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# Section 1115 Demonstration Waiver: Texas Healthcare Transformation and Quality Improvement Program

Extension Public Meeting

**July 2015**

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# 1115 Transformation Waiver

- Three major components:
  - Statewide Medicaid managed care through the STAR, STAR+PLUS, and Children's Medicaid Dental Services programs (including carve in of inpatient hospital, pharmacy and children's dental services).
  - Provider reimbursement to offset uncompensated care costs (Uncompensated Care [UC] Pool)
  - Incentive payments for hospitals and other providers for healthcare infrastructure and innovation through 20 Regional Healthcare Partnerships (Delivery System Reform Incentive Payment [DSRIP] Pool)
- Five year Medicaid demonstration waiver – 2011 through September 30, 2016

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# Goals of 1115 Transformation Waiver

- Expand Medicaid managed care statewide
- Develop and maintain a coordinated care delivery system
- Improve health outcomes while containing costs
- Protect and leverage federal match dollars to improve the healthcare infrastructure
- Transition to quality-based payment systems across managed care and hospitals

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# Extension Request

- By September 30, 2015, HHSC must submit to the federal Centers for Medicare and Medicaid Services (CMS) a request to extend the waiver.
- In September, HHSC plans to request to continue all three components of the waiver for another five years:
  - Statewide managed care
  - UC pool
  - DSRIP pool
- Texas has made progress related to all five waiver goals, and will propose program improvements toward those goals to support and strengthen the healthcare delivery system for low-income Texans.

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# Statewide Medicaid Managed Care

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# What is Managed Care?

- Healthcare provided through a network of doctors, hospitals and other healthcare providers responsible for managing and delivering quality, cost-effective care
- The State pays a managed care organization (MCO) a capitated rate for each member enrolled, rather than paying for each unit of service provided

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# State of Texas Access Reform (STAR)

- A managed care program that provides acute care services (like doctor visits, hospital visits, and prescriptions) mostly for children of low-income families, and pregnant women
- Assigns each member to a primary care provider (PCP) that serves as the medical home and coordinates care
- 18 managed care organizations (MCOs)
- 2.8 million enrollees as of April 2015

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# STAR+PLUS

- Serves adults age 21 and older who:
  - Have a disability and qualify for Supplemental Security Income (SSI) or have Medicaid because of low income
  - Qualify for Medicaid because they meet a nursing facility level of care and require STAR+PLUS Home and Community Based Services (HCBS) waiver services
- Individuals with intellectual and developmental disabilities (IDD) that receive services through a DADS waiver must enroll in STAR+PLUS for acute care services
- Children and young adults with disabilities, under age 21, may voluntarily enroll in STAR+PLUS

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# STAR+PLUS

- Integrates the delivery of acute care and long-term services and supports (LTSS) through a managed care system
- Main feature - service coordination
  - Specialized care management service that is available to all members and performed by an MCO service coordinator
- Expanded on September 1, 2014, and now operates statewide
- Five MCOs
- 577,000 enrollees as of April 2015

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# STAR+PLUS
# Long Term Services and Supports

- Community-based and institutional long term services and supports available under the State Plan to all STAR+PLUS members:
  - Personal assistance services (PAS)
  - Day activity and health services (DAHS)
  - Community First Choice (CFC) (effective June 1, 2015)
  - Nursing facility (effective March 1, 2015)
- Home and Community Based Services Waiver

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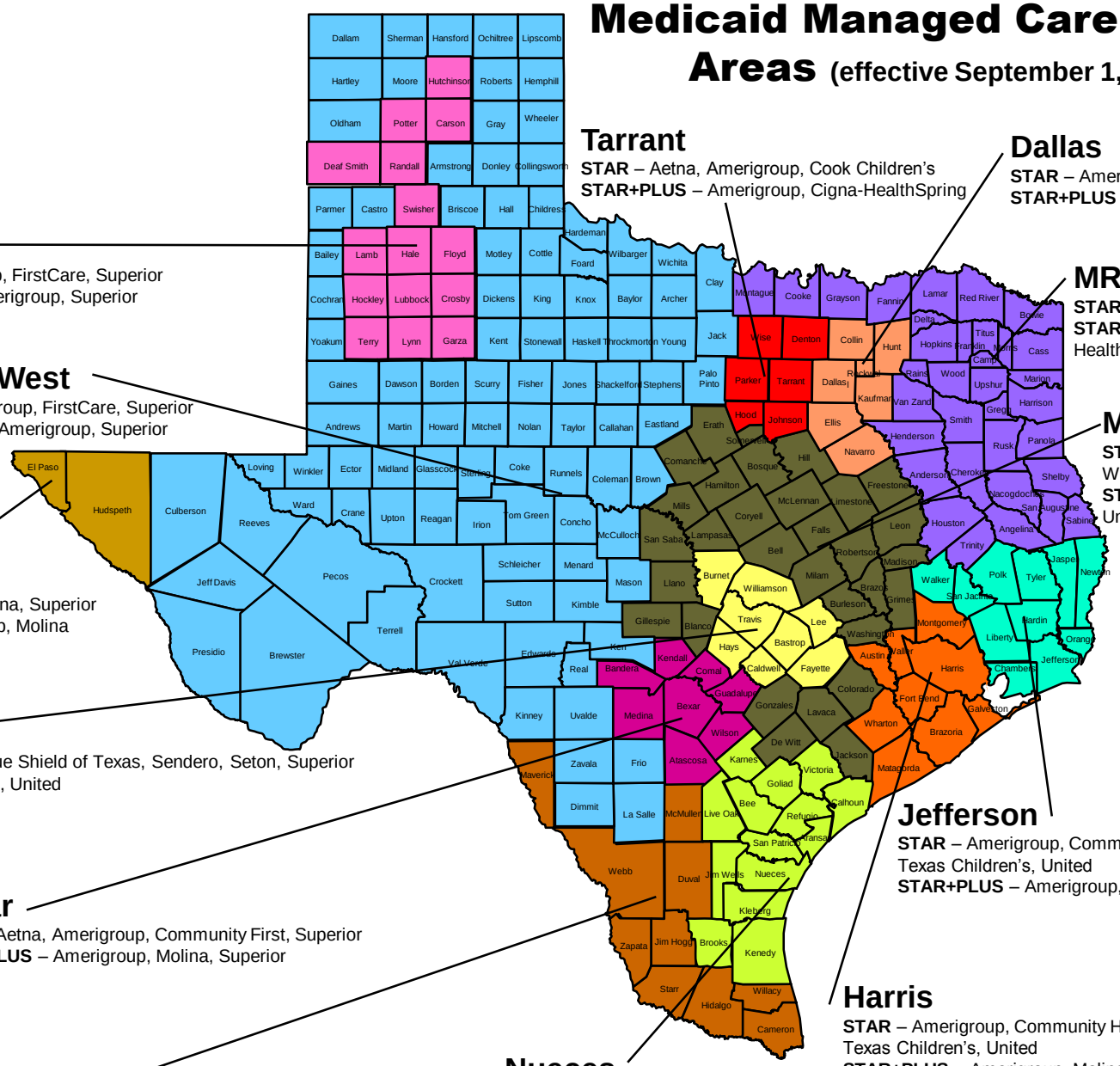
# STAR+PLUS HCBS Services

- Available to adults who meet income, resource, and medical necessity requirements for nursing facility care
- Home and community based services (HCBS) not available under the State Plan as a cost-effective alternative to living in a nursing facility
  - Adaptive aids
  - Adult foster care
  - Assisted living
  - Cognitive Rehabilitation Therapy
  - Dental
  - Emergency response
  - Financial management services
  - Home delivered meals
  - Medical supplies
  - Minor home modifications
  - Nursing services
  - Personal assistance services
  - Respite care
  - Supported Employment and Employment Assistance
  - Therapies
  - Transition assistance services

# Medicaid Managed Care Service Areas (effective September 1, 2014)




## Lubbock
**STAR** – Amerigroup, FirstCare, Superior
**STAR+PLUS** – Amerigroup, Superior

## MRSA – West
**STAR** – Amerigroup, FirstCare, Superior
**STAR+PLUS** – Amerigroup, Superior

## El Paso
**STAR** – El Paso First, Molina, Superior
**STAR+PLUS** – Amerigroup, Molina

## Travis
**STAR** – Blue Cross and Blue Shield of Texas, Sendero, Seton, Superior
**STAR+PLUS** – Amerigroup, United

## Bexar
**STAR** – Aetna, Amerigroup, Community First, Superior
**STAR+PLUS** – Amerigroup, Molina, Superior

## Hidalgo
**STAR** – Driscoll, Molina, Superior, United
**STAR+PLUS** – Cigna-HealthSpring, Molina, Superior

## Tarrant
**STAR** – Aetna, Amerigroup, Cook Children's
**STAR+PLUS** – Amerigroup, Cigna-HealthSpring

## Dallas
**STAR** – Amerigroup, Molina, Parkland
**STAR+PLUS** – Molina, Superior

## MRSA – Northeast
**STAR** – Amerigroup, Superior
**STAR+PLUS** – Cigna-HealthSpring, United

## MRSA – Central
**STAR** – Amerigroup, Scott & White, Superior
**STAR+PLUS** – Superior, United

## Jefferson
**STAR** – Amerigroup, Community Health Choice, Molina, Texas Children's, United
**STAR+PLUS** – Amerigroup, Molina, United

## Harris
**STAR** – Amerigroup, Community Health Choice, Molina, Texas Children's, United
**STAR+PLUS** – Amerigroup, Molina, United

## Nueces
**STAR** – Christus, Driscoll, Superior
**STAR+PLUS** – Superior, United

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# Children's Medicaid Dental Program

- Provides primary and preventive dental services in a managed care environment
- Enrolls each member in a dental maintenance organization (DMO)
- Assigns each member to a main dental home that assesses dental needs and coordinates members' care with specialty providers
- Most children and young adults under 21 who receive Medicaid are enrolled in managed care for dental services
- Two DMOs operate statewide

# Medicaid Managed Care Changes

- Managed care expansions:
  - STAR+PLUS expansion to the Medicaid Rural Service Areas – 9/1/14
  - Inclusion of IDD populations into STAR+PLUS for acute care only – 9/1/14
  - Texas Dual Eligible Integrated Care Project – 3/1/15
- Services added into managed care:
  - Children's Dental – 3/1/12
  - Pharmacy services– 3/1/12
  - Inpatient hospital services carved into STAR+PLUS – 3/1/12
  - Cognitive rehabilitation therapy services – 3/1/14
  - Mental health targeted case management and rehabilitation services; supported employment and employment assistance – 9/1/14
  - Nursing facility services – 3/1/15
  - Community First Choice – 6/1/15

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# Advantages of Managed Care

- Improve health outcomes, quality of care, and cost effectiveness
  - Value-added services such as 24-hour nurse lines, cell phones for high risk members, weight loss programs
  - Case-by-case services
  - Medical home through primary care provider
  - Emphasize preventive care and improve access to care
  - Care management and service coordination
  - Unlimited prescriptions for adults

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# Managed Care Quality Activities

- Texas uses a combination of established sets of measures and state-developed measures validated by its external quality review organization (EQRO).
- Consistent with CMS protocols, MCOs must develop and implement performance improvement projects (PIPs).
- Each MCO must develop, maintain, and operate a quality assessment and PIPs that meets state and federal requirements

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# Financial Incentives

- Pay-for-Quality
  - Provides MCO financial incentives and disincentives based on incremental improvement towards attainment goals.
  - Four percent of each MCO's capitation is at-risk.
  - Baseline year is 2013, and the first measurement year is 2014.
- Value-Based Purchasing
  - MCOs must submit to HHSC a written plan for provider payment structures that promote improved quality outcomes and increased efficiency.
  - Criteria for approval includes:
    - Number and diversity of providers
    - Geographic representation
    - Plan methodology
    - Data sharing strategy

# Member Feedback and Information

- MCO Report Cards
  - Each program service area has MCO report cards to allow members to easily compare the MCOs on specific quality measures.
  - Report cards are updated annually.
- National Core Indicators-Aging & Disabilities
  - The National Core Indicators-Aging and Disabilities (NCI-AD) survey will collect information on the experiences of individuals' receiving various LTSS.
  - HHSC is sampling STAR+PLUS members receiving LTSS.

# Member Feedback and Information

- Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Surveys
  - Texas' EQRO, the Institute for Child Health Policy (ICHP), conducts CAHPS surveys biannually.
  - Specific domains of the CAHPS surveys are included in annual MCO report cards.

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# Managed Care Extension Request

- HHSC plans to request to continue all of the existing managed care programs and initiatives that are authorized under the 1115 Transformation Waiver.
- HHSC will not request changes to the 1115 waiver related to managed care, but will continue to make managed care program improvements, including directives from the 84th Legislative Session.
  - Improved monitoring of MCO's network adequacy
  - Value based purchasing and aligning Medicaid quality strategies
  - Improved collaboration between managed care consumer support systems

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# Uncompensated Care and Delivery System Reform Incentive Payment Pools

# Uncompensated Care and DSRIP

- Under the waiver, savings from historical upper payment limit (UPL) funds and managed care are distributed to hospitals and other providers through:
  - Uncompensated Care (UC) Pool
    - Replaces UPL
    - Costs for care provided to individuals who have no third party coverage for hospital and other services and Medicaid shortfall
  - Delivery System Reform Incentive Payment (DSRIP) Pool
    - New program to support coordinated care and quality improvements through Regional Healthcare Partnerships (RHPs)
    - Transform delivery systems to improve care for individuals (including access, quality, and health outcomes), improve health for the population, and lower costs through efficiencies and improvements

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# UC and DSRIP

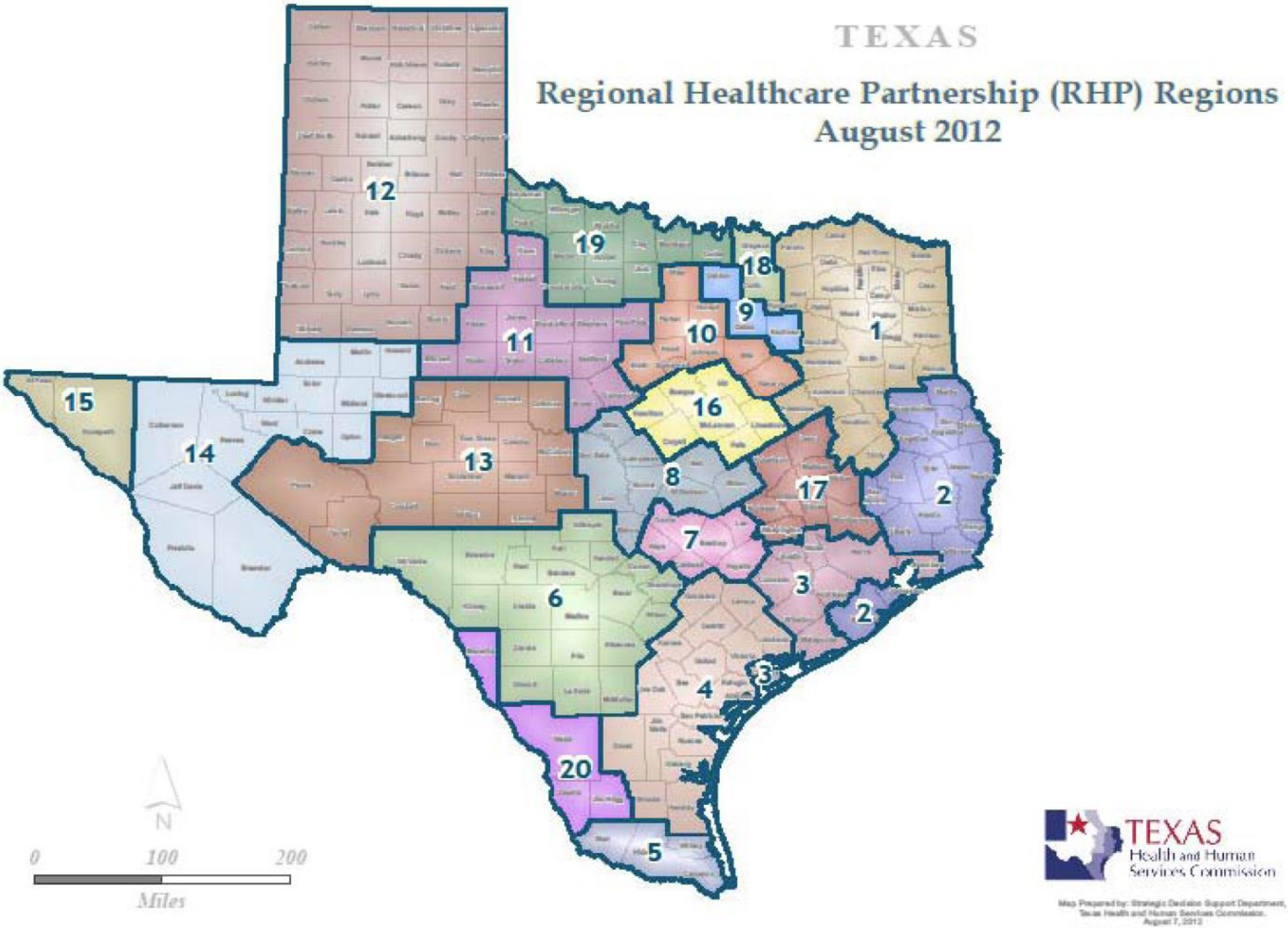
## UC & DSRIP Pool Funding Distribution (All Funds)

| Type of Pool | DY 1 (2011-2012) | DY 2 (2012- 2013) | DY 3 (2013- 2014) | DY 4 (2014-2015) | DY 5 (2015-2016) | Totals |
|---|---|---|---|---|---|---|
| UC | 3,700,000,000 | 3,900,000,000 | 3,534,000,000 | 3,348,000,000 | 3,100,000,000 | $17,582,000,000 |
| DSRIP | 500,000,000 | 2,300,000,000 | 2,666,000,000 | 2,852,000,000 | 3,100,000,000 | $11,418,000,000 |
| Total/DY | 4,200,000,000 | 6,200,000,000 | 6,200,000,000 | 6,200,000,000 | 6,200,000,000 | $29,000,000,000 |
| % UC | 88% | 63% | 57% | 54% | 50% | 60% |
| % DSRIP | 12% | 37% | 43% | 46% | 50% | 40% |

*The non-federal share for UC and DSRIP pool payments (approximately 42 percent) is from intergovernmental transfers (IGT) from local and state public entities.

# Regional Healthcare Partnerships

- Beginning October 1, 2012, to participate in DSRIP and UC, hospitals and other providers must participate in a Regional Healthcare Partnership (RHP).
- In May 2012, HHSC established 20 RHPs:
  - Each RHP is anchored by a public hospital or other public entity.
  - Each RHP submitted a plan that outlined priority community needs and DSRIP projects to improve regional health care delivery.
  - DSRIP target populations are Medicaid and low-income uninsured individuals.


TEXAS
Regional Healthcare Partnership (RHP) Regions
August 2012
12
19
18
9
10
1
11
15
16
14
13
8
17
2
7
3
6
2
3
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# DSRIP Status

- 1,457 active DSRIP projects
- 298 providers – hospitals (public and private), physician groups (mostly affiliated with academic health science centers), community mental health centers, and local health departments
- Major project focuses:
  - 25%+ - behavioral healthcare
  - 20% - access to primary care
  - 18% - chronic care management and helping patients with complex needs navigate the healthcare system
  - 9% - access to specialty care
  - 8% - health promotion and disease prevention
- Over $4.5 billion earned as of January 2015

# DSRIP Alignment with Medicaid Managed Care

- HHSC has worked to align DSRIP with Medicaid managed care quality initiatives, and will propose to further align them during the waiver extension period.
- The potentially preventable events (PPEs) for DSRIP Category 4 hospital reporting mirror the PPE methodology used for MCO Pay-for-Quality.
- HHSC is encouraging coordination between DSRIP projects and MCO performance improvement projects (PIPs).
- DSRIP is a form of value based purchasing (VBP) and will help inform VBP efforts in managed care.
- Best practices and lessons learned from DSRIP will inform Medicaid benefits and program design.

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# DSRIP Pool Extension Request

- Texas requests a $3.1 billion DSRIP pool each year of the extension (the demonstration year [DY] 5 pool level).
- More time is needed to evaluate DSRIP project outcomes and lessons learned.
  - Projects were approved one and a half to two and a half years into the five year waiver, they are relatively early in implementation.
  - Outcomes baseline data was reported in October 2014 to measure outcomes improvements in years four and five of the waiver.
  - The RHP structure has strengthened coordination within local systems of care.
  - Early results indicate many promising projects, but more information is needed to identify best practices and how to sustain and replicate them.

# DSRIP Pool Extension Request

HHSC proposes the following for DSRIP in the extension request. Programmatic details will be included in revisions to the DSRIP protocols that HHSC plans to submit to CMS in early 2016.

- Continue with the existing DSRIP program administrative structure, including the 20 RHPs and role of the anchoring entities to provide regional coordination and technical assistance.
- The majority of the current 1400+ active DSRIP projects will be eligible to continue into the extension period in order to give projects more time to demonstrate outcomes.
  - These projects may be required or encouraged to take a logical step toward transformation.
  - Some projects will not be eligible to continue based on review of the independent assessor and HHSC.

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# DSRIP Pool Extension Request

- Review the Category 3 outcome measure methodologies and how outcome measures align with projects. Texas may propose a structure to better align outcome measures with certain projects and to show meaningful improvement, including outcomes related to pediatrics and behavioral healthcare.
- Establish a new shared performance bonus pool from unearned funds over the course of the extension period (either because projects withdraw or fail to achieve milestones). If a region improves its performance on key measures, all participating providers in the region would be eligible to earn funds from the bonus pool.

# DSRIP Pool Extension Request

- Through the DSRIP protocols, HHSC may propose one or more of the following uses for funds from the $3.1 billion annual pool not allocated to continuing projects:
  - Alternate transformative projects from narrower menu based on lessons learned (potentially including cross-regional initiatives, related to the unique needs of rural Texas)
  - Bring smallest projects up to a minimum valuation level
  - Add funds to a shared performance bonus pool for regions that make improvements on key measures

# DSRIP Pool Extension Request

- Work to streamline the DSRIP program to lessen the administrative burden on providers while focusing on collecting the most important types of information:
  - Allow certain projects to be combined into a single project to reduce reporting burden
  - Reduce and standardize the number of metrics reported
  - Shorten or eliminate the achievement carry forward option (i.e. ability to achieve metrics/milestones in the following DY), but allow for partial achievement and payment for Quantifiable Patient Impact metrics similar to what is allowed for Category 3 performance currently

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# DSRIP Pool Extension Request

- HHSC proposes to further align DSRIP efforts with Texas' Medicaid managed care quality strategy and other value based payment efforts.
  - Develop a value based purchasing roadmap by late 2016 / early 2017 for the extension period.
  - Further align DSRIP and managed care quality measures where possible (e.g. consider some managed care P4Q measures for DSRIP shared performance bonus pool).
  - HHSC will provide CMS Medicaid and inpatient all-payer global trend data such as PPEs from 2012 through the extension period (by managed care plans/areas and RHP) to help show whether combined efforts are having an effect on key measures.

# DSRIP Pool Extension Request

- HHSC outlines in the extension request other ideas under consideration for the protocols to help evaluate the Medicaid impact of DSRIP projects and to further data exchange to support care coordination and systems of care.
  - Require DSRIP projects to report Medicaid IDs of patients served by the project.
  - Require all DSRIP and UC hospitals to provide emergency department admission, discharge, and transfer (ADT) information either to their regional HIE or a State-level HIE.
  - HHSC would provide Medicaid ADT information to Medicaid MCOs for them to share with providers to improve care coordination.

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# Uncompensated Care Pool

STC 44. Uncompensated Care (UC) Pool. Payments from this pool will help defray uncompensated costs of care provided to Medicaid or Demonstration eligibles or to individuals who have no sources of third party coverage, for services provided by hospitals or other providers.

Table 1. Uncompensated Care Pool by Waiver Year

| Type of Pool | DY1 FFY 2012 | DY2 FFY 2013 | DY3 FFY 2014 | DY4 FFY 2015 | DY5 FFY 2016 | Total |
|---|---|---|---|---|---|---|
| | (in billions) | | | | | |
| UC | $3.700 | $3.900 | $3.534 | $3.348 | $3.100 | $17.582 |
| UC - Non federal | $1.546 | $1.587 | $1.460 | $1.404 | $1.329 | $7.326 |

## Primary Features

1. Limited to unreimbursed costs for Medicaid and uninsured patients
2. Transparent to stakeholders, public and decision-makers

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# Uncompensated Care Pool

- The following types of providers are eligible to earn UC pool payments based on their costs related to the Medicaid shortfall (Medicaid payments less cost of care) and uncompensated costs of providing care to the uninsured:
  - Hospitals (public and private)
  - Physician groups that participated in the former Physician UPL Program
  - Public ambulance providers
  - Public dental providers
- As of June 2015, Texas has paid out a total of approximately $11.0 billion from the UC pool.
  - Hospitals - $10.4 billion
    - Public - $4.1 billion
    - Private - $6.3 billion
  - Physician groups - $294.3 million
  - Ambulance and Dental groups - $263.0 million

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# UC Allocation Methodology

- Intended to insure that hospitals that can IGT for themselves do not have excessive advantage over hospitals that cannot IGT for themselves.
- Distinct UC pools for each type of provider (including large public, small public, and private hospitals). If UC costs in a pool exceed the funds allocated to that pool, reduce payments to providers in the pool so that total payments from the pool do not exceed funds allocated to the pool.
- Pool sizes based on the ratio of each pool's "UC need" to the total of all pools' "UC need". "UC need" is based on each pool's sum of HSLs less payments made under DSH.
- Special protections for rural hospitals (hospitals located in counties of less than 60,000 people, critical access hospitals and sole community hospitals).
- Any unused pool funds will be used to offset $466 million "UPL debt" to CMS.

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# UC "Hair Cuts"

- UC pools are not large enough to cover all allowable UC costs.
- Proportional "haircuts" are applied within each pool.
- Demonstration Year One
  - Waiver Aggregate Limit = $3,700,000,000
  - Total allowable UC costs = $5,256,044,324
- Demonstration Year Two
  - Waiver Aggregate Limit = $3,900,000,000
  - Total allowable UC costs = $5,970,883,026
- Demonstration Year Three *
  - Waiver Aggregate Limit = $3,534,000,000
  - Total allowable UC costs = $5,751,244,792

* Five percent holdback pending litigation settlement

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# UC Pool Extension Request

- Texas' UC burden has not decreased, and the existing funding sources do not offset all UC costs for Medicaid and uninsured patients.
- Within budget neutrality, Texas requests a UC pool to support unmet UC costs - $5.8 billion in FY 2017, $6.6 billion in FY 2018 and $7.4 billion each year from FY 2019-2021.

| Texas Uncompensated Care - FY2014-FY2019 | | | | | | |
|---|---|---|---|---|---|---|
| *amounts in billions of dollars (actual and estimated)* | | | | | | |
| **Item** | **FY2014** | **FY2015** | **FY2016** | **FY2017** | **FY2018** | **FY2019** |
| UC & DSH Demand | 7.7 | 7.6 | 7.7 | 8.1 | 8.5 | 8.9 |
| UC Pool (Existing) | (3.5) | (3.3) | (3.1) | | | |
| DSH (reflects ACA Cuts) | (1.7) | (1.7) | (1.8) | (1.6) | (1.2) | (1.2) |
| ***UC Pool Required 2017-2019*** | | | | ***6.5*** | ***7.3*** | ***7.7*** |

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# Extension Request Summary

- When Texas submits its waiver extension request in September 2015, HHSC will request to continue all three components of the waiver – statewide managed care, the UC pool, and the DSRIP pool.
- Texas has made progress related to all five goals outlined in the waiver Special Terms and Conditions (STCs), and will propose program improvements to make further progress toward those goals to support and strengthen the healthcare delivery system for low-income Texans.
- The only change HHSC will request to the STCs is to extend the DSRIP and UC pools for five more years.

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# Next Steps

- HHSC will review input received during the 30-day public comment period (which ends August 5, 2015) to prepare the next draft of the extension request.
- In August, HHSC will post to its website a summary of public comments received and how they were incorporated into the extension request.
- By late August or early September, HHSC staff will submit the extension packet to the Governor's office for review and submission to CMS.
- By September 30, 2015, when the Governor's office submits the extension request to CMS, HHSC will post the extension packet to its website.

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# Public Input

More information on the extension request is available on the HHSC website at:

http://www.hhsc.state.tx.us/waiver-renewal.shtml.

Additional input on the extension request may be submitted through August 5, 2015 to TX_Medicaid_Waivers@hhsc.state.tx.us.

Comments?