

**May 14, 2015 EWC
Waiver Renewal - Discussion of Key DSRIP Issues**

Summary of Goals from Transition Plan Submitted to CMS

When Texas submits its extension request in September 2015, HHSC plans to request 1) to continue at least the demonstration year (DY) 5 funding level for DSRIP (\$3.1 billion annually) and 2) a UC pool equal to the unmet UC need in Texas. Based on current projections, the funding levels between the two pools could be increased and still allow Texas to remain within federal budget neutrality for future waiver years.

State goals for the pools for the extension period:

- Continue to support the healthcare safety net for Medicaid and low income uninsured Texans.
- 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 over 300 DSRIP providers.
- Improve project-level evaluation to identify the best practices in DSRIP to be sustained and replicated.
- Further integrate DSRIP efforts with Texas' Medicaid managed care quality strategy and other value based payment efforts.
- Work to streamline the DSRIP program to lessen the administrative burden on providers while focusing on collecting the most important types of information.

CMS has indicated that changes will be required to the waiver Special Terms and Conditions in order to extend the pools, and HHSC is certain CMS will want additional changes to the waiver. While HHSC understands from CMS that extensions typically are for 3 years (and sometimes 1 year), our current thinking is to request a 5 year extension to see if that might be possible.

- A. In general, HHSC proposes to continue with the existing DSRIP program administrative structure, including the 20 RHPs and role of the anchoring entities to provide regional coordination and technical assistance.**
- B. HHSC proposes that the majority of the current 1458 active DSRIP projects be eligible to continue into the extension period in order to give projects more time to demonstrate outcomes. These projects may take a logical next step toward further transformation. Some projects will not be eligible to continue based on review of the independent assessor and HHSC.**

Process to determine if a project is eligible to continue:

1. All projects from areas included on the 3-year menu may be eligible to continue pending HHSC review of higher risk projects (see 4. Below) and if they meet requirements for projects for the extension period. Some of these projects may be required or encouraged to take a next step toward transformation (for example, an expand primary care project may be ready to move to a patient centered medical home project).

2. Projects from areas not on the 3-year menu (2.4, 2.5, 2.8 and 1.10 [except for learning collaborative purposes]) will not be eligible to continue. Providers of active projects in these areas will have the opportunity to propose a replacement project at up to the same valuation as the previous project with a maximum of \$5M per DY from a narrower menu of project options developed for the extension period, and will be encouraged to build on what they built and learned from the original project. (HHSC plans to further narrow the 3-year project menu to use for replacement projects in the extension period.)
3. Providers of projects withdrawn after 6/30/2014 (associated funds currently are not allocated to a project) also will have the opportunity to propose a replacement project at up to the same valuation as the previous project with a maximum of \$5M per DY from the narrower menu of project options developed for the extension period.
4. Of the projects in 1., HHSC will review data for certain higher risk projects through April 2015 reporting (the 1st of the two reporting periods for DY4) to determine if they are eligible to continue. These projects include:
 - Projects that the independent assessor identified as higher risk (4 or 5) during the mid-point assessment based on information through April 2014.
 - Projects that HHSC determines need additional review based on its review of plan modifications, reporting, low % achievement of DY2-3 metrics through April 2015 reporting, and ongoing project monitoring.
 - HHSC will let providers know by June-July 2015 if their project is under review (i.e., may not be eligible to continue) and will attempt to let providers know by January 1, 2016 if a project is not eligible to continue. In these cases, the provider will have the opportunity to propose an alternative project from the narrower menu of project options developed for the extension period.

C. Requirements for Projects in Extension Period

1. Valuation - Continue with DY5 valuation for subsequent years (including Cat 1-4 split), except HHSC will review the 39 projects that are above \$5 million in Cat 1-2 valuation for DY5 and the lowest valued projects (e.g., below \$100/\$125K for Cat 1-2 in DY5). HHSC will inform providers if they have any projects on this list by June-July 2015. As noted above, projects to replace projects not eligible to move forward may be proposed up to the same valuation as the original project, not to exceed \$5M per DY. Make some minor revisions to Cat 4 valuation to bring providers back in line with the PFM Protocol and to not pay hospitals extra Cat 4 funds for projects outside their home RHP.
2. Reduce the # of metrics/milestones to be reported on:
 - Cat 1-2: QPI milestones required each year - for total QPI and for MLIU QPI (= 75-100% Cat 1-2 valuation) - projects will be required to increase their QPI each year and/or improve the level of services offered each year
 - Cat 1-2: Optional milestones to earn 25% of Cat 1-2 funds each year, such as related to increased data exchange and project-level evaluation/sustainability planning (structured milestones with standard templates).
 - CQI will be required of all projects and will be reported on qualitatively in the semi-annual reporting (vs. through milestones).
 - Cat 3 - HHSC continues to review the Category 3 methodologies and how outcomes align with projects. We may propose a structure to better align outcome measures with certain projects and to show meaningful improvement.

Under consideration:

- Standardize QPI metric language (or perhaps have several options for each project area).
- Minimum % of MLIU to continue DSRIP participation. (For example, in NY, 95% of the funds must go to providers that serve at least 30% Medicaid patients. Or if below a certain MLIU % threshold, consider valuation impact.)

D. What to do with funds from the DSRIP pool not allocated to continuing projects? Propose alternate transformative projects from narrower menu based on lessons learned, bring smallest projects up to a minimum valuation level and/or have a shared performance bonus pool for regions that make improvements on key measures.

These "leftover" funds are from projects not eligible to continue for which the provider doesn't propose an alternate project, other DY5 funds that currently are not allocated to a project, and proposed rebalancing of Category 4 funds for some providers that are outside the PFM Protocol parameters or are participating in multiple RHPs. HHSC currently estimates there may be between \$67-\$299 million in leftover DY5 funds (assuming an annual DSRIP pool of \$3.1 billion) depending on how many of the providers with projects not eligible to continue opt to use those funds for projects from the revised menu.

Options:

1. Allocate the funds to IGT-poor RHPs (RHPs that used less than 80% of their original regional allocation in DY5 - which include RHP 8 (56.3% used), RHP 17 (42.1% used) and RHP 20 (67.3% used) for them to propose additional transformative projects from the revised menu.
2. Keep the funds in the region of the provider that "lost" a project using the 3-year prioritization process to propose additional transformative projects from the revised menu.
3. Increase minimum valuation of the smallest projects (e.g, every project must have a minimum annual valuation of \$125,000-\$150,000).
4. Create a performance bonus pool (to be earned based on shared regional and/or statewide performance).

In addition to considering option 4 above as a potential use for funds not allocated to continuing projects at the outset of the extension, HHSC plans to propose to CMS that funds that don't get earned over the course of the extension period flow into the shared performance bonus pool. If a region and/or all the regions improved performance on key measures, all participating providers in the region/state would be eligible to earn funds from the bonus pool.

E. Work to streamline the DSRIP program to lessen the administrative burden on providers while focusing on collecting the most important types of information.

- Allow certain projects to be combined into a single project to reduce reporting burden (either based on HHSC recommendation or provider proposal), such as cross-regional projects by MHMR centers; smaller projects below a certain valuation threshold being done by smaller providers; similar projects by the same provider in the same region (same project, different populations); potentially the same system doing the same project across multiple hospitals (within a region).
- Reduce and standardize the number of metrics reported (see above under minimum project requirements for the extension period, including reporting templates and consideration of standardizing QPI language)

- Eliminate achievement carry forward (i.e. ability to achieve metrics/milestones in the following DY), or possibly extend to just one reporting period beyond the DY (vs. 2), but allow for partial achievement for QPI similar to what's allowed for Cat 3 pay for performance now - in 25% increments. If eliminate or shorten achievement carry forward, unearned funds would go into the performance bonus pool.
- Modify or eliminate the mid-point assessment review requirement, but continue with ongoing compliance monitoring.

F. Further integrate DSRIP efforts with Texas' Medicaid managed care quality strategy and other value based payment efforts.

- HHSC is exploring how to further incentivize Medicaid managed care value based payment opportunities for DSRIP providers. HHSC plans to develop Quality Alignment/Value Based Payment Roadmap by late 2016-early 2017 to outline how it plans to progress toward Value Based Payment during the course of the extension.
- HHSC is reviewing DSRIP and managed care quality measures to assess where further alignment is possible. For example, the measures used for the DSRIP shared performance bonus pool could align with certain managed care pay for quality measures.
- HHSC plans to analyze Medicaid data, and available all-payer PPE data not only for managed care plans and MCO service delivery areas, but also by RHP. HHSC will have this global trend data to provide to CMS from 2012 through the years of the extension period to show whether combined efforts are having an effect on these measures.

Under consideration:

- Along with QPI information, require DSRIP projects to report Medicaid IDs of patients served by the project. HHSC is working through the privacy requirements for submitting this data.
- As part of DSRIP and UC requirements, require participating hospitals to provide admission, discharge, and transfer (ADT) information either to their regional HIE or the State. HHSC could provide this information to Medicaid MCOs and require that they share it with the patient's primary care provider. This is consistent with HHSC Medicaid HIE/HIT efforts underway with federal funding, and increasing the sharing of ADT information has been discussed with the hospital associations.
- Require hospitals/physician groups that participate in DSRIP to enroll in Medicaid managed care networks.
- Convert Category 4 funds to a shared performance bonus pool (RHP participants could all earn more if the RHP performs well) that aligns to the extent possible with Medicaid managed care.

For Additional Discussion

- ? How to incentivize projects to serve a greater #/% of Medicaid and low-income uninsured patients? - Minimum % threshold; valuation impact?
- ? How to encourage and reward stronger, more resource intensive projects compared to projects that have a lighter patient impact or with a weaker QPI in terms of what's being measured?
- ? Ways to encourage data sharing, including between MCOs and DSRIP providers?
- ? Ways to incentivize systems of care vs. individual project focus?
- ? Thoughts on the performance bonus pool? HHSC will work with its EQRO and present a proposal to both EWC and Clinical Champions.