The Road to Risk

October 20, 2016

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CMS Goals – Volume to Value (2015)

- 30% of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016. Tying 50%of payments to these models by the end of 2018.

- HHS also set a goal of tying 85% of all traditional Medicare payments to quality or value by 2016 and 90% by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs.

Government Payment Programs Encouraging Risk Models

What is MACRA?

- The Medicare Access and CHIP Reauthorization Act of 2015
- MACRA contains
  - Physician Fee Schedule (PFS) updates
  - A new Merit-Based Incentive Payment System (MIPS)
  - A new Technical Advisory Committee for assessing Physician Focused Payment Model (PFPM) proposals and
  - Incentive payments for participation in Alternative Payment Models (APMs)

MACRA: Three Important Changes

- Ending the Sustainable Growth Rate (SGR) formula for determining Medicare payments providers
- Making a new framework for rewarding health care providers for giving better care not just more care
- Combining our existing quality reporting programs into one new system

The Quality Payment Program (QPP)

Two Components:

1. Merit Based Incentive Payment System (MIPS)
2. Alternative Payment Models (APMs)

MIPS

MIPS

- MIPS
  - compresses the Physician Quality Reporting System (“PQRS”), the Value Modifier (“VM”), and the Medicare Electronic Health Record (“EHR”) incentive programs into a single system,
  - evaluates clinicians across four categories and provides a single score

- CMS then uses the score output to determine whether a clinician receives a fee increase, a fee reduction, or no change at all

4 MIPS Categories

1. **Quality** accounts for 50% of a clinician's score in the first year. Clinicians choose to report six quality measures.

2. **Cost** (also called "**Resource Use**") represents 10% of a clinician's score in the first year. The score is based on Medicare claims, which means no reporting requirement for clinicians - uses more than 40 episode-specific measures.

4 MIPS Categories (cont'd)

3. **Clinical Practice Improvement Activities** constitute 15% of a clinician's score in the first year. This metric rewards physicians for clinical practice improvement activities, including those focused on care coordination, beneficiary engagement, and patient safety.

4. **Advancing Care Information** (also known as "**Meaningful Use**") constitutes 25% of a clinician's score in the first year. Clinicians report customizable measures that reflect how they use EHR technology in their day-to-day practices - does not require all-or-nothing EHR measurement or quarterly reporting.

MIPS Payment Adjustments

- The maximum payment adjustment amount starts at 4% in 2019 and incrementally increases to 9% in 2022 and onward
- For 2019 to 2024, there will also be an additional payment adjustment given to the highest MIPS performers for exceptional performance

APM

What is a Medicare APM?

- A CMMI model under section 1115A (other than a Health Care Innovation Award)
- Medicare Shared Savings Program (MSSP)
- A demonstration under the Health Care Quality Demonstration Program or
- A demonstration required by Federal law

An Eligible Alternative Payment Entity

- Eligible alternative payment entity means, with respect to a year, an entity that:
  - uses certified electronic health record technology;
  - pays clinicians based on measures of quality comparable to those used for MIPS; and
  - adopts a Medicaid Medical Home Model <u>or</u> bears more than a nominal amount of financial risk

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Incentive Payments for Qualifying Participants

- In 2019, participants must have at least 25% of their Medicare payments linked to performance.
- In 2022, participants must have at least 75% of their Medicare payments linked to performance.
- CMS exempts Advanced APM providers from MIPS adjustments and instead gives them a lump sum incentive payment equal to 5% of the prior year's estimated aggregate expenditures under the fee schedule.
- Physicians that participate in Advanced APMs will receive an annual across the board fee increase of 0.75% in 2026, higher than the 0.25% annual increase scheduled for MIPS.

Qualifying APM Models

- Comprehensive End Stage Renal Disease Care Model (Large Dialysis Organization arrangement)
- Comprehensive Primary Care Plus
- Medicare Shared Savings Program (Tracks 2 and 3)
- Next Generation ACO Model
- Oncology Care Model – Two Sided Risk Arrangement
- Medicare ACO Track 1+**

Comprehensive End Stage Renal Disease Care Model

- These are organizations in which dialysis clinics, nephrologists, and other providers join to coordinate care for beneficiaries suffering from end-stage renal disease.
- They must possess at least 350 beneficiaries matched to their organization
- These organizations become clinically and financially responsible for all care given to their matched beneficiaries, not just for dialysis care or care that relates to ESRD.
- If model includes a Large Dialysis Organization ("LDO") - a chain that has 200 or more dialysis facilities – the LDO must share liability with CMS for both savings and losses associated with patients' cost of care.

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Comprehensive Primary Care Plus

- CPC+ offers 2 Tracks
- For both Tracks 1 and Track 2, payers provide prospective monthly care management fees to practices based on beneficiary risk tiers.
- Medicare care management fees average to $15 per-beneficiary per-month across four risk tiers in Track 1 and $28 per-beneficiary per-month across five risk tiers in Track 2.

Medicare Shared Savings Program (Tracks 2 and 3)

- Accountable Care Organizations
  - must have at least 5,000 assigned Medicare Fee-For-Service beneficiaries
  - must establish a governing body that represents ACO participants and Medicare beneficiaries
  - must engage in routine self-evaluation to ensure they continuously improve the care delivered to Medicare patients
  - Two of the three options require ACOs to share in both Medicare savings and losses and, therefore, qualify as Advanced APMs
    (Max. risk: Track 2 – 60%; Track 3 – 70%)

Next Generation ACO Model

- Highest risk
- Employs a prospectively set benchmark for how much an ACO should spend, which CMS determines by considering historical information, regional trends, and risk scores for the ACO's population
- Tests the ability of ACOs to assume almost all financial risk by providing two risk arrangements that determine the portion of the savings or losses that accrue to the Next Generation ACO
  - Arrangement A - ACOs have an 80% sharing rate for years 1-3 and 85% for years 4-5
  - Arrangement B - ACOs have a 100% sharing rate
  - Both cap total savings or losses at 15% of the benchmark

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Next Generation ACO Model (cont'd)

Four payment mechanism options:

1. Nominal FFS Payment
   - Payment from CMS for services through the normal fee-for-service channels at standard payment levels

2. Nominal FFS Payment + Monthly Infrastructure Payment
   - Normal fee-for-service payment plus an additional per-beneficiary per-month payment to invest in infrastructure to support ACO activities.
   - CMS will make the infrastructure payment at a rate of no more than $6 per-beneficiary per-month

Next Generation ACO Model (cont'd)

3. Population-Based Payments ("PBPs")
   – PBPs constitute an estimate of the aggregate amount by which fee-for-service payments will be reduced for Medicare Part A and B services rendered by PBP-participating Next Generation participants and preferred providers who agree to receive reduced fee-for-service payments when providing care to aligned beneficiaries during the upcoming performance year.

Next Generation ACO Model (cont'd)

4. All-Inclusive Population-Based Payments ("AIPBP")
   - Beginning 2017, AIPBPs will be determined by estimating the total annual expenditures for care furnished to beneficiaries by Next Generation participants and preferred providers who have agreed to participate in AIPBP. CMS will pay that projected amount to the ACO in a PBPM payment.
   - It is responsible for paying claims for its Next Generation participants and preferred providers with which the ACO has written agreements regarding participation in AIPBP.

Oncology Care Model – Two Sided Risk Arrangement

- Participants must provide enhanced services, including
  - The core functions of patient navigation
  - A care plan that contains the 13 components in the Institute of Medicine Care Management Plan outlined in the Institute of Medicine report, “Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis”
  - Patient access 24 hours a day, 7 days a week to an appropriate clinician who has real-time access to practice’s medical records and
  - Treatment with therapies consistent with nationally recognized clinical guidelines

Oncology Care Model – Two Sided Risk Arrangement

- OCM participants receive regular Medicare FFS payments during the model. In addition, OCM-FFS uses a two-part payment approach for participating oncology practices, creating incentives to improve the quality of care and furnish enhanced services for beneficiaries undergoing chemotherapy treatment for a cancer diagnosis.
- These two forms of payment include:
  - a Monthly Enhanced Oncology Services Payment of $160 per-beneficiary for delivery of OCM enhanced services, and
  - a Performance-Based Payment for OCM Episodes

What is Happening on the Commercial Side?

Providers say…

- Payors are unwilling to share risk
  - 66.7% of hospital C-Suite leaders are interested in pairing up with a provider-owned health plan
  - 28.8% of providers said they participate in shared savings contracts with commercial payers
  - 13.6% of providers said payers are investing in infrastructure to support value-based programs

- Payors are helping to coordinate care
  - 45.8% of providers said they are working more closely with insurers on coordinating care
  - 42.4% payers are providing incremental payments to primary care physicians for care management

"Providers say commercial payers are unwilling to share risk" Modern Healthcare, October 12, 2016

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What Infrastructure Is Necessary for a Value Based Program to Be Successful?

Population Health
Methodist Health System's Solution

Laura L. Irvine, FACHE
EVP Integration and Alignment
Methodist Health System

MPCACO Success to date

Performance Year One (2012-2013)
- $12,717,281 savings
- 78% aggregate quality score
- #13 in the nation
- 220 providers
- 13,000 lives

Performance Year Two (2014)
- $12,612,997 savings
- 85.12% aggregate quality score
- Highest reported quality in N TX
- 330 providers
- 14,700 lives

Performance Year Three (2015)
- $18,718,445
- #13 in the nation
- 90.8% aggregate quality score
- 458 providers/32 specialties
- Contracts with Cigna, BCBS, UHC, CMS
- Partnerships with BSWQA, Catalyst

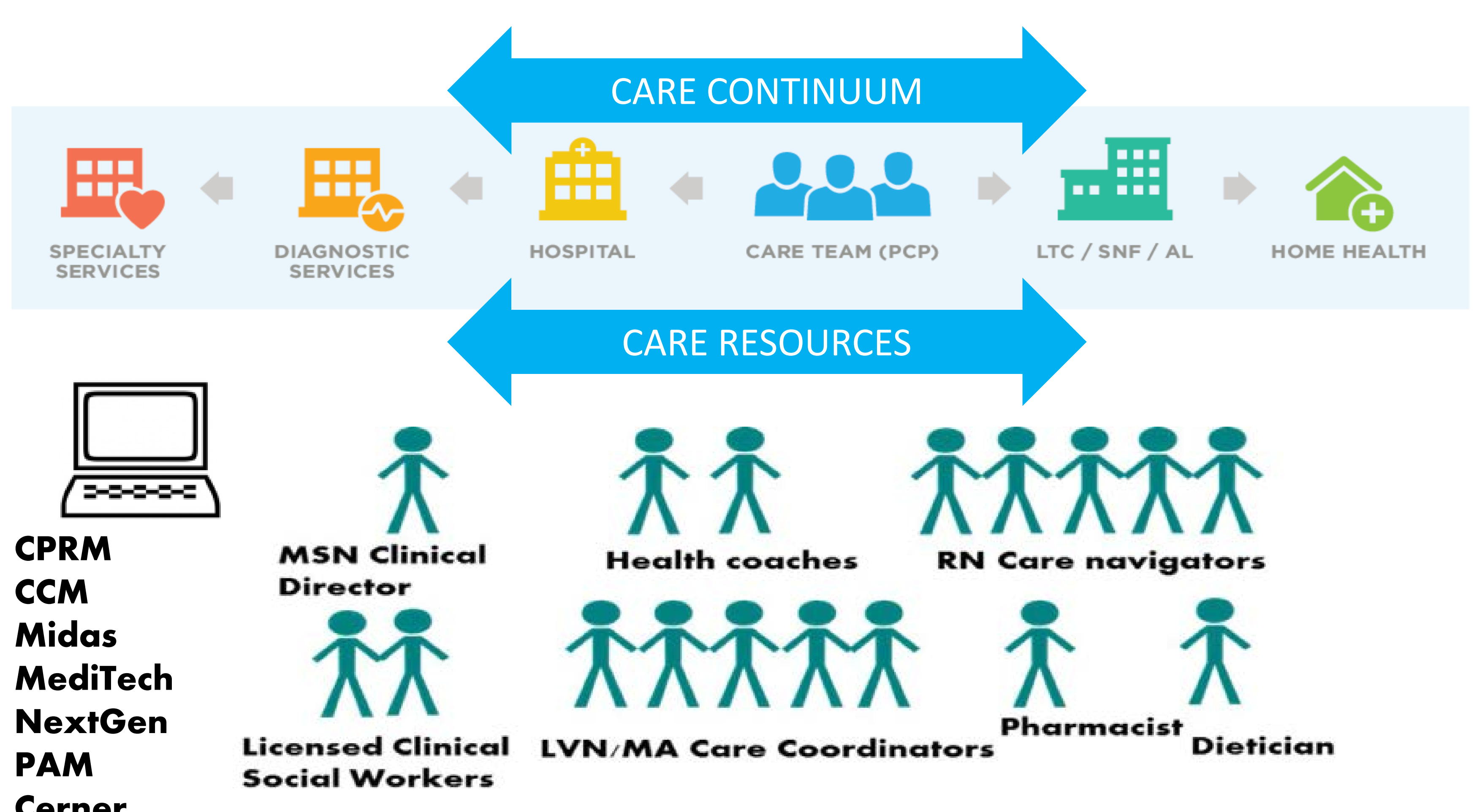
Net $19,789,106 to MHS

$6,828,915 shared

with physician practices

Navigator Program Benefits: Coordinated Patient Care

A team of RNs and care professionals is available to support physicians in coordinating care across the continuum.



Conley Cervantes
AVP Integrated Care Networks

Tenet's ACO Footprint

18 Clinically Integrated ACO Networks Nationwide

32%

Primary Care Physicians in Tenet ACOs

- **83% of Tenet Medicare ACOs generated savings to Medicare in 2015, compared to 52% nationally**
- **Tenet's BCBSTX ACO was the only hospital ACO program to earn a bonus in 2015**

Build momentum, then scale with experience

2013

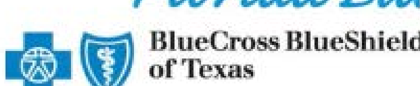
313K lives

Medicare ACOs in 6 markets

2016

826K lives

Medicare ACOs in 15 markets



Risk Arrangements: The Front Lines

Lessons from the Trenches: West Coast

- Providence Health & Services
  - 50 hospitals in the Western U.S.—recent affiliations with St. Joseph of Orange system and Swedish Medical Center
  - Substantial managed medical groups in Northern California, Southern California, Oregon and Washington
  - Significant operations in heavily capitated and highly competitive markets
  - Religious mission

Lessons from the Trenches: West Coast

- Risk Strategy
  - Integration of medical groups under Foundation Model and common branding of physician services and adjusting physician compensation models toward risk
  - Coordination and centralization of contracting across physician organizations
  - Risk sharing between physician organizations and hospitals
  - Optimization of assets and service offerings based on most efficient setting for care and strategic investment in outpatient services providers
  - Development of infrastructure for population health management
  - Development of a private label health plan in California to assume delegated risk
  - Direct contracting with large employers—Boeing, Intel, Nike

Lessons from the Trenches: East Coast

- Trivergent Health Alliance
  - Cooperative venture of three regional hospitals in Maryland
  - Maryland has a unique hospital reimbursement system, with hospital rates regulated by a state agency, rather than negotiated with health plans and some hospitals under a global payment system
  - Hospitals are adjusting to global payments by various tactics, including encouraging the development of outpatient facilities and strengthening primary care physician groups
  - Regional hospitals at risk due to expansion of networks by Johns Hopkins, University of Maryland and MedStar as well as proximity to academic medical centers in Baltimore and Washington, D.C.
  - Challenges due to wide variation in patient demographics—age, relative health, income disparities

Lessons from the Trenches: East Coast

- Risk Strategy
  - Focus on decreasing acute care costs and preservation of market share, preparing for global payments
  - Synergy study led to the formation of a cooperative management services organization, centralizing certain services such as pharmacy, laboratory, purchasing, billing and staffing for nurses and emergency departments, to reduce costs and improve operating margins
  - Trivergent alliance partners are developing a population health strategy, building on an existing ACO participating in the MSSP and studies of potential clinical synergies and efficiencies

The Delivery of Health & Welfare Benefits to Healthcare Systems and Providers

October 20, 2016

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Strategic Development

Traditional Total Rewards/Health & Welfare Program

The Reward Structure Supports the HR Strategy ("The People Plan")

- Business Strategy
  - HR Strategy
    - Total Rewards
      - Compensation
      - Health & Welfare
        - Benefits
        - Retirement
      - Work/Life
        - Time Off
      - Performance & Recognition
      - Development & Career Opportunities

Strategic Development
Healthcare System/Provider

Business Strategy

HR Strategy

Total Rewards

- Compensation
- Health & Welfare
  - Benefits
  - Retirement
- Work/Life
  - Time Off
- Performance & Recognition
- Development & Career Opportunities

Mission
Demonstration
Population Health
Wellbeing
Wellness
Healthcare

Common Issues for Health Care Companies

- Cost Pressures
  - Revenue and margin pressure demands intense focus on cost reduction and management
    - Third-party costs
    - Total compensation
  - Health Reform
- Competition for Skilled Labor
  - Availability of credentialed labor essential
    - Market shortage of key skills
    - Correctly skilled employees on the job at the right time
  - Can lead to overpaying for talent or organization

Common Issues for Health Care Companies

- Balance of Roles: Employer and Provider
  - Roles as employer sponsor
    - Dominant financial support
    - Design to achieve labor goals
    - Fiduciary responsibility
    - Third-party scrutiny and management
  - Roles as health care provider
    - Incentive to provide domestic care
    - Revenue opportunity
    - Employee and patient privacy merge
- Unique Workforce Characteristics
  - 24/7/365; 12-hour shifts
  - Broad range of skills
  - High percentage female
  - Caregiver complex

Issues and Challenges Vary in the Healthcare Sector

- Healthcare segments
  - Acute versus post-acute
- Demographics
- Domestic utilization
  - What was purely an economic play has become a demonstration
- Communication challenges
- Employee privacy/shifting of disease management, wellness and population health to providers
- Leave management
  - Time off, PTO, extended illness banks

Compliance Considerations

- Organizational Structure
  - MEWA
- Corporate Practice of Medicine
- ERISA Fiduciary
  - Plan decisions: exclusive benefit of the participants
  - Prohibited transactions
- ACA tracking and reporting
  - PRN
  - Post-acute: paid by visit
  - Affordability
- Non-discrimination: Section 1557 rules
  - Healthcare organizations that receive federal payments (i.e: Medicare and Medicaid reimbursements)
  - Transgender care
  - Notice requirement

Health Care Nondiscrimination Rule

- ACA Section 1557 prohibits discrimination in certain health care programs and activities on the basis of race, color, national origin, sex, age, or disability
- The Department of Health and Human Services (HHS) issued final rules under ACA Section 1557 in May 2016
  - The final rules identify gender identity discrimination and sexual stereotyping as forms of sex discrimination

ABOUT THE RULE

The rule is generally effective on July 18, 2016

For plan design purposes, the rule is effective the first plan year beginning **on or after January 1, 2017.**

Health Care Nondiscrimination Rule

RELIGIOUS ORGANIZATIONS

The final rule does not contain an exemption mechanism for religious organizations

The rule indicates that sufficient ability to object on religious grounds is available under existing law such as the **Religious Freedom Restoration Act.**

A religious organization that does not intend to comply should consider documenting its objection and the basis for its exemption **from ACA Section 1557.**

Health Care Nondiscrimination Rule

- A “covered entity” subject to the final rules means:

  1. An entity that operates a health program or activity, any part of which receives Federal financial assistance;

  2. An entity established under ACA Title I that administers a health program or activity (e.g. a state-run health insurance marketplace); and

  3. Health programs or activities administered by HHS itself (e.g. the federal health insurance marketplace).

- The final rules are also applied to federal government contractors even if they are not covered entities

Health Care Nondiscrimination Rule

- An entity that operates a health program or activity, any part of which receives Federal financial assistance, would include:
  - A health care system or provider who accepts Medicare Parts A or D or Medicaid
    - o Note: The rules will also apply to the benefits offered by the health care system or provider to its own employees
  - An insurance carrier and/or third party administrator receiving federal funding through participation in the public insurance marketplace
    - o HHS interprets the rule to impact an insurance carrier's and/or third-party administrator's entire book of business
    - o A TPA is not responsible for discrimination due to a plan sponsor's self-insured plan design decisions beyond the TPA's control

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Health Care Nondiscrimination Rule

- Employers who merely provide benefits to their employees but who are not primarily engaged in the business of providing or administering health services or health insurance coverage are not covered entities under ACA Section 1557

- HHS does not have the authority to pursue an employer whose self-insured plan design may be discriminatory under ACA Section 1557

  - For fully-insured plans, HHS has authority over the insurance carrier if it receives federal funding

- HHS will refer matters outside its jurisdiction to other agencies

  - For example, a matter involving an employer's discriminatory self-insured plan design may be referred to the Equal Employment Opportunity Commission (EEOC) who will determine it meets the requirements for an EEOC charge

Health Care Nondiscrimination Rule

- Plans are not required to coverage all health care services related to gender transition, but explicit coverage exclusions for all services is discriminatory
  - Medical management techniques must be reasonable and neutral and their evaluation for compliance will include whether similar services are available under the plan for non-transgendered participants (e.g. hormone therapy, hysterectomies, mastectomies, tracheal shaves, etc.)
  - Certain services available for reconstruction may be avoidable for original “construction” (e.g. breast implants, phalloplasty, vaginoplasty, etc.)
- Sex-specific health care cannot be denied or limited just because the person seeking the services identifies as belonging to another gender but providers are not required to expand services offered
  - A covered provider or plan cannot deny treatment for ovarian cancer for an individual born a woman but identifying as a transgendered man

Health Care Nondiscrimination Rule

- A covered entity must provide a notice to patients or plan participants stating:

1. The covered entity does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities;
2. The covered entity will provide appropriate auxiliary aids and services free of charge to individuals, when needed;
3. The covered entity will provide language assistance services free of charge, when needed;
4. Information on how an individual can obtain the auxiliary aids and language assistance services;
5. The contact information for the individual responsible for the covered entity's compliance with Section 1557, if applicable;
6. Information regarding the grievance procedure for any action prohibited by Section 1557, if applicable; and
7. Information on how to file a discrimination complaint with the Office for Civil Rights.

Health Care Nondiscrimination Rule

- The notice must be posted in conspicuous locations (e.g. break room, patient waiting room) and included in significant publications describing services or benefits

- The notice must provide a statement of language assistance services in at least the top 15 non-English languages spoken in the State where the covered entity is located or does business (model statements available here: http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html)

- A model notice is available in the appendix to the final regulations

- The notice requirement went into effect for covered entities on October 16, 2016

Healthcare Delivery
Case Studies

Custom Network Development

Plan Option 1

TIER 1

Domestic and Select Facilities

Physicians Affiliated with Domestic and Select Provider Facilities

TIER 2

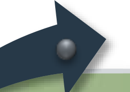
All Major Facilities
Physicians Contracted with Administrator's Narrow Network

TWO TIER NETWORK APPROACH

Steerage Through Benefits to Tier 1 Facilities & Providers

RETAINED 2ND OPTION FOR EMPLOYEE CHOICE

All Major Facilities and Physician Groups

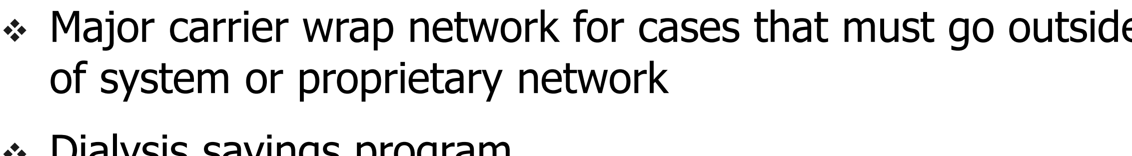


Employer Win

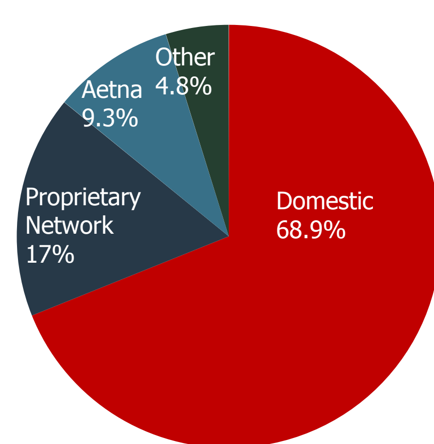
- Projected savings of $26M over a three-year period
- Steerage to quality providers who have demonstrated favorable outcomes

Building a Medical Home

- Direct provider contracts to fill gaps in services system does not offer



- Major carrier wrap network for cases that must go outside of system or proprietary network
- Dialysis savings program
- Medical management to steer care back to system in all possible instances



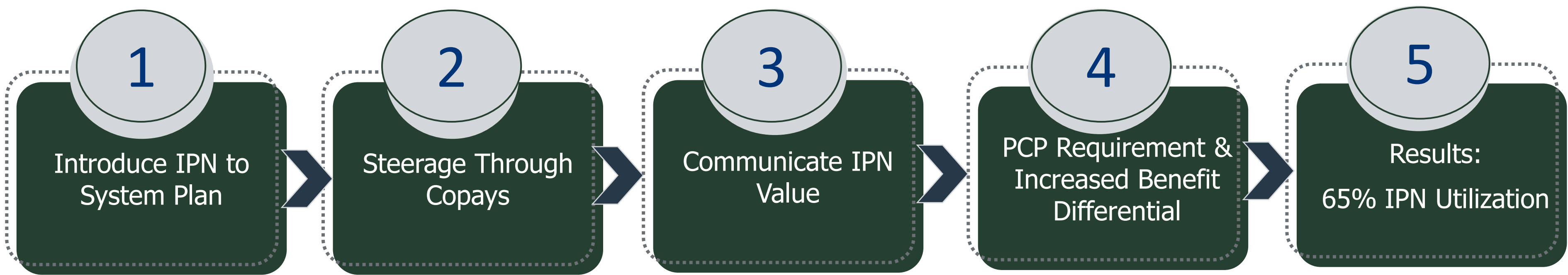
- Primary care clinics and urgent care facilities within system
- Medical home arrangement for target disease states with member benefit for compliance
- Care management
  - Staff health coach for early intervention
  - Care coordinators for pre-visit counseling
  - Nurse navigators for chronic condition management
- Plan design that promotes consumerism
- Electronic medical records for sharing patient data across system

Introducing an Integrated Physician Network

GOALS

- ❖ Build an integrated physician network (IPN)
- ❖ Create provider accountability for patient health
- ❖ Deliver commercial market product

PROCESS



CHALLENGES

- ❖ IPN provider utilization was not tracked prior to network build
- ❖ Reimbursement rate required to attract providers to IPN

Health Risk Management Case Study

About ABC Healthcare System

- Own/lease 5 acute care hospitals and 5 long term acute care hospitals in Texas, New Mexico, Kentucky, and North Carolina
- Approximately 3,000 employees
- Corporate office in Plano
- Decentralized infrastructures and cultures at each location
- Similar to most hospitals, had high medical claims and an unhealthy work force
- Benefit design to drive domestic utilization

Historical Strategy

Year 1

Implemented new online enrollment and benefit administration platform funded by commissions from voluntary products (whole life and critical illness

Introduced formal **participation** based wellness program and provided $200 annual employee contribution incentive (34% participation)

Year 2

Changed medical and pharmacy vendors for optimal administration and improved network discounts

Moved to disincentive model with $500 differential for employees to **participate** in the wellness program (50% participation)

Year 3

Introduced outcome-based wellness program and measurements for Year 4

Implemented **outcome-based** wellness program with 20% disincentive ($1,440 per year)

Measurements Include:

- BMI
- Tobacco Use
- Blood Pressure
- Cholesterol
- All valued at $30 per metric met

Year 4

Continued **outcome-based** wellness program with 25% disincentive ($1,740 per year)

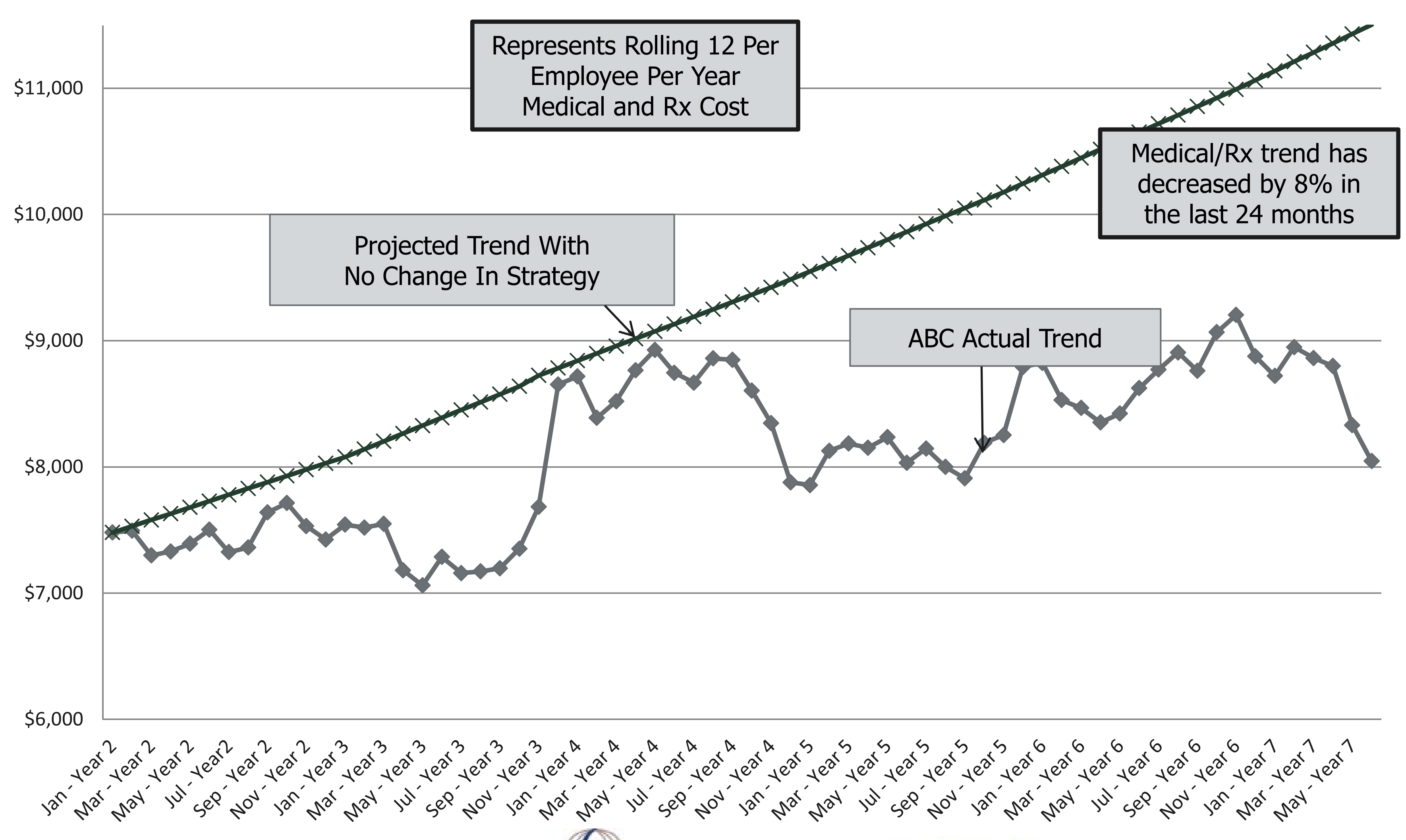
Year 5

Continued outcome based wellness program with $1,740 per year differential. Spouses now required to meet biometric measurements or pay up to an additional $1,740 per year.

Year 6

Introduced full replacement HSA medical plan offering for Year 6

Impact of Historical Strategy
Medical / Rx Claims Trend



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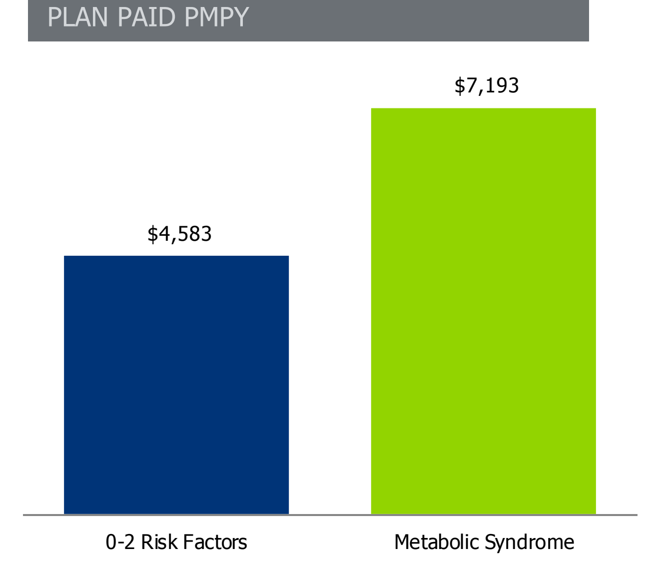
Metabolic Syndrome Analysis

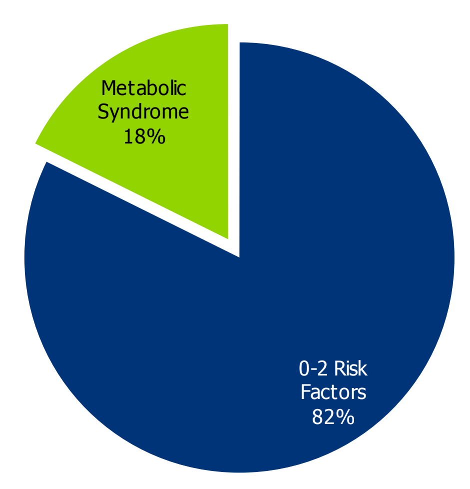
Prevalence of MetS has reduced from 37% in Year 2 to 18% in Year 6

Overall Year 6 Tested Population

PLAN PAID PMPY



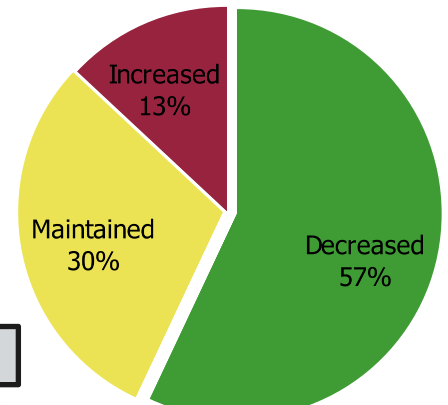
% OF PARTICIPANTS



Cohort Group (Year 5 vs. Year 6)

Members with Metabolic Syndrome in Year 1 by Movement in Year 2			
	Decreased	Maintained	Increased
Number of Members	118	62	27
Average Age	52.7	53.3	50.4
% Female	68.6%	69.4%	59.3%
RRS	1.88	1.74	1.62
RCGI	3.21	2.69	2.89
Average # of Chronic Conditions	2.1	1.8	1.6
% $0 Paid Claims	5.1%	3.2%	14.8%
PMPY Paid Amount	$6,955	$6,561	$9,056

% OF PARTICIPANTS WITH CHANGES IN RISK FACTORS



57% of members with MetS in 2013 decreased at least one risk factor in Year 6

Executive Summary

Year 6 Results (Compared to Year 5)

- Employee participation continues to increase
  - Increased from 79% to 82%
- Significant improvement in spouse participation
  - Increased from 53% to 63%
- Engaged population continues to see improvement in risk factors:
  - Employees at Risk:
    - BMI / Waist = 17% reduction
    - Blood Pressure = 9% reduction
    - Cholesterol Ratio = 15% reduction
- Spouses overall results are improving
  - Prevalence of Metabolic Syndrome decreased from 29% to 23%
  - At-risk for BMI reduced from 45% to 37%
  - At-risk for Blood Pressure reduced from 32% to 28%

Biometric Analysis
Risk Factors Cohort – All Members

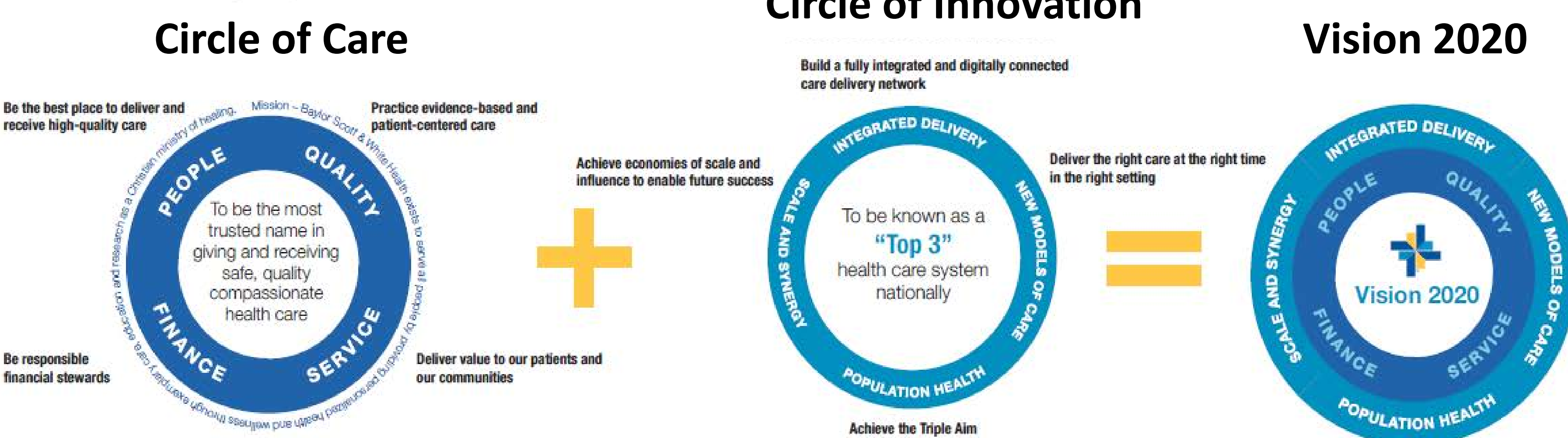
Employees and Spouses, N = 991

TEST	RISK CATEGORY	CATEGORY PARAMETERS	EMPLOYEES AT RISK YEAR 5 #		EMPLOYEES AT RISK YEAR 5 %		EMPLOYEES AT RISK YEAR 6 #		EMPLOYEES AT RISK YEAR 6 %		PERCENT CHANGE
Cholesterol	Moderate	≥ 200	251	327	25.33%	33.00%	228	306	23.01%	30.88%	-6.42%
	High	≥ 240	76		7.67%		78		7.87%		
LDL	Moderate	≥ 130	169	227	17.05%	22.91%	144	204	14.53%	20.59%	-10.13%
	High	≥ 160	58		5.85%		60		6.05%		
HDL	Moderate	≤ 50 or 40*	211	258	21.29%	26.03%	177	238	17.86%	24.02%	-7.75%
	High	≤ 40 or 30*	47		4.74%		61		6.16%		
Ratio	Moderate	≥ 4.5	78	169	7.87%	17.05%	63	143	6.36%	14.43%	-15.38%
	High	≥ 5.0	91		9.18%		80		8.07%		
Triglycerides	Moderate	≥ 150	110	202	11.10%	20.38%	123	206	12.41%	20.79%	1.98%
	High	≥ 200	92		9.28%		83		8.38%		
Glucose	Moderate	≥ 100 or 140	164	212	16.55%	21.39%	154	203	15.54%	20.48%	-4.25%
	High	≥ 126 or 200**	48		4.84%		49		4.94%		
BMI / Waist***	Moderate	≥ 25; ≥ 35 or 40*	308	545	31.08%	54.99%	298	451	30.07%	45.51%	-17.25%
	High	≥ 30; ≥ 40 or 45*	237		23.92%		153		15.44%		
Blood Pressure	Moderate	≥ 130 / 85	211	229	21.29%	23.11%	199	208	20.08%	20.99%	-9.17%
	High	≥ 160 / 100	18		1.82%		9		0.91%		

* Denotes values for females and males.
** Denotes values for fasting and non-fasting individuals.
*** If waist circumference was missing, BMI was used. If both values are present, the better value was used.

BSWQA Driving Population Health Management

BSWQA: An Important *Play* in the BSWH Playbook



FY15 System Goals

People: Be the best place to deliver and receive high-quality care

Quality: Practice evidence-based and patient-centered care

Service: Deliver value to our patients and our communities

Finance: Be responsible financial stewards

★ ***Population Health:*** *Improve population health and establish the future model for health care delivery in America*

Network Overview

BaylorScott&White
QUALITY ALLIANCE

North Texas

Physician Members

Central Texas

North Texas		Central Texas	
Primary Care	766	Primary Care	286
Specialist	2,726	Specialist	823
PCMH	88 Sites 364 Providers	PCMH	58 Sites 281 Providers

Total : 4,601

PCP: 1,052

SCP: 3,549

ACO to ACO Collaborations: 611 physicians

Improving Access-to-Care

Consumer-driven access initiatives reach beyond traditional access points

Traditional Access Point

Consumer Oriented Access Points

Office Visit

ED

Retail Clinics

minute clinic

Team-based Care

Patient Access Center

FollowMyHealth Universal Health Record

eVisits

MDLIVE

Telehealth

Extended Hours

Population Health Analytics

It's about insights… not numbers

CLARIFY

Identify the population

PREDICT

Risk-stratify • predict • proactively engage

MEASURE

What are our outcomes?

Transforming Culture

ACO Success

Depends on physicians across a spectrum of care altering their behavior and **transitioning their way of thinking** so that value-based performance metrics and accountability is achieved

Providers and practices **are changing to adapt to the BSWQA population health asks**

Access ▶ Performance ▶ Documentation

ACO APPROACH

- **Joint Operations Council (JOC) meetings**
- **Data-driven presentations –** *down to provider and practice level*
- **Educating Physicians on Population Health Landscape**
- **BSWQA achieving contract performance metrics**

Comprehensive Care Management (CCM) Goals

Support BSWQA physician success in value-based healthcare

Empower patients to effectively manage their chronic disease(s)

Reduce overall healthcare expense by maintaining patients in their home environment

Complex Care Management

High-Risk (5%)

- PCP Referrals
- Risk Stratification
- Inpatient Transitions

→ **RN Care Manager Intervenes by Protocol**

Review/Revise Care Plan →

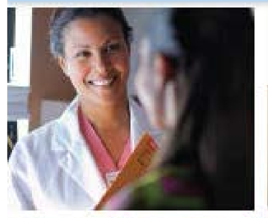
Primary Care Physician

← Review/Revise Care Plan

HealthAccess

***Dedicated* toll-free phone number**

Thank you for selecting
Aetna Whole Health℠ – Baylor Scott & White Quality Alliance
as your new health care plan.



Our network of primary care and specialty doctors at Baylor Scott & White Quality Alliance has the expertise to address virtually every medical need at a care site near you.

Find a BSWQA Doctor.
Call 1.844.279.7589

- Find a Baylor Scott & White Quality Alliance primary care physician
- Schedule appointments
- Request a referral

Wellness – Thrive Goals

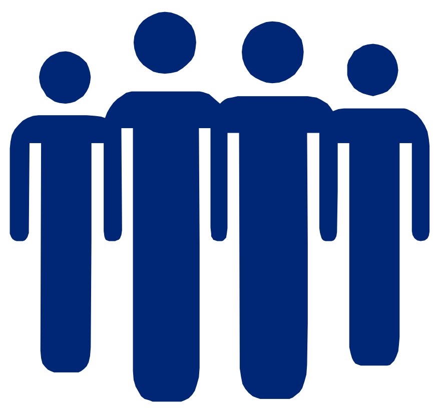
thrive

- Deeper integration with the BSWQA/DM team
  - Referrals between Wellness as employees move from getting their chronic conditions managed to maintaining/improving their overall health
- Improve the direct tie-in with benefit premiums
- Currently using participation-based incentives, and evaluating incentives based on outcomes for the future
- Continue to leverage social media and other scalable communication tools

Scott & White Health Plan

Continue to work to deliver a great member experience

- Scott & White Health Plan administers all employee medical plans (HRA, HSA and PPO) as of 2016
- Leveraging in-house expertise and excellent service delivery abilities
- More opportunities to improve care and health



BSWH – Employee Plan

Bringing it all together

BSWQA and SWHP

- **Tier One employee plan** = Join the BSWQA and contracted with SWHP
- Monitor gaps in coverage and fill as necessary based on standards of access
- Call BSWQA Health Access or visit SWHP employee portal

Understanding Medical Challenges

- Rising costs are a major issue nationwide
- We review costs annually to ensure that employee costs are competitive in the market
- Nationwide market trend is an expected 7-8 % increase
- Systemwide, the majority of our plans cost the same or less than in 2015 and 2016
- Access to quality care

Shared Strategies for Managing Cost Impact

- To help cover the cost of care, the BSWH provides funding through the consumer driven plan design…..CDHPs can help you be smarter about health care
  - Studies show enrollees more likely to:
    - Check coverage and costs before getting services
    - Use wellness programs
    - Talk to their doctor about care options and costs
    - Put together a health care budget
- Lower premiums for low income employees
- All employees can reduce premium costs with $30 per-pay-period wellness credit for participation in Thrive
- Employee costs for medical services are significantly lower for care in the Tier One Preferred Network (primarily BSWQA)
- Use of Tier One is growing

Vision to Support Goals

- Achieve alignment of communication strategies
  - Consumers can be employees
- Synergies of network strategy, well built out
- Service Centers
  - Dedicated, highly engaged quality & speed of answer
- Integrated, aligned tools to manage care
- Insourced HR delivery strategy
- Ease of care: for the right fit at the right time

Telemedicine and Healthcare Technology Trends

October 20, 2016

Nora Belcher, Texas e-Health Alliance
Julie Hall-Barrow, Children's Health
David Phillips, BRG
Gavin George, Haynes and Boone (Moderator)

Haynes and Boone, LLP haynesboone.com

Lockton lockton.com

BRG Healthcare thinkbrg.com

Nora Belcher, Texas e-Health Alliance

Internet Revolution- Value to Users

Internet use exploded once content became accessible and useful.

% U.S. Households Using the Internet at Home

70	60	50	40	30	20	10	0

Computer developed - IBM

TCP/IP Standard

ARPANET

Microsoft

First e-mail sent

WWW HTML

CompuServe

Prodigy

AOL

Mosaic Web Browser

Google

ORBITZ

ING DIRECT Save your money

facebook

twitter

YAHOO!

ebay

WebMD Better information. Better health.

WIKIPEDIA

YouTube

amazon

UBER

HIT Today

1930 1950 1960 1970 1980 1990 1995 1997 2000 2001 2003 2007

Today, health care information technology (HIT) is at the "2001" of the Internet age

Source: U.S. Census Bureau, Population Division, Education & Social Stratification Branch, "Reported Internet Usage for Households, by Selected Householder Characteristics,:2007"; Texas eHealth Alliance: Nora Belcher

What Do We See When We Look Ahead?

Transformational technologies will create new markets

	Wave One	Wave Two	Wave Three
IoT		Smart Home Smart Buildings	Wireless Electricity
Smart Machines		Robots Virtual Assistants	Emotional AI Nanobots
Immersive Experiences		Augmented Reality Virtual Reality	Brain-Machine Interface Haptic Holography
Hypermobility		Wearables	Human Augmentation Personalized Healthcare
3D Transformation		3D Printing	4D printing

Legislative Interest Changes Over Time

Health IT Bills in The Texas Legislature

22
21
30
11
10
9
9
9
9
7
7
6
6
4
3
2
1
0 0 0 0 0

1995 1997 1999 2001 2003 2005 2007 2009 2011 2013 2015

Telemed Filed
HIT filed

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Topics for the Legislature in 2017

- Cybersecurity
  - Multiple interim studies
  - Healthcare already highly regulated
- Health Professional Boards Sunset
- Privacy
  - Property right to DNA
  - Data mining
- Telemedicine
  - The Texas e-Health Alliance, the Texas Medical Association and the Texas Academy of Family Physicians have agreed to work on an agreed-to telemedicine bill for session. Physician concerns include state licensure, standards of care and insurance reimbursement.
  - A working group of a cross-section of stakeholders has been assembled to review the relevant statutes.

What Does It All Mean?

- Health information technology (such as telemedicine) has three major components by which it succeeds or fails in any state, country or program:
  - Regulation
  - Reimbursement
  - Rhetoric
- The current Texas landscape…
  - Medicaid has shifted in terms of policy and now views HIT as an essential tool in the move to value based purchasing
  - Commercial insurers are aggressively pursuing virtual care models
  - Scope of practice was the battleground issue- now it's reimbursement

Julie Hall-Barrow, Children’s Health

About Children's Health

- **Two full-service hospitals** (Dallas and Plano) dedicated exclusively to pediatric care
- More than **50 specialties and subspecialties**
- Outpatient **pediatric imaging** and **surgery centers**
- **Pediatric Group** primary care locations
- **Clinically integrated network** of more than 300 private pediatricians
- Full range of **community health offerings** including school-based **TeleHealth** and **faith-based** programs
- Children's Health **Home Care**
- Children's Health **Telemedicine**
- Children's **Research Institute** at UT Southwestern
- Population Health offerings including an HMO, ACO, MSO and the Health and Wellness Alliance for Children

Extending Care into Our Community

Large, Growing Market

- **1 of 9 children** in U.S. live in Texas

Significant Community Needs

- **29%** of Dallas County children **live in poverty**
- **2 of 3 children need financial assistance**
- **7 out of every 10** public school children in Dallas County eligible **for free and reduced-price meals**
- **18%** of Dallas County children are **uninsured**
- **Only 31%** of TX physicians accept new Medicaid patients (down from 42% in 2010)

We offer programs in:

- ✓ Asthma Management
- ✓ Weight Management
- ✓ Injury Prevention
- ✓ Behavioral Health
- ✓ The Health and Wellness Alliance
- ✓ $65 million in direct charity care

Significant Pediatric Medical Needs

- **50,000** children in N. Texas with asthma
- **36%** of Dallas County kids are overweight or obese
- **28%** of Dallas County children are **malnourished**
- **30%** of toddlers **not fully immunized**

BRG Healthcare

Virtual Health Today @ Children's Health

TeleER/TeleNICU
- Interactive consults on critically-ill children for stabilization & evaluation for transport

Hospital TeleConsultations (non-emergent)
- Neonatology (Sub-specialty)
- Neuro-Immunology

Technology Enabled Remote Study Interpretations
- Cardiology (Echos, etc.)
- Ophthalmology (ROP)
- Radiology (1st & 2nd Reads)

Hospital

Office/Clinic/School

Behavioral Health

Plastics

Neurodevelopmental

Neurology

Acute Care

Home

Remote Patient Monitoring

Asthma (Propeller)

Mobile Apps

Virtual Visit

LOCKTON
Lockton Dunning Benefits

BRG
Healthcare

Why School Telehealth?

- Trusted Partner
- Link between health and learning
- Access

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Where we are…

- Launched Fall 2014
  - 26 K-12 schools
  - Training/Education
  - Mocks
  - Technical Support
    - 1-844-Telemed
- 2015
  - 57 schools
  - Grades K-12
  - Rural, Urban, Charter and ISD's
- 2016
  - 97 schools

Privileged and Confidential

Highlights

- Over 4500 visits have been completed through telemedicine.
- Over 125 nurses were trained and completed telemedicine competencies.
- Live Dashboard for technology and visits.
- Expansion to complete strep/flu testing at point of care.
- Chronic Disease Management
  - Asthma
  - Obesity
- Communication with PCP or connect with a PCP.
- Behavioral Health pilot to launch 2017.

Privileged and Confidential

Legislation and Expansion

- Texas 84th Legislature
- House Bill 1878

HOME | NEWS | EDITORIALS | HEALTH | BUSINESS | COMMUNITY | LIFESTYLE | BLACK EXPERIENCE | VOTER ROLL CALL

Children's Health expands telemedicine to 30 additional schools

A physician consults with a school nurse using the Children's Health School-Based Telehealth Program. CHILDREN'S HEALTH

Special to *The Dallas Examiner*

Also of interest

Children's Health, the leading pediatric health care system in North Texas, officially announced it has expanded its School-Based Telehealth Program to include 30 additional schools in Dallas, Grayson, Collin and Tarrant counties.

FOR A LIMITED TIME

Qualified Wells Fargo customers get special interest rate discounts on Personal Loans and Lines of Credit

› Learn More

The Great Rate Event

FEATURED VIDEOS

Interview: Cast of 'East...

TeleNICU

- In 2012, Children’s Health designed the neonatal-specific telemedicine program – TeleNICU
- Implementation with the first partner began in September 2013. TeleNICU was designed to benefit key stakeholders
  - Families
  - Affiliates
  - Payers
  - Children's Health and UT Southwestern
- Expansion to ER in 2015.

Twenty-four hour access to Level IV NICU, expert UT Southwestern board-certified neonatologists and pediatric subspecialists to interpret medical data, confirm diagnoses and confer on treatment plans.

Inpatient-Consults

Neuro-Immunology

- Limited specialists
- Service-line specific
- Non-dependent on a nurse or other personnel to accompany
- Operated from a mobile device (tablet/iPad)
- Mapped by floor – physician can select any pre-mapped room or drive the robot to the destination

Injury Prevention

- Medical car seats

The RP-VITA has enabled us to evaluate and consult with families and patients as needed – regardless of where I am. While away at research meetings or for any other reason, I can stay connected with our patients and assist in their complex care. It gives me the capability of doing thorough evaluations while not relying on other staff members to "bring" me to rooms. It is the next best thing to being there in person.
– Benjamin Greenberg, MD

Remote Patient Monitoring

The Remote Patient Monitoring (RPM) program enables Children's Health to monitor and connect with patients with chronic diseases, post-surgery or who may need monitoring after discharge.

Medication Compliance

HEALTH CARE AUG 19

Children's Health Dallas testing 'digitized drugs' with sensors inside

Sabriya Rice, Business of Healthcare Reporter

SENSOR INGREDIENTS

Silicon: 0.9mg - Bananas have 5mg per 100 grams
Copper: 0.02mg - Cashews have 2.2mg per 100 grams
Magnesium: 0.01mg - Halibut has 107mg per 100 grams

THE FIRST COMPUTER POWERED BY YOU

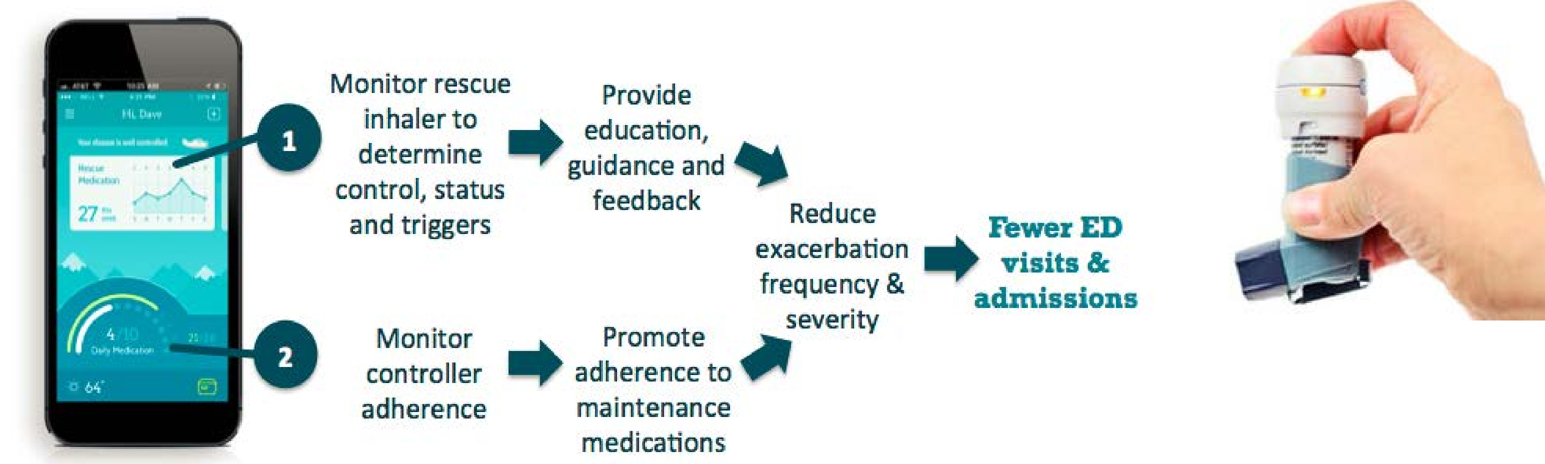
Cleared by U.S. FDA, CE Marked in Europe
Designed to be combined with drugs
Supported by technology and data platform

+

+

Propeller

The Propeller solution pairs sensor-enabled asthma device with clinical outreach in order to potentially improve asthma management. The pilot program was launched in October 2014 to high risk asthma patients meeting the study criteria.



My Asthma Pal

iPhone Apps

Asthma

My Asthma Pal
Health & Fitness

My Asthma Pal is a mobile app designed to enhance asthma self-management and education, with the long-term goal of reducing preventable events, such as Asthma-related ED admissions.

Family Health On Call

FamilyHealth On Call

About | Team | Pricing | FAQs | Contact | Blog | Schedule a Visit

Appointments on your schedule.

Same-day or next-day visits
8 a.m. to 8 p.m.* daily

Schedule a Visit

HOW FAMILY HEALTH℠ ON CALL WORKS

STEP 1
Download our app

STEP 2
Request a visit.

STEP 3
Rest. We'll be there soon.

Family Health On Call

Family Health SM On Call (formerly Mend) delivers high-quality care right on your doorstep. And best of all, you can book your appointment right on your smartphone, tablet or computer.
Simply download our app, request a visit and rest. Our team of highly experienced, board-certified physicians, physician assistants and nurse practitioners will be there shortly. We'll diagnose and treat you right in the comfort of your home, office or just about anywhere.

It's the same great care Mend brought you, just with a new name. It's On Call. It's care on your schedule. On your doorstep.

On Call treats:

- Ear, Nose & Throat
- Respiratory
- Gastro Intestinal
- Illnesses
- Eye
- Skin
- Injuries
- Flu Shots
- Physicals

Family Health Virtual Visit

Getting sick is never convenient. But now seeing a health care provider can be with Family Health℠ Virtual Visit. Using video technology, we're delivering high-quality care right to you, right at your local pharmacy – or for that matter, virtually anywhere.

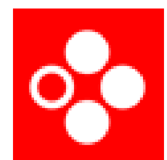
After you're seen in our Virtual Visit Kiosk at Dougherty's Pharmacy, you can download our app or use our web portal to videoconference with a highly experienced health care provider. Get treated right in the comfort of your home, office or virtually anywhere you go, right from your smartphone, tablet or computer for a number of illnesses and injuries, like:

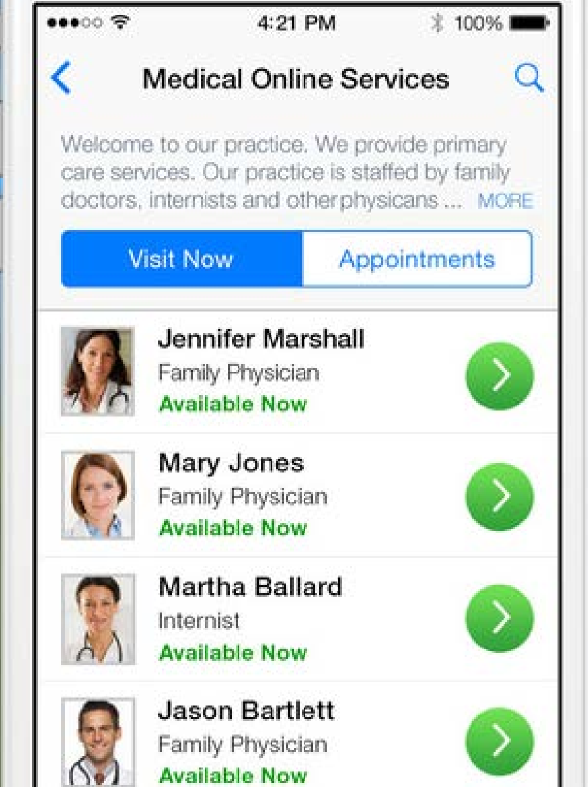
- Flu
- Allergies
- Sinusitis
- Common Cold
- Ear, Nose, and Throat Infections
- Urinary Tract Infections
- Cuts
- Skin Infections, Burns and Rashes

When you're done, fill your prescription with your pharmacy or at Dougherty's. It's that easy. It's Virtual Visit. It's care on your time to get you on your way to feeling better.

Family Health Virtual Visit App

iOS and Android





David Phillips, Berkeley Research Group

An ever-more connected world . . .

Internet of Things (IoT)

- 50 billion devices connect to the Internet by 2020
  - 7 connected devices per person

Goods & Services
- Track materials
- Speed distribution
- Product feedback

Communities
- Traffic status
- Pollution alerts
- Infrastructure checks

Environment
- Pollution checks
- Resource status
- Water monitoring

Homes
- Utilities control
- Security monitoring
- Structure integrity

People
- Wellness monitoring
- Medical case management
- Social needs

haynesboone LOCKTON Lockton Dunning Benefits BRG Healthcare

Internet of Medical Things (IoMT)

Explosive Growth in Embedded Devices

- Medical device market size of $132 billion by 2020
- American Telemedicine Association:
  - 58% of people over age 65 are now using the internet
  - 53% of those say the reason they get on line is to access health information
  - Either for their individual benefits, research topics for themselves, or getting access to direct medical advice

Everything from insulin pumps, catheters, Core Body Temp, portable a-fib monitoring (ECG),

Broad Risks with IoT Healthcare

- Little to no security testing
- Built in default passwords / shared passwords
- Unencrypted patient data
- Misconfigured or poor security settings
- Failure to install manufacturer software updates
- Vulnerable to malware infection
- Denial-of-service attacks – wired or wireless

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Technology Evolution in Telemedicine

Reaching the Masses – Finally

- Proprietary hardware, expensive, slow to change, dedicated to this one purpose
- Now using common HW, commodity pricing, quicker changes, multi-function
- Network robustness has grown exponentially to allow HD quality video as a stable feature
- New Con: No guarantee of a quality experience.
  - When you own the hardware (like Apple) you can customize, following required design specs, etc.
  - Using commodity h/w means people might short memory in the purchasing process, have a lower quality display, etc.

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Telemedicine Links to ERM

- Telemedicine integration with ERM and Data Analytics
  - Must support documentation on consult for reimbursement (non-manual integration)
  - Enhance clinical effectiveness – track outcomes
  - Track patient engagement
  - Again, moving away from proprietary solutions
  - Emerging seamless ERM integration that allow patient data to be visible to the clinician at the point of care and to the specialist brought in to consult

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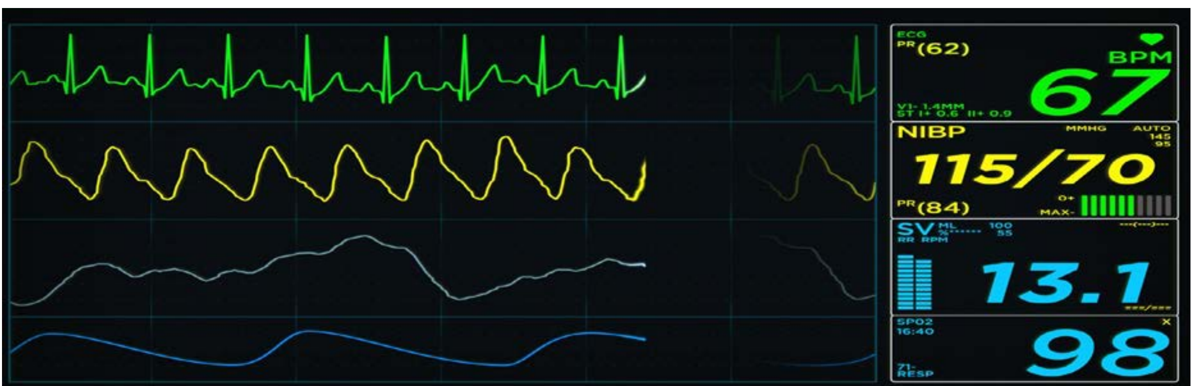
Advances are not Risk Free

People are going to be negatively impacted

- Require testing by contractor or manufacturer as part of procurement (and signing a BAA to share risk)
- Perform a risk assessment considering misuse, unavailability and data handling of any new technology
- Must have a CIO / CISO with responsible for HIPAA
- Training staff and prepare for an outage or cyber incident with a (written) plan



Questions?

Healthcare & Politics Legislative Overview

Michelle "Missy"Apodaca, Haynes and Boone
Freddy Warner, Memorial Hermann

October 20, 2016

Haynes and Boone, LLP haynesboone.com

Lockton lockton.com

BRG Healthcare thinkbrg.com

2016 Election Cycle

- **Presidential Election**
  - **Trump v. Clinton**
- **US Senate (54/46 Republican Majority)**
  - **Republicans defending 2/3 of seats**
- **US House (247/188 Republican Majority)**
- **Texas Legislature**
  - **Texas Senate (20/11 Republican Majority)**
  - **Texas House (99/51 Republican Majority)**

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POLITICAL & LEGISLATIVE DYNAMICS

- **2016 ELECTION CYCLE: Federal - ACA/*Obamacare* remains deeply partisan, divisive issue at all levels of government**
  - **NATIONAL/Federal Election Impacts**
    - **Presidential Election – New Administration is a certainty**
    - **The ACA is here to stay**
    - **Impact of Supreme Court Justice Scalia's death?**
    - **US Senate**
      - **Republicans defending twice as many seats: Can Democrats take back Senate, capitalizing on large presidential election turnout?**
      - **Impossible for either party to reach 60-vote filibuster-proof threshold**
    - **US House**
      - **Republicans should maintain House Majority**
      - **Key House Committees (Ways & Means; Energy & Commerce) will offer *Obamacare* alternatives**

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2016 Elections: Federal Impacts

- **Trump nomination likely jeopardizes down-ballot Republicans**
  - **Republicans lose Senate**
  - **Republicans lose House seats; maintain majority**
- **Executive and Legislative branches likely remain split**
- **Reality of *Obamacare* "repeal and replace" rhetoric**
  - ***It's a math problem…***
- **Supreme Court Nominee, Succeeding Justice Scalia: Senate Minority Leader Reid held up *all* bills authored by Republicans in contested elections**

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Federal Legislative Environment

- **No *must-pass* healthcare legislation in 2016**
- **Results of 2016 election will impact *Lame Duck***
  - **If Clinton wins, and Republicans lose Senate**
  - **If Trump wins, and Republicans maintain Senate, House**
- ***House v. Senate***
  - **Schedule of House Ways and Means Hospital Proposals**
    - **1st Package: ASAP - “bipartisan, non-controversial items”**
    - **2nd Package: Post-Acute, SNP, DSH, physician-owned hospitals**
    - **3rd Package: Political *red meat*: ACA-related proposals**
  - **Senate Finance Committee taking different approaches**
    - **Ex. No support for House Post-Acute, SNP proposals**
    - **HOPD *fixes***

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2016 Elections: State Impacts

- **2017 Legislature will be more ideologically strident than 2015**
- **Health Care will NOT be a priority**
- **Senate v. House dynamics**
- ***Revenue* Averse**
  - **Low oil prices will impact appropriators: Exs., *No new spending; Only fund priorities, etc.***
  - **No tax bills**
  - **No spending of Rainy Day Funds**
  - **Trauma Fund (DRP) in jeopardy; No replacement**
  - **Potential rate cuts**
- **No Medicaid/Coverage Expansion**
  - **Jeopardizes CMS negotiations RE 1115 Waiver continuation**

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State Legislative Environment

- **Weakening State Economy**
  - ***$45-50 per barrel oil*: Impact on appropriators' *psyche***
  - **Comptroller based Revenue Estimate on $65 per barrel**
  - **Downward trend of monthly sales tax receipts**
- **Impact of Texas Supreme Court school finance case**
- ***Tea Party influence* on 4th successive election**
- ***No Tax* pledges**
- **Lingering impact of politics of *Obamacare***
  - ***Medicaid Expansion***
  - ***$1.3 - $1.6B Medicaid Shortfall* for current state biennium**
- **HHSC leadership changes**

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State Dynamics: Major Health Policy Issues

- **HHS spending outpacing all other ("all funds")**
- **Article II v. Article III spending levels**
- ***Refusal* to accept Medicaid expansion funding**
- ***Medicaid funding shortfall* for balance of current biennium**
- **$800M needed for Texas state psychiatric hospitals**
- **Child Protective Services (CPS)**
- **Mental/Behavioral Health remains bipartisan priority**
- **Legislature must direct HHSC to seek 1115 Waiver *continuation***
- ***CMS will not pay for programs Medicaid expansion would have funded***

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Abbott, Patrick and Straus Joint Letter to State Agencies: *Cut budgets 4%*

- **Joint letter follows Speaker Straus' April 19, 2016 letter to House Members - reinforces issues lawmakers must consider in crafting the 2018-19 biennial budget:**
- **LBB letter asking state agencies to prepare LAR's with *10% budget cuts***
  - **Impact of falling oil prices, slowing tax revenue streams, on the Texas economy**
  - **State foster care system is in crisis: Courts may require the 2017 Texas Legislature to address**
  - **Texas Supreme Court ruling in school finance lawsuit**
  - **Funding shortfall in Teacher Retirement System (TRS) health care program**
  - **Rehabilitate aging Texas' state psychiatric hospitals**

STATE POLITICAL & LEGISLATIVE DYNAMICS

- **1115 Medicaid Waiver Renewal/Extension – 5-year waiver expired September 30, 2016; CMS granted 15-month extension, through December 31, 2017**
- **Texas HHSC currently negotiating with CMS for period beginning January 1, 2018: *renewal* or *extension*?**
  - **Texas' failure to expand Medicaid will influence CMS decision**
  - **CMS will *not pay for services which Medicaid expansion would have funded.***
  - **HHSC must gain legislative support/guidance for CMS negotiations**
    - **Hands issue back to the 2017 Texas Legislature**
    - **Returns politics of *Obamacare* and Medicaid expansion to an unfriendly venue**
    - **Jeopardizes continued UC funding and DSRIP projects**

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STATE POLITICAL & LEGISLATIVE DYNAMICS

- **No Long-Term Funding Methodology for *Safety Net* Hospitals – The 2017 Texas Legislature must reconsider the issue, given absence of a sustainable funding source**
  - **2015 Legislature provided $299M for *safety net* hospitals; $213M for state trauma centers; and $80M for rural hospitals**
  - **2013 Legislature provided "one-time" allocation of $300M for Disproportionate Share Hospital (DSH) eligible hospitals**
  - **Recent state legislatures have not supported any tax/revenue bills (ex., hospital bed tax; quality assurance fee)**
  - **Potential Local Provider Participation Fund (LPPF) legislation**
    - **Following 2015 legislative support**
    - **Can *statewide LPPF* enabling statute pass in 2017?**

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STATE POLITICAL & LEGISLATIVE DYNAMICS

- **<u>Critical Policy Issues Loom for Texas Hospitals</u> – The 2017 Texas Legislature to consider the following:**
  - **Driver Responsibility Program (DRP)**
    - **Growing support for legislation which, if passed, would abolish the principle source of funding for trauma centers**
    - **Ex., MHHS trauma centers/emergency departments receive 1/10 of total state trauma funding**
  - **Texas Prompt Pay Statute**
    - **Texas Association of Health Plans led 2015 effort to *gut* the statute, which penalizes insurers for failing to timely pay claims**
  - **End-of-Life**
    - **Growing support for legislation forcing hospitals to treat terminal patients until they can be transferred to more appropriate venues**

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Planning for 85th Legislative Session –

- Rate Cuts
- Interim Charges
- Texas Sunset Review
- More pay for performance and quality initiatives
- HHSC Initiatives & Transformation of the Whole Enterprise
- Trauma Fund
- Waiver Renewal & Supplemental Funds

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Interim Charges - Highlights

- House of Representatives
  - Hospital reimbursement methodologies (supplemental payments, Medicaid safety-net and trauma add-ons, and reimbursement methodologies for rural and children's hospitals).
  - Study the state's trauma system.
  - Growth of the Texas Medicaid program & Effectiveness of Saving initiatives for fraud and abuse, reduce costs, and improve the quality.
  - Review the HHSC's Medicaid managed care organizations policies and procedures including a review of quality initiatives, contract management and Vendor Drug Program drug formularies…encourage increased participation or retention of health care providers in the Medicaid managed care system.
  - Transparency and adequacy of health care networks, and consumer protection legislation regarding disputes over out-of-network services.
  - Penalty calculations under Texas's prompt payment laws.
  - Explore opportunities to expand and improve the delivery of healthcare of telemedicine activities being reimbursed in Texas.

Senate

- Impact of the Section 1115 Waiver - Explore other mechanisms and make recommendations to control costs and increase quality and efficiency in the Medicaid program, including the pursuit of a block grant or a Section 1332 Medicaid State Innovation Waiver for the existing Medicaid program.

- Driver Responsibility Program.

- Improve quality and oversight in long-term care settings.

- Study and make recommendations to address the state's ongoing need for inpatient forensic capacity, including the impact of expanding community inpatient psychiatric beds.

- Examine the cause of action known as "wrongful birth." The study should examine 1) its history in Texas, 2) its effect on the practice of medicine and 3) its effect on children with disabilities and their families. Examine related measures proposed or passed in other states.

Texas Sunset Review

- Texas Medical Board
- Physical Therapy Examiners
- Occupational Therapy Examiners
- Dental Examiners
- Pharmacy Board
- Nursing Board
- Veterinary Medical Examiners
- Chiropractic Examiners
- Professional Counselors, Marriage and Family Therapists and Social Worker Examiners
- Board of Examiners of Psychologists
- Podiatric Medical Examiners
- Optometry Board

Hospital Funding Concerns

- **<u>No Long-Term Funding Methodology for *Safety Net* Hospitals</u>** – The 2017 Texas Legislature must reconsider the issue, given absence of a sustainable funding source
  - 2015 Legislature provided $299M for *safety net* hospitals; $213M for state trauma centers; and $80M for rural hospitals
  - 2013 Legislature provided “one-time” allocation of $300M for Disproportionate Share Hospital (DSH) eligible hospitals
  - Recent state legislatures have not supported any tax/revenue bills (ex., hospital bed tax; quality assurance fee)

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Hospital Funding Concerns

- Local Provider Participation Funds
- Rate increases through MCOs
- ?

Physicians- Texas Medical Association Legislative Priorities

- Medicaid Funding
- Public Health
- Mental health
- Women's health and Public health issues
- GME
- Insurance - Balance "Surprise" billing and Prompt Pay
- Telemedicine
- TMB Sunset and other health licensing agencies (opioid prescribing)
- End-of-Life
- Taxes and Licensing fees
- Corporate Practice of Medicine

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Texas Association of Health Plans Legislative Priorities

- Medicaid Managed Care Formulary
- Freestanding ER
- Telemedicine
- Commercial Insurance Initiatives – Balance Billing and Prompt Pay

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Texas Managed Care Timeline

- STAR+PLUS available statewide on September 1, 2014
- Individuals receiving intellectual and developmental disabilities (IDD) waiver services began receiving acute care services through STAR+PLUS on September 1, 2014
- Nursing facility services carved into STAR+PLUS on March 1, 2015
- The Medicare-Medicaid Dual Eligible Integrated Care Project (Dual Demonstration) began enrolling individuals on March 1, 2015
- Behavioral health integrated on September 1, 2014
- Community First Choice (CFC) in June 2015
- STAR Kids in November 2016
- IDD pilot in 2016
- *Beginning January 1, 2017, behavioral health services in the Dallas service area will be provided through MCOs*
- *On March 1, 2017, adopted kids in FFS will transition to STAR manage care*

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HHSC Initiatives

- MCOs to use same Provider Credentialing - http://www.aperturecvo.com/
- Issue new RFP for STAR and CHIP MCOs
- Continue with Transformation of Whole Enterprise
- 1115 Waiver Negotiations
- Hospital Supplemental Funding

Network Access Improvement Program "NAIP"

- Public Hospitals and health-related institutions
- Existing Medicaid managed care structure
- Costs incorporated into MCO capitation rate
- MCOs develop and implement provider incentive programs with hospitals and HRIs
- Project examples: bonus fund incentives for access to PCPs; expansion of hours/services; targeted specialty recruitment; telehealth/telemedicine; chronic condition-specific focus; pregnancy and childbirth; behavioral health integration; medication management; integrated service delivery for primary and acute care services.

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Quality Incentive Payment Program – Delayed

- The Texas Legislature directed HHSC to base payments through the QIPP upon improvements in quality and innovation in the provision of nursing facility services:
    - Culture change
    - Small house models
    - Staffing enhancements
    - Improved quality of care and life for nursing facility resident

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85th Legislature 2016-2017

Important Dates

9/30/2016 – Current Waiver Expires

11/8/2016 – November Election

1/10/2017 – 85th Texas Legislature Begins

5/29/2017 – 85th Texas Legislature Ends Regular Session

Thru 8/31/2017 – No Deferral of Private Hospital Payments

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Questions and Contact

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FCA Enforcement Trends

October 20, 2016

Employer Shared Responsibility Rule

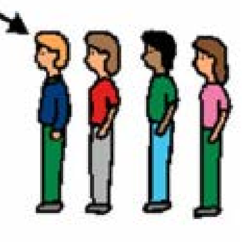
- The Affordable Care Act's (ACA) employer shared responsibility rules apply to "applicable large employers" and include:
  1. Full-time employee (FTE) determination and measurement – Employers must determine their FTEs (those with 30+ hours of service per week on average) and can use two safe harbor methods to help
     - Monthly measurement method
     - Look-back measurement method

  2. ACA reporting – IRS Forms 1094 and 1095 are used to report information about employers and employees, offers of coverage, enrollment, and other required information

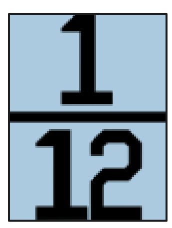
Employer Shared Responsibility Rule

3. Penalties

- IRC Section 4980H(a) “Doomsday penalty” – If an employer fails to offer minimum essential coverage to a minimum threshold of FTEs (95% in 2016) during the calendar year and one FTE enrolls in subsidized coverage in the health insurance marketplace, the doomsday penalty is triggered = $2,160 x (all FTEs – 30)
- The estimated penalty for 2017 is $2,260



- IRC Section 4980H(b) “Per affected FTE penalty” – If an employer does not trigger the doomsday penalty but fails to offer coverage to an FTE or offers coverage that does not meet the ACA’s minimum value or affordability requirements, and that FTE enrolls in subsidized coverage in the health insurance marketplace, a $3,240 per affected FTE penalty is incurred
- The estimated penalty for 2017 is $3,390



- Both penalties are pro-rated monthly

Affordable Care Act Employee Definitions

Full-Time

An employee who is employed an average of **at least 30 hours** of service per week and/or who does average **at least 30 hours** of service per week over the course of a measurement period.

Factors to Consider

Whether the employee is replacing an employee who was a full-time employee

The extent to which employees in the same or comparable positions are considered full-time employees

Whether the job was advertised, or otherwise communicated, or otherwise documented, as requiring hours of service that would average 30 or more hours a week

Part-Time

An employee who an employer reasonably expects, based on the facts and circumstances, to be employed an average of **less than 30 hours** of service per week and/or service per week and/or who does average **less than 30 hours** of service per week over the course of a measurement period.

Variable Hour

An employee for whom the employer **cannot readily determine is reasonably expected to work on average at least 30 hours** per week.

Factors to Consider

Whether the employee is replacing an employee who was a variable-hour employee

The extent to which employees in the same or comparable positions are considered variable hour

Whether the job was advertised, or otherwise communicated or otherwise documented, as requiring hours of service that would vary above and below an average of 30 hours of service per week

Seasonal

A worker who performs labor or services on a seasonal basis, as defined by the Secretary of Labor

A seasonal employee includes one who is in a position for which the customary annual employment period is no more than six months, and the period occurs during the same part of each calendar year (e.g., summer or winter)

An employee may still be considered a seasonal employee should employment be extended in a particular year beyond its customary duration due to special circumstances (i.e., an employee brought in to help complete holiday orders is kept over due to a higher-than-expected order volume)

The ACA applies solely to common law employees

Most employees are **common–law employees**. If disputed, courts and agencies usually use a multi-factor test to determine common-law employee status based on the following three categories:

Behavioral: Does the company control or have the right to control what work is performed and how the worker does his or her job?

Financial: Are the business aspects of the worker's job controlled by the company?

Type of Relationship: Are there written contracts or employee type benefits (i.e. pension plan, insurance, vacation pay, etc.)? Will the relationship continue indefinitely? Is the work performed a core company function?

This is not a new issue for employers that have had and continue to have many other reasons to get this right (e.g., benefits, pay, labor and employment issues). An employer should be consistent in how it classifies an individual across all of these areas.

3 Questions to Ask to Determine a Common Law Employee

Are other individuals with the same job treated as employees by the employer?

How much discretion does the individual have in terms of how the work gets done?

How long has the individual worked for the employer?

Speakers

- **Scott Hogan**, Assistant United States Attorney, Deputy Civil Chief, Northern District of Texas
- **Stacy Brainin**, Partner, Haynes and Boone, LLP

False Claims Act Overview

- Liability: knowingly presents or causes to be presented a false or fraudulent claim for payment to the United States.
- Civil Penalty: not less than $10,781 and not more than $21,563 per claim plus 3 times the amount of damages.
- “Knowingly”: actual knowledge, deliberate ignorance or reckless disregard of truth or falsity; no intent to defraud required.

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Qui Tam Provisions

- A person may bring civil action for the person and the United States.
- Complaint filed under seal. Government has 60 days to elect to intervene – often extended.
- If government proceeds – person receives 15-25%, or if government does not proceed – person receives 25-30% plus reasonable attorneys fees and expenses.
- No jurisdiction if based on public disclosure unless person is original source.
- Anti-retaliation provisions.

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2015 False Claims Act Statistics

- DOJ recovered more than $3.5 billion in FY 2015
  - Down from 2014's $5.6 billion recovery
  - But continued 4-year record of recoveries over $3 billion

- Since 2009, the DOJ has recovered more than $26.4 billion

- Of $3.5 billion in FY 2015
  - $1.9 billion from healthcare industry, including $330 million from hospitals
  - $2.8 billion (more than half) from cases filed by whistleblowers

- Number of *qui tam* suits exceeded 600
  - Down from 2014's 700
  - But way up from 1987's 30
  - Whistleblowers received record $597 million