



Waiver Renewal and Transition Year Updates

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Goals of 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 for the Pools

- The extension request on the funding pools:
 - To continue the demonstration year (DY) 5 funding level for DSRIP (\$3.1 billion annually)
 - An Uncompensated Care (UC) pool equal to the unmet need in Texas, adjusted to remain within budget neutrality each year (ranging from \$5.8 billion - \$7.4 billion per DY)
- The Centers for Medicare and Medicaid Services (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.

- Further incentivize transformation and **strengthen healthcare systems** across the state by building on the Regional Healthcare Partnership (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.

Evolving Federal Perspective 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:
 - Have a 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.

Source: NASHP report for MACPAC, March 2015

Evolving Federal Perspective 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

- Texas indicated to CMS in the extension request that we plan to propose ways to strengthen the DSRIP program in the extension period.
- DSRIP requirements in the extension period will be defined in the revised DSRIP protocols - the Program Funding and Mechanics Protocol (PFM) and the RHP Planning Protocol (DSRIP menu).
- HHSC will consider stakeholder feedback as we work to finalize the protocols for submission to CMS.

DSRIP Planning and Negotiations with CMS

- HHSC previously indicated the DSRIP protocols would be submitted to CMS in early 2016. Based on further discussions with CMS, HHSC now plans to:
 - Submit a proposal for a Transition Year (DY6) Protocol in early 2016;
 - Submit the revised DSRIP protocols for DY7 replacement projects in fall 2016; and
 - Protocols and metrics for DY7 continuing projects projected for completion by January 2017.
- HHSC will submit high-level proposals to CMS for consideration on an ongoing basis.
 - Based on CMS feedback about the feasibility of various elements, HHSC then will work with stakeholders to develop detailed requirements.

Initial proposals planned:

- Transition year (DY 6 - 10/1/2016 – 9/30/2017)
 - Includes parameters for combining projects
 - Laying the groundwork for performance bonus pools
 - Setting a minimum annual valuation amount per provider
- Revised protocols for extension/renewal (beginning 10/1/2017)
 - Continuing and replacement projects
 - Regional performance bonus pools

Transition Year (DY 6)

- HHSC has proposed to CMS that current projects that are eligible to continue or will be replaced be eligible to continue for a transition period of one year (DY 6), including 2.4, 2.5, 2.8 and 1.10 projects.
 - A high level Transition Plan was submitted to CMS in November 2015
- HHSC has posted a proposed Transition Year (DY6) Program Funding and Mechanics (PFM) Protocol on the waiver website with a survey for stakeholder feedback.
 - HHSC plans to submit the proposed transition year protocol (PFM) to CMS in early 2016.
- In summer 2016, providers submit confirmation of whether they plan to continue/replace current projects or if they plan to withdraw projects.

Transition Year (DY 6) - 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 CY 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.

Transition Year (DY 6) - Statewide Analysis Plan (cont.)

At the DSRIP Statewide Summit in August, the following Medicaid measures were highlighted as possible measures for the statewide analysis plan.

- **Behavioral Health Measures**
 - HEDIS Antidepressant Medication Management (AMM): Acute Phase
 - HEDIS Antidepressant Medication Management (AMM): Continuation Phase
 - HEDIS Follow-Up After Hospitalization for Mental Illness (FUH) within 7 Days
 - HEDIS Follow-Up After Hospitalization for Mental Illness (FUH) within 30 Days
- **Access to Care Measures**
 - HEDIS Children and Adolescents' Access to Primary Care Practitioners (CAP)
 - HEDIS Access to Primary/Preventive Care: Frequency of Ongoing Prenatal Care (FPC)
 - HEDIS Access to Primary/Preventive Care: Postpartum Care (PPC-Postpartum Care)
 - Potentially Preventable Events (PPEs)
- **Potentially Preventable Events**
 - 3M Potentially Preventable Admissions (PPA)
 - 3M Potentially Preventable ED Visits (PPV)
 - AHRQ Pediatric Quality Indicator: Asthma Admission Rate (PDI 14)
 - AHRQ Pediatric Quality Indicator: Diabetes Short-Term Complications Admission Rate (PDI 15)

Measuring DSRIP Success – Performance Bonus Pools (PBP)

- HHSC will establish the PBP measures that will be required for all regions, and will develop a list of additional potential PBP measures that a region can select based on the key community needs and DSRIP areas of focus in that region.
 - A draft list of regional PBP measures under consideration, including the measures in the ICHP statewide analysis plan, has been posted on the HHSC website with a survey for stakeholder feedback.
- HHSC will use state-generated data instead of provider-generated data for the PBP measures.
- HHSC will need to ensure that there is no duplication of federal funds (e.g., if PPEs are used for the PBP).
- HHSC seeks stakeholder input on potential Medicaid measures and all-payer measures to help reflect the improvements in healthcare delivery in Texas during the waiver period.

Transition Year (DY 6) - Combining Existing Projects

- The timeline for requesting to combine projects began in January 2016 with a deadline of February 1st for request submissions.
- The combined project would begin reporting in the transition year (DY 6), contingent on CMS approval.
- Projects that were able to request combining included:
 - Cross-regional community mental health center (CMHC) projects;
 - Similar projects by the same provider within one region; or
 - Similar projects by different providers within the same health region and system.

Transition Year (DY 6) - Setting a Minimum Valuation

- HHSC proposes to set a minimum valuation per provider (for Categories 1-4 combined) at \$250,000 per demonstration year for the extension period (including the transition year).
 - Impacts 27 providers (24 hospitals, 3 local health departments) and 35 projects.
 - To increase these providers' valuation, HHSC proposes to use approximately \$3 million of the current \$10.7 million remaining funds not allocated in DY 5 to a region or withdrawn projects.
 - HHSC will review QPI for each of these projects to ensure QPI supports increased valuation.
- Providers may opt out of the increased valuation if intergovernmental transfer (IGT) funds will not be available.

The information on the remaining slides is proposed to be effective beginning 10/1/2017 (for DY 7 through DY 10, or for the extension period approved by CMS).

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, more standardized milestones/ metrics to report for achievement.
- HHSC is considering the following milestones:
 - 60-70% of Category 1-2 valuation: QPI (one milestone for total QPI and one for MLIU QPI).
 - 30-40% of Category 1-2 valuation:
 - Core components, including CQI
 - Sustainability planning, including health information exchange, integration with managed care, and other community partnerships; and/ or
 - Medicaid ID reporting.

Replacement Projects

- HHSC reviewed the projects that were identified as potentially not being eligible to continue (or may require changes to the project scope, milestones/metrics, and/or valuation).
- HHSC notified these projects of the results of the project review in January 2016 to give providers time to plan for replacement projects if needed.
- These providers may propose replacement projects selected from the extension menu, contingent on approval from CMS.
- Replacement projects would be submitted to HHSC during DY 6 at a date TBD (such as a target date of January 1, 2017) upon CMS approval of the revised RHP Planning Protocol.

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.

- The Category 1 & 2 draft extension menu is designed to build on the lessons learned from DSRIP in the initial 5-year waiver.
- The extension menu is a streamlined version of the current RHP Planning Protocol - combined similar project options and removed selected project options to keep **the most transformative options** on the menu.
- 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.
- Best practice options for some project areas were added to the draft extension menu.

Extension Menu (cont.)

- Information from Transformation Impact Summaries and input from Clinical Champions was considered during the development of the draft extension menu.
- Replacement projects and metrics will 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 (posted on the HHSC waiver renewal webpage).
- Stakeholders may provide feedback on the proposed extension menu via the online survey posted on the waiver website.

Switching Category 3 and Category 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)

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.

Category 4 –Performance Bonus Pool (PBP)

- HHSC proposes to set aside 5-10% of each provider's total valuation for each DY for the Category 4 performance bonus pool (PBP) to reward high performing regions.
- The same 5% or 10% set aside as DY 6 applies beginning in DY 7 for smaller and larger providers.

Items in Development

- Ongoing communications process for stakeholder feedback
- Timelines
- Extension menu – stakeholder feedback continues to be incorporated
- Replacement project requirements
- QPI requirements for DY 7 forward
- Additional Category 1 or 2 standardized metrics
- Potential changes to Category 3 measures
- Statewide analysis plan
- Regional performance bonus pool measures and funding
- Further uses for funds not allocated to active projects

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