Texas Health Care Transformation and Quality Improvement Program - FAQ

http://www.hhsc.state.tx.us/1115-faq.shtml

1115 Waiver Approval and Effective Date

Why is HHSC seeking an 1115 waiver under the Social Security Act?

HHSC is seeking a waiver under section 1115 of Social Security Act because that section allows the Centers for Medicare & Medicaid Services (CMS) and the states more flexibility in designing programs to ensure delivery of Medicaid services to eligible recipients. Section 1115 waiver authority will allow HHSC to expand managed care throughout the state while maintaining historic supplemental Medicaid funding to hospital providers.

When will the waiver start?

The waiver effective date will be December 2011. The managed care expansion will occur in two phases: the first expansion in September 2011 to counties contiguous with existing managed care service areas of the state and the second expansion in March 2012 to the remaining areas of the state.

When will the waiver be approved?

HHSC is working with CMS to obtain its approval and approval from its federal partners for the waiver by September 2011.

What happens if CMS doesn't approve the waiver?

If CMS does not approve the 1115 waiver, the current 1915(b) and 1915(c) waivers will remain in effect and amended as necessary to expand managed care. Also, the current managed care waivers would be amended to carve out inpatient hospital services from the managed care capitation rates for the programs that currently include those services in the capitation in order to preserve supplemental payments for hospitals. HHSC also would be required to achieve equivalent cost savings for the state by adjusting provider payment rates or other measures.

Changes to Hospital Supplemental Funding

How will hospital upper payment limit (UPL) programs change under the 1115 wavier?

UPL programs in Texas Medicaid will end after the waiver is approved, for services under managed care capitation and for residual fee-for-service Medicaid services. The 1115 waiver will take the place of the UPL programs as a way for providers to get payments for uncompensated care costs for services provided to Medicaid eligible patients and uninsured patients and incentive payments for health care quality and delivery system reforms.

How will payments be made under the new waiver program?

HHSC is seeking CMS approval for a transition period in the first year of the 1115 waiver. Starting September 2011, hospitals will receive transitional payments similar to prior year's payments or based on the current DSH Hospital Specific Limit methodology to ensure financial stability for hospitals as the state transitions to the new waiver payment methodologies effective in the second year of the waiver.

How will the amount of funding available under the waiver compare to current UPL payments?
Under the waiver, hospital providers may have the ability to leverage more supplemental funding than was available under the UPL programs because of an expanded definition of "uncompensated care" and the addition of incentive payments for health care quality and delivery system reforms.

Will hospitals receive the same amount of funding as they do today?

Hospitals will receive transitional funding for one year consistent with current funding to provide system stability during a transition to funding based on waiver criteria. As under the current UPL program, a hospitals' access to waiver funding will depend on IGT contributions from public entities.

The waiver sets criteria for receipt of funds based on uncompensated care costs (uninsured and unreimbursed cost of serving Medicaid patients) and based on meeting DSRIP requirements identified in approved Regional Healthcare Partnership plans. The waiver includes one year transitional funding to provide system stability, but the waiver is not intended to preserve the status quo on hospital funding.

How will the funding work under the waiver?

The 1115 waiver will provide HHSC the authority to make two types of payments to hospitals: payments for uncompensated care to Medicaid eligible patients and uninsured patients and incentive payments for health care delivery system reforms. Both types of payments will require the

hospital to be a Medicaid-enrolled provider and to have an intergovernmental transfer (IGT) of public funds submitted to the state, by the provider or on its behalf, to serve as the non-federal share of the payment.

Uncompensated care payments will be made to providers that submit a waiver application documenting unmet costs of providing hospital and non-hospital services to Medicaid patients and uninsured patients. The non-hospital service costs include physician costs, other non-physician professional costs, clinic costs, and outpatient drug costs. The addition of these non-hospital costs differentiates the uncompensated care payment under this waiver from a payment under the Disproportionate Share Hospital (DSH) program.

Incentive payments will be made to providers that participate in health care quality and delivery system reforms – this is referred to as the Delivery System Reform Incentive Payment (DSRIP) program. Providers will participate in developing a plan for their region that is a result of collaboration through a Regional Healthcare Partnership. After the plan is approved and in place, the regional partnership will measure and report the outcomes of the region's reform initiatives as the basis for DSRIP payment to qualifying hospitals.

What will providers need to submit for the new payments?

For uncompensated care payments, a provider must submit a waiver application that documents uncompensated care costs for providing hospital and non-hospital services to Medicaid patients and uninsured patients. Non-hospital service costs (costs incurred by a hospital but not allowable under current DSH requirements) can include physician costs, other non-physician professional costs, clinic costs, and outpatient drug costs. The waiver application is currently being developed and HHSC will provide preliminary instructions for completing it.
For DSRIP payments, providers must develop and submit a plan for reform in their region, which is the result of collaboration through a Regional Healthcare Partnership. After the plan is approved and in place, the regional partnership will measure the outcomes of the region's reform initiatives. In the first year of the waiver, incentive payments to public coordinating hospitals will be made based on development and submission of the plan. In later years of the waiver, payments from the DSRIP will be based on meeting defined objectives in the region's plan.

Are there limitations on what waiver funds can be used for? Waiver funds cannot be used for new construction.

Senate Bill 7, 82nd Legislature, First Called Session, 2011, prohibits the use of waiver funds to finance the construction, improvement, or renovation of a building or land unless that construction is approved by HHSC. The commission will be adopting rules for that process.

Will private hospital UPL affiliation agreements be affected by the waiver?

New agreements are not required for hospitals currently participating in the private UPL program to receive payments during the first year of the waiver. However, the way uncompensated care and DSRIP payments are made may create opportunities for change in some existing private hospital UPL affiliation agreements. Existing affiliation agreements that meet the requirements of the waiver may remain in place. Before negotiating an affiliated agreement for the second year of the waiver, hospitals should be aware of how the waiver application will capture costs that are the basis for allowing uncompensated care pool payments.

How will private hospitals be paid for September 2011?

HHSC will pay all current eligible UPL hospitals, public and private, for the month of September in the regularly scheduled federal fiscal year 2011 fourth quarter UPL payment. These payments will be subject to the current federal fiscal year 2011 computed aggregate cap limits and receipt of a valid IGT. HHSC is seeking approval from CMS that future waiver payments correspond to the federal fiscal quarter .

Some large service providers (such as ambulance services or physician practice groups) that are now contracting with non-profit organizations may be contracting with a public hospital once the waiver is operational. Should current service/provider contracts be terminated, revised, or renegotiated before September 2011?
HHSC does not anticipate that the obligations of the parties to the service/provider contracts will be affected during the first year of the waiver. Based on the proposed methodology of computing individual hospitals uncompensated care pool caps on historic UPL payments, it is recommended that the entities that incurred the cost of any service/provider contracts during fiscal year 2011 continue those contracts if appropriate, in the transition year (state fiscal year 2012) as they would be the entity eligible for the reimbursement of those costs.

HHSC's intent in developing and seeking CMS approval for a one-year transition period is to provide an opportunity for financial stability for hospitals currently participating in UPL as the new waiver payment methodologies are implemented.

Will HHSC require public hospitals to provide the same level of IGT as they do today?

As with the current private UPL program, the state does not require a specific level of IGT participation by the eligible public entities. Future IGTs will continue to be voluntary.

Does the waiver require counties to obligate funds for five years?

No. While there will be a four year plan developed within each region that will estimate for each year of the plan the amount of IGT needed to draw the federal funds that will be used to fund both uncompensated care and projects from the DSRIP pool, these plans require only an estimate of the IGT funds that is anticipated to be used. Both the state and CMS understand that the counties cannot obligate funds for five years and that the actual amount of IGT available may change from year to year.

How will the Disproportionate Share Hospital (DSH) program be affected?

The DSH program will continue to operate under the state plan in coordination with the waiver. Existing rules related to DSH caps and hospital participation will remain. Any changes to the DSH program would be requested to CMS through the existing state plan amendment process. HHSC intends to make changes to the DSH program at a later time to complement the system transformation made possible through the waiver.

How will the waiver help hospitals increase access and improve quality?

Both increased access to care and improved quality (along with cost-effectiveness and increased coordination) are among the waiver goals. Under the waiver, hospitals can access uncompensated care funding for health care provided to individuals who are uninsured and to Texans enrolled in Medicaid. Uncompensated care funding under the waiver also can be used to make up the difference between Medicaid costs and Medicaid payments if IGT is available. In addition, DSRIP funds could be available for approved DSRIP projects to support increased access to health care, system improvements for more efficient delivery systems, and improvements in quality which can help reduce hospital costs. HHSC will work with the Regional Healthcare Partnerships and stakeholders as it develops DSRIP protocols and metrics to develop workable approaches to support system improvements.

What is the integrated payment model mentioned in the waiver request?

HHSC will study the feasibility of integrating Diagnosis Related Group (DRG)-based hospital payments with pool payments. The integrated payment would flow through the managed care organizations to hospitals

based on the hospital's performance. This is included in the waiver as a study under the DSRIP program but is not a required payment methodology under the waiver.

Changes to Physician UPL Supplemental Funding

Will HHSC still pay supplemental payments for services provided by physician practice groups under the 1115 waiver?

Uncompensated care payments under the waiver may cover the unmet cost of providing physician services to Medicaid patients and uninsured patients. HHSC will seek clarification from CMS as to whether payments out of the pool may be made to qualifying physician practice groups where appropriate.

Will the payments still be calculated based on 145 percent of the Medicare rate?

Uncompensated care payments under the waiver will be limited to the cost of providing services, and therefore the current physician supplemental funding methodology using 145 percent of the Medicare rate will no longer be used. However, HHSC will compute transition payment caps for the first year based on historical Physician UPL payments.

Regional Healthcare Partnerships

What are Regional Healthcare Partnerships?

A Regional Healthcare Partnership is a collaboration of providers that work collectively to develop and submit to the state a regional plan for health care delivery system reform. The regional partnership will be led by the public hospital provider or providers in the region that agree to provide the intergovernmental transfer (IGT) of public funds as the state share for payments to providers in that region from the DSRIP program under the waiver. Regional Healthcare Partnerships will support coordinated, efficient delivery of quality care and a plan for investments in system transformation that is driven by the needs of local hospitals, communities, and populations, rather than a top-down, one-size-fits-all approach.

Who can participate in a Regional Healthcare Partnership?

Regional Healthcare Partnerships are created and led by public hospitals or local governmental entities responsible for funding the state match in partnership with regional health stakeholders. A provider may join a

partnership if it obtains an affiliation with an entity that provides IGT, participates in the regional plan, and meets related objectives, reporting, metrics, and other criteria defined under the DSRIP program. The rules for developing and implementing a Regional Healthcare Partnership are being formulated in negotiation with CMS.

What is a Regional Healthcare Partnership plan and what is it for?

It's a five-year plan that outlines projects that support delivery system reforms tailored to the needs of the communities, the state and populations served by the regional partnership. The plans will include regional assessments, goals, rationale for projects, annual milestones, metrics, and expected results.

Who approves a Regional Healthcare Partnership plan?

CMS, the state, and hospital representatives will create a model, including required and flexible locally-driven categories and components, for Regional Healthcare Partnership plans. This will serve as the basis for ensuring compliance with the waiver. The state will have responsibility for review and approval of individual plans.

What are the boundaries of the Regional Healthcare Partnerships and who sets them?

HHSC proposes structuring Regional Healthcare Partnerships initially based on the managed care service areas for the 16 large transferring hospitals. The regions initially will be based on current public hospital counties and IGT-based affiliation agreements. For county transferring entities, regions will be based on current public entity governmental areas and IGT-based affiliation agreements. Plans would be updated annually to reflect expanded areas and stakeholders.

Does the waiver legally remove issues with provider related donations?

The federal restriction on provider related donations will remain unchanged. Documentation of uncompensated care costs that provides the basis for payments from the uncompensated care pool in the waiver will increase accountability and transparency for the use of these dollars.
In the development of Regional Healthcare Partnerships, will local stakeholders vote on counties' use of funds?
No, counties and other entities providing state share will control how their funds are used in the waiver.

Waiver Pool Funds

How are the waiver pool funds determined?

The amount of waiver pool funds will reflect the difference between the without-waiver baseline and the with-waiver baseline in the budget neutrality model. This includes hospital supplemental payments previously allocated through the UPL program for all populations, UPL equivalent payments for the current STAR population, supplemental payments allocated through the physician UPL program, and savings from managed care expansion. The waiver pool funds are calculated for the five years of the waiver.