PROCESS FOR EVALUATING AND SELECTING NEW 3-YEAR PROJECTS
(including background information)

Medicaid Transformation Waiver ("1115 Waiver")

HHSC has received federal approval of a waiver that allows Texas to expand Medicaid managed care while using a new methodology to preserve federal supplemental hospital funding historically provided under the Upper Payment Limit (UPL) program. This new methodology provides funding for health care improvements and directs more funding to hospitals that serve large numbers of uninsured patients. Funding is divided into two statewide pools worth $29 billion over five years: (1) an **Uncompensated Care (UC)** pool ($13.6 billion) to reimburse hospitals for uncompensated care costs as reported in the annual waiver application/UC cost report; and (2) a **Delivery System Reform Incentive Payment (DSRIP)** pool ($11.4 billion) to incentivize providers to transform their service delivery practices to develop programs or strategies to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided, and the health of the patients served.

Under the 1115 Waiver, eligibility to get funding requires participation in a Regional Healthcare Partnership (RHP). Texas was divided into 20 RHPs by the 2011 Legislature. RHPs are regions developed throughout the State to more effectively and efficiently deliver care and provide increased access to care for low-income Texans. Each RHP includes a variety of providers to adequately respond to the needs of the community. Each RHP has one anchoring entity (anchor), which is generally a large public hospital. The anchor acts as a primary point of contact for HHSC in the region and is responsible for seeking regional stakeholder engagement and coordinating the regional plan. The regional plan identifies the community needs, the DSRIP projects and investments to address those needs, community healthcare partners, the healthcare challenges, and quality objectives and patient impacts of each DSRIP project in the region. DSRIP funds were allocated to each RHP according to a formula that took into account the RHP's role in the safety net system. RHPs that shoulder a larger burden of Medicaid care and serve a larger share of low-income populations were allocated a higher share of DSRIP funds. The goal of this approach was to ensure that delivery system reforms under DSRIP had the greatest impact on Medicaid and low-income populations.

Regional Healthcare Partnership 12 (RHP 12)

The Texas panhandle region was initially divided into two separate regions, but these two regions subsequently merged into one region (RHP 12) with University Medical Center in Lubbock being selected as the anchor. RHP 12 is comprised of 47 counties in the Texas panhandle. The area is mostly rural and frontier, which means that there are less than 12 people per square mile. There are two urban areas, which are the Lubbock area (Lubbock County) and the Amarillo area (Potter County and Randall County). Within RHP 12, 17 counties have no acute care hospital, 27 counties have 1-2 acute care hospitals, and 3 counties have more than 2 acute care hospitals. RHP 12 is geographically the largest of the 20 regions in the state. RHP 12 was allocated $405,971,566 and originally requested or claimed approximately $390,195,375 in total computable funding over five years; therefore, we did not initially utilize or claim approximately $15,776,191.

New 3-Year Project Process

The unutilized or unclaimed funds were earmarked for two providers for New 3-Year Projects with $15,000,000 earmarked for Northwest Texas Healthcare System in Amarillo (Northwest) and $776,191 earmarked for WJ Mangold Memorial Hospital in Lockney (WJ Mangold). The New 3-Year Process allows

for RHPs and the State to utilize unclaimed RHP allocations. If an RHP does not utilize its entire allocation for the second demonstration year (DY), the remaining DY2 allocation is forfeited by the RHP and the funds may be utilized by HHSC for state initiatives. If an RHP does not utilize its entire allocation for the third, fourth, and fifth DYs, that RHP may propose New 3-Year DSRIP Projects. Of the approximately $15,776,191 not initially utilized by RHP 12, approximately 21.07% or $3,323,432 relates to forfeited DY2 allocations; therefore, the remaining net funds of $12,452,759 currently earmarked per provider for New 3-Year Projects is as follows:

- Northwest - $11,840,081 (after DY2 forfeits)
- WJ Mangold - $612,678 (after DY2 forfeits)

Additional known net funds of approximately $340,719 ($641,648 gross before DY2 forfeits of $246,539 and $54,390) have become available for New 3-Year Projects due to Phase 1 reduction in values associated with two projects; therefore, the current amount available for New 3-Year Projects is approximately 12,793,478 (Northwest $11,840,081 + WJ Mangold $612,678 + Additional known net funds $340,719). Depending on the final results of Phase 1 and the DY4 and DY5 review/evaluation to be performed by CMS, other additional funds may become available for New 3-Year Projects. If any other RHP (outside of RHP 12) is unable to utilize their remaining allocation of DSRIP funds through the New 3-Year Project Process, the remaining allocation for that other RHP (outside of RHP 12) may be utilized by HHSC. If DSRIP funds are still available following HHSC utilization, the remaining funds will be redistributed proportionately (based on their share of the original allocation) to the RHPs that utilized their full RHP allocation.

Each New 3-year Project must:

- be ready for <u>immediate</u> implementation upon approval,
- be <u>prioritized</u> based on regional needs except that the listed projects must alternate by affiliated Intergovernmental Transfer (IGT) entity,
- identify and have <u>written</u> confirmation of the IGT source, and
- demonstrate <u>significant benefit</u> to the Medicaid/indigent populations.

In addition to the above, **<u>Each proposed New 3-year Project must meet the following requirements</u>** (as listed on pages 3 and 4 of the proposed DRAFT process):

- Represent an intervention that is in response to community needs identified in the RHP's needs assessment specific to Medicaid and indigent populations.
- Be on the RHP Planning Protocol DSRIP menu and not an "Other" project option and also no include "Other" Category 3 outcome(s).
- Include quantifiable patient impact milestones in DY4 and DY5 that include the Medicaid/indigent quantifiable impact.
- Submitted along with a completed DSRIP Electronic Workbook.
- The following project options will not be allowed for New 3-Year Projects: (1) 2.4 – "Redesign for Patient Experience", (2) 2.5 – "Redesign for Cost Containment", and (3) 2.8 – "Apply Process Improvement Methodology to Improve Quality/Efficiency". Project area 1.10 – "Enhance Performance Improvement and Reporting Capacity" is only allowable for projects that focus on DSRIP learning collaboratives.
- Projects under area 1.9 – "Specialty Care Capacity" must include a minimum focus of 40% Medicaid/indigent.
- Include milestones that represent implementation activities <u>beginning in DY3 (not just planning activities)</u>.

Since it is not yet known exactly how much of its original DSRIP allocation each RHP will have remaining for New 3-Year Projects, HHSC proposes that by October 31, each RHP submit a prioritized list of possible New 3-Year DSRIP Projects. By a date To Be Determined by HHSC in early December 2013, each RHP must submit the full projects proposed as New 3-Year Projects. By this time, each RHP will have a better sense of the amount of funds it has available for New 3-Year Projects after CMS provides the final results of Phase 1 and the DY4 and DY5 review/evaluation and after HHSC reallocates any available funds between RHPs. As noted in the proposed rule, in order to prevent one or more entities from dominating the prioritization process, each RHP must prioritize the New 3-year DSRIP Projects based on a scoring process except that the listed projects must alternate by affiliated IGT entity. When HHSC receives the full projects in early December 2013, they will check to ensure that each RHP followed the prioritized list. If there is any variation from the prioritized list, the RHP will be required to explain what and HHSC/CMS will decide whether to accept projects.

Scoring Process

Each RHP must use a scoring process for determining project prioritization. Projects are dependent on having an IGT source despite a project's score, but the scoring process should increase transparency in the region and cause providers to focus their efforts on the most transformative projects that have the greatest community need. Each project will be scored by project reviewers. The project reviewers will be experienced healthcare professionals who are familiar with community needs assessments and gaps in service and will provide objective reviews of New 3-Year Projects submitted to RHP 12.

University Medical Center of Lubbock (UMC), as Anchor for RHP 12 under the 1115 Waiver, will provide an honorarium to each project reviewer. This honorarium shall not constitute a conflict of interest between UMC and the project reviewer for this Scope of Work. Each project reviewer will complete a Conflict of Interest Disclosure Form and should disclose if there is an actual, potential, or perceived conflict of interest with any performing provider or any Intergovernmental Transfer (IGT) Entity within RHP 12.

Each project reviewer will participate in at least one pre-review conference call. During the pre-review conference call, the following information will be discussed: (1) 1115 Waiver Background, (2) Summary of Community Needs Assessment, (3) Outline of the Scoring Template, and (4) Reviewer Credentials & Conflicts of Interest. After the pre-review conference call, project summaries and/or narratives and metric tables will be provided to each project reviewer. Project reviewers will be instructed to review the project summaries and/or narratives and metric tables and score the projects using the scoring system as discussed below. Project reviewers will then enter each project's score into the scoring template. Project reviewers will work independently and will be asked not to discuss the projects with each other until the post-review conference call. After each project has been independently scored by each project reviewer, a post-review conference call will be scheduled. During the post-review conference call, the following information will be discussed: (1) Project Scoring and Significant Discrepancies in Scoring (if any), and (2) Other Qualitative Feedback from Reviewers. Project reviewer scores will then be finalized, and the anchor will compile each project reviewer's final scores into a composite score by taking the average of the weighted scores from the template. All weighted average scores will be rounded to nearest hundredth, and all ties will be settled in the following order: (1) by the individual weighted average score of each domain in 1-5 order listed below, (2) by greatest community need addressed in order of most critical need to less urgent need, (3) by Medicaid/low-income uninsured population percentage served, and (4) by coin flip.

All New 3-Year DSRIP Projects will be scored based on a scale of 1-9 (with 9 being the best) using the following weighted average domains:

1. Alignment with Community Needs (30%),
2. Transformational Impact (25%),
3. QPI/Medicaid/Uninsured Impact (25%),
4. Likelihood/Probability of Success (10%), and
5. Sustainability After the Waiver (10%).

Alignment with Community Needs – How well a project addresses one or more of the community needs as identified in the RHP's needs assessment. Providers should focus their efforts on the areas of greatest community need. A summary of RHP 12 community needs in order of urgency is as follows:

1. Critical Need – Severe **primary care** provider shortage, wait time, expense, lack of insurance, access to care,
2. Critical Need – Lack of **mental health services**, inability to get an appointment, lack of insurance, need to use EDs for initial contact,
3. Urgent Need – Poor **insurance support** or **uninsured**,
4. Urgent Need – High incidence of **obesity**, **diabetes mellitus**, and **heart disease**,
5. Urgent Need – Need for **specialists** to assist in the treatment of obesity, diabetes mellitus, heart disease, asthma, chronic lung disease, and other chronic diseases,
6. Urgent Need – Need for **cancer screening** with mammograms, pap smears, colonoscopy, sigmoidoscopy, and rectal exams,
7. Insufficient **maternal and prenatal care**, especially the first trimester teen pregnancy, high percentage of unmarried mothers,
8. Important Need – **Alcohol/substance abuse** and binge drinking,
9. Important Need – **Tobacco use**,
10. Important Need – High prevalence of **asthma** and care issues,
11. Important Need – Inadequate **vaccination** of the population,
12. Important Need – High incidence of **sexually transmitted diseases**,
13. Important Need – Shortage of **dental care**,
14. Important Need – Need for **HIV screening**.

Transformational Impact – Ability of project to transform provider's service delivery practices to improve access to health care, quality of care, patient experience, cost-effectiveness of care provided, and health of patients served.

QPI/Medicaid/Uninsured Impact – Project substantiation and valuation is partially determined by the Quantifiable Patient Impact (QPI) the project will have on the population. Projects must demonstrate significant benefit to the Medicaid/uninsured populations.

Likelihood/Probability of Success – Probability of a project continuing and accomplishing related milestones and metrics through the completion of the Waiver based on funding or resources available to the provider from the Waiver.

Sustainability After the Waiver – Probability of a project continuing for a 5+ year period immediately following completion of the Waiver without any additional funding or resources from the Waiver.

All New 3-Year projects will be scored based on the following 1-9 scale (with 9 being the best):

9. Exceptional – Exceptionally strong with essentially no weaknesses,
8. Outstanding – Extremely strong with negligible weaknesses,
7. Excellent – Very strong with only minor weaknesses,
6. Very Good – Strong but with numerous minor weaknesses,
5. Good – Strong but with at least one moderate weakness,
4. Satisfactory – Some strengths but also some moderate weaknesses,
3. Fair – Some strengths but with at least one major weakness,
2. Marginal – A few strengths and a few major weaknesses, or
1. Poor – Very few strengths and numerous major weaknesses.

For the purposes of this scoring system, RHP 12 used the following definitions from the *Guidelines for Reviewers Including Scoring Descriptors* from the Office of Extramural Research at the *National Institutes of Health*:

- **Minor Weakness**: Easily addressable weakness that does not substantially lessen impact,
- **Moderate Weakness**: Lessens impact,
- **Major Weakness**: Severely limits impact.

After scoring each project using the above 1-9 scale, the proposed New 3-Year Projects will be grouped into one of three Tiers:

1. Tier 1 – Projects from providers with earmarked funds (up to the exact net dollar amount earmarked per provider (earmarked threshold amount)). All Tier 1 projects will be listed in order of score except that the listed projects will alternate by affiliated IGT entity. When and if a provider has utilized their earmarked threshold amount, any remaining lower scored projects for that provider will become Tier 3 projects, subject to the selection process below. If the exact earmarked threshold amount occurs in the middle of a project, the provider can select one of the following: (1) move the current project to Tier 3, (2) increase the value of the previous listed project for that provider (not to exceed 10% of previous project's value), or (3) decrease the value of the current project (with minor project modifications allowed). Subject to the earmarked threshold amount per provider, this selection process will be used by the provider of the next listed project and will continue to be used until a selection has been made on the final Tier 1 project. Any earmarked funds not utilized by an individual provider in Tier 1 will be forfeited and will become Tier 2 funds.

2. Tier 2 – Highest scored project from any additional provider that <u>does not</u> currently have a DSRIP project (new provider). Only **<u>ONE</u>** project (highest scored) per new provider will be included in Tier 2. If a new provider submits more than one New 3-Year Project, then all lower scored projects will be included in Tier 3. All Tier 2 projects will be listed in order of score except that the listed projects will alternate by affiliated IGT entity. If the amount of Tier 2 funds available is not enough to fund all Tier 2 projects, then project funding will be determined by listing order. If the available funding limit amount occurs in the middle of a project, the related new provider can select one of the following: (1) decrease the value of the current project (with minor project modifications allowed), or (2) move the current project

to Tier 3. Subject to available funding limit amount, this selection process will be used by the provider of the next listed project and will continue to be used until all new providers have participated in the selection process. Any Tier 2 funds not utilized by a new provider in Tier 2 will be forfeited and will become Tier 3 funds.

3. Tier 3 – Projects from providers that currently have a DSRIP project (existing providers), projects moved from Tier 1 to Tier 3 due to earmarked threshold amount, and lower scored projects from new providers that did not get included in Tier 2 due to the limit of one project (highest scored) per new provider. All Tier 3 projects will be listed in order of score except that the listed projects will alternate by affiliated IGT entity. When and if only one affiliated IGT entity remains within Tier 3, all remaining Tier 3 projects will be listed in order of score regardless of affiliated IGT entity. If the amount of Tier 3 funds available is not enough to fund all Tier 3 projects, then project funding will be determined by listing order. If the available funding limit amount occurs in the middle of a project, the related provider can select one of the following: (1) decrease the value of the related project (with minor project modifications allowed), or (2) forgo the project and related funds. If the provider forgoes the project and related funds, then this selection process will be used by the provider of the next listed project and will continue to be used until either all funds have been utilized or a selection has been made on the final Tier 3 project. Any funds not utilized in Tier 3 will be redistributed to one or more New 3-Year Projects as selected in either Tier 1, Tier 2, or Tier 3.

Public Meeting and Other

Each RHP must hold a public meeting prior to submitting to HHSC its prioritized list of New 3-Year Projects and must post the proposed list prior to the meeting. When the prioritized list is submitted, the RHP also is to submit a description of the processes used to engage and reach out to potential DSRIP performing providers in the region along with public stakeholders and consumers. The submission also must describe the regional approach for evaluating and prioritizing projects. The submission must include as an appendix a list of the projects that were considered but not selected, regardless of whether they had an identified IGT source.

Timeline

- Early October – HHSC will provide a template and workbook for submission of New 3-Year Projects
- October 9 – Full 3-Year Project due to Anchor
- Week Beginning October 14 – Projects to be Prioritized by Experienced Healthcare Professionals
- October 24 – Required Public Meeting (prior to submitting prioritized list to HHSC)
- October 31 – Submit Prioritized List to HHSC
- Early December – Anchor to Submit Prioritized Full Projects to HHSC
- By December 31 – Initial Approval by HHSC
- By March 1 – CMS Approval
- April – DY3 Reporting Opportunity