

## Texas STC 48 Transition Plan

### **Special Terms and Conditions (STC) 48 Requirement**

Transition Plan for Funding Pools. No later than March 31, 2015, the State shall submit a transition plan to CMS based on the experience with the Delivery System Reform Incentive Payment (DSRIP) pool, actual uncompensated care (UC) trends in the State, and investment in value based purchasing or other payment reform options.

### **Introduction**

The Texas Healthcare Transformation and Quality Improvement Program 1115 demonstration waiver (waiver) has several major components, including authorization for Texas' largest statewide Medicaid managed care programs and two funding pools totaling \$29 billion over five years. The two pools are funded from Texas' historic upper payment limit (UPL) supplemental payment programs and managed care savings. The Texas Health and Human Services Commission (HHSC) understands that the intent of STC 48 is to provide, prior to the formal waiver extension request, an update on the experience with the pools and other value based payment efforts as well as an indication regarding what Texas would propose to do with the two funding pools after the five year demonstration period ends on September 30, 2016.

Centers for Medicare and Medicaid Services (CMS) staff indicated that when the waiver was negotiated and approved in late 2011, the need for the UC pool could decrease as more uninsured Texans were covered under the Affordable Care Act, and the need for the DSRIP pool also might decrease based on the healthcare delivery system improvements achieved during the five year demonstration. HHSC certainly shares the goals of reduced need for UC funds and improvements in how healthcare is delivered in Texas. However, the reality is that the UC burden in Texas has not decreased since 2011 and it took longer than anticipated to get the Texas DSRIP program up and running due to the required infrastructure and collaborative nature of the regionally-based program. Texas continues to need both of these funding pools.

Texas has successfully transitioned from its former UPL programs to the DSRIP and UC pools, which together support the Texas safety net for low income Texans while incentivizing providers to test initiatives to improve patient care and outcomes. HHSC and Texas stakeholders are proud of the groundbreaking work that DSRIP has enabled, including increased regional and cross-regional collaboration between diverse healthcare providers and stakeholders and investments in infrastructure and innovation that Texas plans to build upon to further strengthen healthcare delivery systems. The statewide Medicaid managed care programs in the waiver, together with the two pools, stabilized Medicaid spending growth, as Texas is well under the five year budget neutrality cap for the demonstration. At the same time, Texas' population has grown an average of 7.2 percent per year during the past four years, more than double the national rate of population growth. This is yet another major factor contributing to the need for ongoing funds to support healthcare delivery in the state.<sup>1</sup>

When Texas submits its extension request in September 2015, HHSC plans to request during the extension period 1) to continue at least the demonstration year (DY) 5 funding level for DSRIP (\$3.1 billion annually) and 2) a UC pool equal to the unmet UC need in Texas. Based on current projections, the funding levels between the two pools could be increased and still allow Texas to remain within federal budget neutrality for future waiver years.

---

<sup>1</sup> Population, percent change - April 1, 2010 to July 1, 2014 -Texas 7.2%, USA 3.3%  
Source: U.S. Bureau of the Census, Population Estimates Program (PEP). Updated annually.  
<http://quickfacts.census.gov/qfd/states/48000.html>

State goals for the pools for the extension period:

- Continue to support the healthcare safety net for Medicaid and low income uninsured Texans.
- Further incentivize transformation and strengthen healthcare systems across the state by building on the Regional Healthcare Partnership (RHP) structure.
- Maintain program flexibility to reflect the diversity of Texas' 254 counties, 20 RHPs, and over 300 DSRIP providers.
- Improve project-level evaluation to identify the best practices in DSRIP to be sustained and replicated.
- Further integrate DSRIP efforts with Texas' Medicaid managed care quality strategy and other value based payment efforts.
- Work to streamline the DSRIP program to lessen the administrative burden on providers while focusing on collecting the most important types of information.

### **Experience with the DSRIP Pool**

**The DSRIP program is showing great promise to improve healthcare delivery systems and quality of care. However, more time is needed for the projects to mature beyond their implementation phase and to evaluate which initiatives demonstrate the most promising practices.**

The collective effort from CMS, HHSC, and Texas stakeholders to develop and implement the DSRIP program has been remarkable. There currently are 1,483 active DSRIP projects performed by 305 providers that have earned over \$4.5 billion (all funds) to date for achievement of over 11,800 milestones across DSRIP categories 1-4. DSRIP providers include public and private hospitals, physician groups, community mental health centers, and local health departments. There is great variation in the 305 providers - urban and rural, large and small, public and private, nonprofit and for profit. These providers often are partnering with other entities in their communities to carry out their projects, including federally qualified health centers, healthcare and social services non-profit organizations, and the criminal justice system. The projects focus on infrastructure (Category 1) and innovation (Category 2), both of which are very much needed to improve healthcare delivery in Texas. Texas DSRIP involves projects across the care continuum, with many projects focusing on primary and preventive care, behavioral healthcare, and better coordination of care for those with the most complex needs. Texas' DSRIP model recognizes that whole person health involves physical healthcare, behavioral healthcare, disease prevention and health promotion, and recognition of the social determinants of health.

One strength of the Texas DSRIP program is its regional approach - providers and other stakeholders in 20 regions throughout the state (encompassing 254 counties) formed RHPs, conducted needs assessments to identify priority healthcare needs in each region, and proposed a diverse array of projects to help address those needs. HHSC held a statewide learning collaborative summit in September 2014 with over 460 people in attendance and many others participating via webinar. A key takeaway from the summit was that DSRIP and the RHP structure have encouraged collaboration across the continuum of care among providers who previously had not worked together as much. For example, the over 400 DSRIP projects that focus on behavioral healthcare have led to increased collaboration between community mental health centers, hospitals and other providers. This increased collaboration is also evident in the early results from the formal waiver evaluation, which show many new connections between RHP participants since the outset of the DSRIP program. In its waiver extension request, HHSC plans to propose ways to further strengthen the systems of care that DSRIP has helped build across the state and link this success to better population outcomes. These system changes are critical for providers to continue to better care for their communities and provide UC. Texas' DSRIP program is locally driven, and HHSC will request continued flexibility, such as in project and outcome options, to enable the RHPs and their local providers to implement the projects that are most needed in their communities.

There were multiple delays in the implementation of the DSRIP program as a whole, and that delay makes it difficult to determine at this time the effectiveness of any one DSRIP project. CMS, HHSC, and Texas DSRIP

participants worked diligently to implement the new program, but given the size and scope of Texas' DSRIP program, CMS did not approve projects until mid-2013 to mid-2014, more than halfway through demonstration years (DYs) 2 and 3. DSRIP projects are either four-year projects or three-year projects, so those that required time to establish project infrastructure may still be fairly early in their implementation. In particular, there were some regions of the state, including South Texas (which has great needs), that due to lack of local funding to support projects during the initial RHP plan submission got a later start on many of their projects. HHSC is working with an independent assessor now to perform a mid-point review of projects, and will request from CMS that those projects that are in good standing at the end of this waiver term be afforded more time to serve patients with the systems they have built, focusing on Medicaid and low-income uninsured individuals. HHSC also will request that DSRIP funds not tied to these existing projects be used to expand exceptionally strong projects and/or for new projects with high potential to further transform healthcare delivery in Texas.

Additionally, there were multiple revisions to the two protocols that govern the DSRIP program - the Program Funding and Mechanics (PFM) Protocol and the Regional Healthcare Partnership (RHP) Planning Protocol. The latest substantive revisions to the protocols were completed in May 2014, more than halfway through the five-year waiver term. Program requirements changed for RHPs and their participating DSRIP providers numerous times. One request HHSC receives frequently is to stop changing the program requirements to allow providers to focus on carrying out their projects rather than having to keep up with the many administrative changes to this complex program. HHSC plans to propose in its extension request ways to streamline the DSRIP program to lessen the administrative burden on providers, the State, and CMS, while focusing on collecting the most important types of information.

Notably, in February 2014 the framework for Category 3 DSRIP outcomes, which are the outcome measure(s) associated with each Category 1 or 2 project, changed substantially at CMS' request. This change led to project outcome selections being finalized in August 2014 and outcomes baseline data reporting beginning in October 2014. HHSC will begin to collect data on outcome measure improvements over baseline in October 2015, after the waiver extension request is due. More time is needed to assess the impact of projects on the chosen outcome measures since outcome selections were only finalized in August 2014 and measurement cannot be done prior to completion of the collection of project data. Additionally, while HHSC believes this information will be a key data point that can be used to evaluate projects' effectiveness, such information will only provide a partial picture of the direct impact of each project given that in most cases outcome measures were required to measure populations broader than those served by the project. Also, for many of the DSRIP projects, such as those that focus on chronic diseases, more time is needed to even show intermediate outcomes, as measurement of improvement takes place over a period of many years, not months. HHSC plans to work with DSRIP participants and a recently established Clinical Champions group, comprised of clinical, quality, and operational stakeholders, to determine whether to propose further refinements to Category 3 to ensure that population health improvements are able to be captured for diverse DSRIP provider types and patient populations, including related to pediatrics and behavioral healthcare.

Early DSRIP results show that the program is beginning to improve care for individuals as well as improve population health. A snapshot of the 20 RHPs, their priority community needs and the direct patient impact of some of their projects is demonstrated in a presentation from the September 2014 statewide summit: <http://www.hhsc.state.tx.us/1115-docs/RHP-Snapshot-HHSC-SLC-2014.pdf>. See Attachment A for additional information that demonstrates the variety of Texas DSRIP projects. One component required for each Category 1 or 2 project is a "quantifiable patient impact" (QPI) - the number of additional individuals served and/or encounters provided as a result of the DSRIP project. QPI information is heavily weighted to the final two years of the waiver - DYs 4 and 5 (federal fiscal years 2015 and 2016) - to allow for project development and ramp up, but many projects began to report patient impact in DY 3 as well.

In addition to data from Categories 1, 2 and 3, there are learning collaborative activities across the state that are helping further the success of DSRIP through rapid, continuous quality improvement activities. Nine regional learning collaboratives are focusing on behavioral healthcare, including integrated care, and other common topics include decreasing preventable readmissions, improving care transitions/patient navigation, and increasing patient engagement. The learning collaboratives have encouraged data sharing and analysis.

For example, an RHP 15 learning collaborative for diabetes care reviewed data regarding foot and eye examinations at various clinics, shared referral documentation and marketing materials to educate patients and clinicians about these important services, and months later confirmed a noticeable improvement in these examinations being conducted. Additionally, to support learning collaborative activities some regions are developing shared tools and resources (such as online searchable databases to assist patient navigation) and Plan-Do-Study-Act (PDSA) templates and trainings. See Attachment A for examples of tools developed by two of the regions to share information about their DSRIP projects.

Finally, in Category 4, HHSC and CMS are collecting hospital-level data that will show whether there are improvements in a number of broad population-based measures, including potentially preventable events (hospitalizations, readmissions and complications), emergency department care, and patient-centered care.

Texas needs to continue the DSRIP pool to provide financial support for the innovative activities that have been initiated by local communities through DSRIP thus far. One of HHSC's primary goals for the waiver extension period is to work with CMS and Texas DSRIP stakeholders to determine how to best evaluate which of the projects are "benchmark" projects to sustain and replicate in the Texas healthcare delivery systems for Medicaid and the low income uninsured. To that end, HHSC established a Clinical Champions workgroup in early 2015 that includes clinical, quality and operational experts from around the state. HHSC plans to work with the Clinical Champions to help inform next steps for how to best evaluate the merits of DSRIP projects and how to further strengthen healthcare systems.

### **Uncompensated Care Trends in Texas**

**Texas' UC burden is increasing rather than decreasing, and the existing funding sources do not offset all UC costs. In order to support and maintain the healthcare safety net throughout the state, Texas needs access to a UC pool that, along with other funding sources, reflects the actual amount of uncompensated care provided.**

As the cost-based alternative to Texas' former UPL programs, the UC pool is a key financing component for the healthcare safety net in Texas. UC funds are critical to Texas' health system, especially as Medicare hospital rates and Medicare Disproportionate Share Hospital (DSH) have been reduced and with potential decreases in the federal allocation of Medicaid DSH funds made to Texas.

Texas is proud that both public and private hospitals in Texas participate actively in Medicaid and that Medicaid enrollees have a choice of hospitals for their care. Over 80 percent of Texas Medicaid hospital bed days were at private hospitals in 2012. If UC in Texas grows without offsetting funding sources, the safety net infrastructure in Texas will be weakened and low-income patients either may not have access to care or may have more limited choices for care. UC funds also complement DSRIP in that they provide financial stability to hospitals and other providers to enable them to make investments to improve healthcare delivery that they otherwise may not have been able to make.

There are many factors that contribute to Texas' growing UC burden, including high uninsured rates (over 22 percent) and continued population growth outpacing other states. In addition, the expected UC burden will increase owing to CMS' changes in the definition of uninsured for DSH and UC purposes (where insurance now follows the service and not the person), current federal litigation over the inclusion of commercial insurance payments in the computation of hospital specific limits, and planned federal reductions in state DSH allotments beginning in FFY 2017.

The UC pool uses a cost-based methodology to help hospitals and certain other providers offset the uncompensated care they provide to Medicaid and uninsured patients. Beginning with DY 1 (October 2011 - September 2012), hospitals that sought to participate in the UC pool were required to submit to HHSC a UC application documenting their allowable uncompensated costs, which are auditable. For DY 1, approximately \$6.6 billion in UC costs were reported with about \$1.375 billion in unreimbursed hospital costs remaining after all supplemental payments (DSH and UC) were made. In DY 2, the corresponding figures were \$7.6 billion in uncompensated Medicaid and uninsured costs with \$2 billion remaining in unreimbursed hospital costs after

all supplemental payments were made. While the final DY 3 payments are in the process of being calculated, submitted DSH/UC tools show that providers have provisionally claimed \$7.7 billion in uncompensated Medicaid and uninsured costs, while the combined DY 3 UC and FFY 2014 DSH allocation is approximately \$5.2 billion, leaving a tentative shortfall of \$2.5 billion. As the UC pool declines from \$3.9 billion at its highest point to \$3.1 billion in DY 5 and with expected reductions in federal Medicaid DSH allocations beginning in FFY 2017, there will be fewer supplemental dollars available in future years to offset Texas' large UC burden.

Texas Uncompensated Care - FY2014-FY2019						
<i>amounts in billions of dollars (actual and estimated)</i>						
Item	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
UC & DSH Demand	7.7	7.6	7.7	8.1	8.5	8.9
UC Pool (Existing)	(3.5)	(3.3)	(3.1)			
DSH (reflects ACA Cuts)	(1.7)	(1.7)	(1.8)	(1.6)	(1.2)	(1.2)
Unmet Cost	2.5	2.6	2.8			
<b>UC Pool Required 2017-2019</b>				<b>6.5</b>	<b>7.3</b>	<b>7.7</b>

### **Investment in Value Based Purchasing and Payment Reforms**

**Texas has adopted a strategic direction to increase value based purchasing and payment reform to promote high-value, coordinated care. DSRIP is critical to this effort. In the implementation of DSRIP, HHSC began to align DSRIP with Medicaid managed care. This alignment will be an increased focus going forward, and into the extension period.**

The Texas DSRIP program is a form of value based purchasing, as it enables providers to undertake initiatives to improve how care is delivered and to earn incentive funds based on achieving agreed upon project milestones and related outcomes. DSRIP also is an incubator for value based purchasing in Medicaid managed care, as the findings from DSRIP will demonstrate which types of initiatives may be promising for value based reimbursement arrangements between managed care plans and providers in their networks. While the initial years of DSRIP required concentrated efforts to establish and operationalize the program, now that the program is in place, HHSC is focusing more on further alignment of DSRIP with Medicaid managed care and other quality improvement efforts in Texas. HHSC has an internal workgroup for quality coordination and also is engaging DSRIP participants, the Clinical Champions, Medicaid managed care organizations (MCOs), and other providers in this effort.

#### *Medicaid Managed Care*

Most Texas Medicaid recipients receive their services through MCOs and HHSC continues to move additional populations from fee-for-service into managed care delivery models. Texas is working to drive value based purchasing through Medicaid managed care.

HHSC's Pay-for Quality program provides financial incentives and penalties to MCOs based on year-to-year incremental improvement on specified quality measures. The Pay-for-Quality program includes a risk/reward pool that places up to four percent of the MCO capitation rate at risk. The quality of care measures used in this initiative are a combination of process and outcome measures which include select potentially preventable events (PPEs) as well as other measures specific to the program's enrolled populations. HHSC defined the PPEs for DSRIP Category 4 reporting to mirror the PPE methodology used for MCO Pay-for-Quality. HHSC plans to work to further align DSRIP quality measures with managed care quality measures where possible.

Texas Medicaid MCOs are also required to have performance improvement projects (PIPs), some of which have goals in common with one or more DSRIP projects in a given geographic area. Activities are underway in many regions to further connect similar MCO and DSRIP projects so that they can better coordinate their efforts. For example, to the extent that MCOs and DSRIP providers both have case managers to support

targeted patients, they need to coordinate their efforts to provide the most efficient case management for those patients. If a DSRIP project in a geographic area is successful, this benefits the Medicaid MCOs whose enrollees are served through the DSRIP project. Under its managed care contracts, HHSC also requires each MCO to have a program for targeting outreach, education and intervention for members who have high utilization patterns that indicate typical disease management approaches are not effective. HHSC understands that some of the DSRIP projects with early results, such as reducing hospital readmissions for high utilizers, are beginning to approach MCOs to discuss alternate payment methodologies, which can help sustain DSRIP efforts.

There is growing interest, as recently announced by the Secretary of HHS and in Texas, to encourage MCOs to pay their providers in alternate ways to encourage quality patient care and coordination. HHSC added language to the uniform Medicaid managed care contract, effective September 1, 2014, that requires MCOs to develop and submit a written plan for expansion of value-based provider payment structures, to include an inventory of different payment models that are being deployed, provider types involved, metrics used, methods for evaluation, etc., as well as plans for future models. HHSC is also holding conference calls separately with the MCOs to discuss progress and strategies for advancing this effort.

HHSC recently underwent review by the Texas Sunset Advisory Commission, which made a number of recommendations to the Texas Legislature that are consistent with HHSC plans regarding the coordination of major quality initiatives. For example, there is a recommendation to require HHSC to develop a pilot project to promote increased use of incentive-based payments by MCOs. The work underway in DSRIP will highlight areas where MCOs should pursue incentive-based payments and HHSC is reviewing how to link DSRIP project success to MCO payment strategies. For instance, Texas Medicaid data shows that a high percentage of potentially preventable hospital admissions and readmissions are among individuals with serious mental health and/or substance use disorders, often with comorbidities. Over 25 percent of DSRIP projects have a behavioral healthcare focus, and if they are successful in keeping MCO members out of the hospital, an MCO could pay a DSRIP provider to help coordinate health care and social supports for these high needs individuals.

HHSC is actively moving toward an expanded definition of medical expenses for MCOs, and DSRIP experience is helping inform this process. MCO expenses fall into either medical services or administrative services. While certain services are excluded by federal rule from counting as MCO medical expenses, HHSC is reviewing opportunities in this area. Based on previous MCO feedback, there may be more expenses incurred by MCOs that could be counted towards medical expense, such as peer specialists and community health workers. These are some of the types of services that are effectively being used in DSRIP projects. Since Texas Medicaid MCOs have a cap that limits the deductibility of administrative expenses, if HHSC allows MCOs to count additional services as medical expenses (when such services are recognized by CMS as medical), this will reduce any barriers that may exist for MCOs to use these types of services to best coordinate care for their members. HHSC also is considering implementation of other strategies that may catalyze payment reform.

#### *National Quality Initiatives*

Texas is involved in a number of national quality initiatives that provide an opportunity to further DSRIP projects and learnings. For example, Texas is participating in the CMS Substance Use Disorder (SUD) Learning Collaborative as part of the Medicaid Innovation Accelerator Program. Texas' main goal in this effort is to examine ways to optimize Medicaid SUD benefits. At the same time, HHSC is receiving input from SUD-focused DSRIP projects on their challenges with delivering SUD benefits through Medicaid MCOs, which will help inform the learning collaborative and Medicaid benefits changes. There may be opportunities through these efforts to pilot value based payment approaches with respect to this service (and/or behavioral healthcare services more broadly). Many DSRIP projects also align with the other areas being considered for the Medicaid Innovation Accelerator Program, including population health, integrated behavioral healthcare, perinatal care, and managing super utilizers.

Texas also is participating in SMINET with Rutgers University, which is an Agency for Healthcare Quality and Research (AHRQ)-supported initiative to increase the spread of evidence based practices in the care of

adults with severe mental illness (SMI). This grant draws on AHRQ's proven method of using existing networks of providers and other key stakeholders to disseminate, translate, and implement delivery system evidence. The project focuses on transitions management and overall "person-centered" management of complex patients' healthcare needs as a whole (management of comorbid medical conditions and health risks, and care integration). Several DSRIP projects that focus on care transitions and management for adults with SMI are being invited to participate in this initiative along with Medicaid MCOs.

### *HHSC Quality Institute*

The Texas Institute of Health Care Quality and Efficiency was established by the 82<sup>nd</sup> Legislature in 2011 to improve health care quality, accountability, education and cost containment by encouraging health care provider collaboration, effective health care delivery models, and coordination of health care services. The Institute is administratively attached to HHSC and the Board is appointed by the Governor.

The Strategic Plan of the Institute focuses on the Texas health care sector – both public and private – and recognizes the significant time, energy, and resources that Texas is directing into innovative approaches, such as the development of integrated service delivery models and regionalized system transformation that is the goal of DSRIP, to raise quality and contain costs. Investment in strategies that promote shared decision making between patients and providers; that increase care coordination, especially for individuals with complex medical, behavioral, and social support needs; and that tackle emerging public and community health issues, including chronic disease prevention, can drive improvement across the entire health care system.

The Institute issued its legislative recommendations in November 2014 related to expanded access to care, administrative simplification, health literacy, value-based care, serious and persistent mental illness, and data sharing. These issue recommendations align with DSRIP goals, and HHSC plans to leverage the Institute and its multi-agency, multi-disciplinary structure to support the ongoing work through the waiver to transform care in Texas.

### **Conclusion**

In conclusion, while the DSRIP program is showing great promise in improving healthcare delivery systems, quality of care, and outcomes, more time is needed. The projects must mature beyond their implementation phase and provide the needed information to demonstrate outcomes in order to evaluate which initiatives include the most promising practices. It is important to continue this locally-driven laboratory of innovation. Also, Texas' UC burden is increasing rather than decreasing, and the existing funding sources do not offset all UC costs for Medicaid and low-income uninsured patients. Therefore, when Texas submits its extension request in September 2015, HHSC plans to request to continue both pools during the waiver extension period, with at least the DY 5 funding level for DSRIP (\$3.1 billion annually) and a UC pool equal to the unmet UC need in Texas. Texas also will propose program improvements for DSRIP and ways to better evaluate best practices and further integrate DSRIP efforts with Medicaid managed care and other value based purchasing efforts, which are goals the State shares with CMS.