cont.)

There will be fewer metrics to report for achievement, and more standardized metrics.

- QPI milestones will be required each year – 50% of valuation
 - Request partial achievement of QPI metrics, perhaps with a reduced carryforward window?
- For the other 50% of valuation each year, HHSC is considering two metrics reported via templates.
 - Reporting on core components, including continuous quality improvement (CQI)
 - Sustainability planning, including project-level evaluation, health information exchange, and integration with managed care where appropriate

- HHSC will continue to use the quantifiable patient impact (QPI) of each project for Medicaid and low income uninsured individuals as a key indicator for project impact and valuation.
- HHSC is considering changing all QPI metrics to individuals (vs. encounters), though providers will still maintain encounter-level information to support the patient benefit of the project.
- Depending on the timeline for negotiations with CMS on waiver extension, propose to continue DY5 QPI in DY6 as a transition year until negotiations are completed.

Replacement Projects

- HHSC identified the projects in July that will be reviewed and may not be eligible to continue (or may require changes to the project scope, milestones/metrics, and/or valuation).
- HHSC will notify projects not eligible to continue in early 2016 to give providers time to plan for replacement projects if needed.
- Depending on timelines and CMS negotiations on the extension, HHSC will propose to CMS that current projects that will be replaced be eligible to continue for a transition period, including 2.4, 2.5, 2.8 and 1.10 projects.

Replacement Projects (cont.)

Replacement projects may be submitted in the following circumstances:

- Four-year projects from 2.4, 2.5, 2.8, and 1.10 project areas (except 1.10 for learning collaborative purposes, which may continue)
- Providers of projects withdrawn after June 30, 2014 (so associated funds are not currently allocated to active projects)
- Projects identified from high risk list based on HHSC review
- Providers may also elect to discontinue a current project(s) and propose a replacement
- May be proposed up to the same valuation as original project, not to exceed \$5 million per demonstration year

Replacement projects must use options outlined in the extension menu.

- Extension menu is a streamlined version of the protocol, which combined similar project options and removed selected project options with the aim to keep **the most transformative options** on the menu.
- Category 1 & 2 draft extension menu designed to build on the lessons learned from DSRIP in the initial 5-year waiver.
- Opportunities to “hit the ground running” through replication of strong, existing projects with limited or no planning period.
- Project options not included on the extension menu often may be a component of a project in the extension.
- Some project areas and options were consolidated to avoid duplication of options across project areas.

Extension Menu (cont.)

- Input from Clinical Champions was considered during the development of the draft extension menu.
 - Best practices options for some project areas to be identified based on the Transformational Impact Summaries submitted to the Clinical Champions Workgroup.
- Replacement projects and metrics may be more standardized than the current DSRIP menu.
 - HHSC plans to develop templates for submission of replacement projects, including core components.
- Project options included in the draft extension menu are shown in the Summary of the Transformational Extension Protocol, which also includes a high level reasoning for not including a project option on the extension menu.

Combining Existing Projects

- Cross-regional community mental health center projects that are similar may choose to combine into one or more home regions.
- Projects from one or multiple providers within an RHP that provide similar services to different populations may combine into one project.
 - e.g., Two similar prevention projects, one targeting females and the other targeting males.
- Projects may combine without reducing QPI effort and not to exceed \$5M valuation per DY.
- The performing provider will continue to report and receive payments.
 - Sub-contractors or collaborating providers will continue to report information to the DSRIP provider and receive payments from the DSRIP provider based on fair market value.
- The timeline for requesting combining projects is planned to begin in January 2016.

Funds Not Allocated to Projects

- For projects that must be replaced (and those withdrawn after June 30, 2014), the performing provider will have the opportunity to propose a replacement project from the extension menu.
- Assuming most of these providers opt to do replacement projects, HHSC does not anticipate a large amount of leftover DSRIP funds.
- Latest thinking on possible uses for leftover funds
 - Increase minimum valuation of smallest projects
 - Keep the funds in the RHP that “lost” projects to propose additional transformation projects from the extension menu (including to support learning collaborative activities and enable allowable performing providers that are not current DSRIP providers to participate).
 - Consider supporting broader transformative initiatives to help further current DSRIP activities, including cross-regional initiatives?

In the past months, various stakeholders have shared broader, multi-regional and/or multi-provider concepts to further DSRIP successes. For example:

- Pediatric rapid cycle quality improvement projects at children's hospitals, potentially extending to community hospital and non-hospital settings
- Initiative to support rural hospitals on patient centered medical homes, data driven care coordination, admit-discharge-transfer (ADT) infrastructure, telemedicine, and data collection and reporting
- Develop a system of care for uninsured patients
- Initiative to help coordinate care for emergency department superutilizers

Measuring DSRIP Success - Statewide Analysis Plan

The extension application includes a proposal to analyze Medicaid data and available all-payer potentially preventable event (PPE) data for managed care service delivery areas and RHPs. HHSC will provide this global trend data to CMS from 2012/2013 through the years of the extension period to show whether combined efforts are having an effect on key measures.

- HHSC has been working with Texas Medicaid's external quality review organization, the Institute for Child Health Policy (ICHP), to determine measures ICHP already collects for Medicaid that intersect with DSRIP activities.
- A challenge for statewide analysis of DSRIP results is that HHSC doesn't have access to much data on non-Medicaid populations (including low-income uninsured). HHSC is exploring the use of all-payer data from the Department of State Health Services to add all-payer PPE measures to the statewide analysis.

Measuring DSRIP Success

Switching Cat 3 and Cat 4

Current

- Category 3, Quality Improvements – Healthcare outcomes that are tied to Category 1 and 2 projects (combination of pay for performance and pay for reporting)
- Category 4, Population-Based Improvements – Hospital-level reporting on data in several domains related to potentially preventable events, patient-centered healthcare, and emergency department care (pay for reporting)

Proposal

- Category 3 – Continue to collect project-related outcome data, but switch to pay for reporting outcomes and building measurement capacity
- Category 4 – Change to pay for performance based on regional performance in improving on a set of key measures (regional shared performance bonus pools using state-generated data)

Measuring DSRIP Success

Switching Cat 3 and Cat 4 (cont.)

Rationale for Switching Category 3 and Category 4

- Category 3 is extremely complex and many providers, of all types and sizes, are struggling to accurately complete Category 3 reporting and conform to the technical specifications of the measures.
- There is value in building measurement capacity at the provider level and collecting data on the outcomes related to individual DSRIP projects.
- However, given Texas' volume and variety of outcome measures, state-level data may better demonstrate the overall impact of DSRIP, along with Medicaid managed care and other initiatives, on improving healthcare outcomes and population health.

Measuring DSRIP Success – Regional Performance Bonus Pools

- All DSRIP providers will have their Category 3 converted to pay for reporting
- All DSRIP providers will have a portion of their DSRIP valuation converted to their potential earnings from the region's performance bonus pool
 - 5% of DY5 DSRIP funding for smallest providers
 - 10% of DY5 DSRIP funding for larger providers
 - For Category 4 hospitals:
 - if Category 4 funding is higher than the required bonus pool funding, the additional funding may be used to propose a project from the extension menu (and may be combined with other funds for a replacement project within valuation limits).
 - if Category 4 funding is lower than the required bonus pool funding, the remainder will be made up by taking proportionately from Category 1-3 valuation.
 - For non-Category 4 participants, the 5% or 10% will be taken proportionately from their Category 1-3 valuation.

Measuring DSRIP Success – Regional Performance Bonus Pools

- State-generated data vs. provider-generated data will be used for the regional shared performance bonus pools.
 - Consider ICHP statewide analysis plan measures
 - HHSC will need to ensure no duplication of federal funds (e.g. if PPEs are used for the shared bonus pools)
- There will be some common measures required to be included in the bonus pools for all regions.
- Each region also may select some measures from a list of options for region-specific measures depending on the key community needs and DSRIP areas of focus on in that region.
- HHSC needs stakeholder input on potential Medicaid measures and all-payer measures to help reflect the improvements in healthcare delivery in Texas during the waiver period.

Waiver Communications

- Find updated materials and outreach details:
 - <http://www.hhsc.state.tx.us/1115-waiver.shtml>
- Submit questions to:
 - TXHealthcareTransformation@hhsc.state.tx.us