A Unique Funding Opportunity for Public Health in Texas

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In addition to the Affordable Care Act, states are more frequently turning to Medicaid waivers to achieve the "Triple Aim" goals of improving the experience of care, improving population health, and reducing per capita costs. These demonstration waivers provide opportunities to test innovative ways to finance and deliver care. Texas is currently implementing a waiver known as the Transformation and Quality Improvement Program. Its inclusion of public health agencies is a unique approach to a system typically limited to traditional providers. San Antonio Metropolitan Health District is one public health agency taking advantage of this new funding opportunity to implement 6 new or expanded programs targeting health issues of highest priority in this south Texas region. This article discusses the use of Medicaid waivers and the advantages and challenges of public health agency participation.

KEY WORDS: Medicaid waivers, public health agency participation, Regional Healthcare Partnership, Texas, Triple Aim goals

The transformation of health care is underway in the United States. Most associate this buzz of activity with passage and implementation of the Patient Protection and Affordable Care Act (ACA). However, the ACA is not the only means by which the country is redesigning the financing and delivery of care. In Texas, as in other states, Medicaid waivers are a lesser-known vehicle for health care reform. In this article, we describe the Texas Medicaid 1115 waiver, its use of Regional Healthcare Partnerships (RHPs), and the unique inclusion of local health departments (LHDs) working collaboratively with traditional medical providers to achieve the "Triple Aim" goals of improving the experience of patient *care*, improving the population *health*, and reducing per capita *costs*.[1]

J Public Health Management Practice, 2015, 21(1 Supp), S81–S86

Medicaid, a $436 billion federal and state health care program for low-income individuals and families, is a significant and growing part of the national health care system.[2] According to the US Census Bureau, nearly 18% of people younger than 65 years in the United States were enrolled in Medicaid in 2012, and an equivalent percentage was uninsured. Medicaid eligibility, and consequently coverage, varies by state between 10% and 27%. In Texas, 15% of the population younger than 65 years was enrolled in Medicaid and 27% (6.3 million individuals), was uninsured.[3] Individuals of low socioeconomic status, such as those who are uninsured and/or are eligible for Medicaid, have traditionally experienced higher rates of morbidity and mortality.[4] Consequently, and consistent with the rest of the nation, health care costs in Texas continue to grow. The Texas Health and Human Services Commission (HHSC) projected that state spending on Medicaid would grow from $10 billion in FFY 2011 to $14.6 billion in FFY 2013, accounting for roughly 20.4% of state tax revenues.[5] To help control costs and to improve its health care infrastructure, Texas pursued a Medicaid 1115 waiver as a potential solution.

Medicaid Waivers

Waivers are granted to states by the Centers for Medicare & Medicaid Services (CMS) to pilot innovations in Medicaid and the Children's Health Insurance Program. These arrangements essentially waive

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The authors declare no conflicts of interest.

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DOI: 10.1097/PHH.0000000000000131

various program rules so that federal funds can be used in new ways. One type of waiver is known as the 1115 waiver. Medicaid 1115 waivers focus on financing and delivery of benefit programs and are named for the section of the Social Security Act that gives the Secretary of Health and Human Services authority to approve such activities. In addition to expanding coverage and services, 1115 waivers are used by states to demonstrate "innovative service delivery systems that improve care, increase efficiency, and reduce costs."[6] Or, in other words, the Triple Aim.[1(p760)]

Waivers have been granted to states since 1965, when Medicaid began. Waiver terms and conditions are negotiated between the CMS and each state. Programs are typically approved for 5 years and must be budget neutral for the federal government. As with the Medicaid program itself, the total cost of a Medicaid waiver is only partially funded by the federal government. States must contribute their designated portion of the approved amount based on the federal Medicaid matching rate. Not surprisingly, as health care has exploded in terms of costs and complexity, so too have the number and scope of approved Medicaid waivers.[7] Currently, the CMS has 80 current or pending 1115 waivers in 45 states and the District of Columbia; these waivers are being used to expand coverage to new segments of the population, to enhance benefit options, and to redesign the delivery of care.[8] According to the Government Accountability Office's review of waivers granted since 2007, the current Texas waiver is the largest, with an approved spending limit of $142 billion.[2(p23)]

Texas' waiver, known as the Transformation and Quality Improvement Program, was approved by the CMS in December 2011. Besides expanding Medicaid managed care into the rural areas of the state (urban populations have been covered by managed Medicaid since the mid-1990s), the program created 2 new funding pools worth up to $29 billion over the 5-year term. The $17.6 billion Uncompensated Care pool reimburses selected providers (mostly hospitals) for uncompensated care costs. The innovative $11.4 billion Delivery System Reform Incentive Payment (DSRIP) pool provides incentives to providers for successfully implementing CMS-approved projects to achieve milestones related to improving infrastructure and/or redesigning the delivery of care. Although there are similar DSRIP waivers in California and Massachusetts, what makes the Texas transformation program unique is how it organizes its 254 counties into RHPs and allows a diverse mix of providers, including public health agencies, to participate in the DSRIP program.[9] The DSRIP fund allocated over 5 years (2012-2016) equals an amount that comes close to the $15 billion allocated nationwide over 10 years by the 2010 ACA, which was noted as the largest expansion in federal public health spending in decades.[10] Thus, the Texas DSRIP fund is substantial even when divided among the state's 20 regions.

Regional Healthcare Partnerships

Each of the RHPs is led by an "anchor" organization, usually a county hospital district with taxing authority and statutory obligation to provide health care to its indigent residents. The anchor acts as liaison between the HHSC and the providers, serving in many ways as an extension of state-level program staff. The anchor entity also leads the region's efforts in conducting community needs assessments and organizes collaborative learning opportunities for partners and stakeholders.

In collaboration with advisory committees of health care administrators, clinicians, and public health leaders, the CMS and the HHSC negotiated 2 key protocols that are considered part of the Special Terms and Conditions of the waiver. The first protocol, the Program Financing and Mechanics Protocol, specifies the types of organizations that can participate and how funds should be allocated and distributed. The second RHP Planning Protocol serves as a menu of activities and milestones from which eligible providers could select and submit as DSRIP projects. Unlike the California waiver, for which only public hospitals are eligible, the Texas waiver allows the following entities to act as "performing providers" and participate in the DSRIP funding pool: health systems/hospitals (both public and private), community mental health centers, physician practices (primarily those affiliated with medical schools), and local public health agencies. The Texas waiver is particularly uncommon because it allows for the direct participation of local public health agencies. This unique feature has brought numerous advantages and challenges for those agencies that are engaged in the opportunities the waiver has offered.

Case Study: RHP 6

RHP 6 is anchored by University Health System, the county hospital district in San Antonio, Texas. As described in its RHP Plan, the 20-county region, larger and more populous than many states, encompasses 25 000 square miles and is home to more than 2.3 million residents, 54% of whom are Hispanic. The median income is $36 000; 24% of persons are uninsured. Overall, the region is fairly representative of the state, although there is significant variation among the individual counties. Collectively, 25 providers are implementing 128 DSRIP projects valued at more than $1 billion to address 6 needs identified through the community assessment.[11]

1. Quality of care in Texas (rated as "weak" by the Agency for Healthcare Research and Quality[12]);
2. Management and prevention of chronic conditions;
3. Access to medical and dental care (nearly all counties in the region are declared full or partial Health Professional Shortage Areas for primary care);
4. Integrated behavioral health services (nearly all counties in the region are declared full or partial Health Professional Shortage Areas for mental health);
5. Prenatal and preventive pediatric care; and
6. Mechanisms to lower current high rates of certain communicable diseases such as tuberculosis and syphilis.

The various projects reflect the missions of and communities served by the performing providers. Reflective of the waiver's proscribed allocation of DSRIP pool funds, projects being implemented by hospitals and health systems account for roughly 75% of the total DSRIP pool. These projects most commonly focus on primary care expansion, telemedicine, chronic care management, and patient navigation. Interestingly, a majority of projects, regardless of provider type, are designed to expand and integrate behavioral health in a reasonable attempt to make up for the fact that in 2010, Texas ranked 49th among states for per capita spending on mental health.[13]

The Role of Local Public Health

The Texas 1115 waiver is significant because it recognizes community behavioral health providers (mental health, drug and alcohol acute and rehabilitative care, homeless services) and local public health agencies as eligible participants. Together, they were allocated $1.7 billion, or 15%, of the total DSRIP pool. Given the size of the CMS-approved DSRIP funding pool, Texas wisely recognized that community mental centers and public health agencies contribute valuable programs and services to achieve the waiver goals. Moreover, they could contribute the necessary state funding match through intergovernmental transfer of city and county tax dollars and help the state maximize its use of the DSRIP funds.

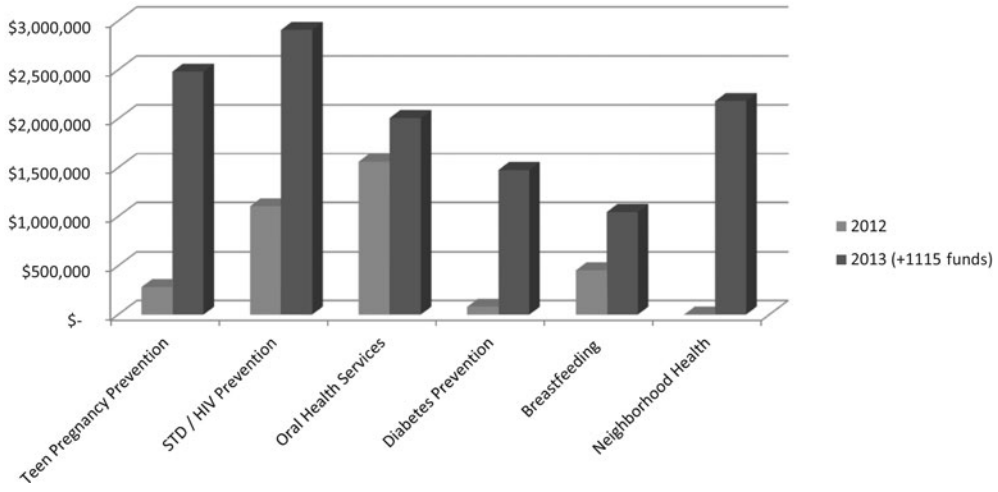
Local public health and community mental health agencies are essential to Triple Aim strategies to improve the US health care system. To achieve the first of the Triple Aim goals, improving the experience of patient care by measures of quality, outcomes, and satisfaction, health providers must be able to care for patients after they leave the clinical setting and return to the community, the natural habitat of local public health. Relative to the second aim, local public health agencies are responsible for measuring and "improving the health of populations" of entire cities, counties, and states, whereas hospitals and clinics are accountable only for the patients who come through their doors. Finally, although the third aim of reducing costs must justifiably focus on reducing cost-related challenges at the institutional level, the greatest savings may come through population-based prevention by reducing the need of people to use the health care system. For example, reduced births to teenagers in San Antonio in 2012 are estimated to have saved $23 million.

It is unfortunate, then, that public health in the United States is chronically underfunded. Less than 3% of the national health budget is spent on public health. In addition, public health is a "patchwork of funding sources and financing arrangements that vary widely across states and communities and that are relatively unstable over time."[14(p2)] Moreover, since 2008, state and local health departments have cut more than 45 700 jobs, and most departments have eliminated at least 1 program.[15] Traditional funding sources such as grants, regulatory fees, and local tax-based support have clearly not been able to keep pace. In response to the chronic underfunding of public health, the 2010 ACA initially authorized, but has since cut back on, increased federal spending of approximately $1.5 billion per year for 10 years. However, even the original amount, divided into categorical grants among 2800 local health departments, is inadequate.

Even with the additional ACA dollars, the categorical grant approach to funding local public health remains insufficient in size, unpredictable in scope, heavily bureaucratic, and often misdirected. An alternative approach is to allow local health authorities to assess the health of their communities, set priorities and goals, develop strategies that correspond to local conditions, and adequately fund them to do so. This is exactly what is happening in Texas through the 1115 waiver.

The San Antonio Metropolitan Health District (Metro Health), as the only local public health agency to participate in the region, was designated approximately 5% of the region's DSRIP allocation, or about $43 million over 5 years. This funding represents entirely new income for the department and raises its annual budget by more than 40%. With these funds, Metro Health proposed 6 new or expanded programs closely aligned with identified priorities, established through community health assessment, community health improvement planning, and departmental strategic planning. Because performing providers are encouraged to target low-income and uninsured residents in addition to Medicaid enrollees, the projects are designed to address the greatest public health needs in ways that will do the most good: true population-based prevention.

FIGURE ● Rise in Program Annual Budgets as a Result of Medicaid Waiver Incentive Funds



Abbreviation: STD, sexually transmitted disease.

The projects proposed by Metro Health and approved by the CMS greatly increase investment in 6 crucial areas of prevention (Figure). First, in collaboration with local private-nonprofits, Healthy Futures and UT Teen Health, Metro Health greatly expanded teenage pregnancy prevention efforts by

- extending scientifically based, abstinence-plus curricula from 6 to 23 middle schools;
- providing case management to 100 teenagers who have already given birth to a child to avoid subsequent unplanned and unwanted pregnancies;
- connecting sexually active teens to free, safe, reliable, and long-acting reversible contraceptives ; and
- educating and supporting local physicians who want to make their practices more accessible to and effective for adolescents.

Second, Metro Health is partnering with the YMCA to offer scientifically validated obesity and diabetes prevention programs that are now free to 500 area residents. Program effectiveness will be monitored with before and after body mass index and hemoglobin A_{1c}. Third, Metro Health has targeted 10 neighborhoods for organizing grassroots activities to prevent obesity through better nutrition, physical activity, environmental improvements for safety, walkability, and exercise and social capital building using the Asset-Based Community Development model. Fourth, the Metro Health Women Infants Children (WIC) program has opened a "Baby Cafe" where any pregnant woman or new mom, not just WIC clients, can learn how to start and sustain breast-feeding, with professional help and peer support. Fifth, Metro Health is greatly expanding school-based, oral health clinics providing examinations and referrals, fluoride treatments, and sealants to address the most widespread of all health problems: dental caries. Finally, Metro Health is remaking its sexually transmitted disease clinic and outreach to population groups that are driving the huge local syphilis epidemic. Over the last 2 years, new cases of syphilis among adults have broken all records and, tragically, San Antonio leads the nation in babies born with congenital syphilis: 32 since January 1, 2012. These additional and very substantial 1115 waiver funds allow the use of promising new innovations against seemingly intractable problems, as well as bringing to scale established interventions that have had limited application.

● Challenges

The advantages for local public health participation in the waiver program are clear: a new and significant source of funding, the ability to develop and implement projects based on community needs, and increased opportunities to collaborate with traditional health care providers working to achieve an aligned set of goals. As with any program of this magnitude, significant challenges are also present. First, the waiver became effective upon approval by the CMS. Practically speaking, this process left no time for regional boundaries or program protocols to be negotiated in advance. In fact, project proposals were initially written over a concurrent 5-month period as drafts of protocols were released by the HHSC. Metro Health had to rely on existing professional staff to understand the complexities of the waiver protocols (including project and measure options and funding allocations), identify community priorities, select potential projects of highest value, and

write the proposals, all while remaining accountable for their primary job responsibilities. Ultimately, DSRIP projects were not submitted to the CMS until 18 months into the 5-year program, and many projects were not approved until the very end of the second year. Yet, all performing providers, including Metro Health, had to be ready to implement the project immediately upon approval, if not sooner, in order to achieve the first set of milestones and earn incentives. Therefore, existing staff were also called upon to implement projects and complete the associated reporting requirements.

Second, project development and approval were especially challenging for nontraditional providers. To expedite CMS approval, the DSRIP protocols were initially based on the California waiver, which had a similar DSRIP funding pool. But because the California DSRIP program was limited to public hospitals, the Texas protocol required an expansion of project options and measures to accommodate the various needs, organizational structures, and populations served by community mental health centers and public health agencies. As of the middle of demonstration year 3, these revisions and accommodations are still taking place. The CMS, the HHSC, and affected performing providers continue to work together to fine-tune projects and ensure that the performance-based milestones, to which providers are held accountable, are appropriate and attainable in the remaining 2 years of the waiver term.

Finally, unlike a traditional grant, where funds are distributed on the basis of estimates of program costs, the DSRIP pool incentive payments are only received if the provider fully achieves process- and implementation-related milestones in the allotted time. Outcome measures must also be earned, although partial payment is allowed on the basis of how much progress has been made. Overall, this performance-based approach is good for taxpayers but creates a considerable financial and administrative challenge even for the most robust local health departments. In addition to staffing constraints described earlier, a certain level of financial liquidity is critical for an organization to embark on and be successful in a program of this design. Yet, despite the challenges described earlier, Metro Health sees the Texas Transformation Waiver as an opportunity to make substantial and meaningful impact on improving the health of the population, especially in the face of impending departmental cuts at the local level.

Conclusion

The 1115 waiver is an unprecedented opportunity to transform the delivery of health care and improve health in Texas. The statewide program, negotiated with the CMS, provides a framework that allows a diverse mix of providers to have local control in identifying community needs and selecting projects that will accomplish the most good within each region. The performance-based DSRIP reimbursement is not "free money." Rather, it is a federal/state match that is earned by achieving approved milestones and outcome measures. The unique participation by local health departments within RHPs provides a comprehensive approach to a community's pursuit of Triple Aim goals and underscores the value of prevention. The Medicaid 1115 waiver provides a new and very substantial source of funding for population-based prevention that may prove transformative for local public health in Texas and could potentially be used toward the same end in other states.[16]

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