



## Uncompensated Care and the Coverage Gap: The Role of the 1115 Transformation Waiver in Texas

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# **Uncompensated Care and the Coverage Gap: The Role of the 1115 Transformation Waiver in Texas**

## **Executive Summary**

Texas and the federal government are far apart on the terms of renewal for a five-year Medicaid 1115 waiver that provides funding for hospital uncompensated care costs and health care delivery system reforms. One goal of the waiver was to build health care infrastructure to support increased demand for services from a newly insured population under Affordable Care Act (ACA) reforms, including Medicaid expansion. However, Texas leaders have declined to adopt Medicaid expansion, foregoing billions in federal funds and leaving more than a million low-income Texans in a coverage gap without access to affordable health insurance coverage. This report examines the relationship between Texas' 1115 waiver and state leaders' decisions related to ensuring access to health coverage for low-income, uninsured Texans.

A large portion of the population served under the 1115 waiver would be eligible for Medicaid if Texas leaders agreed to expand coverage. The 1115 waiver was never envisioned as a substitute for coverage, and was designed to complement, not replace, expanded access to health coverage under ACA reforms. Texas leaders' decision not to expand coverage puts federal funding through the 1115 waiver at risk.

A similar situation in Florida serves as a cautionary tale for CMS' approach to renewing the Texas waiver. Florida leaders have refused to expand Medicaid while at the same time requested that CMS renew their 1115 waiver. CMS responded by proposing to greatly reduce the amount of uncompensated care funds going to Florida under their waiver, and have indicated they will treat other states, including Texas, using a similar logic- no federal funds should be used to pay for services for people who could be covered under Medicaid expansion.

While the 1115 waiver serves an important role in the health care delivery system, state leaders have systematically declined to address the lack of coverage options for Texans with below-poverty wages, ignoring a key opportunity to provide economic stability and additional resources to Texans living in poverty. Texas would receive vastly more federal dollars under Medicaid expansion than under the waiver, with Texas taxpayers contributing a smaller share. Pushing forward with the waiver renewal while refusing to accept federal dollars for expanded Medicaid serves as the latest example in a series of

decisions made by state leaders to deny coverage for the state's uninsured population. State leaders must adopt, embrace and execute a coherent strategy for the 1115 waiver renewal that includes drawing down all available federal funds to expand access to health coverage for low-income Texans.

## **Section 1115 Demonstration Waivers**

Section 1115 of the Social Security Act grants the Secretary of Health and Human Services the authority to approve state demonstration projects aimed at furthering the objectives of the Medicaid program. Referred to as 1115 waivers, these projects provide states flexibility to test new approaches to delivering health care services in Medicaid. Through 1115 waivers, states can design new benefit packages, expand services to new populations and implement a broad range of Medicaid reforms. 1115 waivers are typically pilot or experimental in nature, and provide an opportunity for states to utilize federal Medicaid funds in ways not typically allowed under the program.<sup>1</sup>

1115 waivers must be designed to be budget neutral to the federal government. In other words, the federal government will not approve waivers that are projected to require more federal Medicaid funding than the state would otherwise receive without the waiver. Under 1115 waivers, states receive the same federal matching rates as their traditional Medicaid programs. This means that in Texas, the federal government provides about \$0.60 for every \$0.40 spent by the state.<sup>2</sup>

States submit requests for 1115 waivers to the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services, the federal entity that oversees the Medicaid program. 1115 waivers are approved by CMS for a period of five years, with the opportunity to extend for an additional period, typically three years. However, CMS has the ability to grant multiple extensions and some states have had 1115 waivers in place for many years.<sup>3</sup>

Over the last several decades, states have used 1115 waivers to expand Medicaid benefits to populations not otherwise eligible for Medicaid coverage, to expand the managed care model to new

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<sup>1</sup> Robin Rudowitz, Samantha Artiga, and Rachel Arguello, A Look at Section 1115 Medicaid Demonstration Waivers Under the ACA: A Focus on Childless Adults (Kaiser Family Foundation, October 2013) (Appendix A)

<sup>2</sup> <http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/> Texas' Federal Medical Assistance Percentage (FMAP) is \$58.05 in federal fiscal year 2015. Texas' FMAP has seen slight reductions over the last several years, and will be \$57.13 in federal fiscal year 2016.

<sup>3</sup> Rudowitz, et al.

populations, to support safety net delivery system improvements and to lay the groundwork for health system reforms occurring under the Affordable Care Act (ACA).<sup>4</sup>

## **Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Waiver**

In December 2011, the Texas Health and Human Services Commission (HHSC) received CMS approval for an 1115 demonstration waiver through September 30, 2016. The Texas waiver has two main components: the expansion of the Medicaid managed care model statewide, and the creation of funding mechanisms to reimburse providers for uncompensated care costs and incentivize health care delivery system transformation.<sup>5</sup> The waiver uses savings from the managed care expansion to achieve budget neutrality and finance the new funding pools. This paper focuses on the uncompensated care and delivery system reform elements of the waiver, rather than the managed care statewide expansion.

Apart from the managed care expansion, Texas' 1115 waiver had several broad goals, including preserving federal uncompensated care funds for hospitals, supporting a coordinated care delivery system through regional partnerships and boosting health care infrastructure to prepare for the newly insured under Affordable Care Act (ACA) reforms beginning in 2014.<sup>6</sup> To achieve these goals, the waiver created two new funding pools for hospitals and other eligible providers caring for Medicaid recipients and the uninsured.

First, the Uncompensated Care (UC) pool provides funding to hospitals for uncompensated care costs associated with providing care to uninsured Texans and shortfalls in reimbursement rates for providing care to Medicaid recipients. The UC pool replaces supplement payments received by hospitals under the pre-waiver Medicaid finance system. Hospitals are eligible for UC funding according to historical levels of supplemental funding provided by the state.

The second pool, called the Delivery System Reform Incentive Program (DSRIP), is intended to incentivize regional health system reform by funding projects that work to improve quality of care,

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<sup>4</sup> Kaiser Commission on Medicaid and the Uninsured, An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity (May 2012) <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8318.pdf>

<sup>5</sup> CMS Approval Letter to Texas Health and Human Services Commission for 1115 Transformation Waiver (December 2011) <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/TexasHealthcareTransformationandQualityImprovementProgramCurrentApprovalDocuments.pdf>

<sup>6</sup> Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Waiver Proposal, Texas Health and Human Services Commission (July 2011) <http://www.hhsc.state.tx.us/Waiver-1115-proposal.pdf>

increase access to services and lower costs. DSRIP projects must fall into one of several broad categories, including infrastructure development, program innovation and redesign and quality improvements.<sup>7</sup> The state is divided into 20 regions, called Regional Healthcare Partnerships, which submit DSRIP projects for approval by HHSC and CMS. Each DSRIP project must have public monies, usually local tax dollars, to draw down federal matching funds. Projects must meet certain metrics prior to receiving DSRIP funding. Public and private hospitals, local mental health authorities, academic physician groups and local health departments are eligible to receive funding as performing providers in DSRIP projects. Other providers historically serving the waiver's target populations, such as federally qualified health centers (FQHCs), are allowed to subcontract with performing providers in order to participate in DSRIP projects. Throughout the course of the waiver, funding to the UC pool gradually decreases while funding to the DSRIP pool increases.

The waiver pools are valued at \$17.6 and \$11.4 billion, respectively, bringing the total value of the waiver to \$29 billion over five years.<sup>8</sup> Following the standard Medicaid federal matching rate for Texas, the federal government pays about \$17 billion under the waiver and the remaining \$12 billion is funded primarily by local tax dollars used to draw down the federal match.

As of May 2015, the waiver supported 1,458 active DSRIP projects conducted by 298 providers across the state. Over one-quarter of the projects were related to behavioral health services, 20 percent were aimed at increasing access to primary care and 18 percent were related to chronic care management and support for health system navigation. Because DSRIP projects were approved one-and-a-half to two-and-a-half years into the five-year waiver, concrete data on most project outcomes is still being collected.<sup>9</sup> Whether or not DSRIP funds and projects have collectively achieved health system transformation, and if these achievements are replicable, remains to be seen.

However, what is clear is that no DSRIP project resembles or replaces health insurance coverage. DSRIP projects were not envisioned by CMS or the state as a substitute for health coverage, but were intended to build infrastructure to support increased demand for health care services from populations newly insured under ACA reforms and improve health outcomes while containing costs.

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<sup>7</sup> CMS Approval Letter to Texas Health and Human Services Commission for 1115 Transformation Waiver (December 2011)

<sup>8</sup> Ibid.

<sup>9</sup> Presentation to Texas House Appropriations Committee on the Section 1115 Demonstration Waiver: Texas Healthcare Transformation and Quality Improvement Program, Texas Health and Human Services Commission (May 2015) <https://www.hhsc.state.tx.us/news/presentations/2015/050715-Transformation-Waiver-Overview.pdf>

## Texas Waiver Renewal

In order to renew or extend the waiver, which expires on September 30, 2016, Texas must submit an extension request to CMS no later than September 30, 2015. As mentioned, one objective of the waiver was to prepare health care infrastructure in Texas for increases in demand due to newly insured populations under the ACA beginning in 2014. State leaders failed to fully implement ACA reforms, which impacts Texas' ability to negotiate the waiver extension with CMS. These ACA coverage reforms provide context on the health care environment at the time the Texas waiver was developed, which informs the discussion around waiver renewal.

In order to increase access to health insurance, the ACA created two new mechanisms for low-income Americans to obtain affordable coverage. One was the creation of health insurance marketplaces with tax credits for enrollees between 100 and 400 percent of the federal poverty level. The health insurance marketplace began offering subsidized coverage in Texas in January 2014, and by February 2015 more than a million Texans had enrolled in marketplace coverage.<sup>10</sup>

The other was the expansion of Medicaid coverage to Americans earning up to 138 percent of the poverty level. However, Texas policymakers failed to expand Medicaid as envisioned under the ACA, when in June 2012 a U.S. Supreme Court ruling made Medicaid expansion optional for states. Up to this point, Texas has declined to participate in the ACA expansion of Medicaid, leaving approximately a million Texans in a coverage gap without access to affordable health coverage.<sup>11</sup>

The current 1115 transformation waiver was developed by HHSC and approved by CMS prior to the Supreme Court decision that made Medicaid expansion a state option. Therefore, the underlying assumption in the waiver design was that beginning in 2014, Texans with poverty-level wages would have access to health coverage under Medicaid expansion, and hospitals and other providers would experience an increase in revenues through a newly insured Medicaid population and a subsequent decrease in uncompensated care costs through a reduction in the uninsured. Because Texas leaders declined to expand Medicaid, this shift has not fully occurred.

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<sup>10</sup> Sara Rosenbaum, Sara Rothenberg, and Sara Ely, How Will Texas' Affordable Care Act Implementation Decisions Affect the Population? A Closer Look (The George Washington University, June 2015)

[http://www.tachc.org/content/media\\_release/Affordable%20Care%20Act%20Texas%20Impact%20Analysis%20-%20Full%20Report%20-%20King%20Decision.pdf](http://www.tachc.org/content/media_release/Affordable%20Care%20Act%20Texas%20Impact%20Analysis%20-%20Full%20Report%20-%20King%20Decision.pdf)

<sup>11</sup> Ibid.

A similar situation has developed in Florida where state leaders have refused to participate in the expansion of Medicaid and at the same time requested an 1115 waiver renewal from CMS. Florida's waiver includes a Low Income Pool (LIP) which is similar to the UC pool in the Texas waiver in that it provides uncompensated care funds to Florida's hospitals that care for Medicaid recipients and the uninsured. In 2014, CMS granted a three-year extension of Florida's waiver, but only a one-year extension of the LIP portion of the waiver.<sup>12</sup> As the LIP approached expiration in June 2015, CMS indicated that the fund would not be renewed, in large part due to Florida's refusal to expand Medicaid under the ACA.<sup>13</sup> CMS has indicated it views Medicaid expansion as a more comprehensive approach to providing access to health care to low-income populations than patchwork financing mechanisms that ultimately fail to provide the benefits of coverage to vulnerable Americans.

At the time this paper was written, Florida reached a preliminary agreement with CMS to extend the LIP for an additional two years though at a substantially reduced amount with the state forced to increase expenditures to make up the difference. Under the compromise, CMS also indicated that LIP funds could not be used to cover populations that would be covered under a Medicaid expansion or to make up shortfalls in Medicaid reimbursement rates set by the state if CMS considers rates to be too low.<sup>14</sup>

While details differ between the Florida example and Texas' reality, CMS has indicated to state leaders that they intend to use the same approach utilized in Florida when determining the parameters for the Texas waiver renewal. On its face, one can assume the potential for reductions, perhaps drastic, in Texas' UC pool and possible prohibitions from using UC funds to cover the costs of providing care that would be paid for under a Medicaid expansion or to make up shortfalls in Texas' notoriously low Medicaid reimbursement rates.

## **Texas' Coverage Gap**

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<sup>12</sup> CMS letter from Director Cindy Mann to Florida Medicaid Director Justin Senior (July 2014)  
<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-ca.pdf>

<sup>13</sup> CMS letter from Acting Director Vikki Wachino to Florida Medicaid Director Justin Senior (April 2015)  
<https://kaiserhealthnews.files.wordpress.com/2015/04/justin-senior-fl-041415.pdf>

<sup>14</sup> CMS letter from Director Vikki Wachino to Florida Medicaid Director Justin Senior (June 2015)  
<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/Managed-Medical-Assistance-MMA/fl-medicaid-reform-lip-ltr-06232015.pdf>

Texas' refusal to expand Medicaid coverage under the ACA not only impacts the future of the 1115 waiver, it leaves a million low-income Texans without access to affordable health coverage. Texans earning too little to receive subsidies in the marketplace and too much to qualify for the existing Medicaid program fall in to this coverage gap. The majority of Texans in the coverage gap live in working families and overwhelmingly lack access to affordable employer-sponsored coverage.<sup>15</sup> Numerous studies have demonstrated the health, economic and social benefits if Texas were to agree to draw down federal funds under the ACA to expand coverage to Texans earning below-poverty wages.<sup>16</sup> However, Texas leaders failed to discuss the merits of coverage expansion during the 84<sup>th</sup> legislative session that ended on June 1, 2015 and adjourned until 2017 without solving the coverage gap problem. A dozen bills were filed that addressed the coverage gap, but not a single one received a hearing in either the Texas House or Senate. One Senator attempted to add a Medicaid expansion provision to another piece of legislation, but the amendment failed along party lines. This was the only vote the Texas legislature took related to closing the coverage gap.

As discussed in detail in our previous report titled, *How Will Texas' Affordable Care Act Implementation Decisions Affect the Population? A Closer Look*, not only would an estimated 1.5 million Texans have access to health coverage under a Medicaid expansion, but the state would receive an additional \$128 billion in federal funds over 10 years and only spend \$13.5 billion in state funds over the same period. Under Medicaid expansion, the federal government never pays less than 90 percent of the costs of coverage, compared with the 60/40 match under the waiver. Additionally, these state expenditures would be partially offset by reductions in uncompensated care costs.<sup>17</sup>

In addition to the benefits of insuring a larger percent of Texans, Medicaid expansion would serve as an economic driver in communities across the state. Coverage expansion would create an estimated 300,000 new jobs in Texas<sup>18</sup> and bring vast amounts of Texas taxpayer dollars back to the state to invest in community infrastructure and workforce. Numerous studies demonstrate that

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<sup>15</sup> Rosenbaum, et al.

<sup>16</sup> Perryman Group, *Only One Rational Choice: Texas Should Participate in Medicaid Expansion Under the Affordable Care Act* (February 2013) [http://perrymangroup.com/wp-content/uploads/Medicaid\\_Local\\_Study.pdf](http://perrymangroup.com/wp-content/uploads/Medicaid_Local_Study.pdf); Billy Hamilton Consulting, *Expanding Medicaid in Texas: Smart, Affordable and Fair* (January 2013) [http://www.mhm.org/images/stories/advocacy\\_and\\_public\\_policy/Smart%20Affordable%20and%20Fair\\_FNL\\_FUL\\_L.pdf](http://www.mhm.org/images/stories/advocacy_and_public_policy/Smart%20Affordable%20and%20Fair_FNL_FUL_L.pdf); Families USA, *Texas's Economy Will Benefit from Expanding Medicaid* (February 2013) [http://familiesusa.org/sites/default/files/product\\_documents/TX-and-Medicaid-Expansion.pdf](http://familiesusa.org/sites/default/files/product_documents/TX-and-Medicaid-Expansion.pdf)

<sup>17</sup> Rosenbaum, et al.

<sup>18</sup> Perryman Group, *Only One Rational Choice: Texas Should Participate in Medicaid Expansion Under the Affordable Care Act*

expanding Medicaid has had a positive impact on states' economies. Texas would experience an estimated \$270 billion economic impact over ten years if state leaders were to adopt expansion.<sup>19</sup> Medicaid coverage also brings financial stability to low-income enrollees and research shows reductions in bankruptcy rates and catastrophic out-of-pocket costs for populations gaining Medicaid coverage.<sup>20</sup>

## **Conclusion**

Texas' 1115 transformation waiver serves a critical function in preserving uncompensated care funding for hospitals providing services to uninsured, low-income Texans not eligible for Medicaid coverage. As long as Texas has an uninsured population, there will be a continued need for federal funding for uncompensated care. It is imperative that Texas leaders take a realistic approach to negotiating with CMS for a renewal of the waiver to ensure the continued viability of community and safety-net hospitals that would otherwise have to drastically scale down services or shutter facilities.

Additionally, the DSRIP pool has the potential to generate innovative projects that improve health care quality and lower costs, and ideally identify best practices that can be replicated on a larger scale. However, the waiver does not address the problem facing Texas' health care system at its core: the lack of access to affordable health coverage for Texans living in poverty.

The waiver was designed under the assumption that more than a million low-income Texans would gain access to Medicaid coverage starting in 2014. The waiver's purpose was, in part, to help lay the groundwork for the increase in demand for services from this newly insured population. Texas leaders have chosen to keep Medicaid coverage from these Texans, forcing their continued reliance on safety-net clinics and hospital emergency rooms for access to care. This is one example in a series of decisions state leaders have made that deny access to health care for low-income Texans, including refusing to create a state-based health insurance marketplace and maintaining lower-than-cost Medicaid reimbursement rates.

Instead of utilizing the 1115 waiver as a vehicle to prepare Texas' health care infrastructure for a greater insured population, Texas leaders are pressing forward with a questionable waiver renewal strategy while failing to address the coverage gap. This decision not only puts a portion of the waiver

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<sup>19</sup> Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services, Economic Impact of the Medicaid Expansion (March 2015)

[http://aspe.hhs.gov/health/reports/2015/medicaidexpansion/ib\\_MedicaidExpansion.pdf](http://aspe.hhs.gov/health/reports/2015/medicaidexpansion/ib_MedicaidExpansion.pdf)

<sup>20</sup> Ibid.

itself at risk, it foregoes billions in federal Medicaid funding that could be invested in local communities statewide and reduce the burden of uncompensated care costs that falls on local governments and Texas taxpayers.