Chapter 15: The 1115 Transformation Waiver

History

The Texas Legislature, through the 2012-13 General Appropriations Act, H.B. 1, 82nd Legislature, First Called Session, 2011, and S.B. 7, 82nd Legislature, First Called Session, 2011, instructed the Health and Human Services Commission (HHSC) to expand its use of Medicaid managed care. The Legislature also directed HHSC to preserve federal hospital funding historically received as supplemental payments under the Upper Payment Limit (UPL) program.

The Centers for Medicare & Medicaid Services (CMS) has interpreted federal regulations to prohibit UPL payments to providers in a managed care context. Therefore, CMS advised HHSC that to continue the use of local funding to support supplemental payments to providers in a managed care environment, the state should employ a waiver of the Medicaid state plan as provided by Section 1115 of the Social Security Act.

Accordingly, HHSC submitted a proposal to CMS for a five-year Section 1115 demonstration waiver designed to build on existing Texas health care reforms and to redesign health care delivery in Texas consistent with CMS goals to improve the experience of care, improve population health, and reduce the cost of health care without compromising quality. CMS approved Texas' waiver request on December 12, 2011.

CMS originally approved the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, as a five-year demonstration waiver running through September 2016 that allowed the state to expand Medicaid managed care, including pharmacy and dental services, while preserving federal hospital funding historically received as UPL payments. UPL payments were supplemental payments to offset the difference

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between what Medicaid pays for a service and what Medicare would pay for the same service. The 1115 Transformation Waiver provides new means, through regional collaboration and coordination, for local entities to access additional federal match funds. The 1115 Transformation Waiver contains two new funding pools: the Uncompensated Care (UC) pool and the Delivery System Reform Incentive Payment (DSRIP) pool.

As required by the waiver's special terms and conditions, HHSC submitted a request to CMS by September 30, 2015, to extend the waiver. HHSC requested to continue all three components of the waiver (statewide Medicaid managed care, the UC pool, and the DSRIP pool) for another five years.

In April 2016, HHSC submitted a request to CMS for a 15-month extension of the waiver (October 1, 2016-December 31, 2017), during which HHSC and CMS would continue negotiations on a longer-term agreement. CMS approved the 15-month extension on May 1, 2016. The letter from CMS approving the extension states that CMS and HHSC must agree on the size of the UC pool and DSRIP structure by the end of 2017. The letter references the independent report analyzing the UC and DSRIP pools requested by CMS in November 2015. HHSC submitted the independent report on August 31, 2016 as required.

On January 26, 2017, HHSC submitted a request to CMS for an additional 21-month extension at current funding levels for UC and DSRIP.

Funding

Federal funds available under both the UC and DSRIP pools require local or state intergovernmental transfer (IGT) funding, which is public funding from public hospitals or other governmental entities that may draw down federal matching funds under the waiver. IGT funds draw down approximately 60 percent federal matching funds. For example, a public hospital with $40 million IGT can receive approximately $60 million in federal matching funds for a total payment of $100 million under UC or DSRIP.

In demonstration year (DY) 1, up to $4.2 billion all funds was available for UC and DSRIP, and in all other years, the two pools could consist of up to $6.2 billion all funds for a potential total of $29 billion all funds over five years. In DY 1, most of the waiver funds were directed towards UC, but by DY 5, funds for UC and DSRIP were capped at equal levels. The 15-month waiver extension (referred to as DY 6) continues the UC and DSRIP pools at DY 5 level funding. CMS and HHSC will negotiate funding for any years

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approved beyond December 31, 2017.

Uncompensated Care Pool

UC pool payments are cost-based and help offset the costs of UC provided by hospitals and other providers to indigent or low-income patients, including Medicaid patients. UC payments are based on each provider's UC costs as reported on a UC application. See **Chapter 14, Finances**, for more information on UC.

Delivery System Reform Incentive Payment Pool

DSRIP funding provides financial incentives that encourage hospitals and other providers to focus on achieving quality health outcomes. Participating providers develop and implement programs, strategies, and investments to enhance:

- Access to health care services;
- Quality of health care and health systems;
- Cost-effectiveness of services and health systems; and
- Health of the patients and families served.

To earn DSRIP funds, providers must undertake projects from a menu of projects agreed upon by CMS and HHSC in the Regional Healthcare Partnership (RHP) Planning Protocol.

Funds received from the DSRIP pool cannot be used to maintain existing initiatives or continue services already provided. DSRIP funds can be used to enhance an existing initiative or expand services provided, if such a project is outlined in a plan approved by HHSC and CMS. DSRIP funds are divided into four categories in the RHP Planning Protocol:

- Category 1 projects – Infrastructure Development lays the foundation for delivery system transformation through investments in technology, tools, and human resources that strengthen the ability of providers to serve populations and continuously improve services.
- Category 2 projects – Program Innovation and Redesign includes the piloting, testing, and replicating of innovative care models, such as telemedicine, patient-centered medical home, and innovations in health promotion and disease prevention.
- Category 3 outcomes – Quality Improvements assess the effectiveness of Category 1 and 2 interventions for improving outcomes in the Texas health care delivery system. Each project selected in Categories 1 and 2 has

one or more associated outcome measures from Category 3.

- Category 4 reporting – Population-focused Improvements include a series of reporting measures for a hospital to track the community-wide impact of delivery system reform investments made. Reporting includes data related to potentially preventable admissions, readmissions, and complications, patient-centered health care, and emergency department utilization.

Regional Healthcare Partnerships

Under the 1115 Transformation Waiver, eligibility to receive UC or DSRIP payments requires participation in one of 20 RHPs, which reflect existing delivery systems and geographic proximity. A map of the RHP regions can be found in **Appendix C: 1115 Transformation Waiver Regions**. The activities of each RHP are coordinated by an Anchoring Entity, which is a public hospital or other local governmental entity with the authority to make IGTs, such as a hospital district, a hospital authority, a university health science center, or a county.

The Anchoring Entity collaborates with regional providers to develop an RHP Plan that accelerates meaningful delivery system reforms and improves patient care for low-income populations. The RHP plans include the projects selected by regional providers from the DSRIP projects outlined in the RHP Planning Protocol, the performance improvement expectations related to projects, and the population-based reporting that hospitals submit. Because health system reform requires regional collaboration, providers must select projects that relate to the community needs identified by the RHP, and RHPs must engage stakeholders in the development of RHP plans.

Various providers and governmental entities are participants in the projects:

- IGT entities are public hospitals or other governmental entities that may contribute public funds to draw down federal matching funds under the waiver.
- Performing providers, including public and private hospitals, community mental health centers, local health departments, and physician groups affiliated with an academic health science center, may receive waiver incentive payments for completing project objectives detailed in the RHP plan. Certain entities, such as public hospitals, may serve as both an IGT entity and a performing provider.

The RHP plans must include a shared regional mission; quality goals; and CMS' triple aim to improve

individual care (including access to care, quality of care, and health outcomes), improve population health, and lower costs without harming individuals, families, or communities.

RHP plans must also reflect broad inclusion of local stakeholder engagement.

In December 2012, RHPs submitted five-year plans that describe:

- The reasons for the selection of the projects based on local data, gaps, community needs, and key challenges;
- How the projects included in the plan are related to each other and how, taken together, the projects support broad delivery system reform relevant to the patient population; and
- The progression of each project year-over-year, including the expected improvements that will occur in each DY.

During DY 6A, the first 12 months of the 15-month extension, Anchoring Entities will update the regional community needs assessment that was submitted with the original RHP plan in 2012. Regions will update the regional plan as appropriate to reflect major changes, including changes to the regions' priority needs. Stakeholder engagement will be required as a part of the plan update process.

At the end of state fiscal year 2016, there were 1,451 approved and active DSRIP projects. Providers report twice a year (April and October) on achievement of project metrics and milestones in order to earn DSRIP payments.

Groups of providers and other DSRIP participants use learning collaboratives to identify best practices, share ways to improve projects, and promote quality improvement. HHSC also hosts an annual statewide learning collaborative.

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