

Chapter 4: Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver

*The Quality Improvement Program 1115 Waiver makes two major changes:
expanding Medicaid managed care statewide and establishing two new
funding pools for supplemental payments.*

History and Background

The Texas Legislature, through the 2012-13 General Appropriations Act (H.B. 1, 82nd Legislature, Regular 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 the waiver on December 12, 2011.

The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, is a five-year demonstration waiver running through September 2016 that allows 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 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 funding pools: the Uncompensated Care (UC) and the Delivery System Reform Incentive Payment (DSRIP) pools.

The waiver expires on September 30, 2016. HHSC must submit a request to CMS no later than September 30, 2015, to extend the waiver.

Waiver Funding

Federal funds available under both the UC and the 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 are capped at equal levels.

Uncompensated Care Pool

UC pool payments are cost-based and help offset the costs of uncompensated care provided by hospitals and other providers. UC payments are based on each provider's UC costs as reported on a UC application. (See Chapter 8, Medicaid Spending from All Angles.)

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 (see below for more information).

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 healthcare 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 Regional Healthcare Partnerships (RHPs), which

reflect existing delivery systems and geographic proximity. A map of the RHP regions can be found on the HHSC website at: <http://www.hhsc.state.tx.us/1115-docs/Regions-Map-Aug12.pdf>. The RHPs include public hospitals, public health care districts, health providers, and other stakeholders in a given region. 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 hospitals and other 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. Since 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 kinds of providers and governmental entities are key 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 hospitals, community mental health centers, local health departments, and physician practice plans, 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 be consistent with a regional shared mission, quality goals of the RHP, and CMS’ triple aims to improve care for individuals (including access to care, quality of care, and health outcomes); improve health for the population; and lower costs through improvements (without any harm whatsoever to individuals, families, or communities).

RHP plans must 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 demonstration year.

The RHP plans outlined projects and estimated funding levels for HHSC and CMS approval in fiscal year 2013. With leftover funding, RHPs had the opportunity to propose additional 3-year projects in late 2013.

As of December 2014, there were 1,273 approved and active 4-year DSRIP projects and 218 approved and active 3-year projects.

During years 2 and 3 of the waiver (October 2012 - September 2014), the projects focused on start-up activities, including developing project infrastructure. In 2014, projects also began reporting their direct patient impact and establishing benchmarks for project outcomes. Providers report twice a year (April and October) on annual project metrics and milestones completed in order to earn DSRIP payments.

HHSC is conducting a mid-point assessment in 2014/2015 to evaluate the progress of the projects so far, and to determine if they require any modifications or technical assistance to be successful.

Groups of providers and other DSRIP participants are meeting across the state through learning collaboratives to identify best practices, share ways to improve projects, and promote continuous quality improvement. HHSC also hosts an annual Statewide Learning Collaborative beginning in 2014.
