Overview

• Provide the public with an update on the following 1115 Transformation waiver topics:
  • Health Information Technology (IT) Strategic Plan
  • Delivery System Reform Incentive Payment program (DSRIP)
  • Uncompensated Care
  • Upcoming Amendments
  • Links to the 1115 DY8 annual report and COVID-19 resources will be provided at the end of this presentation
  • Nursing Home Quality Incentive Payment Program
  • Opportunity for Public Comment
Health IT Strategic Plan

Special Terms and Conditions (STC) 39

- The plan consists of strategies and milestones related to Health IT adoption and health information exchange (HIE) in Texas, which will benefit stakeholders served by the 1115 waiver.
- Following public comment the plan was submitted to CMS in March 2020.
- The plan was approved by CMS in May 2020.
Health IT/Health Information Exchange (HIE) Strategies

Medicaid Provider HIE Connectivity
• This strategy is intended to assist Local HIEs with connecting the ambulatory providers and hospitals in their respective areas.

Texas Health Information Exchange (HIE) Infrastructure
• This strategy aids with building connectivity between the Texas Health Services Authority (THSA), which has a statutory charge to facilitate HIE statewide, and the state’s Local HIEs.
Health IT/Health Information Exchange (HIE) Strategies (cont.)

Emergency Department Encounter Notification (EDEN) system

- Texas statewide Health Information Exchange Plan promotes Local HIEs connecting hospitals to their information technology systems and exchanging Admission, Discharge, Transfer (ADT) messages.
DSRIP Update
Reporting Update

• April and October are the deadlines each demonstration year (DY) for providers to report performance data and earn payments.
• Payments for April achievement are made in July.
• Despite COVID-19 response by providers and flexibilities for reporting offered by HHSC, providers reported more measures than in previous reporting periods.
• Submitted data reflect calendar year 2019 achievement and support transition work to analyze current DSRIP data and successes.

Note: Demonstration Year 9 is Federal Fiscal Year 2020
# DSRIP Transition Plan

Texas must transition from DSRIP pool to sustainable reforms when DSRIP ends, Sept. 30, 2021

<table>
<thead>
<tr>
<th>Date</th>
<th>Key Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>By Oct. 1, 2019</td>
<td>HHSC submitted draft Transition Plan to CMS per the waiver special terms and conditions *</td>
</tr>
<tr>
<td>By April 1, 2020</td>
<td>HHSC and CMS must finalize the DSRIP Transition Plan; pending due to COVID-19</td>
</tr>
</tbody>
</table>

* DSRIP Federal Financial Participation (FFP) is at-risk if Texas fails to achieve milestones outlined in the plan.
Transition Plan Revisions

• Clarified the state’s commitment to advancing alternative payment models to promote healthcare quality

• Streamlined milestones to maximize efficiency

• Clarified that the Health Information Exchange connectivity project will support future delivery system reform goals by reducing barriers to provider participation in data exchange

• Clarified that the telemedicine and telehealth assessment results will inform HHSC strategies for continuing to further develop delivery system reform post waiver and enhancing access to care
Transition Plan Updates

• CMS has indicated they are ready to approve the Transition Plan, but have not formally done so because of focus on COVID-19 response
  • There are no penalties to HHSC for the delay in formal approval

• In recognition of the state’s focus on COVID-19 response, CMS offered HHSC the opportunity to amend milestone deliverable due dates
  • HHSC is assessing new deliverable due dates
  • HHSC is at risk for Federal Financial Participation (FFP) if they do not meet deliverable due dates.
Milestone: Develop Proposals for DY11 and Post-Waiver

Deliverable:
• Proposals to sustain healthcare transformation post DSRIP [DY11* and post-waiver]

Progress:
• Analyzing data, including populations served, Medicaid utilization, DSRIP successes and benefits
• Working with cross-agency groups to assess proposals and estimate fiscal impacts
• Reaching out to partners to aid in analysis
• Reviewing other state programs

*DY 11 is Federal Fiscal Year 2022
Other Milestone Progress

HHSC made progress on all Transition Plan milestones, including the following achievements:

• Received and began reviewing provider-submitted DY9 April performance data and cost and savings reports.

• Completed survey of MCOs on Quality Improvement cost guidance.

• Additional research into social drivers of health, including other states’ programs, evidence-based best practices, and successful DSRIP interventions.
Other Milestone Progress (cont.)

HHSC made progress on all Transition Plan milestones, including the following achievements:

• Conducted a survey of rural hospitals to assess current capacity and barriers to use of telemedicine.

• Conducted a survey of anchors and providers on the current Regional Healthcare Partnership structure and recommendations for post-DSRIP structure.
HHSC formed the BPW to engage DSRIP-specific stakeholders and build on DSRIP reporting data.

- Includes DSRIP participating providers, Executive Waiver Committee members, and anchors
- Each Workgroup member selected two Focus Areas to represent their areas of expertise
- Kicked off January 8, 2020
Best Practices
Workgroup (BPW) (cont.)

HHSC formed the BPW to engage DSRIP-specific stakeholders and build on DSRIP reporting data.

• Have completed Survey 1, prioritizing measures from DSRIP key to driving improvements in health status of clients
• Have completed first round of Survey 2, prioritizing the practices from DSRIP key to driving improvements in health status
Nursing Facility Quality Incentive Payment Program Update
Nursing Facility Quality Incentive Payment Program

- **Year 3** – CMS approved waivers to QIPP requirements for COVID-19 response, effective March 1, 2020.
  - Component 1: waived submission of monthly Quality Assurance and Performance Improvement Validation reports.
  - Performance requirements derived from facility-reported Minimum Data Set assessments are waived:
    - Component 3: all three quality measures (component converted to rate increase).
    - Component 4: one of three infection control measure
- **Year 4** – Preprint under review. Pool size > $1 billion.
Uncompensated Care Update
Medicaid Client Services and Supplemental and Directed Payments, FFY 2019, $43.1 Billion*

*Includes all Medicaid client services expenditures and supplemental payment programs, and excludes administrative costs, survey and certification, and vendor drug rebate revenue.

**Other Supplemental Payment Programs include All Funds: QIPP ($424 million), NAIP ($413 million), GME ($123 million), and ICF UPL ($5.9 million)
Medicaid Client Services and Supplemental and Directed Payments by Method of Finance, FFY 2019, $43.1 Billion* (All Funds)

- Regular Medicaid - Federal $17.94 billion, 42%
- Regular Medicaid - General Revenue $12.9 billion, 30%
- Supplemental Payments - Federal $7.14 billion, 16%
- Supplemental Payments - IGT $5.12 billion, 12%

*Includes all Medicaid client services expenditures and supplemental payment programs, and excludes administrative costs, survey and certification, and

Source: FFY 2019 CMS Historical Report
Estimated Texas Medicaid Inpatient and Outpatient Hospital Payments (SFY 2019) and Hospital Supplemental and Directed Payments (FFY 2019), $15.94 Billion* (All Funds)

- Hospital - Inpatient: $4.37 billion, 28%
- Hospital - Outpatient: $2.92 billion, 18%
- Supplemental Payments - Federal: $5.03 billion, 31%
- Supplemental Payments - IGT: $3.62 billion, 23%
- Supplemental Payments - UC: $2.09 billion, 13%
- Supplemental Payments - DSRIP: $1.49 billion, 9%
- Supplemental Payments - DSH: $1.14 billion, 7%
- Supplemental Payments - NAIP/GME: $0.32 billion, 2%

*Includes all Medicaid client services expenditures and supplemental and directed payment programs, and excludes administrative costs, survey and certification, and vendor drug rebate revenue.

## FFY 2020 Estimates - Including Supplemental and Directed Payments to Hospitals, ISDs, Nursing Facilities and ICF/IIDs

<table>
<thead>
<tr>
<th>Program</th>
<th>Supplemental Payment?</th>
<th>Primary Provider Beneficiaries</th>
<th>Other Provider Beneficiaries</th>
<th>State Funds (in billions)</th>
<th>IGT&lt;sup&gt;1&lt;/sup&gt; (in billions)</th>
<th>Federal Funds (in billions)</th>
<th>Total Funds (in billions)</th>
<th>Payment Basis</th>
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<tbody>
<tr>
<td>Medicaid Client Services</td>
<td>No</td>
<td>All Medicaid Providers</td>
<td>None</td>
<td>$12.12</td>
<td>$0.00</td>
<td>$18.88</td>
<td>$31.00</td>
<td>Provision of services</td>
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<tr>
<td>UC</td>
<td>Yes</td>
<td>Hospitals</td>
<td>Local Mental Health Authorities, other</td>
<td>$0.00</td>
<td>$1.51</td>
<td>$2.36</td>
<td>$3.87</td>
<td>Charity Care Only</td>
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<tr>
<td>DSRIP</td>
<td>Yes</td>
<td>Hospitals</td>
<td>Certain physician group practices, public ambulance and dental</td>
<td>$0.00</td>
<td>$1.14</td>
<td>$1.77</td>
<td>$2.91</td>
<td>Achievement of metrics</td>
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<tr>
<td>DSH</td>
<td>Yes</td>
<td>Hospitals</td>
<td>None</td>
<td>$0.00</td>
<td>$0.71</td>
<td>$1.10</td>
<td>$1.81</td>
<td>Uncompensated care: Medicaid shortfall + uninsured cost (not charges)</td>
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<tr>
<td>UHRIP</td>
<td>Directed Payment</td>
<td>Hospitals</td>
<td>None</td>
<td>$0.00</td>
<td>$0.62</td>
<td>$0.98</td>
<td>$1.60</td>
<td>Based on utilization, rate increase</td>
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<tr>
<td>NAIP</td>
<td>Directed Payment</td>
<td>Public Hospitals</td>
<td>None</td>
<td>$0.00</td>
<td>$0.17</td>
<td>$0.26</td>
<td>$0.42</td>
<td>Pass-through payment to Health-related Institutions (HRIs) and Public Hospitals</td>
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<tr>
<td>GME</td>
<td>Yes</td>
<td>Public Hospitals</td>
<td>None</td>
<td>$0.00</td>
<td>$0.01</td>
<td>$0.02</td>
<td>$0.04</td>
<td>Based on cost, FTEs, and utilization</td>
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<td>Hospital Supplemental Payment Subtotal</td>
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<td></td>
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<td>$0.00</td>
<td>$4.16</td>
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<td>SHARS</td>
<td>Yes</td>
<td>Public schools</td>
<td>None</td>
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<td>$0.47</td>
<td>$0.73</td>
<td>$1.20</td>
<td>Medicaid allowable cost</td>
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<td>QIPP</td>
<td>Directed Payment</td>
<td>Public Nursing Facilities</td>
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<td>$0.40</td>
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<td>Achievement of quality metrics</td>
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<tr>
<td>ICF UPL</td>
<td>Yes</td>
<td>Public ICF/IIDs</td>
<td>None</td>
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<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>Difference between estimate of Medicare and Medicaid rates</td>
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<tr>
<td>Other Supplemental Payment Subtotal</td>
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<td>$0.00</td>
<td>$0.73</td>
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<tr>
<td>Supplemental Payment Subtotal</td>
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<td>$0.00</td>
<td>$4.89</td>
<td>$7.62</td>
<td>$12.50</td>
<td>Supplemental Payments = 28.9% of Total Medicaid Provider Payments</td>
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<td><strong>Grand Total</strong></td>
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<td></td>
<td><strong>$12.12</strong></td>
<td><strong>$4.89</strong></td>
<td><strong>$26.50</strong></td>
<td><strong>$43.50</strong></td>
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Uncompensated Care (UC)

- **Authority**: §1115 Waiver
- **Implementation**: December 2011
- **FFY 2020 Estimate**: $3.87 Billion
- **Funding**: Non-federal share provided by participating local governmental entities; public funds transferred to HHSC through intergovernmental transfers (IGTs) and local provider participation funds (LPPFs)
- **Participants**: Public and private hospitals, public ambulance providers, physicians, and public dental providers
Uncompensated Care (UC) (cont.)

- **Authorized Uses of Funds**: Beginning October 1, 2019, UC payments can only reimburse health care providers for charity care provided to uninsured individuals.
  - UC payments can no longer reimburse providers for the Medicaid shortfall or bad debt.
- **Quality Component**: None.
Future Amendments
Web Links to Resources

• 1115 Transformation Waiver Demonstration Year (DY8) annual report
  https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/waiver-overview-background-resources

• COVID-19 provider resources
  https://hhs.texas.gov/services/health/coronavirus-covid-19/medicaid-chip-services-information-providers
Public Comment

**HHSC will now receive public comments.**

Submit comments via the question box on the GoToWebinar dashboard.
Thank you

TX_Medicaid_Waivers@hhsc.state.tx.us