The 1115 Waiver: Coming Together (and Reimbursement Update)

Presented by Discovery Healthcare Consulting Group, LLC

Discussion Points

- State 1115 Waiver Background
- Where we are Today!
  - Uncompensated Care Cost ‘UC Tool’ Update
  - DSRIP Summary and Payment Calendar
- Other Reimbursement Matters
- State DSH Payments
What time is it?

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

- Develop Regional Healthcare Partnerships (RHPs).
- Expand range of reimbursement eligible uncompensated care services.
- Develop delivery system improvements incentives.
- Five Year Funding Approval

RHP Plan Expectations

- **CMS Expectations:**
  - Uncompensated Care will be reduced over the life of the waiver;
    - DSRIP projects will provide Better Access to Patient Care
    - Better Quality of Care Delivery
    - Lower Cost
  - Uncompensated Care providers was expanded from hospitals and physician UPL program to include:
    - Hospital;
    - Physician Groups;
    - Dental Groups;
    - Public Ambulance Providers
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).

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 outpatient Pharmacy Services provided by hospitals participating in the Texas vendor drug program
- Schedule 3 - Cost related to services only provided to Medicaid and/or Uncompensated Care patients (DSH Pmt vs HSL)
Funding Pools:

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>UC</td>
<td>3,700,000,000</td>
<td>3,900,000,000</td>
<td>3,534,000,000</td>
<td>3,348,000,000</td>
<td>3,100,000,000</td>
<td>$17,582,000,000</td>
</tr>
<tr>
<td>DSRIP</td>
<td>500,000,000</td>
<td>2,300,000,000</td>
<td>2,666,000,000</td>
<td>2,852,000,000</td>
<td>3,100,000,000</td>
<td>$11,418,000,000</td>
</tr>
<tr>
<td>Total/UC</td>
<td>4,200,000,000</td>
<td>6,200,000,000</td>
<td>6,200,000,000</td>
<td>6,200,000,000</td>
<td>6,200,000,000</td>
<td>$29,000,000,000</td>
</tr>
<tr>
<td>% UC</td>
<td>88%</td>
<td>63%</td>
<td>57%</td>
<td>54%</td>
<td>50%</td>
<td>60%</td>
</tr>
<tr>
<td>% DSRIP</td>
<td>12%</td>
<td>37%</td>
<td>43%</td>
<td>40%</td>
<td>50%</td>
<td>40%</td>
</tr>
</tbody>
</table>

UC Tool submission for FY 2012-
Lesson Learned

- Schedule 1 - Many delays - Hospital Charge allocation and Physician Cost allocations resulted in the delay of the submission to November 9, 2012.

- Schedule 1 resulted in the majority of the confusion for the UC tool;
  - Charge Allocation:
  - CMS required the cost to be allocated based on physician charges, while this is not captured in the hospital cost report and in most cases not by the hospital.
  - (Note hospitals may want to review their charge structure to include physician and professional charges in the event CMS mandates the physician charges as the allocation basis.
  - HHSC did allow hospitals the option to use hospital cost centers and charges for physician and professional cost; this did simplify for the hospitals and for the HHSC review.

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UC Tool submission for FY 2012-Lesson Learned (Cont.)

- Schedule 1 resulted in the majority of the confusion for the UC tool;
  - Physician time studies:
  - CMS required all hospitals to have physician cost to be determined based on the Medicare time study method;
  - Not all hospitals utilize time studies for the physician services for the hospital cost report and have reported as Part B cost and disallowed for hospital cost.
  - The confusion of Part B reporting was the hospital belief that these cost should not be required to be time studied since this is determined to be all professional cost.
  - CMS and HHSC has determined that without a time study none of the time is allowable;
  - HHSC did allow a hospital without time studies to provide either a certification the time was 100% patient care or a time study proxy.

Time Study Proxy

- Time Study Proxy - were intended to mirror the requirements within the Medicare time study.
- Each physician was required to sign their proxy with their estimated time split;
- For physicians that were not available, an average of the applicable cost center could be used.
- Questions:
  - Should the time study proxy be determined based on the data year (2010) or the program year (2012)?
    - HHSC first indicated the time studies should be based on the data year of 2010 but was uncertain on the determination for the audit year 2012.
    - HHSC then allow for the hospital to utilize physician time study proxies as if for 2012, if the cost and centers were similar.
    - If your hospital did time study proxies based on 2010, our recommendation would be to do a set of time study proxies for 2012 for use in the audit of the 2012 program year.
  - Will time study proxy be allowed for program year 2013 based on data year 2011?
    - HHSC has provided little information on program year 2013.
Time Study Proxy Example:

<table>
<thead>
<tr>
<th>Name of Provider</th>
<th>Inpatient Cost Reporting Period 1</th>
<th>Inpatient Cost Reporting Period 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Name</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For cost reporting periods beginning on or after 10-1-2012, the hospital is expected to obtain adequate and auditable time studies from each physician providing Medicare Part A services to the hospital for the proper application of the RCEs via the Medicare 2552 cost report.
 HHSC has received the majority of the UC Tools and is currently reviewing the data;

There have been some tools that were returned to the providers for clarification or additional data (primarily related to physician time study for schedule 1);

Determination of the final 2012 UC payment amounts should be completed during March 2013 along with applicable hair-cut;

Final payments should be completed during April 2013 and will require the transfer of the inter-governmental funds (IGT)

### UC Projections:

<table>
<thead>
<tr>
<th>RHP</th>
<th>Projected UC DY 1</th>
<th>Projected UC DY 2</th>
<th>Projected UC DY 3</th>
<th>Projected UC DY 4</th>
<th>Projected UC TOTAL</th>
<th>Percent of the Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHP 1</td>
<td>$112,648,995</td>
<td>$118,849,024</td>
<td>$125,456,525</td>
<td>$132,518,575</td>
<td>$489,473,116</td>
<td>2.52%</td>
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<tr>
<td>RHP 2</td>
<td>$155,773,779</td>
<td>$147,181,542</td>
<td>$159,408,851</td>
<td>$171,794,851</td>
<td>$613,359,023</td>
<td>3.14%</td>
</tr>
<tr>
<td>RHP 3</td>
<td>$1,203,010,692</td>
<td>$1,240,985,492</td>
<td>$1,284,930,247</td>
<td>$1,339,988,607</td>
<td>$5,017,983,278</td>
<td>25.75%</td>
</tr>
<tr>
<td>RHP 4</td>
<td>$218,101,925</td>
<td>$240,038,793</td>
<td>$261,770,991</td>
<td>$284,712,602</td>
<td>$1,004,633,151</td>
<td>5.15%</td>
</tr>
<tr>
<td>RHP 5</td>
<td>$246,877,553</td>
<td>$274,452,166</td>
<td>$296,946,121</td>
<td>$320,903,039</td>
<td>$1,091,653,789</td>
<td>5.58%</td>
</tr>
<tr>
<td>RHP 6</td>
<td>$564,388,134</td>
<td>$594,385,839</td>
<td>$655,661,577</td>
<td>$706,549,712</td>
<td>$2,651,313,302</td>
<td>13.58%</td>
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<tr>
<td>RHP 7</td>
<td>$187,367,533</td>
<td>$190,392,628</td>
<td>$193,392,628</td>
<td>$196,392,628</td>
<td>$767,155,457</td>
<td>3.93%</td>
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<tr>
<td>RHP 8</td>
<td>$35,940,827</td>
<td>$34,416,477</td>
<td>$34,884,435</td>
<td>$35,373,748</td>
<td>$139,667,015</td>
<td>0.72%</td>
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<tr>
<td>RHP 9</td>
<td>$779,526,368</td>
<td>$748,596,822</td>
<td>$848,617,250</td>
<td>$897,023,792</td>
<td>$3,245,762,032</td>
<td>16.88%</td>
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<tr>
<td>RHP 10</td>
<td>$457,337,367</td>
<td>$465,335,121</td>
<td>$475,365,842</td>
<td>$484,579,168</td>
<td>$1,881,613,500</td>
<td>9.62%</td>
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<tr>
<td>RHP 11</td>
<td>$50,680,852</td>
<td>$52,435,346</td>
<td>$54,209,355</td>
<td>$55,078,586</td>
<td>$223,404,040</td>
<td>1.08%</td>
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<tr>
<td>RHP 12</td>
<td>$225,137,031</td>
<td>$232,028,134</td>
<td>$238,027,596</td>
<td>$246,052,660</td>
<td>$942,245,700</td>
<td>4.83%</td>
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<tr>
<td>RHP 13</td>
<td>$55,018,524</td>
<td>$55,940,092</td>
<td>$56,866,596</td>
<td>$57,800,682</td>
<td>$241,746,396</td>
<td>1.25%</td>
</tr>
<tr>
<td>RHP 14</td>
<td>$77,256,547</td>
<td>$78,473,073</td>
<td>$79,206,287</td>
<td>$79,951,577</td>
<td>$314,700,444</td>
<td>1.63%</td>
</tr>
<tr>
<td>RHP 15</td>
<td>$205,602,041</td>
<td>$209,807,286</td>
<td>$213,906,073</td>
<td>$217,681,091</td>
<td>$838,050,491</td>
<td>4.29%</td>
</tr>
<tr>
<td>RHP 16</td>
<td>$211,985,880</td>
<td>$226,201,132</td>
<td>$230,122,912</td>
<td>$234,078,635</td>
<td>$914,902,539</td>
<td>4.69%</td>
</tr>
<tr>
<td>RHP 17</td>
<td>$45,196,485</td>
<td>$45,682,101</td>
<td>$46,341,520</td>
<td>$46,824,342</td>
<td>$184,946,405</td>
<td>0.96%</td>
</tr>
<tr>
<td>RHP 18</td>
<td>$50,165,156</td>
<td>$50,577,401</td>
<td>$50,577,401</td>
<td>$50,577,401</td>
<td>$202,297,379</td>
<td>1.04%</td>
</tr>
<tr>
<td>RHP 19</td>
<td>$58,462,152</td>
<td>$59,855,074</td>
<td>$61,644,604</td>
<td>$63,655,716</td>
<td>$236,617,495</td>
<td>1.24%</td>
</tr>
<tr>
<td>RHP 20</td>
<td>$9,094,584</td>
<td>$9,365,106</td>
<td>$9,641,697</td>
<td>$9,923,930</td>
<td>$38,025,497</td>
<td>0.19%</td>
</tr>
</tbody>
</table>

**Grand Total**: $4,693,319,560 $4,693,319,560 $4,767,577,440 $4,927,041,598 $5,131,918,359 $10,519,856,955 100.00%

**UC Pool Cap**: $1,900,000,000 $3,134,000,000 $3,948,000,000 $4,132,000,000 $5,132,000,000 $10,519,856,955

**Potential Haircut**:

- UC -0.17%
- DSRIP -0.28%
- UC Pool -0.32%
- DSRIP Pool -0.40%
- UC Pool Cap -0.67%
- DSRIP Pool Cap -0.89%
Waiver Reimbursement Rule Amendments

- **January 28** – Rule filed with the Texas Register/Shared with Stakeholders
- **February 7** – Rule is presented to HPAC
- **February 8** – Rule is published in the Texas Register as proposed/Comment period begins February 14 – Rule is presented to MCAC
- **February 19 at 2:00** – Rule hearing
- **February 28** – Rule is presented to HHSC Council
- **March 11 – 30-day comment period ends**
- **April 1** – Rule is sent to the Texas Register as adopted
- **April 20** – Rule is effective

Waiver Reimbursement Rule Amendments

- **8 Amendments to the Rule** (Highlights)
  - **Amendment 1** – HHSC wants a break-down of the IGT commitments
  - **Amendment 2** – Reduction to the sum of the UC payments for the aggregate estimates exceeds cap
  - **Amendment 4** – IMD’s may not report cost and payment data for Medicaid and uninsured patients between 21 – 64
  - **Amendment 5** – Providers must have active enrollment in Medicaid at the beginning of the demonstration year and have claim payment eligibility in order to receive UC payments
  - **Amendment 6** – DSRIP payments in DY2 – 5 cannot be paid until HHSC and CMS approve
  - **Amendment 8** – Category 4 reporting requirement for UC hospitals
## Draft DSRIP Payment Calendar

<table>
<thead>
<tr>
<th>Payment Type</th>
<th>IGT Due</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>DY1 DSRIP (RHP 14, 17)</td>
<td>3/7/2013</td>
<td>3/28/2013</td>
</tr>
<tr>
<td>DY1 DSRIP (est. 8 RHPs)</td>
<td>3/22/2013</td>
<td>4/30/2013</td>
</tr>
<tr>
<td>DY1 UC</td>
<td>3/27/13-4/12/13</td>
<td>5/7/2013</td>
</tr>
<tr>
<td>DY1 DSRIP Clean-up (est. remaining 10 RHPs)</td>
<td>4/24/2013</td>
<td>5/15/2013</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment Type</th>
<th>IGT Due</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>DY2 UC Q1-Q2 (proxy)</td>
<td>6/10/2013-6/28/2013</td>
<td>7/20/2013</td>
</tr>
<tr>
<td>DY2 DSRIP (1A of 2)</td>
<td>9/9/2013</td>
<td>9/30/2013</td>
</tr>
<tr>
<td>DY2 DSRIP (1B of 2)</td>
<td>10/21/2013</td>
<td>11/12/2013</td>
</tr>
<tr>
<td>DY2 UC Q3</td>
<td>11/22/2013-12/13/2013</td>
<td>1/16/2014</td>
</tr>
<tr>
<td>DY2 DSRIP (2 of 2)</td>
<td>1/3/2014</td>
<td>1/24/2014</td>
</tr>
<tr>
<td>DY2 Admin</td>
<td>1/20/2014</td>
<td>2/10/2014</td>
</tr>
</tbody>
</table>
Medicare Matters - Reimbursement Update:

- House Bill 8 – Fiscal Cliff Legislation (Short-Term Solutions (??))
  - Medicare Dependent Hospital – extended through FFY 2013
  - Low Volume Payment Adjustment – extended through FFY 2013 - Novitas accepting request now - March 1 (??)
  - Ambulance Fee Schedule Payment Bump – extended through Calendar Year 2013
  - “Doc-Fix” – maintaining Fee Schedule rates through CY 2013
Medicare Matters - Reimbursement Update:

- Reimbursement Reductions not Averted
  - Medicare Outpatient Hold Harmless Payment (TOPPS)
    - Expired December 31st for SCH and rural hospitals less than 100 beds.
  - Medicare Cost Based Lab Reimbursement
    - Based on Hospitals Fiscal Year Beginning date
  - Medicare look back period on RAC audits – now 5 years.

Grumble, Grumble
Future Reimbursement Matters: Medicare DSH Payment

Section 3133 – Affordable Care Act

Beginning in FFY 2014, 25% of the estimated Medicare DSH payment will continue to be paid under current provisions.

The large majority, 75% share of the estimated Medicare DSH payments will be adjusted by two factors and distributed based on appropriated Pool of available funds:

- Factor 1 – Reduce remaining 75% of estimate DSH payment as a result of the estimated decrease in uninsured.
- Factor 2 – Target remaining of 75% of estimated Medicare DSH payments to individual hospitals based on their proportion of the amount of uncompensated care provided to DSH hospitals, nationally.

Medicare DSH

How will CMS define ‘uninsured’?

- Five National Surveys
  - U.S. Census Bureau
    - Survey of Income Program and Participation
    - American Community Survey
  - Bureau of Labor Statistics
    - Annual Social and Economic Supplement
  - Agency for Healthcare Research and Quality
    - Medical Expenditure Panel Survey
  - National Center for Health Statistics
    - National Health Interview Survey
Medicare DSH

How will CMS definition ‘uninsured’?

- Five National Surveys – Short-falls
  - Recall Period – How far back do surveys go
  - Timeliness – Time period of each survey
  - Continuity of Data – Survey Administration changes over time
  - Medicaid definitions – Accuracy of State data and differing measurements by state
  - Undocumented Immigrant – does the survey data include?

Medicare DSH Payment

Defining Uncompensated Care

- Varying Federal Programs (Medicare, Indian Health Services, Health Information Technology)

- Varying States Definitions (Waiver State or non-Waiver State)

- Ultimately, this will most likely be defined through W/S S-10 of the Medicare Cost Report
  - Medicaid, SCHIP, Charity, and Bad Debt
Summary - Medicare DSH

- Section 3133 – ACA
- Change in Medicare DSH
  - Historic computation based on percentage of Medicaid utilization and
  - Percentage of supplemental security to total Dual Eligible patients
  - 25% - based on historic computation
  - 75% - based on hospitals apportionment of the change / decrease in uninsured and uncompensated care

Medicaid 2013 DSH Update

- HHSC released a draft of the new DSH rule for 2013 on February 6, 2013. It was presented at the Hospital Payment Advisory Committee on February 7, 2013
- Changes to be aware of:
  1. Pools will mirror along Waiver RHP areas; except for State-owned hospital (Teaching, IMD, and chest);
  2. DSH Pools:
     a. Hospitals in an RHP Area with an urban public hospitals (8 RHPs)(Pool A);
     b. Hospitals in all other RHP Areas (Pool B);
  3. Pool funding / allocation dependent on funds remaining after State-owned Hospital allocation. Uncertain on split between pools (possibly 76% - 24%);
  4. Urban public hospitals have days weighted within their pool;
  5. The DSH allocation within the pools will be based on 50% Medicaid Days and 50% Low Income Days;
  6. Private IMD funding subject to IMD exclusion limit first, then applied to state-owned IMDS;
  7. Rural public or rural public-financed hospitals may be eligible for DSH fund in addition to the projected annual payments (not to exceed DSH HSL).
Medicaid 2013 DSH Update (cont.)

- Current estimate for Pool funding:
  - State-owned (Teaching and IMD): $319 M all funds
  - Pool A: $381 M in IGT - approximately $718 M all funds
  - Pool B: $100 M in state general revenue - approximately $246 M all funds

- Total estimated DSH Allocation: $1,682 M (2012 as Proxy)
- Estimated Available Allocation: $1,283 M

- Remaining un allocated DSH: $335 M
  - Possibly available for Public Rural Hospitals as

Let’s eat...