CASE STUDY

HEALTH MANAGEMENT ASSOCIATES

Medicaid Waivers and Payment Models

MARYLAND

Creation of an All-Payer Model Progression Plan

HMA is providing strategic support to Maryland in an effort to clinically and financially integrate services through the All-Payer Model demonstration project. The APM Progression Plan provides a framework for the alignment of long-term care, specialty care and other vital services to focus on chronic and complex patients, contain cost-growth and improve the quality of care for these patients.

View the PDF
http://www.hscrc.maryland.gov/documents/md-maphs/pr/Maryland-All-Payer-Model-Progression-Plan.pdf

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VERMONT

THE CLIENT

The State of Vermont (Governor's Office of Health Reform and the Green Mountain Care Board)

THE CHALLENGE

In 2014, state leaders decided that Vermont should request authority from the Centers for Medicare and Medicaid Services (CMS) to include Medicare in a comprehensive delivery system reform that would enable a common regulatory and provider reimbursement framework and a consistent and aligned set of quality measures across all major healthcare payers. The state needed to develop and negotiate this federal-state agreement, known as an All-Payer Model Agreement.

THE APPROACH

Health Management Associates (HMA) and its subcontractor Optumas began in April 2015 to support the development of Vermont's All-Payer Model Agreement. The process was complex and multi-faceted and included the following elements:

+ Significant education from the HMA team to state staff about the elements of a Model Agreement based on a recently-established similar agreement between CMS and the state of Maryland.

+ Ongoing engagement of state stakeholders who were working through design details of the ACO model

+ Presentation of analysis to the state based on Vermont claims data or expenditure analysis reports to help inform the negotiating position

+ Regular communication with CMS and the need to appreciate CMS preferences and operational parameters in the development of Vermont's proposals.

THE RESULTS

On October 27, 2016, Governor Peter Shumlin, Green Mountain Care Board Chairman Al Gobeille and Vermont Agency of Human Services Secretary Hal Cohen signed the Model Agreement, adding their signatures to those of President Barack Obama and Sylvia Burwell, Secretary of the U.S. Department of Health and Human Services. The Model Agreement authorizes Vermont to operate an All-Payer Model beginning January 1, 2018, and sets the policy and financial terms of the delivery system reform. Under the agreement, Vermont will:

+ Regulate an ACO program based on the federal Next Generation model, which will be aligned across all three payers (Medicare, Medicaid and commercial insurance)

+ Constrain growth for all-payer covered services to less than 3.5 percent

+ Limit growth in Medicare to a set amount (0.1 or 0.2 percent) below national federal growth projections for Medicare

+ Establish ACO benchmarks that comply with the financial targets

+ Meet ACO "scale targets" intended to ensure that the delivery reform model is adopted across all payers

+ Retain Medicare funding for primary care transformation through Vermont's Blueprint for Health.

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CASE STUDY

HEALTH MANAGEMENT ASSOCIATES

TEXAS

THE CLIENT

Texas Health and Human Services Commission

THE CHALLENGE

In December 2011, Texas received approval of the Texas Healthcare Transformation and Quality Improvement Program, a Medicaid Section 1115 waiver. As a condition of the waiver renewal, CMS required the Texas Health and Human Services Commission (HHSC) to commission an independent study of the state's uncompensated care costs and payments, the impact of environmental factors, and potential policy changes. HHSC hired Health Management Associates (HMA) to conduct the study.

THE APPROACH

In April 2016, HHSC hired HMA to conduct the Uncompensated Care (UC) study for submission to CMS by August 30th. As required by the waiver Special Terms and Conditions, our evaluation included the following key areas of analysis:

+ A detailed description of the composition of current Medicaid hospital payments
+ Analysis of Medicaid financing and how the non-federal match is funded
+ Estimated costs incurred by hospitals to provide services to Medicaid beneficiaries compared to corresponding payments received
+ Estimated cost of uncompensated care and the portion of care attributed to charity care
+ Analysis of the adequacy of Medicaid payments in relation to cost incurred by hospitals
+ Assessment of recent economic and environmental trends within Texas that may impact future reimbursement levels and the cost of caring for low-income populations
+ Estimated financial impact of: 1) implementing a Medicaid expansion for low-income adults; 2) Medicaid Disproportionate Share (DSH) reduction required by the Affordable Care Act (ACA); 3) reestablishing supplemental upper payment limit (UPL) payments; and 4) fully funding Medicaid hospital costs through payment rates.

The evaluation included extensive quantitative analysis of detailed financial data provided by 356 hospitals participating in the Texas Medicaid DSH/UC Poll program. We also researched and evaluated demographic and economic factors related to the healthcare market and the impact on health services provided to uninsured residents. As needed, we conferred with hospital representatives to clarify questions regarding the data and participated in several stakeholder meetings to discuss project activities and findings.

CASE STUDY

HEALTH MANAGEMENT ASSOCIATES

THE RESULTS

Our evaluation resulted in a comprehensive report with the following key findings:

+ Texas hospitals face significant uncompensated care burden, estimated at $5.2 billion prior to supplemental pool payments in FY 2015. When Medicaid shortfall is included, unreimbursed costs grow to $8.7 billion. Before supplemental payments are considered, the payment to cost percentage across all hospitals is 48.4 percent. After the application of Graduate Medical Education (GME) and DSH payments as offsets to cost, the payment to cost percentage across participating hospitals increases to 58.8 percent.

+ Using a process that imputes the value of charity care based on the definition adopted by the Healthcare Financial Management Association (HFMA), and applying the "imputed charity care" factor to uninsured bad debt, we estimated $4.2 billion of the $5.2 billion of uninsured cost is attributed to charity care, and the remainder is bad debt.

+ In FY 2015, DSH payments to Texas hospitals totaled $1.72 billion, which offset approximately 10 percent of uncompensated care. Under the most favorable assumptions for the state, reductions in DSH allotments scheduled to begin in FY 2018 will range from $134 million in 2018 to $537 million in FY 2025. Under the least favorable conditions, the cuts will range from $386 million in FY 2018 to $1,534 million in 2025.

+ While the implementation of a Medicaid expansion would blunt the impact to a certain degree, it would not come close to eliminating the uncompensated care burden in the state.

+ Without payments from the 1115 waiver, Texas hospitals could incur $8.2 billion in unreimbursed Medicaid and uninsured care even after a Medicaid expansion. Including unreimbursed costs from the physician groups, ambulance providers and dental providers that currently receive a portion of the UC Pool payments adds $420 million to this amount, yielding a combined total in excess of $8.6 billion.

These findings are among the numerous key issues that CMS continues to negotiate with HHSC. As discussions regarding the waiver renewal continue, HMA is providing additional assistance as needed pending a final decision by CMS.

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