

## **TERMINOLOGY: Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver**

The list below consists of common terminology referring to the 1115 Transformation waiver.

**1115 Waiver:** A waiver under section 1115 of Social Security Act that allows CMS and states more flexibility in designing programs to ensure delivery of Medicaid services.

**Anchoring entity** (anchor): The single IGT entity in an RHP serving as the primary contact to HHSC responsible for providing opportunities for public input to the development of RHP plans and coordinating discussion and review of proposed RHP plans prior to plan submission to the State.

**Centers for Medicare and Medicaid Services (CMS):** The U.S. federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program.

**Delivery System Reform Incentive Payment (DSRIP):** Incentive payments available for projects under the Transformation waiver to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. Projects eligible for incentive payments must come from the DSRIP menu, be included in an HHSC and CMS-approved RHP plan and have corresponding metrics and milestones.

**Demonstration year (DY):** A 12-month period beginning October 1 and ending September 30. The 1115 Transformation waiver currently consists of five demonstration years from 2011 to 2016.

**DSRIP Menu:** A menu of HHSC and CMS-approved projects that contribute to delivery transformation and quality improvement. Only projects from this menu performed as outlined in an HHSC and CMS-approved RHP plan with corresponding metrics and milestones are eligible for payments from the DSRIP pool.

**Intergovernmental Transfers (IGT):** State and local funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity and eligible for federal match under the 1115 Transformation waiver. This does not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

**IGT Entity:** A state agency or a political subdivision of the state—such as a city, county, hospital district, hospital authority, or state entity—with IGT eligible for federal match to fund an RHP's UC or DSRIP.

**Medicaid managed care:** A system under which the state pays a set fee each month to a health plan to provide care for a Medicaid client, who selects a primary doctor from the plan's network to coordinate care. This differs from a traditional fee-for-service system that bases provider payment on quantity of service rather than quality. In 2011, the Texas Legislature directed HHSC to expand managed care within the state Medicaid program with the goal of achieving high-quality, cost-effective health care.

**Performing Provider** (performer): A Medicaid provider participating in an RHP, who works with an IGT entity and likely other participants to implement a DSRIP project.

**Program Funding and Mechanics Protocol (PFM Protocol):** A document, drafted by HHSC and pending CMS approval, outlining DSRIP requirements for RHPs including the minimum number of projects, organization of the RHP Plan, plan review process, required reporting, allocation of available pool funds, valuation of projects, disbursement of funds, and plan modifications.

**Regional Healthcare Partnerships (RHP):** Regions developed throughout the State to more effectively and efficiently deliver care and provide increased access to care for low-income Texans under the 1115 Transformation waiver. Each RHP will include a variety of participants to adequately respond to the needs of the community.

**RHP Participant:** An entity participating in an RHP as outlined in an RHP plan. A participant may be an IGT entity, a performer, an anchor, or another stakeholder.

**RHP Plans:** A plan to identify the community needs, the projects, and investments under the DSRIP to address those needs, community healthcare partners, the healthcare challenges, and quality objectives of an RHP. These plans must be submitted to the State and CMS for approval and shall include estimated funding available by year to support UC and DSRIP payments. RHP anchoring entities shall provide opportunities for public input to the development of RHP plans, and shall provide opportunities for discussion and review of proposed RHP plans prior to plan submission to the State.

**Texas Health and Human Services Commission (HHSC):** The state governmental body that oversees the Texas health and human services system operations and administers programs including Medicaid and CHIP.

**Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver** (the Transformation waiver): The vehicle approved by HHSC and CMS for expansion of managed care within the State Medicaid program while preserving federal supplemental hospital funding historically provided under the UPL program.

**Uncompensated Care (UC):** Costs of uncompensated care provided to Medicaid eligibles or to individuals who have no funds or third party coverage for services provided by the hospital or other providers.

**Uncompensated Care Application (UC Protocol):** The documentation needed for hospitals and other providers to report their uncompensated costs to receive reimbursement under the Transformation waiver.

**Upper Payment Limit (UPL):** Historic supplemental payments made to certain hospitals and providers to make up the difference between what Medicaid actually paid for Medicaid clients and what Medicare would have paid for the same services—when Medicaid is provided through managed care. UC and DSRIP funds available under the 1115 Transformation waiver replaced funding available under the former UPL program.