



# The Present and Future of Medicaid

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# Discussion Agenda

- ▶ Federal Push to Reduce Medicaid Funding
- ▶ Quick Primer on how Texas Medicaid is Funded
- ▶ Texas Medicaid - Current Areas of Focus
- ▶ Future Challenges
  - ▶ 1115 Waiver Renewal
  - ▶ UC Disallowance
- ▶ New Opportunity
  - ▶ LPPF
  - ▶ UHRIP
- ▶ Concluding Thoughts

## Texas Medicaid Perspective – Health Coverage

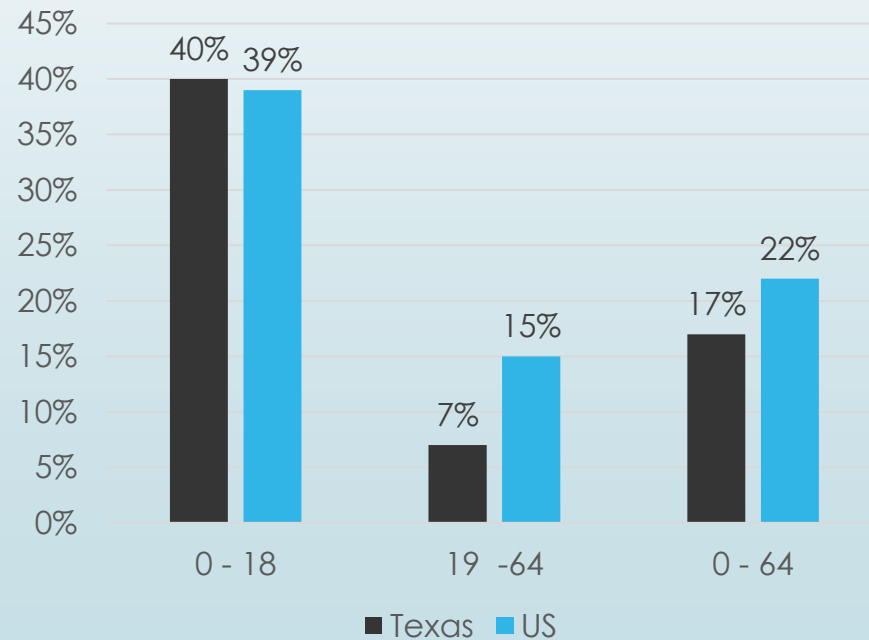
	Age 0 to 18	Age 19 to 64	Total – Age 0 to 64
Employer	3,298,300	9,522,200	12,820,500
Non-Group	383,600	1,393,400	1,777,000
Medicaid	3,002,400	1,170,200	4,172,600
Other Public	224,500	835,200	1,059,700
Uninsured	691,200	3,568,000	4,259,200
Total	7,600,000	16,489,000	24,089,000

Source: Kaiser Family Foundation, 2015

# % of Population Covered by Medicaid or Uninsured – Texas vs U.S.

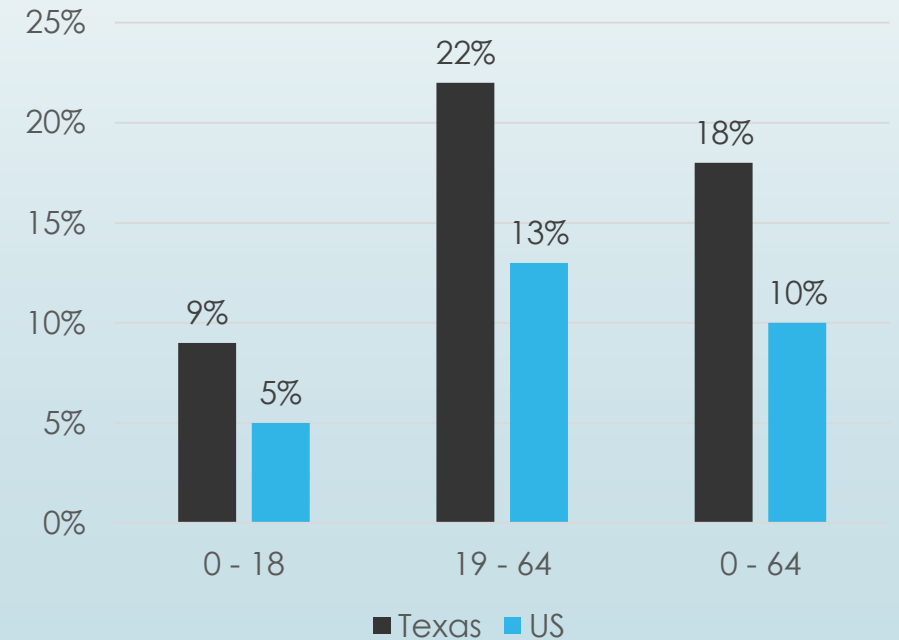
## Texas Medicaid

% of Population by Age Group



## Uninsured

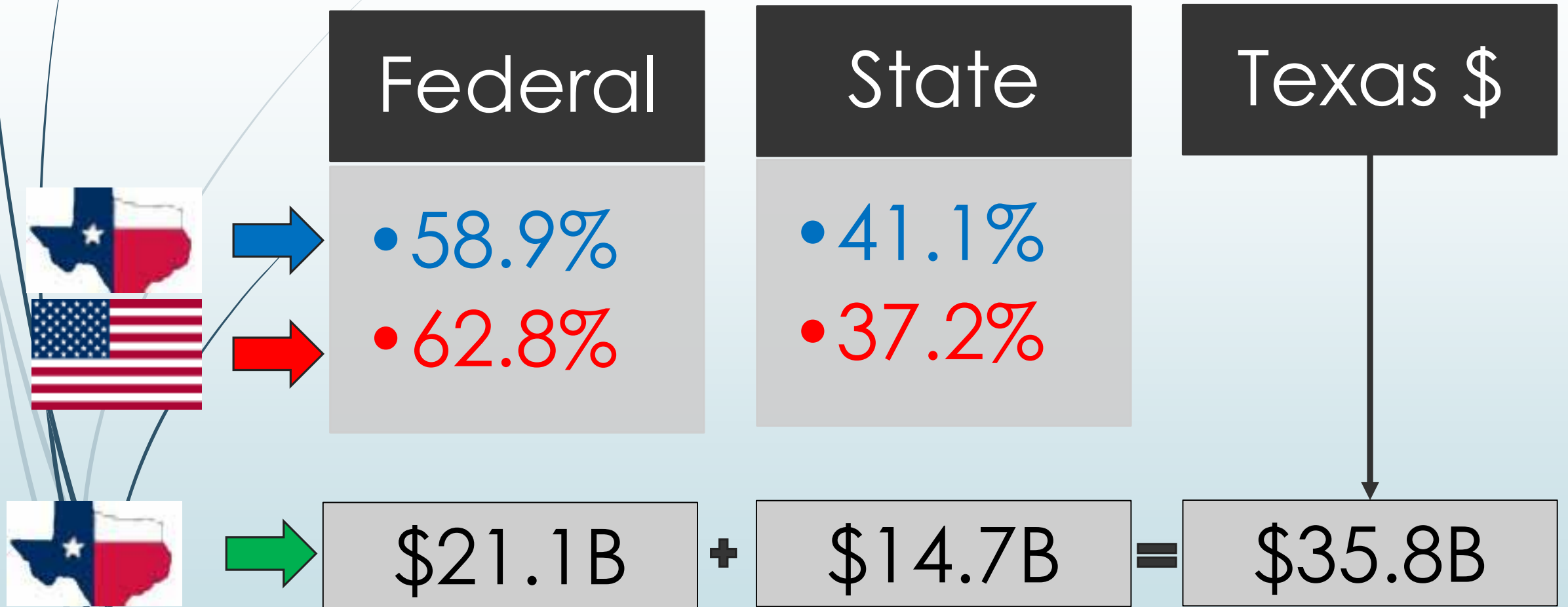
% of Population by Age Group



# Medicaid Program Financing Background

- Medicaid **is jointly financed** by states and the federal government.
- Medicaid **enrollment varies** significantly among states based on each state's decision to expand or not expand Medicaid as a result of the ACA.
- States and the federal government **share in the financing** of the Medicaid program. Under federal Medicaid law, the federal government pays between 50 and 74 percent of all the costs of providing services to beneficiaries under the program.
- How do providers receive payment for providing services for Medicaid patients? Most states pay for Medicaid services through **fee schedules** or through risk arrangements with managed care organizations who contract with providers. These payments are typically below the cost of care for a health care provider.
- Fee schedules in Texas reimburse approximately **55% to 65%** of the total cost of care
- Medicaid **supplemental payments** and grants are used as an enhancement to fee schedule payments.
- Medicaid also partially **funds services to medically indigent (UC) patients**, who are not enrolled in Medicaid, through supplemental payments.

# Texas Medicaid Funding Overview



Source: Kaiser Family Foundation, 2015

# Texas Dependence on 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

# Inter-Governmental Transfer (IGT) Defined

- ▶ **IGT's** (Intergovernmental Transfer) are used to fund various supplemental payment programs
- ▶ **IGT** - The process used to transfer funds between;
  - ▶ the Federal government
  - ▶ any unit of local government (including, but not limited to, a public hospital, hospital district, county, city, or Local Mental Health Authority); or
  - ▶ any state agency
- ▶ **IGT Source** – Must come from a qualifying governmental entity and can only come from qualifying revenues of the governmental entity.
- ▶ **FMAP** - Each state's IGT program has a specific matching percentage called the Federal Medical Assistance Percentage (FMAP). This is a percentage amount that the federal government will match when a state provides its portion (referred to as the state share). The percentage amount is established annually and varies from state to state depending on the state's per capita income.
  - ▶ For the state of California the FMAP is 50%, or an exact match. This means that for every 1 dollar the state funds, the federal government will also fund 1 dollar.



# Challenges with Setting Up and Funding Supplemental Payment Programs

## ► **Funds Available to Pay Providers**

- CMS and State agreement on funding pool size (i.e., 1115 Waiver, DSH, UPL, etc.), program requirements, and funds flow methods/requirements (i.e., MCO pass through rules)
- Budget neutrality calculation

## ► **Funds Available to Finance IGT's**

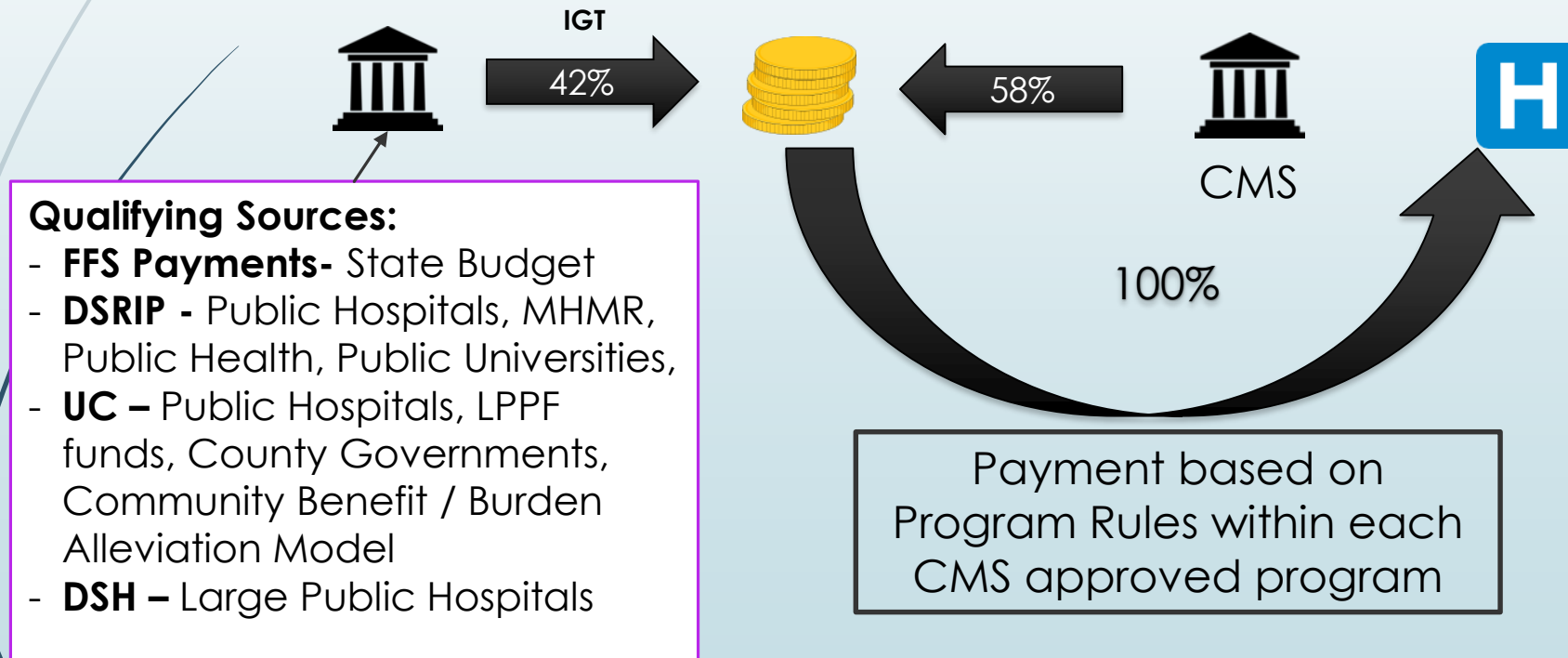
- Source
- Available Funds (IGT capacity test)

## ► **Working capital management of funds. Is the cash available when IGT's are due and payable?**

## ► **Congressional oversight (GAO report) and Political Influence**

# Federal Matching Process

## Illustration of Medicaid Federal Matching for Texas:



# Texas Medicaid – Current Areas of Focus

- ▶ **Figuring out CMS Priorities and Direction:**
  - ▶ **UC Funding** is not a long term solution /expanded coverage is a long term solution
  - ▶ Medicaid programs should pay **adequate FFS rates**
  - ▶ **Managed care integration** – programmatic and supplemental payments
  - ▶ **Recent CMS decisions** regarding Florida supplemental payments
- ▶ **1115 Waiver Extension** (incl. Extension of the Extension)/Renewal
  - ▶ UC Pool Size/Continuation
  - ▶ DSRIP Program Development – Transition from an “**infrastructure/ramp up**” focus on targeted “**projects**” to entity performance on “**measured bundles**” of care
- ▶ **Shift of IGT Financing:**
  - ▶ **CMS Disallowance** of Community Benefit Intergovernmental Transfer (IGT) Financing Model
  - ▶ Use of **Local Provider Participation Funds** (Provider Fee’s) to fund enhanced Medicaid Payments

# Texas Medicaid – Future Areas of Focus

- ▶ Federal Health Reform / ACA Repeal and/or Replace – dead or alive?
- ▶ ACA
  - ▶ Health Insurance Marketplace/Exchange – Limited impact in Texas due to withdrawal of most insurance companies
- ▶ Future IGT Financing Option - Local Provider Participation Funds
- ▶ Future FFS Rate Enhancement Option - Uniform Hospital Rate Improvement Program

# Financing and Enhancing Medicaid Payment Rates

# Texas Medicaid – What is an LPPF and how is it used ?

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- ▶ LPPF is an IGT financing mechanism, not a reimbursement program
- ▶ Local Provider Participation Funds (“LPPF”) provide Inter-Governmental Transfer (IGT) to access federal matching funds for Medicaid Supplement programs including UC, DSRIP, and UHRIP
- ▶ LPPF program is effectively an assessment on total net patient revenues (NPR) on the nonpublic hospitals within a county. The assessment cannot exceed 6% of NPR
- ▶ In Texas, state legislation is required for granting a “local option” that provides the public hospital or other government authority to administer an LPPF assessment on the nonpublic hospitals
- ▶ Prior to the 2017 legislative session, LPPF bills have been approved in 11 rural counties in Texas for funding UC and DSRIP payments
- ▶ LPPF bills were approved for 8 additional urban counties in the most recent legislative session and included LPPF bills for Dallas and Tarrant Counties

# Local Provider Participation Fund (LPPF)

## History in Texas

### ➤ LPPF BACKGROUND

- During the 83rd and 84th sessions, the Texas Legislature overwhelmingly passed legislation that granted 11 counties and the city of Beaumont the flexibility and local choice to create Local Provider Participation Funds
  - The hospitals in these communities received millions of additional dollars in Medicaid UC and DSRIP payments as a result; those dollars otherwise would have gone elsewhere
- The LPPF provides a stable revenue stream to support the non-federal share of Medicaid Payments
  - Unlike other funding mechanisms, the level of IGT generated by the LPPF is predictable and reliable
- The 85<sup>th</sup> Legislature passed LPPF legislation for Dallas and Tarrant County, and the Dallas and Tarrant County Hospital Districts are currently in the early stages of implementing LPPFs

## Federal Rules Regarding the LPPF

- ▶ The LPPF is consistent with CMS rules regarding provider taxes
  - ▶ Broad-based: The tax must apply to every hospital in the county that provides inpatient care
  - ▶ Uniform: The same tax rate must apply to all providers subject to the tax
  - ▶ No hold harmless: No unit of government may guarantee that a paying provider is held harmless for all or any portion of the funds paid into the LPPF
- ▶ Because CMS rules require that the LPPF be uniform and broad-based, some hospitals will pay more into the LPPF than they receive in benefit in the form of an increased Medicaid payment
  - ▶ Hospitals that have little or no Medicaid volume, or are not eligible for additional Medicaid payments through the state's Section 1115 waiver will not receive a direct benefit from the payments that the LPPF generates
    - ▶ These hospitals are referred to as net loss hospitals



# Community Benefit Payments

- Net benefit hospitals ensure that net loss hospitals benefit through a **community benefit payment** directly from one of a number of the benefiting hospitals
  - This arrangement does not violate the hold **harmless prohibition** because the prohibition only applies to units of government; it does not prohibit hospitals that benefit from the tax from agreeing to make payments to net loss hospitals
  - The community benefit payment **fosters political support** for the LPPF among the local hospitals by ensuring that all hospitals benefit from the program
- In existing regions, the community benefit payment is generally equal to **105 percent** of the amount the Mandatory Payment, and is paid to the net loss hospital within 30 days after the net loss hospital makes its mandatory payment
  - In exchange, the net loss hospital's agrees:
    - to use that money to **enhance the provision of high-quality health care** services to patients in the County;
    - **to support implementation** of Mandatory Payments by the County; and
    - to **timely pay** the Mandatory Payments as required by the county
- The LPPF only works if everyone that is subject to the fee ends up with a benefit
- It's important to note that the **government entity is not a party to the grant agreement**

# Texas Medicaid – Uniform Hospital Rate Increase Program (“UHRIP”)

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- **UHRIP is a hybrid reimbursement program.** The program has had a tough start getting traction in Texas
- THHSC is currently seeking approval from CMS to implement the UHRIP for hospital services in SFY beginning September 1, 2017
- If approved, hospital providers in an designated region (called a Service Delivery Area (SDA)), would see significant increases to **rates paid** by **Medicaid Managed Care Organizations** (MCO) for Rate increases may be allowable up to 95% of costs
- This rate increase would **reduce hospitals’ Medicaid shortfall** in the managed care service delivery areas in which the program is implemented and **reduce dependence on shrinking UC payments**
- **Proposed rates** by class have been submitted to HHSC for the Dallas and MCO regions

## Texas Medicaid – Uniform Hospital Rate Increase Program (“UHRIP”)

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- ▶ HHSC is currently calculating the available rate increases based on several factors including: MCO enrollment changes; fees for Medicaid MCO administration, risk pools, and other fees; IGT sufficiency; 95% Medicaid shortfall threshold, actuarial trending factors; and estimated budget neutrality impact
- ▶ HHSC must submit calculated rates to CMS for approval prior to program implementation
- ▶ Requires a sponsoring governmental entity:
  - ▶ JPS for the Tarrant County SDA
  - ▶ Parkland for the Dallas County SDA
- ▶ Medicaid managed care participation negotiations are in progress

# Texas Medicaid – Local MCO Service Areas

## ► Tarrant County MCO Service Area

- Tarrant
- Denton
- Wise
- Parker
- Hood
- Johnson

## ► Dallas County MCO Service Area

- Dallas
- Collin
- Hunt
- Rockwall
- Kaufman
- Ellis
- Navarro

# Texas Medicaid - LPPF / UHRIP Distribution

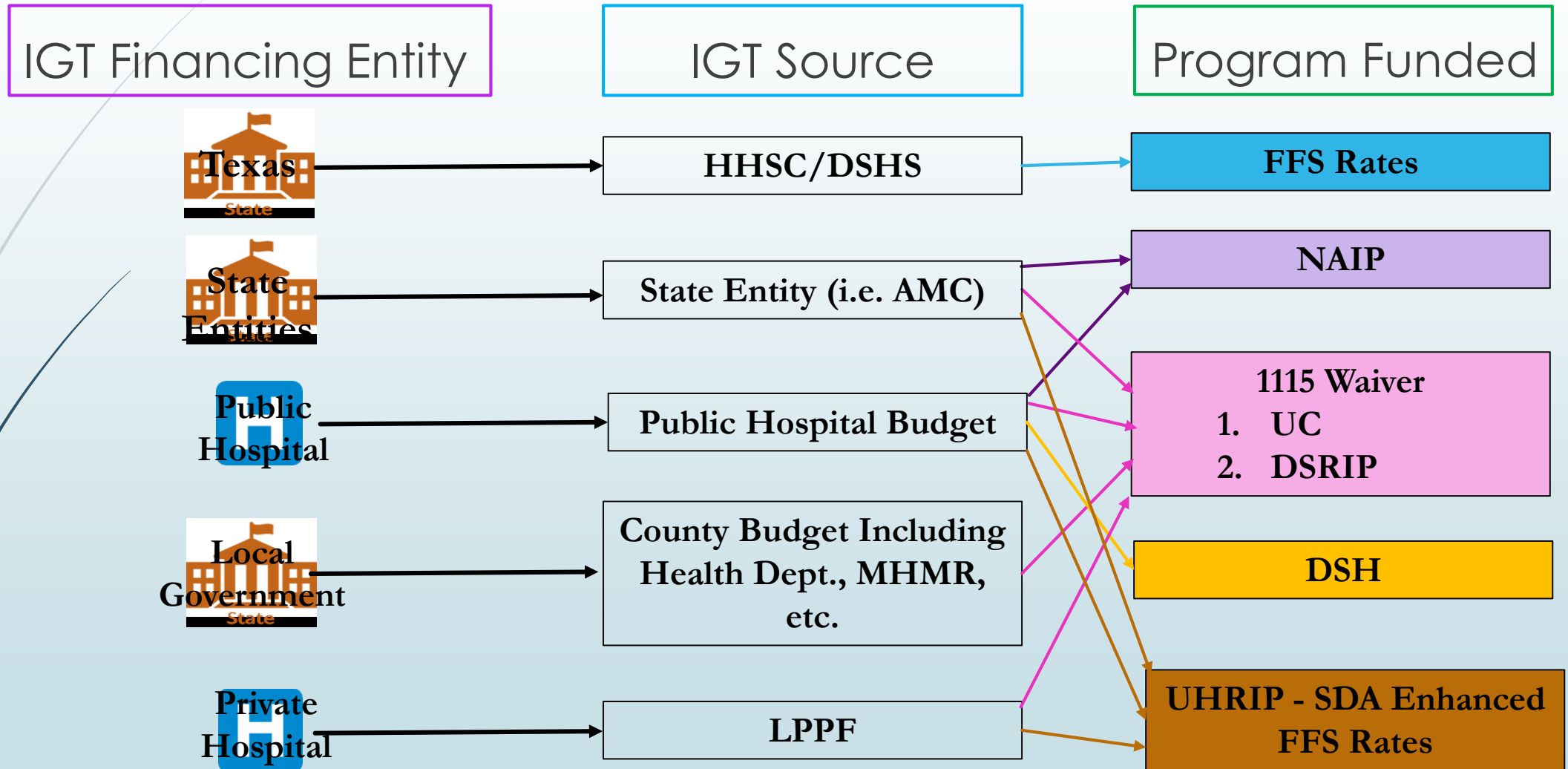
## Methodology of SDA's Shareable Net Benefit

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1. The SDA benefit calculation is based on most recent available data at time of settlement.
2. Eligibility for an affiliate distribution requires all LPPF mandatory payments are paid on agreed upon date to pay to fully fund the necessary IGT.
3. Hospital Specific Benefit Calculation:
  - a. The benefit is the difference between the increased UHRIP MCO payments (inclusive of the MCO quality payment gain/loss) and expenses.
  - b. Expenses include applicable LPPF mandatory payment, MCO expenses, UC loss/gain, DSH loss/gain, LPPF administration expense, and grant expense (Base Grant + 5% Incentive Payment).
  - c. Grant expense is for mitigation of private hospitals that incur a negative net benefit due to LPPF fee's in excess of UHRIP payments.
  - d. Adjustments will be made in the event that secondary or substitute IGT sources are used to fund HHSC approved UHRIP MCO payments.
4. The remaining shareable net benefit is spread to all remaining non-public UHRIP participants based on an agreed upon allocation method (i.e., % share of UHRIP payments).

# Concluding Thoughts

# Medicaid Program Funds Flow for Hospitals



# 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

- **Where do we go from here?**
  - **Tune into the environment**
  - **Check the vision**
  - **Test support**
  - **Examine progress**
  - **Search for synergies**



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