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2/18/2015

RHP4 Learning Collaborative

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Agenda

9:00	Welcome	Jonny Hipp
9:10	Opening Remarks	Linda Wertz
9:15	DSRIP Project Updates	Providers
10:30	Break	
10:40	DSRIP Project Updates Continued	Providers
11:45	Raise the Floor Initiative Update	Dianne Longley
12:00	Lunch	
12:45	Workgroups -Patient Engagement -Access to Care	
2:45	Follow-up and Closing Remarks	Linda Wertz

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Raise the Floor Initiative

June 2014 – June 2015

– Increase use of social media to communicate health information to patients/clients

July 2015 – September 2016

– Organize and host community wide/regional health fair to promote DSRIP improvement activities

Social Media Challenges

- Receiving executive approval to engage in social media activities
- Staff training/responsibility
- Ongoing responsibility for keeping media/web pages current and fresh
- Clients do not have access to phone/computers
- How to measure patient utilization and effectiveness of program
- Complexities of programs
- Assuring compliance with federal state laws and regulations

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Challenges cont.

- Attracting patients to program
- Continuing to grow the program/increase participants
- Keeping interest of participants with relevant, timely information
- Delays in implementation that are outside control of the team responsible for program
- Patient compliance with instructions and recommendations
- Obtaining physician engagement and support

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Opportunities for Collaboration and Technical Assistance

- Share examples of promotional materials and information that have been successful
- Technical assistance related to development of new information, more sophisticated applications
- Ideas on how to increase participation and getting more people involved in programs
- Coordinate with other hospitals throughout region to view and “like” web pages and share health and wellness information throughout the collaborative

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Next Steps

- Continue to implement and advance social media activities
- Reach out to seek advice and assistance from other providers; see provider reports on RHP4 website for contact information
- Begin identifying opportunities to use social media to plan and promote regional health fair
- Need volunteers for next collaborative to demonstrate websites, media initiatives!

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CDC Social Media Toolkit

- Provides an introduction and step-by-step guidance for building and implementing a media strategy
- Includes a discussion of 12 different types of tools and how to use them effectively
- Social media strategy worksheet to help develop your organizational plan
- Social media Evaluation Worksheet to track progress
- The Health Communicator's Social Media Toolkit, published by Centers for Disease Control and Prevention – Office of the Associate Director for Communication
  - http://www.cdc.gov/socialmedia/Tools/guidelines/pdf/SocialMediaToolkit_BM.pdf

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CDC: Top Lessons Learned from Using Social Media

- Make strategic choices and understand the required level of effort to maintain
- Go where the people are, particularly the people you are targeting
- Adopt low-risk tools first, especially when encountering internal resistance
- Messages should be accurate, consistent and science-based
- Create portable content (mobile applications, videos) that can be easily shared

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Updates on Current Events

- HHSC staff is in the process of reviewing **Provisionally Approved metrics**. For Provisionally Approved metrics that need more information, HHSC will request additional information in mid-February (target date is Feb. 16) and ask that the information be provided by early March (target date is March 6).
- **Category 3:** HHSC will send out a RHP summary of Category 3 projects to the anchors. They will be asking anchors to share this information with their providers to ensure the status (reported or carried forward) is accurate.
- **Change Requests:** HHSC is reviewing the Round 2 change request submissions and Myers & Stauffer is reviewing the Round 1 submissions that required their review. HHSC plans to send HHSC's Round 2 preliminary determinations and Myers & Stauffer's Round 1 determinations to anchors/providers by mid to late February.

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Updates on Current Events

- **Mid Point Assessment:** HHSC is reviewing draft recommendations for the first regions (1, 4, 5, 8, 11, 13, 16, 17, 18, 19 and 20) and will be contacting providers regarding plan modifications recommended by the independent assessor.
- **Project Withdrawal:** CMS approved the proposed timeframe of February 1, 2015 – May 1, 2015 for withdrawal of a project from DSRIP after the mid-point assessment per the PFM protocol. Providers do not have to wait until the mid-point assessment process is complete.
- **DY2 Unspent Funds Update:** CMS requested additional information to which HHSC responded.

Waiver Renewal/Extension

Timeline

- October 1, 2013 – September 30, 2014 — DY 3
- October 1, 2014 – September 30, 2015 — DY 4
  - March 31, 2015 HHSC transition plan due to CMS
  - Public transparency process
  - March 31, 2015 Waiver under Section (a) Request due to CMS
  - September 30, 2015 Waiver Extension (e) Request due to CMS
- October 1, 2014 – September 30, 2016 (waiver expires) — DY 5
  - Negotiations: from request through approval no later than 10/1/2016

Source: Presentation - Teaching Hospital of Texas- 1115 Waiver-Maureen Milligan | RHP 14 Learning Collaborative on July 18, 2014.

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Current Waiver

- The Texas Healthcare Transformation and Quality Improvement Program was approved on December 12, 2011 for a demonstration period ending September 30, 2016.
- Texas Goals at the Time:
  - Protect UPL funding with a Medicaid Managed Care Expansion
- The current waiver includes:
  - The geographic expansion of comprehensive managed care
  - Creation of a $29 billion Safety Net Care Pool Funding, targeting uncompensated care (UC) and Delivery System Reform Incentive Payments (DSRIP)
- In order to preserve access to waiver funding and continued operation of Medicaid managed care, the waiver must be extended or renewed.

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Waiver Development

- CMS recommended Texas use the California waiver approach (then the Massachusetts approach…)
- DSRIP as a tool to transform health care
- Texas' argument for the waiver and DSRIP
- UC is preferred by hospitals
- DSRIP preferred by CMS
  - Community Assessments
  - Provider Collaboration & Coordination – new partnerships; new approaches; local innovation
  - Outcomes and Metrics as basis for payment – Accountability and Transparency compared to UPL funding

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Waiver Extension Authorities

- Section 1115 identifies several potential extension authorities though some are only available to States at specific times during their renewal.
  - The authorities have different time frames and characteristics.
  - All states with new 1115 waivers receive the initial authority at 1115(a) which provides for up to five year approval periods.
- **Section 1115(e)** is the authority that states may use to extend a waiver authorized under 1115(a). States may request an extension using the same terms and conditions as utilized in the initial approval. Extensions under this authority can be provided for 3 years.
- **Section 1115(f)** is the authority that states may use to extend a waiver that was extended under 1115(e). All terms and conditions are open to negotiation under this authority. Extensions under this authority can be provided for 3 years.
- **Section 1115(a)** is the authority that states may use to extend a waiver extended under any of the authorities above. The renewal period can range up to 5 years, all terms and conditions are open for negotiation.

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Construction of Waiver Pools

The State's budget neutrality agreement consists of two components:

1. Per capita amounts attached to populations, including managed care savings attributable to populations under the 1915(b) waiver that was subsumed, and
2. Amounts attributable to three UPL programs, inpatient hospital, outpatient hospital and physician.

Over five years, the diverted UPL programs contributed approximately $8.3 billion to the total $29 billion in pool spending and the remaining $20.7 billion is attributable to managed care savings achieved through the demonstration.

	DY 1	DY 2	DY 3	DY 4	DY 5	Total
UC	$3.7 b.	$3.9 b.	3.534 b.	$3.348 b.	$3.1 b.	$17.582 b.
DSRIP	$500 m.	$2.3 b.	2.666 b.	$2.852 b.	$3.1 b.	$11.418 b.
Total/DY	$4.2 b.	$6.2 b.	$6.2 b.	$6.2 b.	$6.2 b.	$29 b.
% UC	88%	63%	57%	54%	50%	60%
% DSRIP	12%	37%	43%	46%	50%	40%

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Current DSRIP Pool

- Total of 1,258 individual projects as of December 31, 2013
- Total of $2.1 Billion (all funds) claimed under the DSRIP through January 2014

Strategies for Arguing DSRIP Success

DSRIP – Texas Construction is Unique among all states with DSRIP.
What can we do to support the goals and objectives in an extension?

- **Utilize RHPs (Community Level Approach)**
  - Collaboration of public and private providers
  - True community and Healthy Neighborhood approach
  - How can we demonstrate the impact of a community approach?
- **Unique/Unusual Partnerships (Provider Level Approach)**
  - Collaborations made possible because of DSRIP funding
  - Developing new service modules (combining social and medical services for example)
  - Identify successful examples – data to demonstrate
- **Impact on Communities and Individuals (People Impacted Level)**
  - Changes in access, health status, quality of life, community outcomes
  - Examples from RHPs and specific projects
  - How best to demonstrate impacts on people?

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Strategies for UC Funding

What can we do to support the goals and objectives?

Uncompensated Care Pools

- What arguments to use for continued access to UC funding?
- What is the likelihood of increasing the available funding?
- How does request for UC funding relate to no Texas' Medicaid Coverage Increase?

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Questions and Contact Information

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