Texas Waiver 2.0

Brittani Bilse

Brittani Bilse Consulting

Managed Care Hospital Transition 1115 waiver

BUDGET NEUTRALITY SUMMARY: March 2017 Update with 5 year renewal

WITH WAIVER SUMMARY	DY 07 (FFY 18)	DY 08 (FFY 19)	DY 09 (FFY 20)	DY 10 (FFY 21)	DY 10 (FFY 22)
Aged and Medicare Related	$ 4,649,505,226	$ 4,992,547,141	$ 5,354,102,518	$ 5,741,999,955	$ 6,137,208,776
Blind and Disabled	$ 8,132,085,779	$ 8,679,909,700	$ 9,264,908,726	$ 9,889,630,402	$ 10,513,724,885
Adults	$ 2,079,957,518	$ 2,194,552,624	$ 2,317,472,863	$ 2,448,888,697	$ 2,584,133,143
Children	$ 8,053,882,798	$ 8,524,424,217	$ 9,022,799,233	$ 9,550,515,368	$ 10,073,874,091
Other UPL Programs (Not Included in Population)	$ -	$ -	$ -	$ -	$ -
Non-Pool Expenditures	$ 22,915,431,321	$ 24,391,433,683	$ 25,959,283,340	$ 27,631,034,421	$ 29,308,940,895

Managed Care Hospital Transition 1115 waiver

BUDGET NEUTRALITY SUMMARY: March 2017 Update with 5 year renewal

	DEMONSTRATION YEARS (DY)				
	DY 07 (FFY 18)	DY 08 (FFY 19)	DY 09 (FFY 20)	DY 10 (FFY 21)	DY 11 (FFY 22)
Waiver Pool	DY 7	DY 8	DY 9	DY 10	DY 11
Uncompensated Care Pool Payments	$ 3,101,776,278	$ 3,101,776,278	$ 2,334,323,270	$ 2,334,323,270	$ 2,334,323,270
DSRIP	$ 3,100,000,000	$ 3,100,000,000	$ 2,910,000,000	$ 2,490,000,000	$ -
Network Access Improvement Project					
NAIP Expenditures	$ 426,149,909	$ 426,149,909	$ 426,149,909	$ 426,149,909	$ 426,149,909
Nursing Facility Directed Payments	$ -	$ -	$ -	$ -	$ -
Delivery System & Provider Payment Initiatives					
Quality Incentive Payment Program (QIPP)	$ 400,000,000	$ 550,000,000	$ 500,000,000	$ 550,000,000	$ 600,000,000
Uniform Hospital Rate Increase Program (UHRIP)	$ 600,000,000	$ 1,250,000,000	$ 1,150,000,000	$ 1,325,000,000	$ 1,500,000,000
Expenditures (Over)/Under Cap w/Savings Rollover	$ 2,392,650,999	$ 1,830,173,399	$ 2,822,191,049	$ 3,031,763,747	$ 5,351,971,256

Budget neutrality figures are estimated and subject to change as history and projections are updated.
Projections for NAIP, QIPP, UHRIP are estimated and evaluated annnually as each year comes due.
Uncompensated Care Pool figures for DY09-11 are not yet final.

DY 9 and 10

- In June 2018, CMS and Texas Medicaid will meet and discuss the DSRIP transition.
- In late 2018, HHSC will begin working with stakeholders to:
  - Determine how the reduced funding pools for DY9-10 will be distributed
  - Refresh the menu of Measure Bundles and measures for DY9-10

Uncompensated Care

Hospital Uncompensated Care Pool 2.0

- DY 7 – FY 2018
  - Partial Payment in September 2018 – the lowest payment option
    - 9/06/18 Last day to submit your IGT into TexNet
    - 9/07/18 IGT Settlement date
    - 9/17/18 Payments to Transferring Hospitals, i.e. Large public hospitals, as defined in 1 Tex. Admin. Code §355.8201(b)(14)
    - 9/28/18 All UC Providers paid
  - 2 Recent Issues with a significant impact on the distribution of uncompensated-care (UC):
    - (1) federal judicial decisions were issued in two lawsuits related to the calculation of the hospital-specific limit (HSL); and
    - (2) there has been an increase in the number of urban hospitals that have sought and received designation as a rural referral center (RRC) from the Centers for Medicare & Medicaid Services (CMS), thereby becoming eligible as "Rider 38 hospitals" for UC.
- Final DY 7 Payment expected December 2018 – 5 options pending

Hospital Uncompensated Care Pool 2.0

- HHSC has proposed an amendment for comment in the Texas Register:
  - Amendment to 1 TAC §355.8201.
  - A growing number of large urban hospitals have obtained Medicare designations as Rural Referral Centers (RRCs) and have a rural or higher classification under UC.
  - HHSC proposes to eliminate preferential treatment for Urban RRCs beginning in demonstration year 8.
  - HHSC proposes to allow urban RRCs to receive preferential treatment up to the level of eligible uncompensated costs in DY 7 only.

DSRIP

DSRIP Timeline

- September – EQRO reports sent to providers for Category D
  - Prepare for Patient Satisfaction Reporting
    - Measurement period will be standardized starting with the October DY7
      - 10/1/2016 - 9/30/2017 (DY6)
    - In April or October of 2019, DY 8 reporting, depending on when "Top-Box" response data is available, the period will be
      - 10/1/17 - 9/30/18 (DY 7)
  - Prepare for Quality Baseline Reporting
- October 4 – October DY 7 Reporting Webinars
- October 31 – Deadline for October Reporting
- January 2019 – IGT and Payment

Quality Reporting – Lessons Learned

- Accepted
  - Approved for payment for the baseline reporting milestone in October DY7 and are approved to report performance year 1 (PY1 in April 2018).
- Flagged for TA
  - Approved for payment but require additional communication between the provider and HHSC to resolve the baseline TA flag before PY1 can be reported.
  - Insignificant denominator volume for the currently approved achievement payer type,
  - Unreasonably low baseline rate (typically for process measures with a positive directionality), and
  - Adherence to measure specification.
  - TA Fixes:
    - Changes to the milestone structure,
    - baseline measurement period,
    - approved approximate baseline, or
    - baseline numerator of zero.
- Not Accepted
  - Not approved for payment.
  - Do not meet the minimum baseline reporting requirements (for example, not reporting the all-payer rate when required and there is clearly an all-payer volume), or
  - Provider indicated that significant modification requests were pending.

State of Change

Transition Plan

- HHSC must also submit a DSRIP Transition Plan to CMS by 10/1/19.
- The Transition Plan will include Texas' planned milestones for making progress toward Value-Based Purchasing (VBP) and other initiatives when DSRIP ends.
- For example, a milestone could relate to VBP contractual targets for Medicaid MCOs in 2020-2021, or to other pay-for-quality efforts in Medicaid Managed Care.

Attribution

DSRIP Quality Measures and Bundles

- Documentation of Current Medications in the Medical Record
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Medication Reconciliation Post-Discharge

Star Bonus Measures

Source	Measure	Description
3M	Potentially Preventable Emergency Room Visits (PPVs)	Hospital emergency room or freestanding emergency medical care facility treatment provided for a condition that could be provided in a nonemergency setting
HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Percentage of children 3 months - 18 years of age who were diagnosed with upper respiratory infection and were not dispensed an antibiotic prescription on or three days after the episode
HEDIS	Prenatal and Postpartum Care (PPC)	• Timeliness of Prenatal Care: the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization • Postpartum Care: the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery
HEDIS	Well Child Visits in the First 15 months of Life (W15)	Percentage of members who turned 15 months old during the Measurement Year and who had six or more well-child visits with a PCP during their first 15 months of life

Star Bonus Measures

Source	Measure	Description
3M	Potentially Preventable Emergency Room Visits (PPVs)	Hospital emergency room or freestanding emergency medical care facility treatment provided for a condition that could be provided in a nonemergency setting
HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Percentage of children 3 months - 18 years of age who were diagnosed with upper respiratory infection and were not dispensed an antibiotic prescription on or three days after the episode
HEDIS	Prenatal and Postpartum Care (PPC)	• Timeliness of Prenatal Care: the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization • Postpartum Care: the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery
HEDIS	Well Child Visits in the First 15 months of Life (W15)	Percentage of members who turned 15 months old during the Measurement Year and who had six or more well-child visits with a PCP during their first 15 months of life

Star Bonus Pool Measure

Source	Measure	Description
3M	Potentially Preventable Admissions (PPAs)	Hospital admission that may have been prevented with access to ambulatory care or health care coordination.
CMS	Low Birth Weight	Percentage of live births that weighed less than 2,500 grams (5.51 pounds)
CAHPS	Children with Good Access to Urgent Care	Percent of caregivers who, when surveyed, responded their child always got urgent care for illness, injury or condition as soon as needed
CAHPS	Adults Rating their MCO a 9 or 10	Percent of adult members who rated their MCO a 9 or 10 (on a scale of 0-10) when surveyed

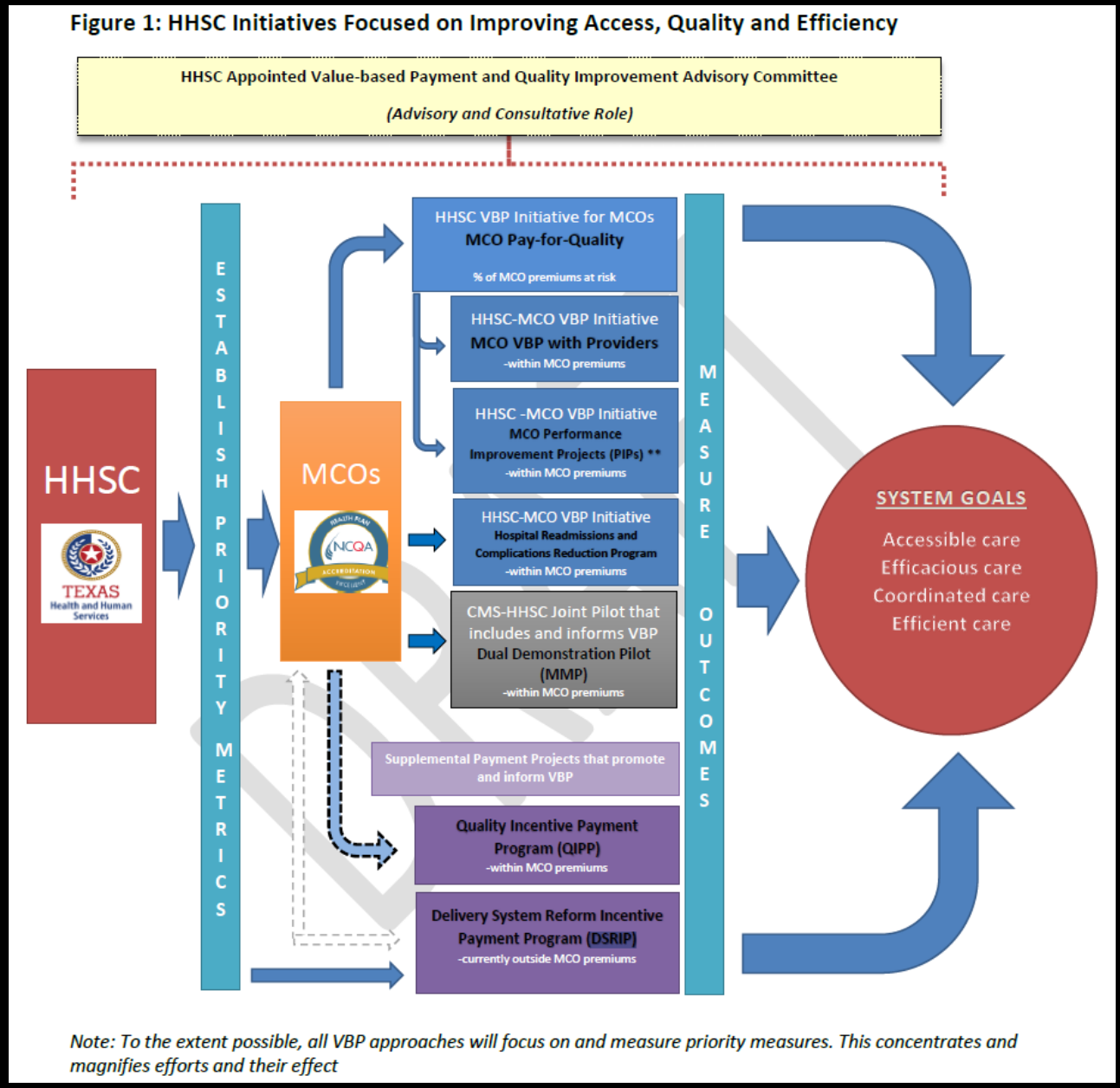
STAR+PLUS Program Measures

Source	Measure	Description
3M	Potentially Preventable Emergency Room Visits (PPVs)	Hospital emergency room or freestanding emergency medical care facility treatment provided for a condition that could be provided in a nonemergency setting
HEDIS	Diabetes Control - HbA1c < 8% (CDC)	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had HbA1c control (<8.0%).
HEDIS	High Blood Pressure Controlled (CBP)	The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90).
HEDIS	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotics (SSD)	Percentage of members 18 to 64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test.
HEDIS	Cervical Cancer Screening (CCS)	Percentage of women 21 to 64 years of age who were screened for cervical cancer.

STAR+PLUS Bonus Pool Measures

Source	Measure	Description
3M	Potentially Preventable Readmissions (PPRs)	Return hospitalizations resulting from care or treatment deficiencies provided during a previous hospital stay or from post-hospital discharge follow-up.
3M	Potentially Preventable Complications (PPCs)	Hospital-based harmful events (e.g., accidental laceration during a procedure) or negative outcomes (e.g., hospital acquired pneumonia) that may result from the process of care and treatment rather than from a natural progression of underlying disease.
AHRQ	Prevention Quality Indicator (PQI) Composite	Number of admissions per 100,000 member months ages 18 and older for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, angina without a cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection
CAHPS	Adults with Good Access to Urgent Care	Percent of adults who, when surveyed, responded they always got urgent care for illness, injury or condition as soon as needed
CAHPS	Adults Rating their MCO a 9 or 10	Percent of adult members who rated their MCO a 9 or 10 (on a scale of 0-10) when surveyed

Value Road Map



Pursuit of Promising Models to Advance VBP in Texas

- **Delivery System Reform Incentive Payment Program (DSRIP) as a Key Incubator for VBP**
- **Uniform Hospital Rate Increase Program (URHIP):**
- **Accountable Health Communities (AHC)**
- **Certified Community Behavioral Health Clinics (CCBHC)**
- **Accountable Care Organizations (ACO)**
- **VBP to Support Interventions for Populations with Complex Needs and High Cost (i.e., "Superutilizers")**

Budget Neutrality

- CMS issued new Budget Neutrality Guidance – Reduce Federal Spending:
  - “Budget neutral demonstration projects will not result in federal Medicaid spending that exceeds what it would likely have been absent the demonstration.”
  - Manatt notes this is the first time budget neutrality has formal CMS guidance and gives way for the Trump Administration to scrutinize waivers.
  - Re-Evaluating Current Waivers
    - States will have limited savings carryforward, in Texas that is $1.6 billion per year DY 7 - 11.
    - Rebase January 1, 2021

State Match or IGT

- CMS Administrator Seema Verma testified before the Senate Homeland Security and Government Accountability Committee on improper payments in the Medicaid program, which often result in higher federal spending.
- The Honorable Eugene L. Dodaro testified before the Committee on the risks associated and the need to strengthen program integrity.
- The Department of Health and Human Services DEPARTMENTAL APPEALS BOARD Appellate Division issued a decision on disallowing federal financial participation.
- Noteworthy Issues:
  - A state must finance at least 40 percent of the non-federal share from state funds, while the remainder may be drawn from sources such as local government contributions. Act § 1902(a)(2).
  - Demonstrations made up one-third of Medicaid spending in fiscal year 2015.
  - Committee discussed additional audits for Improper Payments.

Questions