REGIONAL HEALTHCARE PARTNERSHIPS: Updated Map & Next Steps

April 2, 2012

In early April 2012, the Texas Health and Human Services Commission (HHSC) issued an updated map outlining proposed Regional Healthcare Partnership (RHP) boundaries under the Texas Healthcare Transformation and Quality Improvement 1115 waiver ("the 1115 waiver"). The updated map incorporates feedback HHSC received from a February 2012 survey distributed to Executive Waiver Committee members, public and private hospitals, counties, and other interested stakeholders, as well as additional input received at public meetings and via the waiver email address (TXHealthcareTransformation@hhsc.state.tx.us).

This updated map is not the final map, but is the next step towards drawing the final map. HHSC is asking for RHP regional geographic boundaries and anchors be determined by May 1, 2012, to ensure regions will have sufficient time for participants to work together to develop the RHP regional plans (i.e., to assess community needs, select corresponding Delivery System Reform Incentive Payment (DSRIP) projects, and determine funding levels). HHSC continues to encourage participating entities to decide in which RHP they will participate consistent with the parameters of the waiver as outlined below.

HHSC Approach to Updating the RHP Map

In reviewing hundreds of responses, including conflicting information, HHSC considered the following information when updating the RHP map:

1. Compared the preliminary map and stakeholder feedback to consider potential changes and identify outliers— counties not contiguous or areas with conflicting stakeholder input.
2. Reviewed funding considerations, including intergovernmental transfers (IGT) available under the upper payment limit (UPL) program for fiscal year 2011.
3. Identified RHP feedback trends – including acceptance of or concern over counties' placement on the preliminary map, suggested anchor entities, possible IGT concerns, and justification for suggested changes to preliminary RHPs.
4. Created three new RHPs (#17, #18 and #19) in response to feedback that the needs of these regions are viewed by the regions as being materially different from the regions in which counties were placed on the preliminary map.
5. Determined placement of outlier counties based on: (1) a county's own preference, (2) historical patient flow, (3) potential IGT levels in each RHP, and (4) geographical proximity.

Next Steps

RHP geographic boundaries and anchors need to be finalized by May 1, 2012, to enable RHP plan development to move forward. To assist in meeting this deadline, HHSC will schedule a conference call with an optional online webinar component by April 20, 2012, for each of the 19 geographic regions identified on the updated map. On these conference calls, HHSC will discuss how each region abides by the requirements and principles listed below and receive feedback from potential RHP participants in each proposed region. HHSC will accept proposed amendments to this updated map that are consistent with the RHP requirements and principles outlined below. HHSC will provide a form that can be submitted via the waiver email address to confirm RHP regions and anchors. Based on feedback received in April, HHSC plans to announce the final map on or around May 1, 2012.

What is a Regional Healthcare Partnership?

I. **Defining an RHP –** As outlined in the 1115 waiver's Special Terms and Conditions (STCs), RHPs will be developed throughout the State to deliver care more effectively and efficiently and provide increased access to care for low-income Texans. Each RHP will include a variety of healthcare providers to adequately respond to the needs of the community, and the process of forming each RHP will evidence meaningful participation by all interested providers.

   a. **RHPs must reflect patient flow and geographic proximity** – The activities funded by DSRIP are to be based in RHPs that are directly responsive to the needs and characteristics of the populations and communities comprising the RHP. Each RHP will have geographic boundaries. HHSC is currently working with CMS to determine if entities may participate in more than one regional plan based on certain principles. For instance, to reflect existing patient flow patterns, HHSC intends for specialty providers, such as children's hospitals and burn care, to be able to participate in more than one RHP.

   b. **RHP responsibilities** – The RHP plan will identify community needs, the projects and investments under DSRIP to address those needs, community healthcare partners, the healthcare challenges and quality objectives within the RHP, and the metrics described in State protocol associated with each project and quality objective. Within each RHP plan, each IGT entity will specify what providers it will support for uncompensated care (UC) and what specific DSRIP projects it will fund. The State and CMS must approve each RHP plan.

   c. **Participation is voluntary** – Participation in an RHP under the 1115 waiver is completely voluntary. However, participation is required for entities seeking to access federal funds through the waiver effective October 1, 2012. Although counties and providers may choose not to participate, the map will show every county in Texas as located within an RHP region. Entities may choose to participate in an RHP plan as an anchor, IGT provider, and/or performing provider receiving funds for UC or DSRIP, or as a general stakeholder involved in RHP planning meetings.

   d. **Healthcare delivery system transformation is a key goal of the waiver, and inclusion will contribute to RHP success –** A key goal of the waiver is for local entities to have the opportunity to receive new federal matching funds for projects that transform the Texas health care delivery system while improving the quality of care provided. Meaningful improvement by providers participating in an RHP is essential to the success of DSRIP projects in each RHP. RHPs limiting participation—and as a result limiting potential IGT—also limit potential for such transformation. In addition, the waiver sets benchmarks for how much funding each year is to be spent on UC vs. DRSIP. For rural and suburban areas, participating in a region with a larger metropolitan area or other entity with substantial IGT likely will assist with reaching the benchmarks for DSRIP spending. As a result, HHSC encourages RHPs to be as inclusive as possible.

II. **Anchoring entities coordinate–but do not control–RHPs and do not control participant IGT funding –** In convening stakeholders, guiding the development of RHP plans, and reporting on the progress of the entire RHP to HHSC and CMS, anchors have an important role in RHP development. However, the role of an anchor is administrative. Anchors are to coordinate efforts within an RHP, but cannot dictate conditions of another entity's IGT plan. <u>Each transferring entity with IGT funds determines how to use its own public funds within the parameters of UC and DSRIP waiver requirements.</u>

e. **Each RHP must have one anchoring entity –** Anchors may delegate administrative functions (where there is not conflict of interest), such as data collection and reporting, but may not delegate to a contracting entity any decision-making authority that is specifically assigned to the governmental entity under the waiver, HHSC policy or rules, or state law.

f. **Potential anchoring entities** – As outlined in the waiver, in RHPs with a public hospital, the anchoring entity should be a public hospital. In regions without a public hospital, the following entities may serve as the anchor:
   I. A hospital district.
   II. A hospital authority.
   III. A county.
   IV. A State university with a health science center or medical school.

g. **Anchors need financial solidity** – In regions with multiple eligible entities that express interest in the anchor role, a consideration in selecting the anchor should be IGT capacity, as the waiver envisions that one of the anchor's roles is to financially anchor the RHP.

h. **Anchor funding** – Because anchors will incur additional expenses in fulfilling their responsibilities, HHSC is working with CMS to determine the best mechanism to compensate them for allowable administrative expenses, provided the anchor puts up the corresponding IGT. In particular, HHSC is working with CMS to figure out on how a non-hospital anchor may get paid for its responsibilities. The anchor may be eligible to receive a portion of the DY1 DSRIP funding for its allowable expenses as anchor, but the plan is for most of that funding to be available for DSRIP participants.