THE 1115 WAIVER FROM THE ANCHOR HOSPITAL PERSPECTIVE

September 17, 2013

Topics

• 1115 Waiver 101
• What makes up a DSRIP Project?
• Current status of statewide plan approval
• Payment Update
• Questions
ABC’s of the 1115 Waiver

• What is an 1115 Waiver?
• Why did Texas adopt an 1115 Waiver?
• How is the 1115 Waiver structured in Texas?
• How is the Waiver funded?
Section 1115 Research & Demonstration Projects

- Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs.
- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible
- Providing services not typically covered by Medicaid
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.
- In general, section 1115 demonstrations are approved for a five-year period and can be renewed, typically for an additional three years.
- Demonstrations must be “budget neutral” to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the waiver.

Why Did Texas Adopt a Waiver?

- Texas Medicaid budget shortfall
- Managed care imperative
- Collateral damage – Elimination of Upper Payment Limit (UPL) payments of $2.8 billion (annually)
- CMS desire to promote innovation, fund based on performance, and focus providers on the triple aim:
  - Better care for individuals – Focus on access, quality & outcomes
  - Better health for the population
  - Lower cost through improvement – Without harm
1115 Waiver Objectives

- Expand existing Medicaid and managed care programs statewide

- Replace the existing UPL payment program and establish a focus on developing innovative service delivery solutions within the guiding parameters of the CMS triple aim. This is funded through two pools:
  - Uncompensated Care (UC) Pool
  - Delivery System Reform Incentive Payments (DSRIP)

- Create Regional Health Partnerships (RHPs) to encourage regional collaboration, expand access and enhance the quality of care in a cost-efficient manner

Goals of the 1115 Waiver

- $29 Billion - $$ provided to incentivize a transition from system designed to generate volume (heads in beds) to managing outcomes (results)
- 5 year waiver
- CMS budget neutrality
Structure of the 1115 Waiver

- Regional Healthcare Partnership – Collaboration
- Hospitals
- Non-hospital providers
- Physician practices
- Local mental health resources
- County health departments
- Academic medical centers
- Physicians
- Engagement of stakeholders in the community
Key Constructs of the 1115 Waiver

- Regional Health Partnership (RHP)
  - Payment program bringing providers and others together to look at the health of a population
  - New relationships
  - Care coordination component
  - At the same time preserves governing authority of participants
- Roles
  - Anchor Entity
  - IGT Entities
  - Provider Participants
  - Collaborative Stakeholders
  - CMS/HHSC

Key Constructs

- Opportunity for patient care innovation
- Increased care coordination and collaboration for a given region’s health outcomes
- Outcome focused on the PATIENT— clinical events, recovery and health status, experience in the health system, & efficiency/cost
- Funding
  - How are funds generated?
  - Intergovernmental Transfer (IGTs) – generating federal matching funds (.42 cents of IGT returns $1.00 dollar of total funds)
  - How are funds paid?
  - 2 Pools – Uncompensated Care (UC) and Delivery System Redesign Incentive Pool (DSRIP)

- Participation is voluntary and not tied to ACA
Key Elements of the RHP Plan

- RHP Plan Template – DSRIP projects, objectives, milestones, metrics, measures, and values
- RHP Plan
- Executive Summary
- Description of the RHP Organization
- Community Needs Assessments
- Stakeholder Engagement/Public Input
- RHP Plan Development – Regional Approach
- Number of Projects – (meet minimums)
- Organization of DSRIP projects
- Descriptions (Categories 1-4)
- Requirements (Categories 1-3, 4)
- Project valuation

TERMINOLOGY
TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 115 WAIVER
- **1115 Waiver**: A waiver under section 1115 of Social Security Act that allows CMS and states more flexibility in designing programs to ensure delivery of Medicaid services.
- **Anchoring entity (anchor)**: The single IGT entity in an RHP serving as the primary contact to HHSC responsible for providing opportunities for public input to the development of RHP plans and coordinating discussion and review of proposed RHP plans prior to plan submission to the State.
- **Centers for Medicare and Medicaid Services (CMS)**: The U.S. federal agency that administers Medicare, Medicaid, and the State Children’s Health Insurance Program.
- **Delivery System Reform Incentive Payment (DSRIP)**: Incentive payments available for projects under the Transformation waiver to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. Projects eligible for incentive payments must come from the DSRIP menu, be included in an HHSC and CMS-approved RHP plan and have corresponding metrics and milestones.
- **Demonstration year (DY)**: A 12-month period beginning October 1 and ending September 30. The 1115 Transformation waiver currently consists of five demonstration years from 2011 to 2016.
- **DSRIP Menu**: A menu of HHSC and CMS-approved projects that contribute to delivery transformation and quality improvement. Only projects from this menu performed as outlined in an HHSC and CMS-approved RHP plan with corresponding metrics and milestones are eligible for payments from the DSRIP pool.
- **Intergovernmental Transfers (IGT)**: State and local funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity and eligible for federal match under the 1115 Transformation waiver. This does not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.
- **IGT Entity**: A state agency or a political subdivision of the state—such as a city, county, hospital district, hospital authority, or state entity—with IGT eligible for federal match to fund an RHP’s UC or DSRIP.
- **Medicaid managed care**: A system under which the state pays a set fee each month to a health plan to provide care for a Medicaid client, who selects a primary doctor from the plan’s network to coordinate care. This differs from a traditional fee-for-service system that bases provider payment on quantity of service rather than quality. In 2011, the Texas Legislature directed HHSC to expand managed care within the state Medicaid program with the goal of achieving high-quality, cost-effective health care.
- **Performing Provider (performer)**: A Medicaid provider participating in an RHP, who works with an IGT entity and likely other participants to implement a DSRIP project.
- **Program Funding and Mechanics Protocol (PFM Protocol)**: A document, drafted by HHSC and pending CMS approval, outlining DSRIP requirements for RHPs including the minimum number of projects, organization of the RHP Plan, plan review process, required reporting, allocation of available pool funds, valuation of projects, disbursement of funds, and plan modifications.

- **Regional Healthcare Partnerships (RHP)**: Regions developed throughout the State to more effectively and efficiently deliver care and provide increased access to care for low-income Texans under the 1115 Transformation waiver. Each RHP will include a variety of participants to adequately respond to the needs of the community.
- **RHP Participant**: An entity participating in an RHP as outlined in an RHP plan. A participant may be an IGT entity, a performer, an anchor, or another stakeholder.
- **RHP Plans**: A plan to identify the community needs, the projects, and investments under the DSRIP to address those needs, community healthcare partners, the healthcare challenges, and quality objectives of an RHP. These plans must be submitted to the State and CMS for approval and shall include estimated funding available by year to support UC and DSRIP payments. RHP anchoring entities shall provide opportunities for public input to the development of RHP plans, and shall provide opportunities for discussion and review of proposed RHP plans prior to plan submission to the State.
- **Texas Health and Human Services Commission (HHSC)**: The state governmental body that oversees the Texas health and human services system operations and administers programs including Medicaid and CHIP.
- **Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver**: The Transformation waiver: The vehicle approved by HHSC and CMS for expansion of managed care within the State Medicaid program while preserving federal supplemental hospital funding historically provided under the UPL program.
- **Uncompensated Care (UC)**: Costs of uncompensated care provided to Medicaid eligibles or to individuals who have no funds or third party coverage for services provided by the hospital or other providers.
- **Uncompensated Care Application (UC Protocol)**: The documentation needed for hospitals and other providers to report their uncompensated costs to receive reimbursement under the Transformation waiver.
- **Upper Payment Limit (UPL)**: Historic supplemental payments made to certain hospitals and providers to make up the difference between what Medicaid actually paid for Medicaid clients and what Medicare would have paid for the same services—when Medicare is provided through managed care. UC and DSRIP funds available under the 1115 Transformation waiver replaced funding available under the former UPL program.
What's in a DSRIP Project?

- DSRIP Projects were selected from a menu of project options among three Categories provided by HHSC and CMS
  - Category 1: Infrastructure Development
  - Category 2: Innovation & Redesign
  - Category 3: Quality Improvement Outcomes
  - Category 4: Population Focused Improvements
What's in a DSRIP Project?

- Types of project options:
  - Cat 1: Expand Primary Care Capacity, Enhance Urgent Medical Advice, etc.
  - Cat 2: Enhance Medical Homes, Expand Chronic Care Management Models, Redesign for Cost Containment, Care Transitions, etc.
  - Cat 3: Re-admission rates, ED utilization, Length of Stay, etc.

- Project submissions included:
  - Category 1 or 2 project narrative and milestone table
    - Linked to at least one Category 3 Outcome
  - Category 3 Outcome(s) narrative and milestone table

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### Category 1 & 2 Projects

- Narrative:
  - Project Description
  - Starting Point/ Baseline
  - Rationale
  - Related Category 3 Outcome Measure(s)
  - Relationship to other Projects
  - Relationship to Other Preforming Provider's Projects in the RHP
  - Plan for Learning Collaborative
  - Project Valuation
- Milestones/ Metric Table
  - Identifying Project and Provider Information
  - Milestone bundles
  - RHP Planning Protocol Reference
  - Incentive Payment Amount

### Category 3 Outcomes

- Narrative:
  - Identifying Outcome Measure and Provider Information
  - CHF Re-admission rates, ED utilization, etc.
  - Outcome measure description
  - Rationale
  - Outcome measure valuation
- Milestones/ Metric Table
  - Identifying Outcome and Provider Information
  - Starting Point/ Baseline (if applicable)
  - Process Milestones/ Outcome Improvement Targets
  - RHP Planning Protocol Reference
  - Incentive Payment Amount
Category 4 Reporting

- 6 domains of quality outcome indicators:
  - Reporting Domain 1: Potentially Preventable Admissions (PPA)
  - Reporting Domain 2: 30-day Readmissions
  - Reporting Domain 3: Potentially Preventable Complications (PPC)
  - Reporting Domain 4: Patient Centered Healthcare
  - Reporting Domain 5: Emergency Department
  - Reporting Domain 6: Initial Core Set of Health Care Quality Measures

- Purpose of reporting measures is to gain information on and understanding of the health status of key populations and to build the capacity for reporting on a comprehensive set of population health metrics

CURRENT STATUS OF STATEWIDE PLAN APPROVAL
Approval timeline

• December 31, 2012: All 20 Regions submitted RHP Plans
• January-April 2013: HHSC provided initial feedback and required revisions on RHP Plans and submitted to CMS
• April-June 2013: CMS reviewed RHP plans and provided Initial Approval letters
• May-October 2013: RHPs worked through revisions to obtain full CMS Approval for DY2-3
• October 2013-March 2014: RHPs will work with HHSC & CMS for full plan approval through DY5

CMS Staged Review & Approval

• All 20 Regions in Texas have been formally reviewed by CMS and received “Initial Approval”
• Once RHP plans were approved by HHSC they were submitted to CMS for review & initial approval
• “Initial Approval” for Demonstration Years (DY) 2 and 3
• “Full Approval” for DY 4 and 5 by March 31, 2014
CMS Review – Initial Approval Letter Contents

• Initially Approved Projects (DY 2-3)
• Initially Approved Projects with Priority Technical Corrections (DY 2-3)
• Projects approved, with an adjustment to project value (DY 2-3)
• Projects not approved at this time
• Category 3 Outcomes not approved at this time

Phased Revision Process (1 – 4)

<table>
<thead>
<tr>
<th>Phase</th>
<th>Affected Projects</th>
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</table>
| 1     | Projects initially approved, with an adjustment to project value (Table 5)  
       | Projects not approved at this time (Table 6)  
       | Improvement milestones overlap improvement targets (projects with priority technical correction identified in table 4) |
| 2     | All projects – confirm, revise, identify quantifiable patient impact and Medicaid/indigent impact for each project |
| 3     | Projects with DY2 metrics identified by HHSC as needing revision in order to make DY2 payment |
| 4     | All projects – priority technical corrections and Category 3 changes. HHSC has created a new Category 3 menu of outcome options |
REGIONAL PROJECT INFORMATION

Region 9
### RHP Plan submitted to CMS

<table>
<thead>
<tr>
<th>Number Proposed</th>
<th>Proposed Total Project Value (Total computable)</th>
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<tbody>
<tr>
<td></td>
<td>DY1</td>
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<tr>
<td>Initial plan submission</td>
<td>n/a</td>
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<tr>
<td>Category 1 &amp; 2 (Projects)</td>
<td>111</td>
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<tr>
<td>Category 3 (Outcomes)</td>
<td>220</td>
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<tr>
<td>Category 4 (Providers)</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>349</td>
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By the Numbers

CMS initially approved 84% of the projects & 79% of the DY1–3 $$’s requested.

<table>
<thead>
<tr>
<th>Number Approved</th>
<th>Initially Approved Project Value (Total computable)</th>
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<tbody>
<tr>
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<tr>
<td>Initial plan submission</td>
<td>n/a</td>
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<tr>
<td>Category 1 &amp; 2 (Projects)</td>
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<tr>
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<tr>
<td>Category 4 (Providers)</td>
<td>18</td>
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<tr>
<td>Total</td>
<td>292</td>
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5/8/2013
What is important for you to know as a finance leader?

- DSRIP Risk
- Managing and Ensuring a Successful DSRIP Project
- Understanding the Financial Integration Aspect of the 1115 Waiver & DSRIP Projects
- DSRIP Revenue Recognition
Health System P&L Management

<table>
<thead>
<tr>
<th>Historical FFS Environment</th>
<th>Today’s Reality</th>
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<tbody>
<tr>
<td>Increased Patient Volume</td>
<td>Same or decreased patient revenue regardless of volume</td>
</tr>
<tr>
<td>X</td>
<td>- Incremental cost increases</td>
</tr>
<tr>
<td>Increasing FFS Rates</td>
<td>+ Risk Based Rewards (i.e. DSRIP, JV’s, M&amp;A’s, etc.) + Efficiency Gains</td>
</tr>
<tr>
<td>- Incremental Cost Increases</td>
<td>= Organizational Survival</td>
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<tr>
<td>= Organizational Growth</td>
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DSRIP Risk

- **Short Term (2013 FY) Risks**
  - Organizational understanding of DSRIP funding driven on achievement and not activity (FFS)
  - Failure to act to meet necessary for meeting DY2 milestones

- **Long Term Risks**
  - **Project Performance Risk** – Burden for continuous improvement and execution while performance expectations change (HHSC and CMS will continue to “raise the bar”)
  - **Funding Conduit Risk** – (Anchor/IGT provider’s performance critical to funding regional performing provider projects)
  - **Conditional Plan Approval** - Impact of conditional Region 10 Plan approval for outcomes in years DY 4 and DY5