

Richard W. Snyder II, MD
President's Page
B as in Billions

With this one I will be channeling my inner Carl Sagan, “Billions and billions.” And no, I am not referring to the number of words by which I have exceeded the limit of my collective President’s Pages to date. The billions I am focusing on are the more than \$4 billion in *supplemental* federal and local money that Dallas hospitals are set to receive over the next four years to care for the county’s uninsured and Medicaid populations, while the physicians, the ones who actually provide the care for the patients, will receive next to nothing.

UPL and DSH, “Can I Buy a Vowel?”

For the last several years, Dallas private hospitals have been the beneficiaries of federal supplemental matching programs for the services that they provide for the uninsured and Medicaid populations. (Warning: this article will contain an excessive number of governmental mumbo-jumbo acronyms. However, these are terms with which we physicians all desperately need to become familiar, almost as familiar as SGR.) Two of the more important ones are the Disproportionate Share Hospital (DSH) and the Upper Payment Limit (UPL) programs. Medicaid DSH payments provide financial assistance to hospitals that serve a large number of low-income patients, such as people with Medicaid and the uninsured. Medicaid DSH payments are the largest source of federal funding for uncompensated hospital care. In 2009, roughly \$11.3 billion was distributed nationwide, with Texas hospitals receiving approximately \$960 million. UPL is a program that allows hospitals to be reimbursed for the difference between what Medicaid paid for the service and what the hospital charged, up to a certain cap, generally a Medicare rate.

Starting in 2007 in Dallas County, private hospitals and local governmental entities (Parkland Hospital District) formed affiliations that contributed funding needed to draw down the federal dollars available under the UPL program in a federal-to-state match ratio of approximately \$1.50 to \$1. This meant that for every \$1 the county provided from qualified governmental sources, in this case the Parkland Hospital District, the federal government would match that with roughly \$1.50 in an Intergovernmental Transfer. The intent of the UPL program was to expand inpatient and outpatient care for Medicaid and uninsured populations. Because the program reimbursed hospitals the difference between what Medicaid paid and what the hospital charged, this created a misaligned incentive for hospitals to increase their charges. Because hospitals aren’t required to report how they use the UPL funding, taxpayers (and physicians) couldn’t see how the dollars were being used. In terms of UPL funding, the enhanced federal matching dollars meant more than \$250 million annually to Dallas County hospitals to bridge this hospital Medicaid cost-to-charge gap.

When taken together, the DSH and UPL programs have meant north of a billion *supplemental* dollars to Dallas County hospitals on a yearly basis for the care they provided for the uninsured and Medicaid patients. Wait a minute, did I say for the care they *alone* provided? That is the little known fact that no one wants to talk about; how Dallas public and private hospitals receive eye-popping sums of supplemental governmental funds for care provided, mostly through physicians, to uncompensated and Medicaid populations, while the physicians themselves realize next to nothing.

Now, all of this is about to change.

The Waiver

On July 13, 2011, the Texas Health and Human Services Commission submitted a proposal, “Texas Healthcare Transformation and Quality Improvement Program,” aka “The Medicaid 1115 Waiver” or “The Waiver.” If you suffer from an extreme form of insomnia or are an obsessive-compulsive health

economics geek, please see the DCMS Web site for the original 110-page document. The proposal, which was approved on Dec. 11, 2011, is a demonstration waiver under Section 1115 of the Social Security Act. Simply put, the 1115 Waiver allows the state to expand Medicaid managed care as a percentage of the total Medicaid program. It does not change who is eligible for Medicaid; it just shifts a greater percentage of traditional Medicaid patients into a managed care plan. Think Star and Star-Plus. By shifting more patients from traditional Medicaid into a risk-based, managed care model, the state intends to control costs while improving coordination of services and to preserve federal funding for hospitals. (Wait a minute ... controlling costs by shifting more patients into a capitated, risk-based managed care model, which we all know is accomplished principally by physicians in the outpatient setting at a loss, just to preserve billions in federal and local supplemental funding sources *for hospitals*? What am I missing in this picture? More on this later.)

When a Waiver is Not an Expansion

The Medicaid 1115 Waiver should not be confused with the Medicaid Expansion as called for in the Affordable Care Act (ACA). The Medicaid 1115 Waiver is NOT part of the ACA. The Waiver does not *expand* the Texas Medicaid population or who is eligible. The Waiver *shifts* more Texans from current traditional Medicaid into managed care Medicaid. The Medicaid expansion promoted by the ACA expands Medicaid to more uninsured populations without making it more efficient, and definitely increases cost. For example, if the ACA Medicaid expansion were fully implemented in Texas, it would add more than 2 million people to the Medicaid program and cost the state more than \$27 billion over 10 years. On the other hand, the Medicaid 1115 Waiver puts a greater focus on reducing costs by paying for improved quality and efficiency.

A waiver is needed to accomplish this because federal rules generally cause that states that expand managed care for Medicaid see a reduction in funding to hospitals under the UPL program. The idea is that if the state realizes a reduced cost benefit by shifting a greater proportion of their traditional Medicaid patients into a managed care Medicaid program, then the federal government should also receive a cost benefit and should not have to fund some of these hospital supplemental Medicaid matching programs to the same level. In the Waiver, Texas requested federal approval to redirect the UPL funding at the same par level it would have received over the ensuing five years, more than a billion dollars (and change!), while expanding the Texas Medicaid managed care program. The Waiver does not bring more money to the state; it merely allows the state to preserve the federal funding it would have received benefitting *the hospitals* if managed care were not expanded.

The new funding program under the 1115 Waiver consolidates the programs by combining the hospital UPL funds, physician UPL funds and DSH funds with the savings generated by expanding managed care, and creates new funding pools that will be used to help improve healthcare services and reimburse hospitals for uncompensated care. These new funding pools go by the names Uncompensated Care Pool (UC) and Design System Reform Innovation Project Pool (DSRIP). Remember these acronyms like you would your kids' initials because the numbers associated with them are Carl Sagan-like. The Waiver also seeks to increase local control over how key Medicaid funds are used and intends to make the payment process much more efficient, transparent and accountable. Consequently, taxpayers (and physicians) should be able to know exactly how their money is being used. The end result is a Medicaid system that should reward performance and make better use of tax dollars. The only real question is, *whose performance is being rewarded?*

In the Waiver document introduction, the "overarching goals" of the proposal are revealing: "Expand risk-based managed care statewide; Support the development and maintenance of a coordinated care delivery system through the creation of Regional Healthcare Partnerships; Improve outcomes while containing cost growth; Protect and leverage financing to improve and prepare the healthcare infrastructure to serve a newly insured population; Transition to quality-based payment

systems across managed care and hospitals; Provide a mechanism for investments in delivery system reform including improved coordination in the current indigent care system now providing services to individuals likely to gain coverage in 2014.”

The document states that the proposed demonstration will transform the delivery of care and payment systems into one that is more “transparent and accountable.” This is unlike the previous funding programs (UPL and DSH) that the new system will replace. These overarching goals reveal a program that is not only patient-centered, but one that must be, by its very nature, physician-centered as well.

The proposal introduction provided specific elements that all relate to the overarching goals: “Flexibility to direct Waiver savings into a pool to cover uncompensated care costs by hospitals and other providers (that is code for you and me); Flexibility to reinvest waiver savings for delivery system reforms that expand provider capacity, improve care efficiencies, and align provider incentives in a manner that promotes quality and helps prepare providers for healthcare expansion in 2014.”

Clearly, fundamental to the transformative goals and elements of the Waiver demonstration project is the primacy of the physician in the delivery of care in the inpatient and especially the outpatient settings. The take-away point is that **the success (or failure) of the 1115 Waiver’s Overarching Goals and Elements hinges on the central role of the physician in this whole process. The problem, however, is that despite what the document explicitly proposes, reimbursement to physicians largely has been ignored in the discussions of the various committees to date.**

The Waiver details how the cost savings will come from managed care expansion that will be redirected into the UC and DSRIP Pools, primarily benefitting hospitals but also should benefit physicians. Under Texas Medicaid managed care, the state pays a health plan a set fee each month to provide health care for a Medicaid client. The client selects a primary care provider from the plan’s network, and that doctor coordinates the client’s care. The Star program is Texas’ primary Medicaid capitated Managed Care Organization (MCO), serving 1.3 million enrollees out of a total Medicaid population of around 3 million. Star-Plus is an integrated delivery system of acute care services and community-based long-term services. As the proposal states, “the full-risk capitated managed care approach also offers the maximum cost control to the state.... Under the full-risk model, MCOs have incentives to coordinate care and services that reduce cost of inpatient care, over-utilization of prescription drugs, and other expensive categories of health services.” (Hmmm, this sounds a lot like a rationing mechanism. See my November President’s Page.)

On Page 4 of the [document](#), the Waiver proposal states that the Star MCOs “must improve access to physicians per contract requirements, which include access to routine, urgent and emergency care.” This requirement was confirmed in a Nov. 7, 2012, public hearing in Dallas concerning the Waiver. The Community Needs Assessment Task Force listed at the top priority for Dallas County “primary and specialty capacity,” highlighting that the “demand exceeds available medical physicians in these areas, thus limiting healthcare access.” The proposal also specifically reinforces the need for “reduced admission rates for such chronic conditions such as COPD, CHF, diabetes,” and preventive services such as “well-visits, HbA1c testing, LDL-screening.” The Needs Assessment Task Force agreed, listing “Chronic Disease, Adult and Pediatric” as the third priority. This screams of outpatient physician-directed care. The Waiver goes to great length to emphasize the value of the MCO members having a long-term, well-established personal outpatient physician to “coordinate care,” which reduces costs and performs these other preventive services.

The main problem here for Dallas County is that only 19 percent of PCPs accept traditional Medicaid, and that number has been in a free fall for the last several years. Medicaid managed care plans generally pay even less, and, as a consequence, have even less physician participation. This has created insurance coverage with merely the illusion of access. As I have stated before, coverage is not the same thing as access, and access to a waiting list is not access to health care. The Waiver explicitly

states that real access to physicians, not just coverage, must be improved. I agree that access is being improved as the details of the Waiver are beginning to materialize, but it is not access to physicians. How can one justify a program that hinges on the central role of physicians to coordinate care, reducing cost to the state (while the physicians themselves lose money with each patient they see), but that principally benefits hospitals by preserving *their* access to supplemental governmental funding sources exceeding a billion dollars annually?

The primary access point by which low-income patients (uninsured and Medicaid) enter the hospital system is through the emergency department. Remember that hospitals are exposed to the risk of caring for the uninsured and Medicaid patients in the ED by federal mandate via the EMTALA law. (Oh no! There is that word again – mandate! I thought the Supreme Court redefined it as a tax!) EMTALA requires *hospitals* to provide a call list. It is a myth that EMTALA forces/mandates physicians to serve on ED call lists to serve the unassigned. We are “mandated” to serve on ED call lists by our own hospital bylaws, not by the federal government.

As the Old Saying Goes, “Follow the Money!”

Quietly, a titanic struggle is raging in Dallas County boardrooms over the destination of these billions of dollars (and change!) in federal matching funds that hospitals have been receiving annually. The Waiver does not alter the amount of public funding that is available to hospitals; in fact, that was the main point – the Waiver preserves the funding. The 1115 Waiver *waives* the federal requirement to decrease the amount of money paid to hospitals collectively if Medicaid managed care is expanded. It does, however, change how that money is distributed. Under the plan, public and private hospitals that treat large numbers of uninsured and Medicaid patients, AND provide the best services, will get the most funding. Texas’ uncompensated care totaled \$15.1 billion in 2009, and while the hospitals bore the majority of these costs, the physicians took on a substantial part of that burden, as well. It is a testimony to the vast amounts of dollars at stake that the CEOs themselves of the hospital systems (Baylor, THR, HCA, Methodist, and Parkland) are serving on the boards that are wrestling with this issue. Your DCMS staff and the TMA are at the table of these discussions, as required by the Waiver. It is necessary and appropriate for medical societies to be involved because the Waiver clearly calls for the use of these new funding pools to include physicians to reimburse them for the roles they play in this program.

The UC and DSRIP Pools are intended for the “development and maintenance of a coordinated care delivery system through Regional Healthcare Partnerships (RHPs, Dallas, Denton and Kaufman counties are in Region 9) and to provide a mechanism for investments in delivery system reform. The funding pool will have two distinct components for which federal participation would be requested: payments to hospitals and other eligible providers to cover uncompensated care costs (UC Pool, approximately \$850 million the first year), and a delivery system reform incentive payment program for hospitals (DSRIP Pool, approximately \$250 million).” Note the language for “other providers.” See the DCMS Web site for proposed breakdown by hospital.

Now UC It, Now U Don’t

The document further states that included in the funding pools will be “supplemental payments allocated through the physician UPL program and cost efficiencies achieved from moving populations and services to risk-based managed care.” In other words, not only do these funding pools include the traditional hospital funding sources that hospitals enjoyed for caring for the uninsured and Medicaid populations (on the backs of physicians) via the UPL and DSH mechanism, they also include the savings that we physicians will generate through managed care cost reductions and a redirection of physician UPL into the Medicaid 1115 Waiver funding streams.

Yes, that’s right. I said “physician UPL program.” How many of you have heard of a supplemental reimbursement program for physicians? It has been in existence for several years but hasn’t been very

well advertised. In 2005, this represented \$116 million statewide. If you're unfamiliar with it, don't worry; it's being redirected into the Medicaid 1115 Waiver process. But, as noted on Page 12 in the section titled "Continuation of Enhanced Payments to Physicians" (Continuation? I didn't know we were supposed to be getting enhanced payments to begin with!), "Texas also proposes to continue to provide enhanced payments from the UC Pool to physicians serving Medicaid. UPL physician payments are included in the 'without waiver' calculations and in the UC Pool under 'with waiver.'"

Throughout the document, enhanced physician payments through the UC Pool are mentioned repeatedly, reinforcing their essentialness to the success of the Waiver. This begs the question, *where are the enhanced physician payments?*

The Forgotten "Other Healthcare Providers"

At the Nov. 7, 2012, public hearing concerning the Waiver, the publically furnished documents (see DCMS Web site) echo the original intent of the proposal to include physician participation in the UC funding streams. "The Uncompensated Care Pool payments are designed to help offset the costs of uncompensated care by the hospital or '*other healthcare providers*.'" However, this element of the original proposal has been conveniently forgotten.

Furthermore, through the DSRIP Pool, physicians will continue to play the central role. Novel, transformative and innovative care delivery projects are the key descriptors to this funding pool. Texas proposed to design the DSRIP as "the vehicle to support coordinated systemic care and quality improvements through Regional Healthcare Partnerships The incentive payment program seeks to transform hospital care delivery systems by delivering proactive and planned prevention and primary care services for all patients; increasing patient access by expanding the primary care workforce; and offering timely, proactive, coordinated medical home care from a multidisciplinary team that is highly adept at managing chronic disease." The document states, "Texas would make a future adjustment to the 'without waiver' budget cap to reflect payment increases up to Medicare levels in 2013 and 2014 for primary care services." Clearly, this suggests that the *minimum* enhanced physician care payments should be to Medicare levels.

At the public hearing in November, this notion was echoed in the DSRIP Pool payment description as "incentive payments to hospitals and *other healthcare providers* that develop programs and strategies to enhance access to health care, increase the quality of care, improve the cost-effectiveness of care, and benefit the health of the patients and families served." Again, the "other healthcare providers" is code for the group that includes the physicians. These proposals cannot be accomplished without including doctors in the reimbursement mechanism, as the original Waiver proposal intended. Unfortunately, with only 19 percent of Dallas County PCPs participating in Medicaid due to inadequate reimbursement, this will not be possible.

"Quality, efficiency, cost-reduction, coordination of care, enhanced community and home-based services, risk-based managed care, enhanced primary care, and preventative services" are all goals of the Texas Medicaid 1115 Waiver mechanism that are repeated throughout the document. They also are the keys to the success of the demonstration that lie predominantly with the physician. *Health care is provided through physicians*. I have never seen a hospital system or its CEO listed on a call roster, or serving as an attending or consultant. Guidelines and Appropriate Use Criteria are written by, and for, clinicians. Thus, it is only through the physicians that the aims and goals of the Waiver, "Texas Healthcare Transformation and Quality Improvement," can truly become manifest. And that is precisely why the physicians must figure much more prominently in the Waiver planning process and reimbursement mechanism. It is only pragmatic to do so. If only 19 percent of PCPs participate in a program designed to meet the needs of our current Medicaid population and the needs of the 30 percent of the county who are uninsured but who may become insured in 2014, we clearly need more.

The only way to do that is to enhance payments to physicians as explicitly called for in the Texas Medicaid 1115 Waiver.

This is not about physicians trying to do a money grab and lay claim to a revenue stream purely for self-interest. If independent physician practices cannot maintain economic viability as a consequence of their participation in this program, they will be forced to withdraw from the Medicaid insurance program (as many have already done) or go bankrupt. This does not serve the interests of any of the parties involved: hospitals, physicians, patients, or the local community. This just perpetuates the illusion of access. Your DCMS staff has been at the table with the hospital systems for the last 9 months as a key stakeholder; however, to a certain extent we are out-gunned and out-manned. We have been participating in good faith and trust. Unfortunately, decisions made by the hospitals late in the process have undermined this trust. The original stated goals of the Waiver funds have been clouded, diluted and redirected. The “enhanced physician payments” that were discussed in the UC tool of the original Waiver proposal have been lost in recent funding proposals.

We need the participation and support of all physicians to make this program work, not only from a clinical standpoint, but also from the original design perspective. From a practical standpoint, how UC and DSRIP care manifest at the hospital and outpatient levels mostly is determined locally at each specific hospital location. Many of these programs and innovative projects, such as indigent care clinics and coordination of chronic disease management, are unique to specific hospitals, systems and their aligned physician medical staffs. One of our main concerns is that physicians will be unknowingly “drafted” by their affiliated hospitals or 501A to provide both inpatient and outpatient care for these patients on a charity basis, thus allowing the hospitals to draw down supplemental federal dollars at an astonishing rate.

Consequently, local physician hospital and system leaders will have to provide direction on how those “enhanced physician payments” should and must specifically manifest to their particular medical staffs and physician system affiliations. One possible mechanism is to make enhanced payments to those who serve on call schedules. Another is to reimburse physicians to at least a Medicare rate for outpatient services through a DSRIP program such as DCMS’ My Medical Home (the new Project Access Dallas 2.0). I am sure there are other “innovative and transformative” enhanced physician payment mechanisms we can propose. DCMS is ready to assist Dallas physicians in this process. It is, however, incumbent upon the DCMS membership to invest themselves in the process, learn the nuances of the current and emerging funding mechanisms and the innovative delivery models, partner with DCMS, and become leaders in their local physician communities. The big winners would not only be the hospitals and physicians, but especially the patients and Dallas County as a whole.

The Big Question?

My primary question is worth repeating: how can you ask the physicians to continue to subsidize hospital systems by seeing low-income patients at a loss, just to preserve the hospitals’ draw-down of supplemental governmental payments estimated in the eye-popping range of \$4 billion to \$5 billion over the next four years?

Only Carl Sagan could know! “Billions and billions!”