## May 17, 2013

## 1:30-3:00 p.m.

**Call-in: 877-226-9790**

**Access Code: 3702236**

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| **1.** | **General Anchor Communication** | |
|  | **CMS Initial Review Findings**   * All RHP Plans feedback expected from CMS by the end of next week if not sooner * HHSC has sent instructions for addressing CMS feedback to 8 RHPs * Revised companion document to CMS letter issued today   **DY 1 Payments**   * DY 1 payments are in process for June 18th payment. * There will be a delay in the DY 1 DSRIP Payment for entities who submitted IGT with a Tex Net Sweeps date (settlement date) of May 1, 2013. The April 23, 2013, IGT notification email had indicated an estimated payment date of May 17, 2013, This revised payment issue date is May 23, 2013. * The remaining providers who were waiting for CMS approval to receive DY 1 DSRIP will be paid in November.   **Monitoring**   * Staff is continuing to work with state leadership and CMS on monitoring that would occur through an independent entity. A small portion (up to 1%) of UC and DSRIP IGT is under discussion. Expedited rules will be proposed this summer. They will go to the HHSC advisory committees (HPAC, MCAC, and HHSC Council) between June 11-14 and will be published as proposed in the Texas Register on June 28th, to be expedited for adoption by August 31, 2013.   **DY 3 Projects**   * Funding of DY 3 projects through the plan modification process also will be included in expedited rules that will follow the same timeline as the monitoring rules (above). HHSC will send a draft of the rules for stakeholder feedback soon. These rules also reflect the recent changes to the PFM Protocol.   **Learning Collaborative information**   * CMS has offered to provide training, possibly via webinar, on learning collaborative, once CMS has completed the 45-day review process for all RHP Plans expected to be completed by the end of May. * We have sent RHP 17 questions to CMS and have staff dedicated to work with CMS on this issue that will include guidance on the learning collaborative plan that is required to submit to CMS by October 1, 2013.   **Waiver Team Staffing**   * New staff to introduce: Andres Guariguata was hired by HHSC quality unit to work with the Waiver team and to coordinate with broader HHSC Quality initiatives; and John Scott, Manager of Operations, will have a key role for the reporting, payment and plan modifications processes. * One of our key staff, Carisa Magee has taken a promotion in Medicaid CHIP Acute Care Policy as a manager and will be transitioning to the new position by July 1. We will have additional staff coming on board, including staff contact for anchors, for which Carisa has played a key role.   **Regional Advisory Committee (RAC) Meetings**   * Information will be provided to anchors early next week for the RAC meetings in June for purposes of waiver update. | |
| **2.** | | **CMS RHP Plan Review and Results** |
|  | CMS results provided via letter that is sent to HHSC and RHP anchor contact. HHSC has developed companion document to assist anchors and providers to organize responses needed for CMS divided into 4 phases:   * Phase 1: Focuses on Tables 5 (Projects initially approved, with adjustment to project value) and Table 6 (projects not approved at this time). Also includes one priority technical correction – overlap of improvement milestone and improvement target. Timeline information included in companion document. * Phase 2: Quantifiable patient benefit and Medicaid/indigent impact – information needed by CMS for DY 4&5 valuation review. Spreadsheets targeted to go to anchors next week (staggered). Responses needed by a set date in June (due date will be included with the spreadsheets). HHSC will work with RHPs on coordination with Phase I changes. * Phase 3: Any technical corrections needed for DY 2 payment. Information will be provided to anchors and affected providers in late May to June. Providers will have two weeks to make the corrections. The due date will be included in the Phase 3 notice. Note: we are getting questions about changing an approved DY 2 milestone to a different milestone. Given that we are halfway through DY 2, the timeline is challenging for any changes. Milestone changes for approved DY3-5 milestones that were not identified by HHSC or CMS technical comments should be addressed through the plan modification process (under development). * Phase 4: Priority technical corrections. Process under development by HHSC.   Phase 1 key information:   * HHSC is developing cover sheets for each project affected that are sent to Anchors for coordination with providers. * Providers will provide cover sheets for projects to their anchor to submit to HHSC. The cover sheet will identify documents to submit with the cover sheet and whether a revised project is included. * HHSC is working with CMS to send provider responses to CMS for review in weekly batches, rather than by RHP. Information will be submitted by project, not by the entire RHP Plan. * All submissions to HHSC from the anchors must include a completed cover sheet. HHSC will let the anchor and provider know when the information has been submitted to CMS or whether additional information is required in order to send to CMS. * HHSC is encouraging providers to make revisions to current projects, rather than develop new projects, unless HHSC has provided information that CMS has indicated a project is not likely approvable. New projects need to be reviewed by HHSC, and start a new 45-day clock once submitted for CMS review. Replacement projects can be submitted to HHSC no later than July 31, 2013. For projects for which CMS has proposed a reduced value, if the provider accepts the lower value, the provider may not reduce the strength of the project (such as by removing metrics or reducing the strength of metrics). * For projects that CMS has requested milestones and metrics specific to Medicaid/uninsured populations, HHSC encourages providers to add the Medicaid/uninsured metric and continue to include the metric representing the full population served. If a provider reduces the overall patient impact metric, the overall valuation may be impacted when CMS does its DY4-5 valuation review this summer.   **Additional refinement of parameters for replacement projects:**  If a provider chooses to submit a replacement project for a project CMS has indicated they will not likely approve, the provider has the option to propose replacement projects at the same value or less that could be implemented beginning DY 2.  The replacement project has to meet the following requirements:   * Represent an intervention that is in response to community needs identified in the RHP’s needs assessment. * Given the need for timely review, the project must be on the RHP Planning Protocol DSRIP menu and not an “Other” project option and also not include “Other “Category 3 outcome(s). * New information -- Additional refinement: The 1.10 “Enhance Performance Improvement and Reporting Capacity” can only be used for projects focused on Learning Collaboratives; 1.9 “Specialty Care Capacity must include a minimum focus of 40% Medicaid, unless a compelling justification can be made for a lower threshold; 2.4 “Redesign for Patient Experience” and 2.5 “Redesign for Cost Containment” may not be submitted as these projects have received close scrutiny from CMS and have been challenging to get approved. * Include milestones that represent implementation activities beginning in DY 3 and not just planning activities. * Submitted along with a completed DSRIP Feedback Changes Electronic Workbook. * Replacement projects would also need to undergo review by HHSC and subsequently submitted to CMS. CMS would start a new 45-day clock for the replacement projects separate from the initial RHP Plan submission. * New information – Replacement projects must be submitted with a complete Cover Sheet that is provided through the anchors, with “Replacement Project” designated as the option the provider is selecting from the CMS results letter.   **Revisions to RHP Plans**   * Now that all RHPs have submitted their plan in response to formal feedback and RHP Plans have been submitted to CMS, **providers should not make changes to projects unless at the request of HHSC or CMS**. (This includes the project narrative – CMS has emphasized that project narratives are important parts of the plan.) * When revisions are made, RHPs must work from the clean copy of their plans. Providers will highlight or include strikethroughs for revisions made *at the request of HHSC or CMS*. | |
| **3.** | **Technical Changes to RHP Plans** | |
|  | **Contact Changes:**  If there are contact information changes that may impact notifications for payment, please use following process:   * Using the RHP Contact Change Form, modify the existing contact information to include the email address of the new CEO and Director – if it would be helpful to the new leadership in place, also provide a back up email to someone at both facilities that has worked on the RHP Plan and is familiar with the process.  They will be able to assist with the transition. * Send the contact form to the Waiver mailbox at [TXHealthcareTransformation@hhsc.state.tx.us](mailto:TXHealthcareTransformation@hhsc.state.tx.us) * Update Section I Organization table with the updated information in the next RHP Plan submission.   **TPI/TIN Changes:** If there are changes to TPI or TIN, please email Rhonda Hites at [Rhonda.hites@hhsc.state.tx.us](mailto:Rhonda.hites@hhsc.state.tx.us). Rhonda will notify the waiver team of approved TPI and TIN changes. Update Section I Organization table with the updated information in the next RHP Plan submission.  **IGT Entity changes:** The IGT Entity(ies) for each project/improvement target is listed in the Workbook Data under the “IGT” tabs. To see what information HHSC currently has for each project, please check the posted Plan Data for your RHP at <http://www.hhsc.state.tx.us/1115-RHP-Plans.shtml>.  If you have changes to the IGT Entity listed in the Plan Data, please complete the ***IGT Entity Change Form***. Complete one form for each IGT Entity. IGT Entity changes must be received no later than **August 31, 2013** for August DY 2 DSRIP payment processing. Any changes received after August 31, 2013 will go into effect for the October DY 2 DSRIP reporting. | |
| **4.** | **DY 2 Reporting** | |
|  | **DY2 Reporting Format**  HHSC is in the process of transferring all milestones and metrics into Excel for DY2 reporting and will verify information with Performing Providers beginning late next week (Phase 3). Files for provider correction will be sent on a rolling basis after RHPs have received their cover sheets. A companion document for Phase 3 will be posted on the waiver website.  For the manual DY2 reporting, Performing Providers will use an Excel template to report progress on each metric, e.g. a metric is to draft a plan, the Performing Provider would enter Yes/No for the metric and attach the plan to the ShareFile site that is being set up. ShareFile users will be based on information provided in Section I. of the RHP Plan.   * June reporting is no longer an option. The first opportunity for DY 2 reporting is August 2013, and the second is October 2013. * DY 2 August reporting is limited to:   + Category 1 and 2 projects that were included in the CMS Initial Review Findings document under:     - “Table 3 – Initially approved projects”     - “Table 4 – Initially approved projects with priority technical corrections”     - “Table 5 – Projects initially approved, with an adjustment to project value” that accepted the CMS alternate project value (column “Initially approved DY 2 – 3 project value (total computable)”). HHSC must be notified of the provider’s acceptance of the CMS alternate project value no later than **June 7, 2013** to begin reporting in August.   + Category 3 improvement targets that were initially approved in the CMS Initial Review Findings document with related Category 1 or 2 projects listed in Table 3, Table 4, or Table 5.   + Category 4 status report on capability to report domains 1, 2, 4 and 5 using HHSC’s *Category 4 Status of Capability to Report Template* that is under development. | |
| **5.** | **Additional Information** | |
|  | Some questions from providers:    --Will providers be penalized if they achieve certain Cat 1 or 2 metrics that were planned for DY3 in DY2?  Two examples we’ve been given – 1) A provider plans to hire a specialist in DY3, but has located good candidate and would like to go ahead and hire them toward the end of DY2 rather than in DY3.  Could they still count this as a metric achieved in DY3?  2) A provider is seeking ACGME approval for additional physician training slots.  If they can approval sooner than expected (DY2 vs DY3), can they still claim that as DY3 achievement?  I thought the answer to both of these would be yes since the achievement is still during the waiver period and we don’t want to slow projects down.  Information from CMS – Yes, providers can achieve milestones early, but they must wait to claim those milestones in the appropriate demonstration year.  (i.e. you can’t claim DY 3 milestones in DY 2).  Also, as noted in the PFM protocol, it may require retargeting for providers who meet their milestones two years in advance.    --Will there be an opportunity to change the Cat 3 outcome for a project after the standard methodology for achievement levels is determined by CMS and HHSC on October 1?  We understand that providers are concerned around the Cat 3 uncertainty at this stage, think providers should have the option to change, and would like figure out the most streamlined way possible for them to request a Cat 3 change if needed once the achievement levels are established.  Information from CMS – Yes, providers can change the Cat 3 outcome as part of a plan modification.  CMS would like them to change the outcome if it turns out that they are a high performer on the measure.  Note: HHSC is developing a timeline specific to Category 3 and will include this process in the planning.    --Regarding the Cat 4 funding as a % of total DSRIP funding, do you think that CMS will want to reduce Cat 4 back down to no more than 10% (or 15% if doing the extra domain) once Cat 1 and 2 project values are settled?  Information from CMS: CMS has concern about providers whose Cat 4 DSRIP is more than 15% of their total DSRIP after value adjustments, but if it is feasible, we would like for providers to be consistent with the PFM percentages.    --With the staged approval process, and the chance that project values for DY4-5 could be less than for DY2-3 based on the review later this summer, what happens if a provider gets initial approval, begins the project, but then decides not to continue it for DY4-5 (or DY3-5) based on the September 1 valuation review?  Information from CMS: CMS and HHSC will work together on valuation issues that projects may be at risk to continue with lower valuation. CMS has indicated that  funds for a project that is discontinued at this stage should not be available for reallocation to other DSRIP projects. | |

*For waiver questions, email waiver staff:* [*TXHealthcareTransformation@hhsc.state.tx.us*](mailto:TXHealthcareTransformation@hhsc.state.tx.us)*.*

*Include “Anchor:” followed by the subject in the subject line of your email so staff can identify your request.*