2014-2015

Health Care Innovation in Texas: Renewing the Medicaid Transformation Waiver

TEXAS HOSPITAL ASSOCIATION

Introduction

The Texas Health Care Transformation and Quality Improvement Program, otherwise known as the 1115 Medicaid Transformation Waiver, is redesigning the delivery of health care in Texas to make it more efficient and effective. The Waiver is a collaboration of the Texas Health and Human Services Commission, the Centers for Medicare & Medicaid Services and more than 300 local health care providers, including hospitals, community mental health centers, local health departments and physician groups.

Valued at nearly $30 billion over five years, the Waiver supports projects that improve access to needed services and reduce health care costs.

Waiver History

The 1115 Medicaid Transformation Waiver was born in 2011 from the need to control public health care spending in Texas. When the 82nd Legislature convened in January 2011, the state faced a $27 billion budget deficit. Expanding the use of Medicaid managed care throughout the state was seen as a fairly simple and highly effective means of injecting cost predictability and restraint into the health and human services system, which was consuming an ever-growing share of the state's budget. Budget analysts predicted that Texas could save approximately $400 million a year in state general revenue by expanding the use of capitated managed care statewide for Medicaid enrollees.

The cost to Texas hospitals of Medicaid managed care expansion, however, was the loss of $2.8 billion a year in supplemental payments from a program known as the "upper payment limit" program. This program was critical to maintaining the health care safety net in Texas since the state was reimbursing most hospitals at only 51 percent of costs. Under federal law, UPL payments and calculations are based only on fee-for-service spending. Expanding managed care statewide would significantly reduce fee-for-service spending and practically eliminate supplemental hospital payments. Losing nearly $3 billion in annual funding would have been catastrophic for the state's hospitals.

To preserve these supplemental payments and expand Medicaid managed care statewide, the state opted to pursue a five-year Section 1115 Medicaid Waiver that would allow it to:

- **Enroll more Medicaid beneficiaries into managed care;**
- **Reimburse hospitals for certain uncompensated care costs; and**
- **Implement innovative service delivery systems that improve care, increase efficiency and reduce costs.**

Waiver Financing: Uncompensated Care and Delivery System Reform Incentive Payment

Under the terms of the Waiver approved by the Centers for Medicare & Medicaid Services in December 2011, supplemental payment funding, managed care savings and other negotiated funding are allocated between two statewide pools worth $29 billion (All Funds) over the five-year Waiver period. As shown in the chart on page 2, funding from the pools is distributed to hospitals and other providers to support the following objectives:

- **An uncompensated care ("UC") pool to reimburse providers for the costs of care provided to low-income, uninsured individuals and for Medicaid under-reimbursement; and**
- **A Delivery System Reform Incentive Payment ("DSRIP") pool to incentivize hospitals and other providers to transform their service delivery practices to improve quality, health status, patient experience, coordination and cost-effectiveness.**

Of particular concern for Texas hospitals is the decrease in UC funding over the life of the Waiver, especially as the Waiver was negotiated under the assumption that the state would expand Medicaid coverage. While this funding decreases, the amount of uncompensated care provided by Texas hospitals and other health care providers is not decreasing. Existing funding sources do not offset all of the uncompensated care costs for Medicaid and

Waiver Renewal: Key Points

Worth up to $30 billion to communities across Texas.

❖

Reduces inefficient health care spending.

❖

Increases access to timely and appropriate health care services.

❖

Improves chronic disease management.

❖

Reduces unnecessary hospital readmissions.

❖

$11.5 billion in payments are earned, not simply given, by meeting performance metrics and demonstrating success.

❖

Positions Texas at the forefront of health care innovation.

❖

Efforts to renew the Waiver must begin now.

	Year 1 (2011-12)	Year 2 (2012-13)	Year 3 (2013-14)	Year 4 (2014-15)	Year 5 (2015-16)	Total
UC	$3.7B	$3.9B	$3.534B	$3.348B	$3.1B	$17.582B
DSRIP	$500M	$2.3B	$2.666B	$2.852B	$3.1B	$11.418B
Total/Year	$4.2B	$6.2B	$6.2B	6.2B	$6.2B	$29B
% UC	88%	63%	57%	54%	50%	60%
% DSRIP	12%	37%	43%	46%	50%	40%

uninsured patients. In addition, while DSRIP dollars are projected to account for a growing percentage of funding by the end of the five-year Waiver term, hospitals and other DSRIP providers must earn these dollars by meeting metrics and performance outcomes. If projects are not successful, hospitals do not earn DSRIP dollars. This is particularly important because many DSRIP projects required hospitals and other providers to invest a significant amount of their own funds up front to get the projects designed and implemented.

DSRIP performing providers report twice a year on project metrics and milestones, as agreed upon by THHSC and CMS. To date, DSRIP participants have earned payments of about $2.58 billion in all funds for metric achievement in the second and third years of the Waiver. Reporting in October will yield a next round of payments in January 2015 if the performing providers have met established metrics.

DSRIP Projects

There are currently 1,491 approved and active DSRIP projects operating throughout Texas. The vast majority (1,274) are four-year projects, with the remainder running for three years. Reflecting the statewide need for a stronger behavioral health care system, more than 25 percent of the approved projects focus on improving access to behavioral health care services. Among the rest of the projects:

- 20 percent focus on improving access to primary care;
- 18 percent focus on chronic care management and helping patients with complex needs navigate the health care system;
- Nine percent focus on improving access to specialty care; and
- Eight percent focus on health promotion and disease prevention.

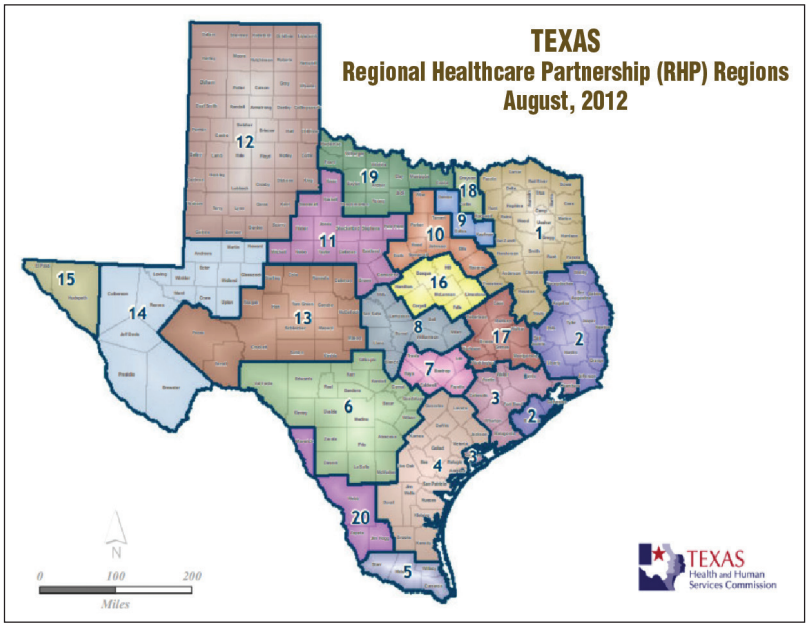
Managing so many projects requires a governing structure. The Waiver divides the state into 20 regional healthcare partnerships, each of which is coordinated by a public anchoring entity (see table on page 3). Each RHP designed a plan based on a community needs assessment that identified the priority health care needs for each particular region. Local DSRIP projects implemented by more than 300 participating providers across the state are designed to meet those priority health care needs.

DSRIP projects are homegrown and designed locally with local resources and partners to meet local needs. Importantly, however, these local projects taking place in communities across the state have national implications. Other states are beginning to look at Texas to see how the state has partnered with CMS to develop and implement a transformation project of a scale and scope not seen previously.

In addition, although DSRIP projects primarily serve the health care needs of the Medicaid and low-income uninsured populations, the effects of re-engineering the health care system are far-reaching and will benefit the privately insured as well.

DSRIP Projects: Innovation in Action

With nearly 1,500 local DSRIP projects underway in communities across Texas, there is no such thing as a representative DSRIP project that can serve as an example for the whole state. Nonetheless, the four projects described on pages 3 and 4 provide a glimpse into the DSRIP projects' scope and their impact on patient care and health care costs.



Successes in Improving Care

Regional Healthcare Partnership	Anchoring Entity
1	University of Texas Health Science Center at Tyler
2	University of Texas Medical Branch
3	Harris Health System
4	Nueces County Hospital District
5	Hidalgo County
6	University Health System
7	Travis County Healthcare District (Central Health)
8	Texas A&M Health Science Center
9	Dallas County Hospital District (Parkland Health & Hospital System)
10	Tarrant County Hospital District (JPS Health Network)
11	Palo Pinto General Hospital District
12	Lubbock County Hospital District -University Medical Center
13	McCulloch County Hospital District
14	Ector County Hospital District (Medical Center Health System)
15	University Medical Center of El Paso (El Paso Hospital District)
16	Coryell County Memorial Hospital Authority
17	Texas A&M Health Science Center
18	Collin County
19	Electra Hospital District (Electra Memorial Hospital)
20	Webb County

Telemedicine to Improve Access to Specialty Care and Reduce Wait Times: RHP 4 (Corpus Christi area)

To address the severe shortage of neurologists in RHP 4, one of the region's critical access hospitals implemented telemedicine to provide access to neurology care for patients with suspected stroke. In 2011, 53 patients with stroke symptoms presented at the hospital's ER, but without access to a neurologist, all were transferred to other hospitals. For those with stroke symptoms, timely access to appropriate diagnosis and treatment is essential.

IMPACT:

- **Early diagnosis**
- **Early treatment**
- **Improved health outcomes**
- **Reduced long-term health care costs**

John presented at the ER and was diagnosed by a neurologist via telemedicine as having acute ischemic stroke. Within just over an hour and a half of arriving at the ER, he was receiving prescribed treatment and was stabilized with no long-term visual field loss or palsy. In the absence of DSRIP-supported telemedicine, John would have been transported via ambulance to another facility more than 100 miles away, losing valuable time and increasing the probability of negative long-term health outcomes.

Community Care and Intensive Case Management To Reduce ER Visits: RHP 7 (Austin area)

To address the over-reliance on hospital ERs by area residents without health insurance for chronic illness management and medications, a large health system developed a community care and intensive case management program. Program team members assist patients in navigating the health care system, help with identifying and overcoming barriers – such as difficulty in obtaining medications or in finding transportation to appointments – and provide care in outpatient offices and in patient homes. The team includes a social worker who is available for counseling to help patients better handle problems in their lives and to find ways around hurdles that may have kept them from receiving appropriate medical care in the past.

Gloria, who struggles with diabetes and liver disease, visited the ER 11 times in 2013. After enrolling in the DSRIP-supported community care and case management program, Gloria has visited the ER only once.

IMPACT:

- **Better management of chronic diseases**
- **Care delivered at the right time in the right setting**
- **Improved health outcomes**
- **Reduced hospital ER use**
- **Reduced health care costs**

Nurse Case Management to Reduce ER Visits: RHP 9 (Fort Worth area)

RHP 9 encompasses a large urban area where more than 40 percent of the residents have low incomes. Lack of access to appropriate and timely community-based health care is a significant barrier to health for many of these residents. As a result, the hospital ER is often the primary source of health care and social services. To reduce ER reliance and improve access to community-based care and supports, a large hospital system implemented a nurse navigator program to provide care coordination and avoid unnecessary ER visits and hospitalizations.

IMPACT:

- **Better management of chronic diseases**
- **Care delivered at the right time in the right setting**
- **Improved health outcomes**
- **Reduced hospital ER use**
- **Reduced health care costs**

Susie had uncontrolled diabetes and asthma and struggled with multiple persistent psychiatric disorders. She also had no stable job history and was often homeless. Susie frequently relied on the hospital ER when her physical and behavioral health conditions were at a crisis point. In 2013, she had nine visits to the ER and four inpatient admissions. After enrolling in the DSRIP-supported navigation program, she had just one visit to the ER and no inpatient admissions. Her diabetes was under control and her emotional state was improved, allowing her to make better personal decisions. She also keeps her appointments with health care professionals and has an established place to live.

Crisis Stabilization Services for Those With Mental Illness to Avoid Hospitalization or Incarceration: RHP 2 (Galveston area)

The Gulf Coast Center's Bayou House Crisis Respite Care Center reopened in August 2013 with DSRIP support. Its goal is to stabilize individuals suffering from a mental health crisis through a short-term stay in its facility where clients receive guidance counseling and psychological and social rehabilitative services. In the absence of such a facility, individuals experiencing mental health crisis often end up in hospital ERs, inpatient psychiatric institutions or jails.

Jim came to the Bayou House after calling the center's hotline. Unable to speak without crying, Jim was homeless, had gone through a recent divorce and was severely depressed. He was also not receiving the social security retirement benefits to which he was entitled. Bayou House staff took Jim to the social security office and got his social security retirement payments started. He was also connected to a psychiatrist who started him on anti-depressant medications. After a week at the Bayou House, Jim was emotionally stronger and able to make a plan for his future. He received his first social security check a month after visiting the social security office and was discharged from Bayou House to friends in Galveston.

IMPACT:

- **Improved social service support and mental health care for those in mental health crisis**
- **Improved health outcomes**
- **Reduced hospital ER and inpatient use**
- **Reduced incarceration**
- **Reduced health care and other public costs**

Key Dates

- RHP plans submitted to THHSC: Dec. 31, 2012
- CMS initial approval of most four-year DSRIP projects: May 2013
- CMS initial approval of most three-year DSRIP projects: May 2014
- Transition plan to be submitted to CMS: **March 31, 2015**
- Waiver renewal to be submitted to CMS: **Sept. 30, 2015**
- CMS to approve or deny waiver renewal: **March 30, 2016** (only if the state's Waiver renewal request is for three years and has no changes to the Waiver terms and conditions)
- Waiver to expire: **Sept. 30, 2016**

Questions should be addressed to John Hawkins, senior vice president of advocacy and public policy, at jhawkins@tha.org or 512/465-1505.

393-092914