Discussion Items

- Current Texas Medical Supplemental Payment Program Background/Context
- 1115 Waiver Strategic Priorities and Considerations
- Tactical Priorities/Considerations - 1115 Waiver 1.0B
- Where do we go from here?
- Questions / Comments
Current Texas Medical Supplemental Payment Program Background/Context
Overview of Texas Medicaid Supplemental Payment Programs

1115 Waiver
- DSRIP $3.1 billion (DY5-2016)
- UC $3.1 billion (DY5-2016)
- Hospitals, MHMR, MD's/AMC, Public Health

DSH
- $1.8 billion (DY5-2016)
- High Medicaid / Safety Net Hospitals
- Funded largely by 6 public hospitals

MPAP/QIPP
- $535 million (DY5-2016)
- Long Term Care
- Funded through complex ownership arrangements with an IGT provider

NAIP
- $527 million (DY5-2016)
- Designated AMC's & public hospitals
- Similar to DSRIP but focused on expanding access
Supplemental Payment Funding

- Intergovernmental Transfers (IGT's) are funded in 3 principle ways in Texas:
  - Public hospitals or other entities (i.e. county governments)
  - State funds for programs that benefit state institutions
  - Through a model title “community benefit” or “burden alleviation”
The Unanswered Medicaid Funding Questions Facing Texas Providers on January 1, 2018

1. Will the DSRIP Program be extended or begin to be phased out over 3 years?

2. How much will the Uncompensated Care (UC) Pool be reduced?

3. How much will Medicaid DSH be reduced?

4. What financing mechanisms can we use to fund Intergovernmental Governmental Transfers (IGT's)?

5. How will supplemental payments be funded through Managed Care Organizations (MCO’s)?
Change is Hardest in the Middle

Kanter’s Law:
Everything looks like a failure in the middle. Everyone loves inspiring beginnings and happy endings; it is just the middles that involve hard work.
by Rosabeth Moss Kanter

- Checklist to determine when to pull out and when to persist:
  - Tune into the environment
  - Check the vision
  - Test support
  - Examine progress
  - Search for synergies
1115 Waiver Strategic Priorities and Considerations
1. **Coverage** is best way to assure beneficiary access to health care.
   - UC should not pay for costs that could be covered under a Medicaid expansion. The UC Pool will be limited to:
     - The size of the costs for uncompensated care and charity care for low-income individuals who are uninsured and can not be covered through Medicaid … [based on] hospital Medicare cost reports [S10] and projections of potential impact on Medicaid expansion in Texas.

2. Medicaid payments should support provision of services to Medicaid and uninsured individuals; and

3. Medicaid payments must be sufficient to promote provider participation, and care management.
Strategic Priorities & Considerations

- **CMS concerns and direction:**
  - UC Funding is not a long term solution
  - Medicaid programs should pay adequate FFS rates
  - Managed care integration – programmatic and payments
  - IGT deferral / financing

- **UC Funding**
  - DY5 – UC costs estimated at $7.1 billion (funding at $3.1 billion)
  - UC Study in progress – Health Management Associates (draft sent 7/15 & final report due 8/31)
  - CMS aversion to funding impact of Medicaid expansion and shortfall (unfunded costs)
Medicaid Managed Care Integration

- Promulgated through new Medicaid managed care (MCO) rules finalized April 25, 2016 effective July 5, 2016
- Affects MCO’s, hospital, LTC, and physician funding through MCO’s
- CMS Goal:
  - Modernize Medicaid Managed Care (Impact: Eliminate most Supplemental Payments as they operate today (DSH, GME, & FQHC’s excepted)
  - Align the efforts by MCO’s and Supplemental Programs to improve the Triple Aim Outcomes for the Medicaid Population
  - Limit funding of separate payments directly to providers from both HHSC and Managed Care payers
- Significant Challenges for Texas:
  - How are the payments for the uninsured population included or sourced?
  - Will providers see payment reductions due to – Texas tax on MCO’s premiums and MCO administrative payment?
  - Risk of IGT paid prior to reporting of achievement for DSRIP?
- Opportunity for Texas? – Potential additional UC funding up to a % of UPL
Direct Pay Prohibition Under Managed Care

Fee for Service

Base Payments to Providers

Managed Care

Supplemental Payments

State

Exposed Payments

MCO

Enhanced Capitation Payments to MCOs

Negotiated Rates to Providers

13
## State Directed Payments Permitted Under New Final Rule

### Permissible Directed Payments
- State can require MCO’s in contract to:
  - Implement VBP
  - Participate in delivery system reform initiatives
  - Adopt a minimum or maximum fee schedule or provide a uniform $ or % payment increase to providers

### Transitional Mandatory Pass-Through Payments
- *During transition period, states may require plans in contract to pass certain payment amounts to certain providers*
  - Payments not tied to utilization of services
  - For hospitals, nursing facilities, and physicians only
  - Time-limited
    - Hospitals 10 years with phase down
    - NF & physicians 5 years
IGT Deferral /Financing

- CMS has attempted on multiple occasions to invalidate Texas’s unique approach to generating funding of IGT’s through “burden alleviation” or “community benefit” approach.

- In 2015, CMS issued a deferral letter to Texas indicating that this approach was not consistent with Federal requirements. CMS later rescinded that position and gave notice to Texas HHSC that a new method of IGT financing had to be in place by September 2017.

- There exists uncertainty as to what CMS will do in 2017. Three options exist:
  - Enforce September 2017 notice date
  - Extend notice to December 31, 2017 consistent with the 1115 Waiver extension
  - Do nothing and allow the existing financing model (burden alleviation) to continue

- An additional CMS concern has been raised regarding the Pay to Play approach to IGT allocation. CMS prefers broad voluntary participation and allocation of IGT’s/Federal funds in the supplemental payment programs. NAIP and MPAP are being put on hold because of the rapid increase in payments and the Pay-to-Play financing of IGT’s.
CMS Issued an information bulletin on July 29, 2016 that has a number of questions related to the MCO pass through rules and the current *Pay to Play* rules for IGT financing. The 2 most important concerns to Texas include:

- The bulletin indicates that CMS believes that adding or increasing pass-through payments is inconsistent with the goals and objectives of the Medicaid managed care regulations. Therefore, the opportunity for increasing supplemental payments would not be allowed in Texas.

- The rule states that the *Pay-to-Pay* approach to financing supplemental payments is not permitted under the new MCO rules. The document specifically states: *MCO plan expenditures for provider payments does not condition provider participation in the arrangements on the provider entering into or adhering to intergovernmental transfer agreements.* This has potential significant ramifications for all supplemental payment programs.
Proposals on the Table

- HHSC proposals to CMS for funding supplemental payments through MCO’s and reduce or eliminate unfunded UC costs:
  - **#1** – Direct supplemental payments passed through MCO’s and paid to health care providers
  - **#2** – Use IGT’s to increase health plan premiums for the purpose of raising reimbursement rates to providers in a region

- **Financing options** for funding IGT’s:
  - Current “burden alleviation” or “community benefit” model
  - Local Provider Participation Fee (LPPF)
  - Statewide Provider Fee
Figure 1

States with provider taxes or fees in place in FY 2015

In place in FY 2015
- 3+ provider taxes/fees (32 states including DC)
- 2 provider taxes/fees (12 states)
- 1 provider tax/fee (6 states)
- No provider taxes/fees (1 state)

NOTES: Includes Medicaid provider taxes as reported by states. It is possible that there are other sources of revenue from taxes collected on health insurance premiums or health insurance claims that are not reflected here.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2015.
Other Factors That Will Impact Future Supplemental Payments

- **HHSC Leadership Changes:**
  - New Commissioner
  - New DSRIIP leadership team

- **Budget Neutrality** estimates and its impact on available funds

- **Political Influences:**
  - Presidential election
  - Democrat vs Republican control of the Senate
  - Texas Legislature
    - Medicaid funding and 1115 Waiver renewal requirements
    - Funding equity between healthcare and education
Tactical Priorities/Considerations - 1115 Waiver 1.0B
Texas Transition Year (DY6 A/B) PFM (i)

- Modifications to Transition Year/Demonstration Year Naming:
  - Demonstration Year (DY) **6A** = Federal Fiscal Year 2017 (October 1, 2016 to September 30, 2017)
  - Demonstration Year (DY) **6B** = The last 3 months of DY6 (October 1, 2017 – December 31, 2017)
- **Cat 1 to 4 remains the same**
- **MLIU definition** remains as proposed with the **broader** definition ("or" as opposed to "and")
- 4 components of **Cat 1 and 2 milestones/metrics** are equally weighed at 25%:
  - QPI
  - MLIU (Note: to be eligible for MLIU QPI payment, each performing provider must report for each DSRIP project the MLIU individuals served or MLIU encounters at the individual or encounter level as opposed to the percentage of total QPI. There may be exceptions dependent on HHSC approval.)
  - Core Component
  - Sustainability Planning
Texas Transition Year (DY6 A/B) PFM (ii)

- **Eligible Projects:**
  - All projects are eligible to proceed during the extension unless notified by HHSC.
  - Performing providers with total DSRIP project values below $250,000 are eligible to increase their project value(s) to $250,000.
  - Performing providers can withdraw a project after the 2nd payment for DY7 and before the 1st reporting period of DY8 with no recoupment. Money will be recouped if project is withdrawn anytime other than that timeframe.
  - New projects can commence no sooner than the beginning of DY6B.

- If a Category 3 metric is P4P in DY5, it will remain P4P in DY6A/B. Category 3 Thresholds for DY6 include:
  - If QISMC baseline is between HPL and MPL, DY6 requires **25% gap closure** (20% in DY5).
  - If QISMC baseline is below MPL, DY6 requires **15% gap closure** (10% in DY5).
  - IOS requires a DY6 gap closure of **12.5%** (10% in DY5).
Texas Transition Year (DY6 A/B) PFM (ii)

- **Performance Bonus Pool was removed.** Cat 4 continues with the removal of RD-6. Valuation limited to **10% of Total DSRIP funds**
- **DSRIP Funding Allocation %s** – CAT 1&2 – no more than 57%, CAT 3 – no less than 33%, and CAT 4 – No more than 10%.
- **Anchor entities** will get an **allocation** payment for unused DSRIP funds and must
  - Submit a DY6 LC plan and document actions
  - Conduct an Extension Stakeholder Engagement Forum to promote collaboration in next phase of the waiver
  - Update the RHP’s community needs assessment by June 2017
- **Compliance monitoring** will continue
Where do we go from here?
Key questions that must get answered in the next 12 months:

- What solutions can Texas develop in place of Medicaid expansion that gets CMS excited to extend the 1115 Waiver and fund UC?
- How do we minimize the risk of loss of funds?
- How do we manage to survive through the 'messy middle'?
Questions / Comments

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