

# Executive Waiver Committee

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**February 2, 2017**  
**10:00 a.m. – 12:00 p.m.**

# Waiver Updates

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**HHSC Transformation Waiver Team**

**February 2, 2017**

# October DY5 Reporting Results

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- In total for October reporting, Performing Providers reported achievement of 58.6 percent of the 9,084 DY4-DY5 Category 1-4 milestones/metrics.
- HHSC approved 95 percent of the reported milestones/metrics for a total of \$2.06 billion in approved DSRIP payments.
- Based on available IGT, \$2.05 billion was paid for DSRIP in January 2017, for a total of \$9.9 billion in DY1-5 payments to date.

# DY7-8 Proposal

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- HHSC requested to CMS an additional 21 months of level funding for the UC and DSRIP pools, and a continuation of the managed care provisions of the 1115 Waiver, through September 30, 2019.
- The implementation of the DSRIP structure is dependent on CMS approval of the additional 21 months and DSRIP protocols.
- HHSC is posting a survey for feedback on the waiver website.

# DSRIP DY7-8 Proposal

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- The DY7-8 draft program structure evolves from project-level reporting towards targeted Measure Bundles that are reported by DSRIP Performing Providers as a provider system.
- DY7-8 serves as an opportunity for Performing Providers to move further towards sustainability of their transformed systems, including development of alternative payment models to continue services for Medicaid and low-income or uninsured individuals after the waiver ends.

# DSRIP Funding

- The DSRIP pool allocation for DY7-8 would be \$3.1 billion per DY.
  - The \$775 million allocated to DY6B would be combined with the \$2.325 billion agreed to for DY7.
- A Performing Provider's total valuation for DY7 and DY8 would be equal to its total valuation for DY6A with the following exceptions:
  - If HHSC determined that a DSRIP project was ineligible to continue in DY6A, then the Performing Provider may use the funds associated with the DSRIP project beginning in DY7.
  - If a Performing Provider withdrew a DSRIP project between June 30, 2014 and June 30, 2016, then the Performing Provider may use the funds associated with the DSRIP project beginning in DY7.
- HHSC is seeking proposals for uses of the remaining DSRIP funds, estimated at \$25M available per DY.

Categories 1-4 in DY2-6 would be transitioned to the following Categories in DY7-8:

- Category A - Required reporting that includes progress on core activities, alternative payment model arrangements, costs and savings, and collaborative activities.
- Category B - Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP)
- Category C - Measure Bundles
- Category D - Statewide Reporting Measure Bundle, similar to the previous hospital Category 4 reporting expanded to include all Performing Providers.

# Category Funding Distribution

	<b>DY 7</b>	<b>DY 8</b>
<b>Category A - required reporting</b>	0%	0%
<b>Category B - MLIU PPP</b>	10%	10%
<b>Category C- Measure Bundles</b>	80 or 85%	80 or 85%
<b>Category D - Statewide Reporting Measure Bundle</b>	5 or 10%	5 or 10%

\*If private hospital participation minimums in the region are met, then Performing Providers may increase the Statewide Reporting Measure Bundle funding distribution to 10%.



## Category A: Required Reporting

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Each Performing Provider would be required to report the following during the second reporting period of each DY as a basis to be eligible for payment of Categories B-D.

- **Core Activities** - Each Performing Provider would report on progress and updates to core activities.
- **Alternative Payment Methodology (APM)** - Each Performing Provider would report on any progress toward or implementation of APM arrangements with Medicaid managed care organizations or other payors.
- **Costs and Savings** - Each Performing Provider would submit costs of the core activities and forecasted/generated savings in a template approved by HHSC or a comparable template.
- **Collaborative Activities** - Each Performing Provider would be required to attend at least one learning collaborative, stakeholder forum, or other stakeholder meeting each DY.

## Category B: MLIU PPP

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- Each Performing Provider would be required to report the total number of individuals and number of MLIU individuals served by their system each DY.
- Each Performing Provider would be required to submit the baseline total number of individuals and the baseline number of MLIU individuals served by their system in the RHP Plan Update, based on the averages of DY5 and DY6.
- The number of MLIU individuals served and the ratio of MLIU individuals served to total individuals served would be maintained each DY with an allowable variation.
  - The allowable variation would be determined by HHSC once Performing Providers have submitted their baselines, based on provider size and types.
- Partial payment would be available for MLIU PPP.

## Category C: Measure Bundles

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- Measure Bundles would consist of measures that share a unified theme, apply to a similar population, and are impacted by similar activities.
- Bundling measures:
  - Allows for ease in measure selection and approval.
  - Increases standardization of measures across the state for providers with similar activities.
  - Facilitates the use of regional networks to identify best practices and share innovative ideas.
  - Continues to build on the foundation set in the initial waiver period while providing additional opportunities for transforming the healthcare system and bending the cost curve.

# Measure Bundle Connections to Previous Categories 1 and 2

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- Each Measure Bundle would connect to at least one DSRIP Category 1 or 2 project area on the Transformational Extension Menu (TEM).
- Most DSRIP Category 1 and 2 project areas could be connected to one or more Measure Bundles.
- The most common Category 1 and 2 project areas could connect to multiple bundles because they are broad activities.
- Performing Providers would be required to describe the transition from DY2-6 projects to the selected Measure Bundles in the RHP Plan Update.

# Measure Bundles Menu

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- HHSC will work with stakeholders to finalize a menu of Measure Bundles.
- The final menu may include measures taken from common existing Category 3 outcome measures, new or updated measures from authoritative sources, and innovative measures developed for DSRIP by participating entities to fill gaps in current standardized measures.
- Innovative measures may be developed--pending interest--by a Texas entity functioning as a measure steward.
- Bundles would include a mix of related process measures (currently designated as non-standalone [NSA]) and patient clinical outcomes (currently designated as standalone [SA]).

# Measure Bundle Point Value

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Each Measure Bundle would be assigned a point value based on one or more of the following factors:

- The number of measures in the bundle and the difficulty of the measures in the bundle. (Ex: Current Category 3 stand-alone (SA) measures are worth 3 points, and current Category 3 non stand-alone (NSA) measures are worth 1 point).
- Whether the measure is pay-for-performance (P4P) or pay-for-reporting (P4R).
- Whether the bundle is considered a state priority. (Ex: If the bundle is considered a state priority, one point could be added to its value).

# Measure Bundle Selection Criteria

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- Each Performing Provider would be assigned a minimum point threshold for Measure Bundle selection based on DY7 valuation and its size and role in serving the Medicaid and uninsured population.
  - HHSC is considering using factors such as Medicaid and uninsured charges and inpatient days as reported in the Uncompensated Care (UC) Tool, UC payments, and Disproportionate Share Hospital (DSH) payments.
  - There will be a cap on the minimum point threshold for providers with very high valuations.
- Performing Providers would select one or more bundles to meet or exceed their minimum point threshold.

# Example: Minimum Point Threshold

- Standard point valuation: \$200,000
- Minimum point value cap: 100
- Minimum points increased for providers with a statewide ratio greater than 2

	Hospital A	Hospital B	Hospital C
DY7 Valuation	\$2,000,000	\$5,000,000	\$180,000,000
% of Statewide DY6 valuation	.05%	.125%	4.5%
% of Medicaid/UC Burden Factors	.04%	.02%	4.2%
Statewide Ratio	.8	6.5	1.07
Minimum Points	10	81	100



# Measure Bundles for CMHCs and LHDs

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- HHSC is proposing that each Community Mental Health Center (CMHC) is required to select a combination of measures to create one or more Measure Bundles.
- HHSC is seeking proposals from Local Health Departments (LHDs) for their Measure Bundle requirements.
- HHSC anticipates flexibility in measure selection for CMHCs and LHDs.

# Measure Bundle Milestones

- The milestone structure and valuation for DY7-8 would be as follows:

	P4R Measure	P4P Measure
<b>DY7</b>	100% Reporting Year (RY) 1 reporting milestone	25% baseline reporting milestone
		25% Performance Year (PY) 1 reporting milestone
		50% PY1 goal achievement milestone
<b>DY8</b>	100% RY2 reporting milestone	25% PY2 reporting milestone
		75% PY2 goal achievement milestone

# Measure Bundle Reporting

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- For P4P measure goal achievement milestones, each Performing Provider would be paid for achievement of the MLIU rate.
- For P4P and P4R measure reporting milestones, each Performing Provider would be required to report the rate for All-Payer, Medicaid, and LIU payer types (with some exceptions due to volume or data limitations) to be eligible for payment of the reporting milestone for the measure.
- Partial payment would be available for P4P measure milestones.
- Carryforward of reporting, not carryforward of achievement, would be allowed for all goal achievement milestones.

## Category D: Statewide Reporting Measure Bundle

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- Each Performing Provider would be required to report on the Statewide Reporting Measure Bundle according to the type of Performing Provider.
- The measures would be similar to the previous Category 4 population-focused measures with additional measures developed for non-hospital Performing Providers with stakeholder involvement and feedback.

# Private Hospital Participation Regional Incentive

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- If a region maintains its current level of private hospital participation, each Performing Provider in the region would be allowed to shift 5 percent of their total valuation from Category C (P4P) to Category D (P4R).
- A region would maintain the private hospital participation at submission of the RHP Plan DY7-8 update.
  - A 3 percent decrease may be allowed in each region and considered maintenance.
- The current statewide private hospital DY6 valuation is \$868 million. With the allowable 3 percent decrease, there would be a statewide minimum total private hospital valuation of \$842 million in DY7-8.

## Estimated Timeline

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- February 9, 2017 – Webinar scheduled to present proposed PFM Protocol.
- February 2017 – Gather stakeholder feedback on the draft PFM Protocol using the survey posted on the waiver website. HHSC is particularly interested in feedback on:
  - Definition of provider “system”
  - Factors and weights to determine minimum point thresholds for hospitals and physician practices
  - Requirements for LHDs
  - Uses for remaining DSRIP funds – estimated \$25M available per DY
- March 31, 2017 – Submit PFM Protocol to CMS for approval.

## Estimated Timeline

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- February – May 2017 – Gather stakeholder feedback on the Measure Bundles.
  - Clinical Champions subgroups
  - CMHCs workgroup, in collaboration with the Texas Council
  - LHDs workgroup
- June/July 2017 – DY7-8 proposed rules posted for public comment.
- June 30, 2017 – Submit Measure Bundle Protocol to CMS for approval.
- August 2017 – Targeted CMS approval of protocols.

## Estimated Timeline (cont.)

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- November 30, 2017 – Anchors submit RHP Plan Updates, including:
  - Updated community needs assessment
  - MLIU PPP - baseline total number of individuals and baseline number of MLIU individuals served by each Performing Provider's system
  - Measure Bundle selections
  - New activities or ongoing activities from Performing Providers' initial Category 1 or 2 projects to improve performance on the measures in their selected bundles
- April 2018 – first opportunity for Performing Providers to report measure bundle baselines.



# Waiver Communications

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- Find updated materials and outreach details:
  - <https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver>
- Submit questions to:
  - [TXHealthcareTransformation@hhsc.state.tx.us](mailto:TXHealthcareTransformation@hhsc.state.tx.us)