NAVIGATING THE 1115 WAIVER
From RHP plans to improved patient outcomes to incentive payments and everything in between.

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TODAY’S DISCUSSION

• RHP Plans – Statewide overview and discussion of what’s in it for the patient for Region 10
• What is important for you to know as a finance leader?
• Lessons learned and what’s ahead?
• ABC’s of the 1115 Waiver (Supplemental)
TEXAS RHP PLANS OVERALL

- RHP plan size
  - 197 pages to 2,370 pages
- IGT providers
  - 289 total providers statewide
  - Range of 3 to 30 providers per region
- Preforming providers
  - 330 total providers statewide
  - Range of 3 to 36 providers per region
- UC only participants
  - 82 total participants statewide
  - Range of 0 to 11 participants per region

DSRIP PROJECTS AND OUTCOMES – STATEWIDE SUMMARY

- Category 1- Infrastructure Development
  - 616 projects throughout the state
  - RHP’s ranged from 7 projects to 60 projects
- Category 2- Innovation and Redesign
  - 693 projects throughout the state
  - RHP’s ranged from 7 projects to 86 projects
- Category 3- Quality Improvements
  - 1,397 outcomes throughout the state
  - RHP’s ranged from 14 outcomes to 205 outcomes
Selected Project Areas

Top Category 1 Project Areas:
- 1.1 – Expand Primary Care Capacity (156 projects)
- 1.9 – Expand Specialty Care Capacity (101 projects)

Top Category 2 Project Areas:
- 2.9 – Establish/Expand a Patient Care Navigation Program (66 projects)
- 2.2 – Expand Chronic Care Management Models (56 projects)

PROJECT VALUATIONS

- Lowest project value (both Category 1 or 2):
  - $40,025

- Highest project value (both Category 1 or 2):
  - $57,954,751

- Within individual regions:
  - Smallest range of project values: $6,171,139
  - Largest range of project values: $57,871,968
MAJOR AREAS OF COMMUNITY NEED

**Capacity**
- Increase capacity in primary and specialty care

**Access**
- Eliminate or reduce barriers to access

**Delivery Transformation**
- Change the manner in which health care is delivered

**Population Health**
- Improving health and wellness of the region through cooperation among providers
WHAT IS IMPORTANT FOR YOU TO KNOW AS A FINANCE LEADER?

- Three phases of DSRIP project life cycle
- Plan approval timelines and current HHSC update
- Funding and accounting issues
Three phases of DSRIP project life cycle

- Plan Development
- Plan Approval and Business Planning
- Operationalizing the DSRIP Projects into Day to Day Life

AN 1115 WAIVER DSRIP PROJECT

Owner is someone who...

Is an intrapreneur with a high need for achievement who is driven by an internal locus of control and is willing to accept the risk of using innovation as a tool to shatter the status quo, not for the purpose of reselling a product in a market, but rather for the higher calling of supporting healthier and better lives.
HHSC DSRIP PLAN FEEDBACK

- Common DSRIP plan issues:
  - **Valuation** - Not providing sufficient information to justify
  - **Patient Benefit** - Need to be able to quantify, (i.e., volume of services or number of clients served – particularly in DY 5)
  - Providers may do several things to better justify the valuation:
    - **Improve the project summary, narrative, and tables to better explain the patient benefit**
    - **Increase the patient benefit** (providers can demonstrate patient benefit through their Category 1 or 2 milestones and/or select stronger Category 3 outcome(s) to support the proposed value)
    - **Reduce the proposed valuation**, and/or
    - **Replace the project** with another project(s)
  - Semi-annual Reporting – DY 2 (2013) and DY 3 - 5
HHSC DSRIP PLAN REVIEW

- HHSC plans for all regions to receive feedback by **early February**
- **Feedback** includes a note indicating the 15-day response deadline to address HHSC’s concerns. A region may request up to an additional 15 days if need more time is needed. (Please note that any additional time it takes your region to address the feedback may delay DY 1 payments)
- Both **anchors and performing providers** will be notified and must work together to modify the plan
- If a **project is pulled**, 2 options exit:
  - Replace the project with one or more new projects; or
  - Do not replace/Funds available to the region in DY 3
- Any **critical changes not made** could risk HHSC not moving plan to CMS (i.e., IGT not identified, plan not signed, etc.)

RHP APPROVAL TIMELINE

- **Final RHP Plan submission with Pass 1, 2 and 3 Projects – December 31, 2012**
- **December 21, 2012** (Region 10)
- **HHSC deadline for final RHP Plan submission with all required documents**
  - Dec. 31, 2012
- **HHSC 30-day formal review**
  - Following date of full plan submission
- **CMS 45-day formal review**
  - Following receipt of approved plans from HHSC
- **CMS approval or denial of RHP plans**
  - May 1, 2013 or 15 days after receipt of revised plan
FUNDING AND ACCOUNTING ISSUES

- Timing of UC and DSRIP payments
  - FY 2012 UC statewide cap calculation and funding (March)
  - DSRIP Year 1 funding
  - SFY 2013 Q1 interim UC payment
  - SFY 2013 UC tool filing
  - DSRIP Year 2 transition issues and payment
- Accounting Issues (all payments subject to audit)
  - Depends on FYE 12 date (9/30, 12/31, Other)
  - FY 2012 revenue and IGT estimates for UC and DSRIP
  - FY 2013 transition year payments
  - Reserve estimates for nonperformance
  - 2013 DSH
- Project valuation
- Gross versus Net DSRIP Funds

DSRIP PROJECT FUNDING FORMULA
FOR AN ANCHOR FACILITY

<table>
<thead>
<tr>
<th>DSRIP Project Funds</th>
<th>Example Project</th>
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<tbody>
<tr>
<td>Gross DSRIP Project Value</td>
<td>$39,237,572</td>
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<tr>
<td>- Inter-Governmental Transfer (IGT of 41.78%)</td>
<td>($16,393,458)</td>
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<tr>
<td>= Net DSRIP Funds</td>
<td>$22,844,114</td>
</tr>
<tr>
<td>- JPS IGT Commitment to Private Providers (Allocated based on Gross DSRIP Project Value (14.6%))</td>
<td>($5,728,686)</td>
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<tr>
<td>= Performance Adjustment Reserve (Assume 20% of Net)</td>
<td>($4,568,823)</td>
</tr>
<tr>
<td>= Net DSRIP Project Funds Available</td>
<td>$12,546,606</td>
</tr>
<tr>
<td>Net to Gross %</td>
<td>32%</td>
</tr>
</tbody>
</table>
LESSONS LEARNED AND WHAT’S AHEAD?

• Learning Collaboratives

• Key lessons learned

LEARNING COLLABORATIVES

• Definition - A learning collaborative brings together organizations who are testing similar innovations, clinical interventions or process improvements so that the organizations can learn from each other and share best practices.

• Waiver Requirements for Learning Collaboratives:
  • 1. Review data every week;
  • 2. Convene participants at least bi-weekly to share results, breakthroughs, and challenges;
  • 3. Set 1-2 quantifiable goals, with a deadline, preferably defined in terms of outcomes;
  • 4. Invest more in learning than in teaching, at the front lines where care is delivered;
  • 5. Support a small, lightweight web site to help sites share ideas and simple data;
LEARNING COLLABORATIVES

- Key Requirements:
  6. Set up simple, interim measurement systems to drive improvement;
  7. Employ regional “innovator agents” to travel from site to site to:
     a. Rapidly answer practical questions about implementation,
     b. Spread best practices, and
     c. Receive training in improvement tools and skills by the State or RHP;
  8. Set up face-to-face learning (meetings or seminars) at least semi-annually;
  9. Celebrate success every week;
  10. Mandate “raise the floor” improvements and pursue “raise the bar” performance; and
  11. Use metrics to measure its success such as: rate of testing, rate of spread, time from idea to full implementation, commitment rate (e.g., 50% of organizations take action for any specific request), number of questions asked per day, network affinity/reported affection for the network.

KEY LESSONS LEARNED

- The opportunity to build something from scratch is not as appealing as once thought but it does provide the edge to continued innovation and improvement of outcomes.
- When there is no plan “B”, we can actually get things accomplished in a time frame that we could not have otherwise done.
- “Collaboration” is more than just a buzz word. New roles and partnerships have been formed and regional providers are more financially integrated.
- The journey is a marathon and not a sprint. HHSC and CMS will continue to move the thresholds and requirements as they learn more with other Waivers, ACA, ACO’s, etc. “Nimble” and “agile” are 2 terms we must get use to.
- Waiver renewal – what happens next? Don’t be surprised by where this could go.
CONTACT INFORMATION

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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

The lifetime income of you and 17,110 of your average guy friends would equal 29 Billion Dollars.
-Wallstats.com
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 1115A 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 – CONT.

• 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