The 1115 Waiver: Broken into Pieces (and More)

Discussion Points

- State 1115 Waiver Background
- Where we are Today!
  - Uncompensated Care Cost and ‘UC Tool’
  - Delivery System Reform Incentive Payments (DSRIP)
- Projections going Forward
  - UC Tool Completion and Funding of IGT
  - DSRIP Menu Protocols and Project Funding
- State DSH Payments
Transformation Waiver Overview

Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver:

- Managed care expansion
  - Allows statewide Medicaid managed care services.
  - Includes legislatively mandated pharmacy carve-in and dental managed care.

- Hospital financing component
  - Preserves upper payment limit (UPL) hospital funding under a new methodology.
  - Creates Regional Healthcare Partnerships.
Transformation Waiver Purpose

- Protects Hospital and Healthcare Entity Supplemental Payments
- Expand range of reimbursement for eligible uncompensated care services.
- Incentivize delivery system improvements and improve access and system coordination.
- Allow RHPs, which are collaboration partnerships anchored by public hospitals in coordination with local governments and other healthcare stakeholders

Waiver Pools

- Under the waiver, trended historic UPL funds and additional new funds are distributed to hospitals through two pools:
  - Uncompensated Care (UC) Cost Pool
    - Costs of care provided to individuals who have no third party coverage for the services provided by hospitals or other providers (beginning first year).
  - Delivery System Reform Incentive Payments (DSRIP)
    - Support coordinated care and quality improvements through RHPs to transform care delivery systems (beginning in later waiver years).
RHP Principles

- RHP is an organization of public/transferring hospitals, local governments, private hospitals and other stakeholders designed to plan and redesign health infrastructure.
- Anchored by a Public Hospital, these entities serve as the single point of contact and help coordinate RHP activities.
- Develop plans to address local delivery system concerns with a focus on improved access, quality, cost-effectiveness, and coordination.
- RHP should reflect delivery systems and geographic proximity.
- UC and DSRIP pools are dependent on RHP plan participation.

RHP Plan Expectations

- CMS Expectations:
  - Planning process that demonstrates regional collaboration focused toward three overarching goals:
  - Better Access to Patient Care
  - Better Quality of Care Delivery
  - Cost Containment
  - Projects that address community needs and are transformative to delivery of care in the region
  - Projects that demonstrate outcomes by the end of the initial waiver period (September 2016)
Waiver Reporting Requirements

- Uncompensated Care Cost payments
  - Healthcare Providers are required to submit a completed waiver application (‘UC Tool’) that documents UC cost for providing hospital and non-hospital services to Medicaid and uninsured patients.
  - State DSH Providers vs. Non-state DSH providers

- DSRIP Payments
  - Providers must submit project plans illustrating innovation and reform in healthcare delivery in the region
  - Collaborative effort through an RHP
  - Measurement of outcomes of the plans submitted

Waiver Pools - What is Available?

- Total of $29 Billion has been allocated toward the Waiver over the entire five years

<table>
<thead>
<tr>
<th>Pool Funding Distribution in Billions</th>
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<tr>
<td>-----------</td>
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<tr>
<td>% UC</td>
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<tr>
<td>% DSRIP</td>
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- The UC Cost Component is estimated at approximately $3.7B, $3.5B, $3.3B, and $3.1B each year of the waiver in available cap dollars.
- The state has already projected that computed UC cost will exceed aggregate cap for available UC funding - UC ‘Haircut’ projected.
- DSRIP Funding is estimated at approximately $2.5B as available project dollars
- Initial Participation and community needs will determine flow of dollars for DSRIP funding (“Pass 1” and “Pass 2” allocations)
Big Questions: UPL vs 1115 Waiver

- How will the hospital upper payment limit change under the 1115 Waiver?
- Will hospitals receive the same amount of funding under the Waiver as they have under UPL?
- Will current private hospital UPL affiliation agreements be affected by the Waiver?
- Does the Waiver remove issues with the Prohibitive Provider Donation Rules?

UC Cost Pool

- The state UC Tool application - designed to calculate unreimbursed cost of providing care to Medicaid, uninsured, and underinsured patients
  - Received CMS Approval in July 2012
  - State posted initial version of UC Tool - August 9th - with a Proposed September 10th deadline for completion
  - UC Tool was removed from HHSC website - August 24th - correction of pre-populated fields and formulas in calculation
  - UC Tool has been re-posted to website on Wednesday, September 19th - Proposed deadline of October 22nd
  - UC Tool was taken down again yesterday for correction of DSH Pymts.
UC Cost Survey (UC Tool)

- The state contracted with Deloitte and Touche in formation and development of the Uncompensated Care Cost Survey.

- UC Tool is fundamentally correct in computing UC Cost, however incorporation of state payment system data into the Tool has caused for delay in implementation processes.

- The baseline data for the UC Tool is the Medicaid / Medicaid Cost Report data and the recent state DSH application.
  - If the Hospital filed a DSH application - most of the support was filed w DSH application.
  - If a Healthcare provider did not or was not required to file a DSH application - required to support charity care, cost of uninsured services, and unreimbursed cost not reported on the cost report.

UC Payment Status

- UC payments for demonstration year (DY) 1 are scheduled for disbursement in the first quarter of Calendar year 2013.

- Certain Hospitals receiving Disproportionate Share (DSH) and certain hospitals receiving waiver transition payments may receive UC payments toward the end of this year.

- Each hospital’s advance payment will be reconciled when the UC application (UC Tool) is submitted and audited.

- In the event that the UC application does not support the amount of advance payment for UC cost, excess funds will be recouped. For hospitals that transition payments that are in excess of UC application, it is recommended not to submit the UC application for DY 1.
UC Tool

- Schedule 1 - Costs related to direct patient care services of hospitals, physicians, mid-level practitioners that are excluded from allowable cost on the Cost Report.

- Schedule 2 - Cost related to direct patient care services of physicians and other services that are not reflected in the financial records of the healthcare facility, but are in the records of a professional organization owned controlled by healthcare organization.

- Schedule 3 - Cost related to outpatient Pharmacy Services provided by hospitals participating in the Texas vendor drug program.

- Schedule 4 - Cost related to services only provided to Medicaid and/or Uncompensated Care patients (DSH Pmt vs HSL).

UC Payment Status

- Must be in an RHP to receive UC or DSRIP funding.

- Hospitals that only plan to participate in UC funding will not be eligible to receive DSRIP funding for the required Category 4 reporting.

- Small and Rural Community Hospitals are exempt from DSRIP Category 4 reporting for UC.  (Category 4 - Population based Improvements)

- UC Hospitals must also participate in an Annual Healthcare Partnership (RHP) learning collaborative.
UC Tool Questions

- Do I have to Participate
  - No - You do not have to Participate

- How will HHSC handle an aggregate Uncompensated Care Cost that exceeds the aggregate funds available?
  - There will most likely be a proportional reduction of UC dollars to all providers (UC “Haircut”)

- Where/ Who will we submit the UC Tool to?
  - Instructions for submission are on the HHSC - RAD website

- Once we have completed the IGT funding process for UC, when can we expect to receive payment
  - Approx 30 days from receipt of IGT

Grumble, Grumble
RHP Plans: Two Protocols

- Two Protocols serve as a basis for the Regional Healthcare Partnership Plans development and DSRIP funding.

- Program Funding and Mechanics (PFM) Protocol
  - Approved by CMS on August 31, 2012

- RHP Planning Protocol (DSRIP Menu)
  - Final Approval and Issuance of the Menu is expected soon
  - State projection was today - September 21st.

RHP Plans: PMF Protocol

- Program Funding and Mechanics (PFM) Protocol includes outlines:
  - Minimum number of DSRIP projects per RHP
  - Requirements for each DSRIP performing provider
  - Organization of the RHP Plan
  - Funding allocations between and within RHPs
  - Maximum project valuations
  - Plan Review Process
  - Required Reporting Requirements
  - Plan Modification Guidelines
RHP Plans: Planning Protocol

- The RHP Planning Protocol outlines the Menu of Projects eligible for DSRIP funds:
  - Category 1 - Infrastructure Development - Foundation for the Delivery System through investment in people, processes and technology.
  - Category 2 - Program Innovation and Redesign - Pilot projects, test and innovations in Healthcare models
  - Category 3 - Quality Improvements - Healthcare delivery outcomes improvement targets tied to category 1 and 2 projects
  - Category 4 - Population-based Improvements - Requires all RHPs to report on the same measures (Required participation, except for small rural hospitals)

RHP Plans: Status and Next Steps

- Worth mentioning again - Planning Protocol (DSRIP Menu) expected to issued at any time, sooner rather than later. State anticipated - September 21st.
- Plans projected due date to HHSC - October 31st
- Examples of Proposed DSRIP Projects
  - Primary care Expansions (New locations and hours)
  - Behavioral Health expansions
  - Telemedicine options for specialty care
  - Crisis stabilization units and dental clinic expansions
  - Workforce expansions
  - Chronic Care management models
DSRIP Funding Structure

- “Pass 1” Funding - RHP must meet minimum project criteria and valuation measures to obtain First Pass DSRIP dollars
  - Hospitals must collaborate and pool DSRIP funding

- “Pass 2” Funding - Based on unused “Pass 1” Allocation amounts after the first pass and redirected by the RHP to fund additional projects.
  - Participation in Pass 2 is based on certain eligibility criteria

- DSRIP Payments will be funded and paid twice year, based on HHSC and CMS approval
  - Performing providers will be required to report on milestone bundles to be eligible for DSRIP funding.

RHP 12 Projected Calendar

- September 21st - FinalProjected date for approval of RHP Planning (DSRIP Menu) - Draft is actually out yesterday

- September 21st - Pre-Populated Electronic Templates available
- Approximately September 24th and 26th - Regional Work Sessions
- September 28th - Pass 1 Projects and Templates due to Anchor
- October 5th - Pass 2 Projects and templates due to Anchor
- October 6th - 19th - Anchor Review and put plans together for submission
- Approximately October 22nd and 24th - Hold Public Hearing
- October 25th - 26th - Plans open for public comment
- October 31st - RHP Plans must be submitted to HHSC
State DSH Payments

- Updating the DSH Payment Methodology in Response to a Petition for the Adoption of a Rule
- Hospitals participating in the Texas Medicaid program that meet the DSH program conditions of participation and that serve a disproportionate share of low-income patients
- HHSC, as the Medicaid single state agency, establishes each hospital’s eligibility for DSH reimbursement and the amount of reimbursement
- The vast majority of the non-federal share of payments to hospitals under the DSH program comes from members of the Texas Coalition of Transferring Hospitals (TCTH). TCTH is a coalition of hospital districts in Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Tarrant, and Travis counties.

DSH Audits

- Changed the Way IGT was Treated
- Pre-DSH Audits, IGT was not counted against the TCTH Hospital Specific Limit
  - Under this theory, TCTH Hospitals could recover up to 60% of the IGT through the Upper Payment Limit Program Payments
- Now, the IGT is a direct reduction of the HSL
- Impact for the TCTH is that 60% of the IGT used for DSH statewide is used for non-TCTH hospitals and no recovery is available through UPL
DSH Methodology

- For DSH program year 2012, separate funding pools are created for children’s hospitals, rural hospitals, urban public hospitals (i.e., hospitals owned by or under an operating lease with TCH members), and all other hospitals.
- The amount of funds available for distribution within each pool is expressed as a percentage of the federal DSH allotment:
  - children’s hospitals (8.36%);
  - rural hospitals (5.98%);
  - urban public hospitals (51.25%);
  - all other hospitals (34.41%).
- The percentages are based on multiple factors, including historical payment amounts in each category, historical intergovernmental transfer (IGT) amounts, and to ensure a sufficient return of federal funds.

DSH Methodology (cont.)

- Based on current estimates and sufficient IGTs are made, the estimated funds for program year 2012 resulting from application of the rule would be as follows:

<table>
<thead>
<tr>
<th>DSH Funding Pool</th>
<th>Estimated Allocation</th>
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<tbody>
<tr>
<td>Children’s Hospitals</td>
<td>$100,000,000</td>
</tr>
<tr>
<td>Rural Hospitals</td>
<td>$71,500,000</td>
</tr>
<tr>
<td>Urban Public Hospitals</td>
<td>$613,000,000</td>
</tr>
<tr>
<td>All other hospitals</td>
<td>$417,000,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$1,201,500,000</strong></td>
</tr>
</tbody>
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DSH Methodology (cont.)

- The pool methodology will be implemented in the 4th quarter of DSH program year 2012.

- Payments already made to each hospital during the program year will be deducted from the payment amounts calculated using the revised methodology.

- HHSC will not recoup any payments already made that exceed the revised payment amounts. Each pool will be reduced by the amount of payments already made to hospitals in that pool that exceeded the revised payment amounts.

DSH Methodology (cont.)

- Half of the DSH funds in each of the funding pools for rural, children’s, and all other hospitals are allocated based on Medicaid days and half on low-income days. This methodology is consistent with the historical DSH allocation methodology, except that this is calculated within each pool, rather than on all available DSH funds.

- Funds in the pool for the urban public hospitals are allocated based on 100% low-income days.

- If there are remaining or non-allocated funds available within any pool (e.g., when a hospital's initial payment amount exceeds its hospital-specific limit), the excess funds will be allocated to hospitals within the same pool with available DSH room.
FY 2012 DSH Payment Timeline

- September 21st - Projected date TCHT will transfer non-federal matching share for 4th Quarter DSH Payment under the new methodology.

- September 28th - Projected date for 4th Quarter DSH Payment to hospitals.

- Timing could be adjusted for delays in the fund transfer or adjustments to the transfer amount.

- Notice of 4th Quarter DSH Payment Amounts should be available the week of September 24th.

Let’s eat...
FY 2013 DSH Payment

- Governor's proposal uses a combination of TCTH funds and State General Revenue (GR)

- Two Pools of Funding
  - TCTH Pool is its own RHP with a Funding History
    - IGT Approx. $318M from TCTH hospitals
  - Other Pool is based on the amount of GR
    - IGT is Approx $100M
  - Still under lots of negotiation