Sustaining the Momentum – How do we prepare for the 1115 Waiver renewal?

Introduction

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<tr>
<th>Areas of Expertise</th>
<th>Client Types</th>
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<tr>
<td>Advanced Performance Improvement</td>
<td>Hospitals and health systems</td>
</tr>
<tr>
<td>Population Health including the 1115 Waiver (nationally)</td>
<td>Academic medical centers</td>
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<td>Care Delivery Redesign and Clinical Integration</td>
<td>Integrated Delivery Networks</td>
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<td>Managed Care Finance &amp; Analytics</td>
<td>Public health care systems, Health Districts</td>
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<td>Health Care Talent Development</td>
<td>Large physician organizations (medical groups, IPAs)</td>
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<td>HIT Optimization</td>
<td>Community health centers</td>
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<td>Project Management</td>
<td>Health plans</td>
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<td>Strategic Planning &amp; Management</td>
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</table>
**Today's Discussion Context**

**Speaker Bias / Approach**

- Experience with 1115 Waiver in Region 10 as an anchor organization
- Experience with NY Waiver and belief that Texas will be challenged by CMS to adopt *some* of the elements of the NY waiver
- Belief that DSRIP provides a rare opportunity to support organizational efforts to develop strategies to achieve the triple aim: improved patient outcomes, improved patient satisfaction, & reduce per capita costs
- We are at a critical juncture with the 1115 waiver regarding performance on the current projects, distractions regarding waiver uncertainties, and radical industry focus on population health strategy

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**Texas STC 48 Transition Plan – Goals**

1. Further incentivize transformation and strengthen the RHP structure
2. Improved DSRIP project evaluation and identify DSRIP best practices
3. Further integrate DSRIP and Managed Medicaid
4. Streamline the DSRIP program to lessen the administrative burden
5. Continue to support the healthcare safety net (aka by increasing UC funding)
Texas Waiver Renewal – Goal #1

*Further incentivize transformation and strengthen healthcare systems across the state by building upon the Regional Healthcare Partnership (RHP) structure.*

New York 1115 Waiver

- The 1115 waiver was approved in New York in 2014 with up to $8 billion in federal funds for all transformation programs
  - Up to **$6.42 billion** is specifically available for DSRIP payments to providers
- New York DSRIP Stand-Outs:
  1. Safety net system transformation - PPS role is highly engaged with providers, CBOs and MCOs
  2. Accountability for reducing avoidable hospital use – 25% reduction across state required
  3. Roadmap to Value Based Payment – competition with MCOs, depending on specific PPS situation, piggy-back DSRIP payments with MCO payment changes
Texas and New York DSRIP

High Level Themes

• Collaboration by providers
• Organization of regional structures to determine priorities and projects at the local level
• Identification of DSRIP funding which bases payment on performance
• Federal, state and local accountability
• **Sustainability** by establishment of permanent, sustainable delivery system structures and projects
• Regionally develop DSRIP plans

Common DSRIP Program Plan Elements

• Statement of goals
• Identification of participating providers (participation voluntary)
• Performance assessment including community needs assessment, regional planning, and public input
• Detailed milestones and metrics to set achievement expectations
• Governance structure of the regional organization
• Project attestation and certification
• Learning collaborative commitment

Texas vs. New York DSRIP Structure

Regional Health Partnerships

RHPs will be developed throughout the State to deliver care more effectively and efficiently and provide increased access to care for low-income Texans. Each RHP will include a variety of healthcare providers to adequately respond to the needs of the community, and the process of forming each RHP will evidence meaningful participation by all interested providers.

Performing Provider Systems

Eligible major public general hospitals and other safety net providers are encouraged to form coalitions that apply collectively as a single Performing Provider System. The state will review each of the proposed Performing Provider Systems and may require additional connectivity to additional medical, behavioral health, long term care, developmental disabilities or social service providers as required to build a comprehensive regional performance network. Coalitions will be evaluated on performance on DSRIP milestones collectively as a single Performing Provider System.
Texas vs. New York DSRIP Structure

<table>
<thead>
<tr>
<th>Area</th>
<th>PPS</th>
<th>RHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational Authority</td>
<td>Formal &gt; Drive to System Outcomes</td>
<td>Informal &gt; Administrative</td>
</tr>
<tr>
<td>Role/Name</td>
<td>Lead Provider</td>
<td>Anchor</td>
</tr>
<tr>
<td># of Projects</td>
<td>5 to 10 with cross participation</td>
<td>No cap with individual entity projects</td>
</tr>
<tr>
<td>Startup Investment</td>
<td>$100 million</td>
<td>$500 million</td>
</tr>
<tr>
<td>Regionalization</td>
<td>DSRIP member attribution with a clearly defined business relationship</td>
<td>Entire state with 20 designated regions</td>
</tr>
<tr>
<td>Target Population</td>
<td>Medicaid</td>
<td>Total with required self pay &amp; Medicaid %</td>
</tr>
<tr>
<td>Funding</td>
<td>Joint budgets and funding distribution plan</td>
<td>Individual by entities that could obtain an IGT commitment from a gov’t entity</td>
</tr>
</tbody>
</table>

Performing Provider Systems (PPS)

- Safety net Hospitals can become “Performing Provider Systems” (PPS) leads
  - Responsible for completing milestones and measures to receive DSRIP funds
  - PPS leads are the only entity that can receive DSRIP funds
  - Numerous PPS have multiple leads, traditional competitors, pulled together
- PPSs create networks that include other providers in their systems through contracts and agreements.
- Each PPS must implement a minimum of 5 projects and a maximum of 10 projects
  - Each participating provider must complete project 2.a.i
  - Some providers are eligible for an 11th project focused on the low and non-utilizers and the uninsured
Texas Waiver Renewal – Goal #2

*Improve project-level evaluation to identify the best practices in DSRIP to be sustained and replicated.*

Today’s DSRIP Project Reality

- *The journey thus far*…
- Life in the shoes of a DSRIP project participant….*feeding the CMS/HHSC bureaucracy*
- The *oh so subtle cultural transformation* that has occurred….
- Life in the shoes of an overcommitted healthcare leader and executive….*survival of the fittest*
- The *not so clear opportunity*..1115 Waiver renewal
Strategic planning & the future of your current DSRIP projects

- It is crucial to link the DSRIP projects to your strategic plan.
- What is the cost-benefit of your current DSRIP projects?
- How do we tie the DSRIP projects to the organization’s managed care and population health strategies?

DSRIP Project Decision Options

- MODIFY / SCALE
- GO
- NO GO
Why is a sustainability assessment of the DSRIP projects important?

- It's just good business to understand the ROI (and not just the financial ROI) and sustainability of the DSRIP projects.
- Absent a disciplined assessment, DSRIP project continuation decisions will become strictly a political process.
- Understanding DSRIP 1.0 is critical to understanding DSRIP 2.0.
- DSRIP projects naturally link to:
  - Eventual Medicaid expansion
  - Medicare shift to quality and value based payments
  - Population health strategy development
  - Managed care strategy and negotiations
- Staff are concerned about their future.

What criteria do we feel is critical in evaluating an organization’s DSRIP projects?

- Managed Care impact
- Population characteristics
- Clinical effectiveness
- HIE/Data infrastructure
- Operational efficiency
- Human capital investment
- Net cash flow
- Physicians & Partners
- Market impact
Questions you may want to ask?

- How well do we understand the population served?
- How has this project impacted patient care outcomes for the population served?
- What is the perspective of the patient care providers on how this project has impacted patient care services?
- Are there lessons learned from this project which can be used in an expanded way in the organization?
- How has this project impacted operating efficiency and/or effectiveness?
- Is this project viewed as self-sustaining financially without availability of future DSRIP revenues?

Questions you may want to ask?

- Has this project enabled the organization to differentiate itself in the market?
- What new skill sets have been developed?
- What impact will the waiver renewal have on maintaining qualified staff?
- What information limitations and gaps exist with this project?
- How would you describe the strategic fit of this project to the strategic plan?
- Have we been able to quantify the financial impact (in terms of reduced PMPM costs) of this project to the managed care organizations?
What should a well design assessment yield?

- Retrospective ROI (value proposition) with respect to:
  - Financial performance
  - Patient care outcomes
  - Human capital / staff competencies
  - Service line/market position

- Predictive future sustainability/applicability:
  - Patient care outcomes
  - Operating impact – culture and process
  - Revenue growth and/or protection - Value based payments from Medicare, Medicaid, managed care, and other sources of payment

- Linkage to the state’s goal of better population outcomes and achievement of “good standing” status to enable continued DSRIP funding

Texas Waiver Renewal – Goal #3

Further integrate DSRIP with Texas’ Medicaid managed care quality strategy and other value based payment efforts.
Current System: Fee for Service

- Incentivizes volume over value
- Pays for inputs vs. outcomes
- Induces fragmentation & silos
- Reward avoidable readmission over successful transition to integrated home care

Project Valuation and Payment

- Texas project valuation basis — Patient Benefit Driven
  - Complexity of implementing the project, including:
    - Complexity of the project intervention
    - Difficulty of implementation
    - Teaching hospital
    - Size & scope of the project
    - Size of target population
    - Impact of the project
    - Investment & resources needed
- New York project valuation basis — Formula Driven Including:
  \[ \text{Payment} = \text{[Project PMPM]} \times \text{[# of beneficiaries]} \times \text{[project application score]} \times \text{[DSRIP months]} \]

- Payment Goal — 80% of total MCO payments to PPS providers in level 1 VBP (upside only) by year 5 of the waiver
  - 50% of those through Level 2 VBP (upside and downside risk)
NY Transition from Current to Future State

- **DY 1 – DY 2 or 3**
  - DSRIP payments serve as new investment funds
  - Separate from current MCO/FFS Medicaid payment streams to providers, but coordinated with any new risk-based contracts

- **DY 3 or 4 – DY 5/beyond: FISCAL TRANSFORMATION**
  - Traditional Medicaid costs (per member) declining due to reduced ED visits and hospitalizations
  - PPS, as a provider network or providers directly, must consider new arrangements with MCOs - shared savings contracts, risk contracts based on total medical spend per Medicaid beneficiary
  - PPS and/or PPS providers contract with MCOs/NYS for new services that have proven to be successful in containing costs

NY VBP levels

<table>
<thead>
<tr>
<th>Level 0 VBP</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS + Bonus and/or withhold based on quality scores</td>
<td>FFS + Upside-only shared savings when outcome scores are sufficient</td>
<td>FFS + Upside shared savings available when outcome scores are sufficient; downside risk reduced when outcome scores are high</td>
<td>Capitation + Outcome based component</td>
</tr>
</tbody>
</table>
NY Timeline

- Growth plan for every MCO-PPS combination
- MCOs with more ambitious plans will receive PMPM bonus DY3 and on

2016

- At least a level 1 VBP arrangement (upside only) for PCMH/APC and care bundle or subpopulation for every MCO/PPS combination

2017

- >50% of MCO payments will be contracted through Level 1 VBPs (upside only)
- 30% of those costs contracted through Level 2 VBP* (upside and downside risk)

2018

- 80-90% of total MCO-PPS payments in level 1 VBP (upside only)
- 70% of those through Level 2 VBPs (upside and downside risk)

2019

* May be moved up or down depending on overall trend towards financial sustainability and high value care delivery as measured through overall DSRIP measures and cost of care measures for bundles and subpopulations

Texas Waiver Renewal – Goal #4

A. **Work to streamline the DSRIP program to lessen the administrative burden on providers while focusing on collecting the most important types of information.**

B. **Maintain program flexibility to reflect the diversity of Texas’ 254 counties, 20 RHPs, and over 300 DSRIP providers.**
Administrative Simplification - Areas to Watch

- Extension of existing DSRIP projects with limited project change. Expect some form of justification.
- Development of a unique DSRIP project member identification
- RHP-wide projects – potentially based on trending of Cat 4 outcomes

Thoughts on project simplification

- Broad sharing of projects tied to regional outcomes
- HHSC to benchmark projects for broader statewide and/or regional application linked to better population outcomes
- Possible stricter formula for determining project valuations with carry forward values for existing projects
- Fewer projects?

Texas:
* 130 project options on menu
* 1,483 projects implemented
* No maximum number of projects per provider or RHP

New York:
* 44 project options on menu
* Only 39 of 44 projects on menu selected among all PPS
* Maximum 11 projects per PPS
Texas Waiver Renewal – Goal #5

Continue to support the healthcare safety net for Medicaid and low income uninsured Texans.
## Total UC – FY 2014 to FY 2019
amounts in billions of dollars (actual and estimated)

<table>
<thead>
<tr>
<th>Item</th>
<th>FY2014</th>
<th>FY2015</th>
<th>FY2016</th>
<th>FY2017</th>
<th>FY2018</th>
<th>FY2019</th>
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<tbody>
<tr>
<td>UC &amp; DSH Demand</td>
<td>7.7</td>
<td>7.6</td>
<td>7.7</td>
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<td>UC Pool</td>
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<td>(3.3)</td>
<td>(3.1)</td>
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<td>(1.8)</td>
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<td>6.5</td>
<td>7.3</td>
<td>7.7</td>
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UC / Medicaid Expansion Politics

NationalJournal
Rick Scott Says He Will Sue Obama Administration Over Medicaid Hardball. The Florida governor announced Thursday that he will take legal action as negotiations with CMS stall. 4/17/15

TEXAS 1115 WAIVER CHALLENGE – DEMONSTRATING THAT EXTENDING THE DSRIP PROGRAM (AND FUNDING) WILL REDUCE UC GROWTH
CMS Principles for UC Pools

1. **Coverage rather than uncompensated care pools** is the best way to secure affordable access to health care for low-income individuals, and uncompensated care pool funding should not pay for costs that would be covered in a Medicaid expansion.

2. Medicaid payments should **support services provided to Medicaid beneficiaries and low-income uninsured individuals**.

3. Provider payment rates must be sufficient to **promote provider participation and access**, and should support plans in managing and coordinating care.

Note: CMS acknowledged that each state and its pool is different, but they want to apply these same principles across all states.

Final Considerations for Texas Waiver Renewal

- Adoption of a statewide utilization reduction goal – impact UC trend
- Formal Integrated Delivery System (IDS) standards & PCMH NCQA certification
- Evolution to value based payment reform
- Increased alignment (financial & quality indicators) with Medicaid Managed Care Organizations
- Greater focus on health informatics integration (HIEs) & data sharing – unique UC beneficiary identification
- Regional performance goals and clinical outcomes
- Funding incentives for high performing Regions