The Extension of the Texas 1115 Waiver ? What is Next'

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With only nine days left before the expiration of the existing 1115 Waiver, in late December 2017, the Centers for Medicare & Medicaid Services (CMS) approved another extension of the 1115(a) demonstration project, “Texas Healthcare Transformation and Quality Improvement Program” (2017 Waiver) for an additional five-year term from October 2017 to September 2022. The 2017 Waiver extension will allow the state to maintain its use of capitated Medicaid managed care model to continue to improve the delivery of healthcare to Texans. The 2017 Waiver is still funded by supplemental payments and managed care savings, but it should be noted that, at an estimated $25 billion over five years, it will receive $2 billion less in funding than the previous 1115 Waiver. According to the Texas Health and Human Services Commission (HHSC) Executive Commissioner, Charles Smith, the renewal “preserves critical support for the state’s hospital safety-net” by providing needed funding through the Uncompensated Care (UC) pool, without which, hospitals serving vulnerable patient populations would face potentially insurmountable financial struggles. Whether the renewal ultimately lives up to the Executive Commissioner’s lofty expectations remains to be seen; the 2017 Waiver comes with new requirements and potentially far-reaching modifications.

Prior Texas Waivers

In 2011, Texas’s first 1115 Waiver (2011 Waiver) began and was originally set to expire in September 2016, but its term was extended by fifteen months to December 2017. Using the authority and flexibility provided by the 1115 Waiver in designing its Medicaid program, Texas implemented alternative strategies geared primarily toward cost-containment and improvement of statewide access to care.[1] The principal mechanisms through which the 2011 Waiver sought to accomplish its approved objectives included:

- **MMC**: Expansion of Medicaid managed care (MMC) from regional to statewide coverage through STAR, STAR+PLUS, and Children’s Medicaid Dental Services
- **UC**: State and federal shift in hospital reimbursement for uncompensated care from the Upper Payment Limit program to an UC pool, which was designed, in part, to change the focus from claims to costs incurred
- **DSRIP**: Creation of an incentive pool, called the “Delivery System Reform Incentive Payment” (DSRIP) program in order to enhance state healthcare infrastructure and develop innovative approaches to improving healthcare quality and control costs. DSRIP allowed providers to earn payments for meeting certain CMS and HHSC-approved reporting and performance metrics for “a wide range of innovative projects”[2]

The HHSC’s May 2017 Final Evaluation Report described the 2011 Waiver as a “massive experiment in transforming healthcare.” The report employed stakeholder surveys to assess overall satisfaction and perceived areas of strength and weakness. Commonly identified strengths included: (i) increased available funding, (ii) opportunities for innovation, (iii) support for partnerships between public and private organizations, and (iv) accountability systems.[3] And, reported areas of weakness related primarily to: (i) the exclusion of certain types of services and

providers, (ii) competing priorities and agendas, (iii) limited menu of DSRIP project options, and (iv) time and effort constraints related to defining and understanding new systems for implementing, documenting, and reporting UC and DSRIP activities.[4]

The 2017 Renewal

The 2017 Waiver retains the three major components of the 2011 Waiver—statewide Medicaid managed care, the UC pool, and the DSRIP incentive pool—subject, however, to new standards and additional requirements. The most substantial changes among the modifications outlined in CMS's approval relate to the gradual elimination of DSRIP funding and the new method for calculating and distributing UC payments.

DSRIP

Under the 2017 Waiver's terms, federal matching funds of DSRIP activities will be reduced each year until it ceases entirely in 2021, at the end of the fourth year. HHSC must submit a transition plan to CMS, establishing protocols for how delivery system reforms will continue to operate as DSRIP funding is phased out or, alternatively, how DSRIP programs will be phased out along with the funding. In addition, HHSC was required to draft a new Program Funding and Mechanics (PFM) protocol that explains how Texas will implement the new Special Terms and Conditions (STCs) relating to DSRIPs. CMS approved the new PFM and described some of its major updates:

> [Texas] has improved its measure bundles to focus more on outcome measures, added a robust and comprehensive attribution methodology, refined the process by which providers may distribute funding across measure bundles, included a suitable and accountable performance and payment methodology for providers with high or maximized performance baselines, and enhanced how providers will specify, link and report core activities to outcome.[5]

While the DSRIP allowed for innovative healthcare delivery projects and increased access to care under the 2011 Waiver, with the decreased funding and the state's reliance on Medicaid managed care, it is unclear whether there will be any new funding opportunities for healthcare providers in the 2017 Waiver's DSRIP.

Uncompensated Care

While not as severe on its face, the 2017 Waiver's new methodology regarding the calculation and distribution of UC payments could end up affecting healthcare delivery in Texas even more than the DSRIP funding wind-up. As a condition of the renewal, the current "UC tool" must be transitioned into a modified "S-10 Worksheet" in order for UC payments to be calculated and distributed based upon hospital charity care costs alone, excluding costs associated with Medicaid shortfall or bad debt.[6] While this will not affect the first two years of the 2017 Waiver, these changes may cause a substantial reduction in UC funding beginning in 2020, which is the first year where UC funding will be directly tied to the new S-10 formulation of charity care costs.[7]

Under the 2011 Waiver, UC pool payments were calculated based on the cost of all services furnished to Medicaid beneficiaries and uninsured patients, minus all payments received. The cost-based payment structure also included the difference between the amount of Medicaid's reimbursement for a given service and what Medicare would pay for that service (i.e., the Medicaid "shortfall" referenced above). The 2011 Waiver's data tool also incorporated a broader definition of

charity care than that under the S-10, which defines charity care based on strictly construed principles developed by the Healthcare Financial Management Association.[8] The UC payment protocol (due to CMS by March 30, 2018) must include precise definitions of eligible uncompensated provider charity care costs for each qualifying provider type. After the definitions are established, it will be critical for all providers to accurately report 2017 charity costs, as widespread failure to do so will cause UC payments to default to the reduced amount of $2.3 billion for 2020-2022 until all charity costs have been accurately reported.[9] Moreover, if the HHSC fails to meet any of the prescribed deadlines, CMS will impose a 20 percent reduction in expenditure authority from the UC pool for the applicable year.

The effective dates of the changes in UC and the winding down of DSRIP funding over the 2017 Waiver's term, as well as other important deadlines to watch, are described in more detail in the table below.

Conclusion

As the effects of the 2017 Waiver take shape, the Texas healthcare industry must remain informed about the changes described above and the respective timelines shown below. The funding provided under the 2011 Waiver was instrumental in granting Texas healthcare providers the opportunity to be innovative in their delivery of care, while allowing the state to expand Medicaid managed care. Accordingly, the 2017 Waiver's modifications will likely not change the state's objectives to continue increasing industry integration and access to healthcare via the managed care system. However, as DSRIP will be phased out, it is unclear if some of Waiver's funds will be available to support other programs, or if the original DSRIP projects will be continued or incorporated into managed care. Moreover, the impact of UC pool changes, particularly in relation to charity care hospitals, while currently uncertain, will become more evident with each passing deadline over the new Waiver's five-year term.

Year	DSRIP Funding	Uncompensated Care Pool	Required Actions and Other Key Dates
10/1/17-9/30/18	$3.1 Billion	≈ $3.1 Billion	*1-1-18*: CMS approved HHSC's revised PFM. *3-30-18*: HHSC must submit draft UC funding & reimbursement protocol to CMS. *7-31-18*: Upon CMS approval of UC payment protocol, HHSC must publish notice of proposed rulemaking and public hearing in Texas Register.
10/1/18-9/30/19	$3.1 Billion	≈ $3.1 Billion	*1-30-19*: HHSC must publish final administrative rules to implement required UC pool distribution methodology, to be effective by *9-30-19*. *5-1-19*: HHSC must submit revised UC application tools for all provider types. *8-31-19*: CMS deadline for approving revised UC tools. *9-30-19*: Final effective date for Texas Administrative Code rules on UC pool distribution methodology.

10/1/19-9/30/20	Reduced to $2.9 Billion	Resized and adjusted based on 2017 S-10 charity care costs (or $2.3 billion default)	*10-1-19*: New UC pool distribution methodology implemented. *10-1-19*: HHSC must submit DSRIP transition plan to CMS. *3-31-20*: Final DSRIP transition plan must be approved by CMS.
10/1/20-9/30/21	Reduced to $2.5 Billion	Resized and adjusted based on 2017 S-10 charity care costs (or $2.3 billion default)	
10/1/21-9/30/22	No Funding	Resized and adjusted based on 2017 S-10 charity care costs (or $2.3 billion default)	*10-1-21*: Federal matching funds for DSRIP are discontinued.

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[1] Letter from John Cornyn, Senator, et al., U.S. CONGRESS to Hon. Thomas E. Price, M.D., Sec., DHHS, & Hon. Seema Verma, Admin., CMS (June 7, 2017).

[2] *Evaluation of the 1115(a) Tex. Demonstration Waiver – Healthcare Transformation and Quality Improvement*, Final Evaluation Report, TEX. HHSC (May 30, 2017).

[3] *Id.* at 30.

[4] *Id.* at 29. Letter of approval from CMS Dir. of Sys. Reform and Demonstrations to Stephanie Muth, Texas Medicaid Assoc. Comm'r. of Medicaid and CHIP (Jan. 19, 2018).

[5] Letter of approval from CMS Dir. of Sys. Reform and Demonstrations to Stephanie Muth, Texas Medicaid Assoc. Comm'r. of Medicaid and CHIP (Jan. 19, 2018).

[6] Certain hospitals—primarily children's, cancer, and rehabilitation hospitals—will not be required to complete the S-10, in which case an alternate methodology using CMS-approved cost reports will be used to determine charity costs. *See* Letter of approval from Seema Verma, Admin., CMS, to Charles Smith, Exec. Comm'r, HSSC; *see also* *Milestones for Texas' New Medicaid 1115 Waiver*, TEX. HOSP. ASS'N (Jan. 2018) (hereinafter *Milestones*).

[7] *See Milestones, supra*, note 14.

[8] HMA Weekly Roundup: Trends in State Health Policy, HEALTH MGMT. ASSOCS. (Jan. 24, 2018).

[9] *Texas Medicaid Waiver Renewal – Summary*, HHSC RATE ANALYSIS DEPT (Dec. 29, 2017).