



CMS, the Waiver & Sustainability

RHP 10

Learning Session 2

Sustainability

June 30, 2016

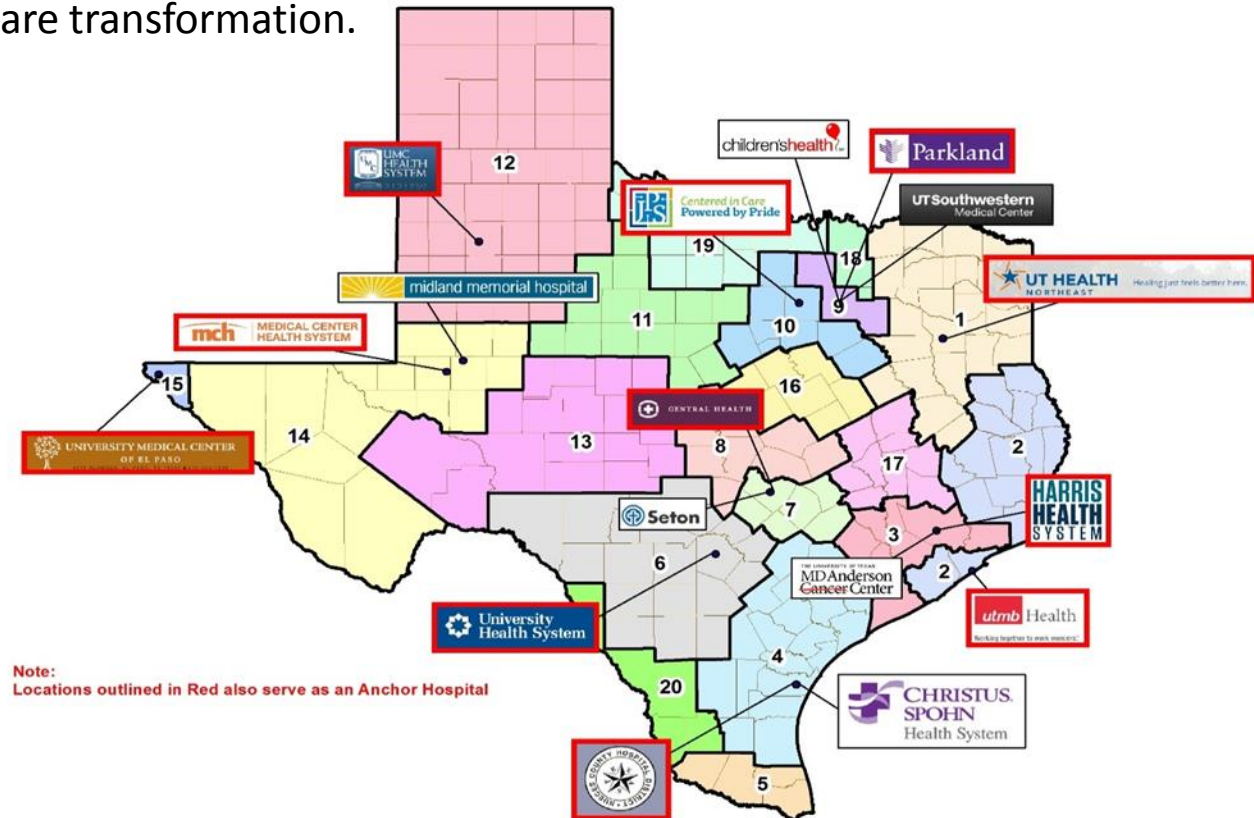
Maureen Milligan

President and CEO, Teaching Hospitals of Texas

Teaching Hospitals of Texas

Core Commitments

- Supporting access to quality care for all with a special focus on vulnerable populations;
- Providing and coordinating essential community health services such as trauma and disaster management; and
- Preparing for the future by training tomorrow's health care providers and supporting health research and healthcare transformation.

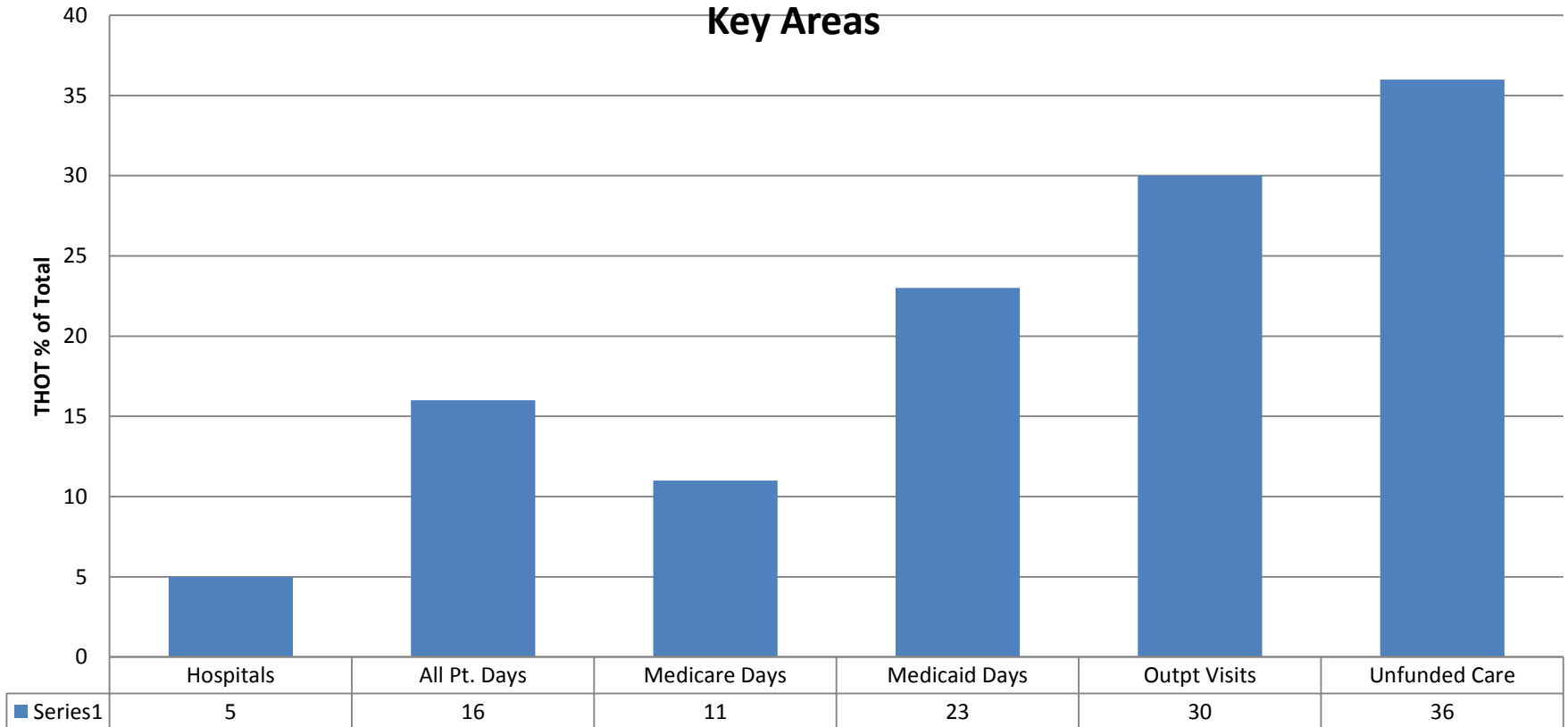




THOT – What we do

THOT % of All Hospital Activity

Key Areas



- **Trauma care - 10 of the state's 17 highest level, regional trauma centers (Level 1)**
- **Waiver support - 11 of the state's 20 anchors for the 1115 Transformation Waiver**
- **GME: About 63 percent of Texas hospital systems' Graduate Medical Education (GME) residency positions;**
- **THOT member transferring hospitals provide the majority of IGT (state match) supporting Medicaid DSH and Waiver payments to Texas hospitals**

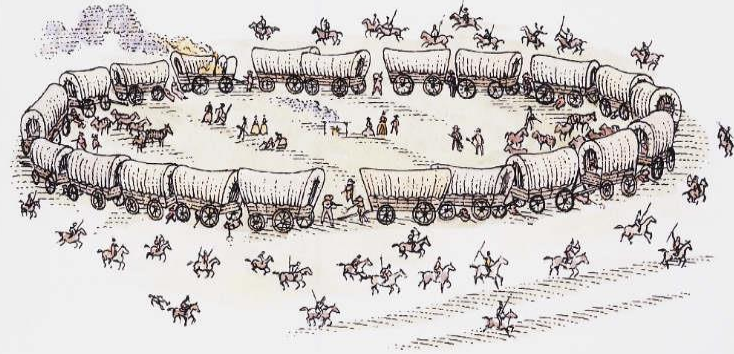
Charting a Texas Course Through CMS' Perfect Financial Storm



Sustainability of Waiver & Medicaid Funding

CMS' Strategy

Encirclement is a military term for the situation **when a force or target is isolated and surrounded** by enemy forces.



- This situation is highly dangerous for the encircled force: at the [strategic](#) level, because it cannot receive supplies or reinforcements, and on the [tactical](#) level, because the units in the force can be subject to an attack from several sides. Lastly, since the force cannot [retreat](#), unless it is relieved or can break out, it must either fight to the death or [surrender](#).
- Encirclement has been used throughout the centuries by military leaders, including generals such as [Alexander the Great](#), [Khalid bin Waleed](#), [Hannibal](#), [Sun Tzu](#), [Shaka Zulu](#), [Wallenstein](#), [Nader Shah](#), [Napoleon](#), [Moltke](#), [Heinz Guderian](#), [von Rundstedt](#), [von Manstein](#), [Zhukov](#), [Patton](#) and **CMS?**

CMS' Strategy

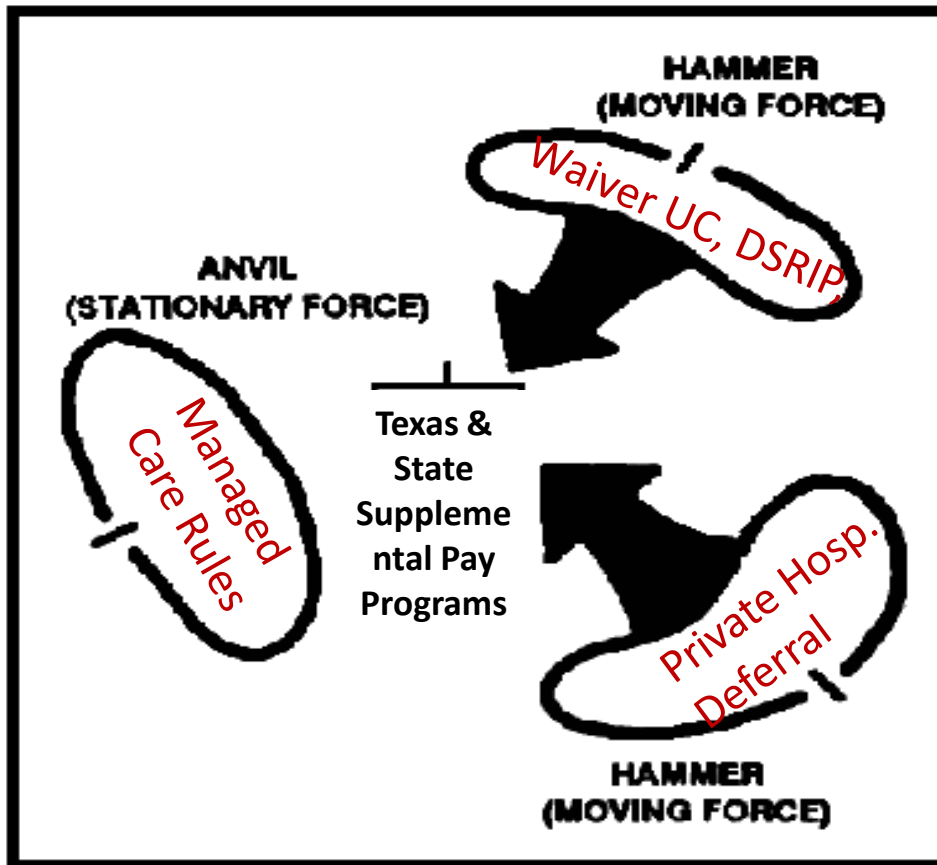
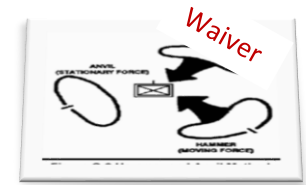


Figure C-2 Hammer and Anvil Method

Discussion

1. Waiver Status
2. Deferral, DSH
3. Managed Care Rules
4. Strategy

The Waiver



- CMS provided a 15 month extension
 - October 2016 – December 2017
- Extension funding:
 - Delivery System Reform Incentive payments maintained at current year 5 level: \$3.1 Billion
 - Uncompensated Care Payments maintained at current year 5 level: \$3.1 Billion

Renewal Negotiations

During the extension:

1. Reach agreement on adequate & appropriate Texas Medicaid payments under managed care.
2. State submits independent UC analysis.
3. State submit reforms to improve:
 - Medicaid payments; funding mechanisms; quality of care.



Renewal Negotiations

UC Analysis

- Health Management Associates developing the report:
 - Draft due to CMS July 15, 2016
 - Final due August 31, 2016.
- Report goal is to:

“...to ensure sustainable, transparent, equitable, appropriate, accountable and actuarially sound Medicaid payment systems and funding mechanisms for hospital providers that will ensure quality health care services to Texas’ Medicaid beneficiaries throughout the state.”

Core CMS Principles

1. Coverage is best way to assure beneficiary access to health care.
 - UC should not pay for costs that could be covered under a Medicaid expansion. The UC Pool will be limited to:
 - the size of the costs for uncompensated care and charity care for low-income individuals who are uninsured and can not be covered through Medicaid ...[based on] hospital Medicare cost reports [S10] and projections of potential impact on Medicaid expansion in Texas.
2. Medicaid payments should support provision of services to Medicaid and uninsured individuals; and
3. Medicaid payments must be sufficient to promote provider participation, and HMO care management.

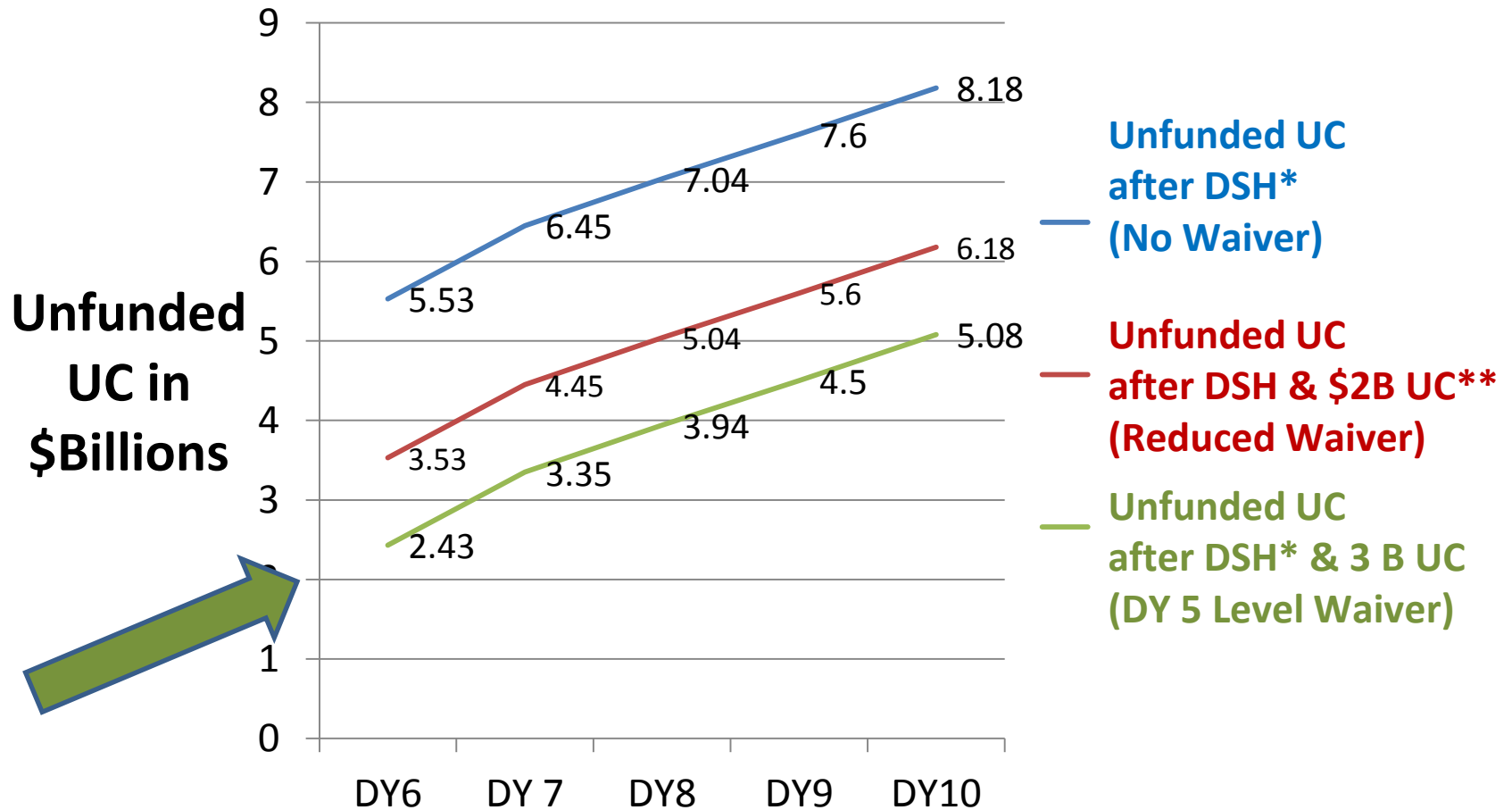
Renewal Risks

If no agreement reached between CMS and Texas

- No UC will be available beyond 2017 except at reduced amounts consistent with CMS principles:
- UC limited to costs of uninsured who could not be covered in an expansion
- DSRIP will phase down by 25% in 2018 and an additional 25% each year thereafter.

Negotiation of Budget Neutrality & UC rebasing

Unfunded UC Growth – Different Waiver Scenarios



*UC after DSH rough estimate - THA workpapers

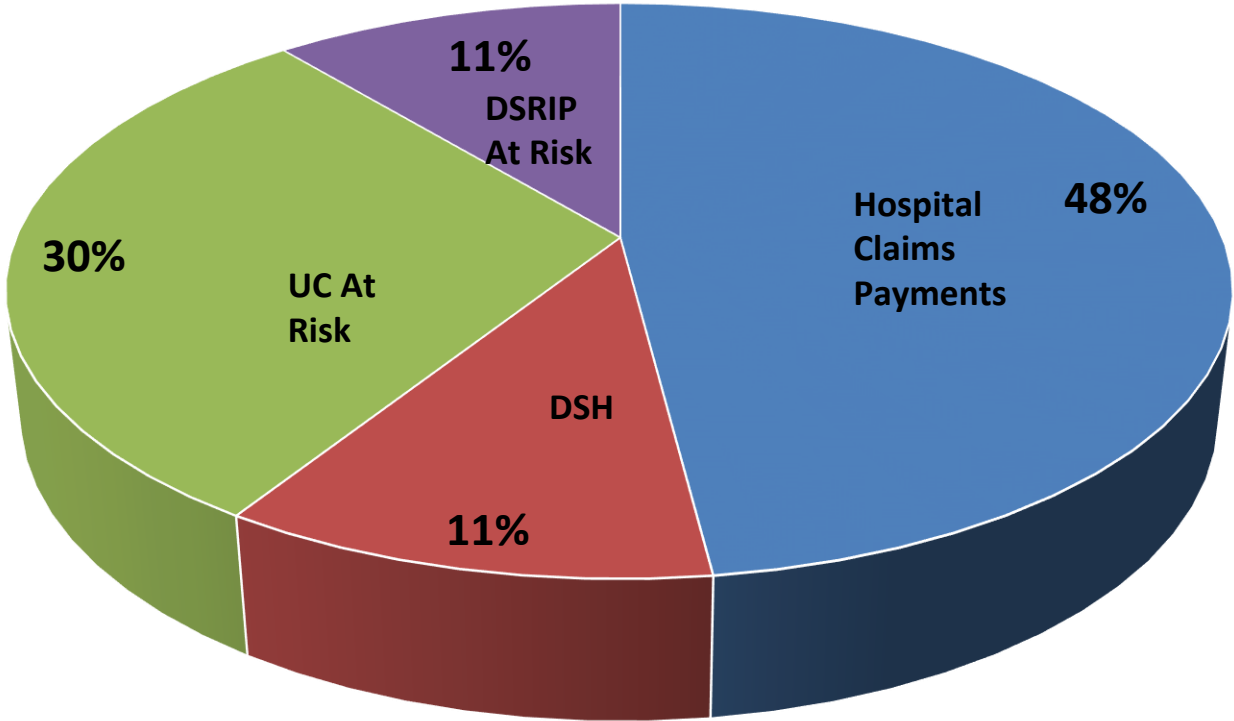
** For Illustration only; not an estimate UC after DSH rough estimate - THA workpapers

DSRIP: Lost or Changed

- DSRIP not available for Uninsured?
- DSRIP in Managed Care:
 - Valuation vs. Cost
 - Different Distribution Method (not directly to provider)
 - What MOF: IGT or ?
 - QIPP Lessons: IGT 3 months in advance with payments over 6 months
 - No IGT conditionality or “Pay to Play”?

Renewal Risks

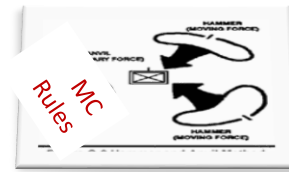
40% of Medicaid Hospital Payments are at Risk*



- Medicaid Hospital Claims Payments
- Medicaid DSH Payments
- Medicaid Waiver UC Pool Payments
- Medicaid Waiver DSRIP Pool Payments

*2013 data used by HHSC in 2015. Percentages of UC and DSRIP have changed to: 50/50.

Managed Care Rules



- Finalized by CMS: April 25, 2016
- Affects HMOs and Hospital Funding through HMOs.
- CMS Goal: Modernize Medicaid Managed Care
(Impact: *Eliminate most Supplemental Payments as they operate today (DSH and GME Excepted)*)?
- At Risk or Changes in: QIPP, NAIP and more

Proposed Policy Changes

- CMS maintains its prohibition against direct payments by states to providers for services delivered under managed care contracts
 - Exceptions for GME, DSH, and FQHCs
- CMS explicitly prohibits states from directing plan expenditures under contracts, except under these specified circumstances:
 - Implementation of value-based purchasing models
 - Mandatory participation in a multi-payer delivery system reform
 - Adoption of a minimum fee schedule or uniform rate increase for all providers of a particular service



FEDERAL REGISTER

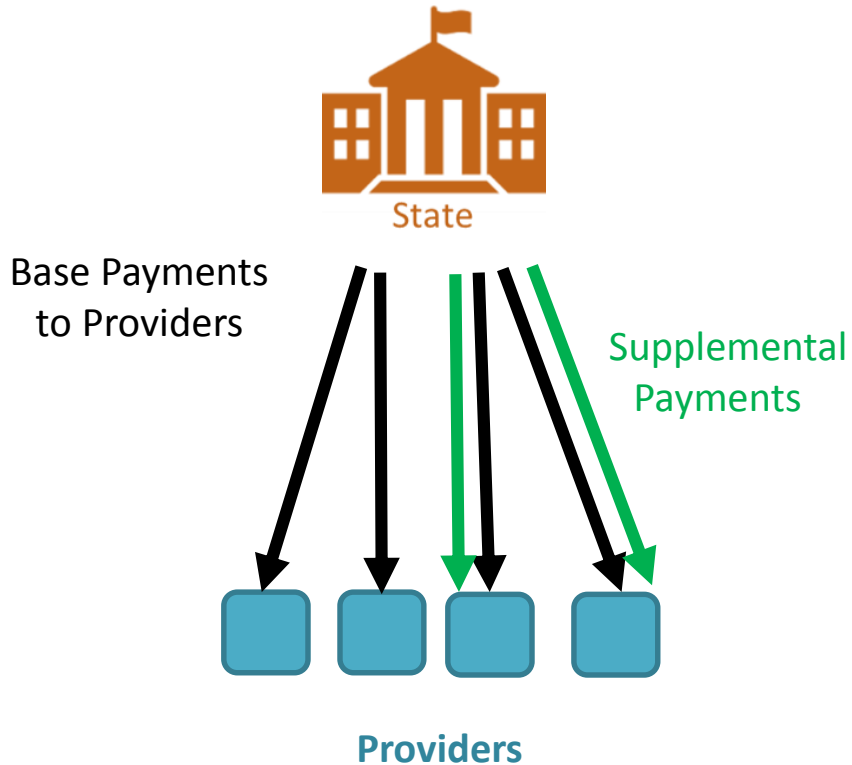
Vol. 80 Monday,
No. 104 June 1, 2015

Part II

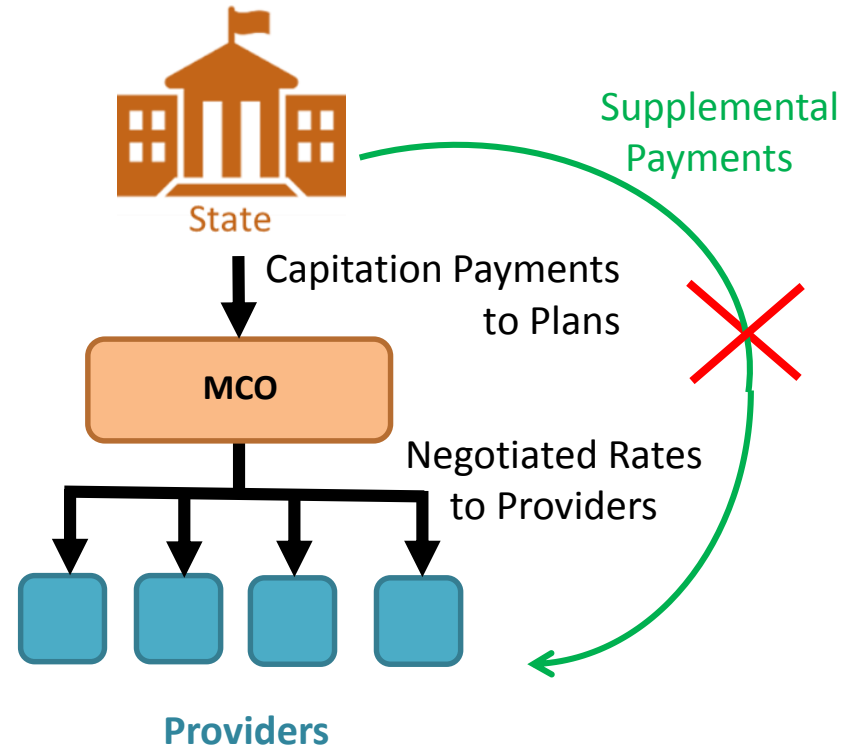
Department of Health and Human Services
Centers for Medicare & Medicaid Services
42 CFR Parts 431, 433, 438, et al.
Medicaid and Children's Health Insurance Program (CHIP) Programs;
Medicaid Managed Care; CHIP Delivered in Managed Care; Medicaid and
CHIP Comprehensive Quality Strategies, and Revisions Related to Third
Party Liability; Proposed Rules

Direct Pay Prohibition Under Managed Care

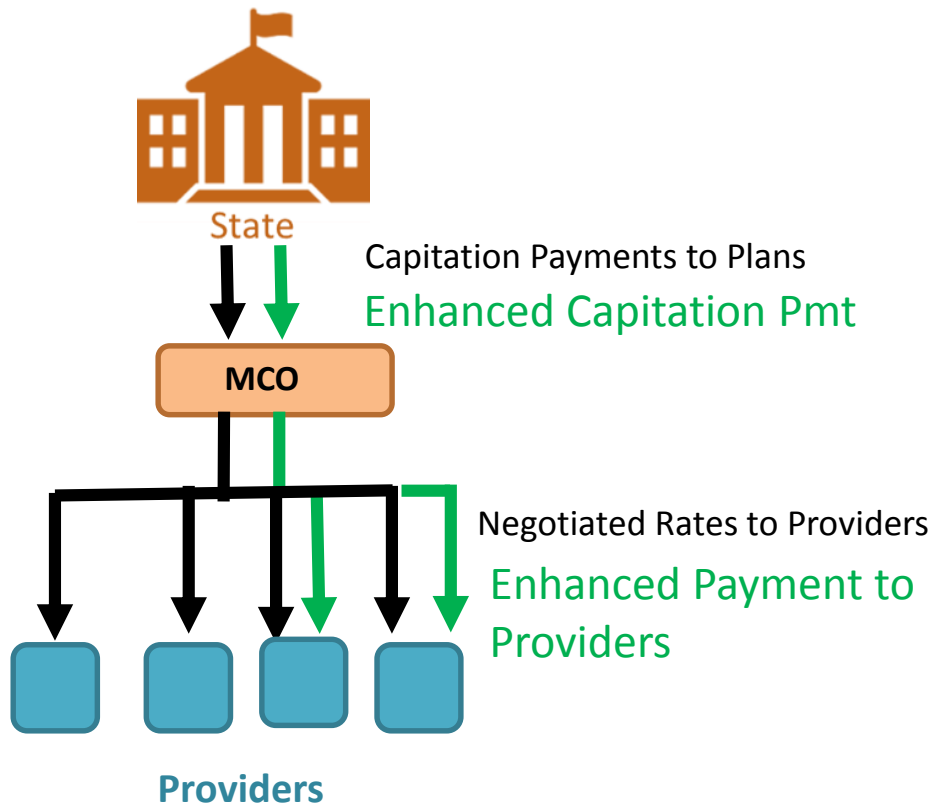
Fee for Service



Managed Care



Enhanced Payments Through Managed Care Plans



- To what extent can states require or otherwise encourage plans to actually pay the enhancement to providers?
- CMS interprets direct pay prohibition to also prohibit state from requiring plans to pay providers supplemental amounts not related to delivery of services

State Directed Payments Permitted Under New Final Rule

Permissible Directed Payments

State can requires plans in contract to:

1. implement VBP
2. participate in delivery system reform initiatives
3. adopt a minimum or maximum fee schedule or provide a uniform \$ or % payment increase to providers
 - For example: LPPF funded rate increases.

Transitional Mandatory Pass-Through Payments

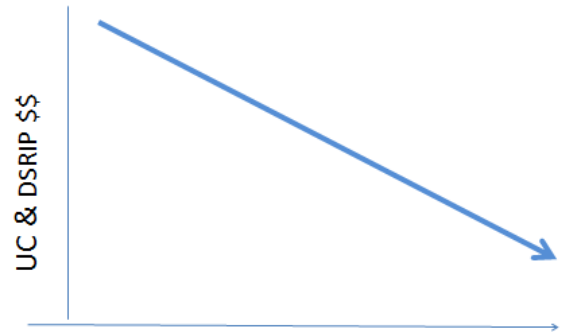
- *During transition period*, states may require plans in contract to pass certain payment amounts to certain providers
- Payments not tied to utilization of services
- For hospitals, nursing facilities, and physicians only
- Time-limited
 - Hospitals 10 years with phase down
 - NF & physicians 5 years

Permissible Directed payments: The fine print

- May be limited to a state-created class of providers
 - » Public hospitals, teaching hospitals, other
 - » Eliminated requirement in proposed rule to apply equally to public and private providers
- May not condition provider participation on the provider entering into or adhering to IGT agreements
- Must be tied to utilization and delivery of services
- Must have written approval prior to implementation
- May not automatically renew
- Must be evaluated against quality goals
- May not re-coup payments made to managed care organizations

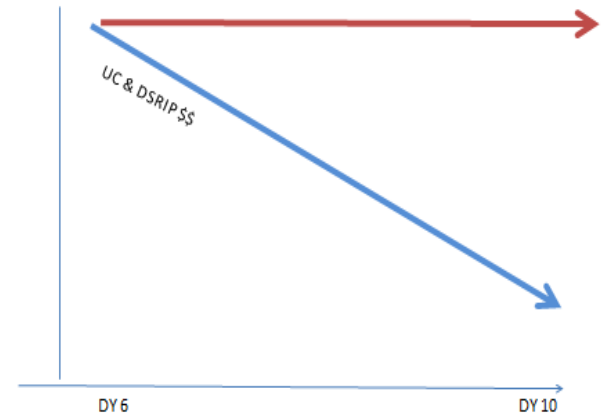


Where does
this leave us?



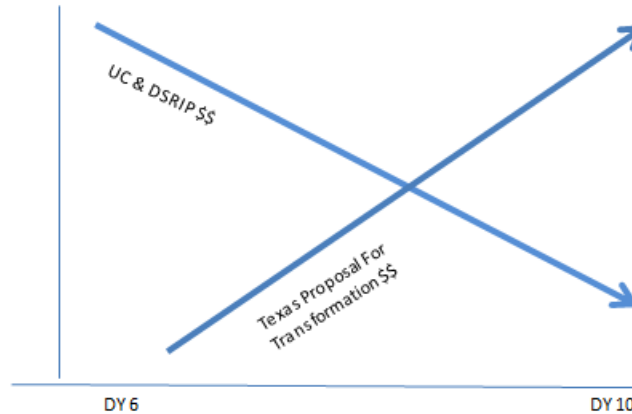
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Where do we
want to be?



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How do we
get there??



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How do we get there?

- CMS is looking for...something.
- One option is a vision and path to local, accountable integrated provider systems that could include DSRIP-Displaced Uninsured Texans. These systems would be:
 - transformed (payments based on quality, outcomes, VBP, APMs, etc.)
 - Integrated with local community based organizations
 - Focused on community engagement
 - Actively engaged with individuals in the community to understand needs, challenges and inform on best ways to interact with healthcare systems.

Key Timelines

- May 2016 15 Month Extension Begins
- July 15, 2016 Draft UC Study to CMS
- August 31, 2016 Final UC Study to CMS
- January 2017 Session Starts
- May 31, 2017 End of Session
- September 2017: Private Hospital Deferral?
- December 31, 2017 Waiver Extension Expires
- 2018 DSH Reductions Begin
- January 2018 Waiver II Begins?
- October 2021 Waiver II Ends
- 2027 Pass Through Payments Expires



RHP 10 Learning Collaborative Children's Health System of Texas

Pete Perialas
Chief Strategy Officer and
Senior Vice President,
Population Health

Children's Health DSRIP Program

Active projects within 3 Regional Healthcare Partnerships (RHPs):

- RHP 9: Dallas, Denton, Kaufman
- RHP 10: Tarrant, Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, Wise
- RHP 18: Collin, Grayson, Rockwall

Children's Health projects and outcome measures:

- 19 Category 1 and Category 2 (Infrastructure and program innovation/redesign)
- 19 Category 3 outcome measures (quality improvement)
- Also reporting on all 6 Category 4 Domains

Category 1: Infrastructure

- Telemedicine
 - Expanded to 57 schools in the 2015-2016 school year
- New Children's Health Pediatric Group Clinics (CHPG)
 - 14 clinic openings since DSRIP began
- Extended Hours & Nurse Advice Line
 - Nearly all sites have some form of extended hours
 - 24 hour nurse advice line available to all families, not just CHST
 - Medical District location open 365 days a year until 1am
- Integrated Behavioral Health
 - Psychiatry and Psychology providers have been hired to support the CHPG clinics.
- Disease Management Registry
 - First registries developed focused on Asthma and Obesity
 - Program has since expanded to include 9 Registries

Category 2: Program Innovation/Redesign

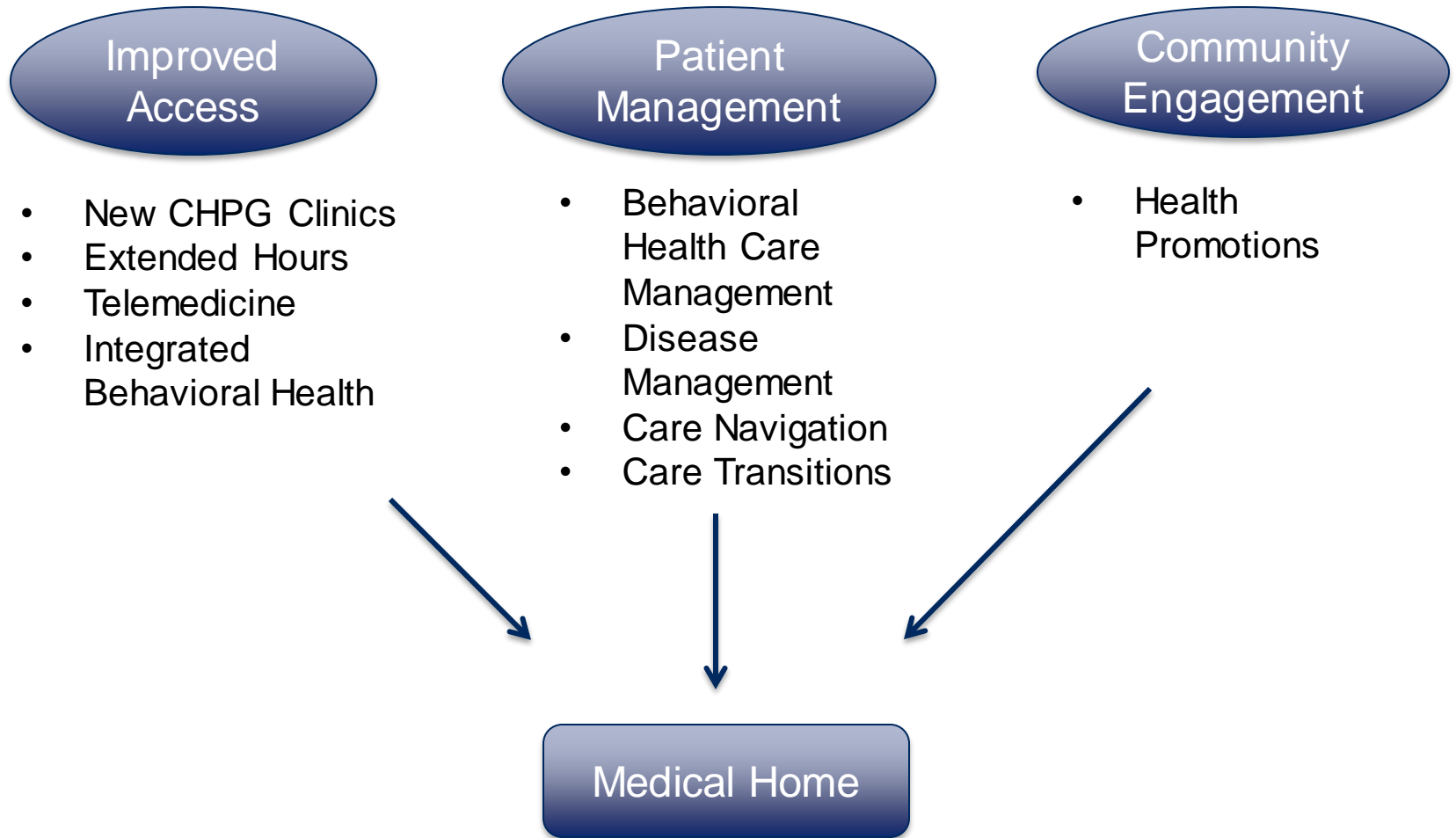
- Care Transitions
 - Providing tools for transition from pediatric to adult medicine
- Health Promotions
 - Community focused with multiple initiatives aimed to provide education and outreach programs
- Medical Homes
 - All clinics are functioning under NCQA standards
 - All but the most recently opened clinics have acquired Level III recognition
- Care Navigator
 - Improving resource utilization and connecting patients and their families with a Medical Home
- Behavioral Health Care Management
 - Care Managers have been imbedded into all CHPG clinics and is expanding to support additional Community Centers

Category 3: Quality Improvement

- Reduction of Ambulatory Care Sensitive Conditions (ACSC)
- Improving ADHD Medication Management
- Reducing Levels of Depression
- Improving Asthma Outcomes

Measure	Associated Cat 1 or 2 Project
IT-1.22 Asthma Percent of Opportunity Achieved	Medical Homes
IT-2.26.e.i Average PHQ-9 Depression Screening Scores	Behavioral Health Care Management
IT-2.23 Pediatric Asthma Admission Rate	Disease Management Registry
IT-9.2 Reduce ED Visits for ACSC, Adult	Care Transitions
IT-9.3 Reduce Pediatric ED visits for ACSCs	New Clinics
	Telemedicine
	Extended Hours
	Care Navigation
IT-9.4h Pediatric/Young adult Asthma ED visits	Health Promotions
IT-11.6 Follow-up care for children prescribed ADHD medications - Initiation Phase	Behavioral Health in CHPG
IT-11.6 Follow-up care for children prescribed ADHD medications - Continuous Maintenance Phase	

Breaking Down Barriers to Integration



Integrating Our Delivery System

