



Regional Healthcare Partnership Structure Post DSRIP

**Texas Delivery System Reform
Incentive Payment Transition Plan**

**Health and Human Services
Commission**

June 2021



TEXAS
Health and Human
Services

Table of Contents

Table of Contents	ii
1. Milestone Background	1
Regional Healthcare Partnership Structures in the 1115 Waiver.....	1
DSRIP Transition	1
2. RHPs and Anchors in DSRIP	2
Benefits of the RHP Structure.....	2
3. Essential Functions to Sustaining Healthcare Transformation	4
Post-DSRIP.....	4
Potential Regional Coordinating Entity Structure.....	5
4. Conclusion	7

1. Milestone Background

Regional Healthcare Partnership Structures in the 1115 Waiver

The Centers for Medicare and Medicaid Services (CMS) approved the initial Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Demonstration (1115 Waiver) in December 2011. A key component of the 1115 Waiver is the Delivery System Reform Incentive Payment (DSRIP) program, which incentivizes hospitals and other providers to improve access to care and quality of care for Medicaid beneficiaries and low-income uninsured individuals.

The DSRIP program is organized by 20 Regional Healthcare Partnership (RHP) structures across the state. The regions were determined through a stakeholder input process and were required per the RHP Planning Protocol (Attachment I to the 1115 Waiver) to be coordinated by a public hospital or local governmental entity, called an anchor. The RHP Planning Protocol required an RHP Plan to “accelerate meaningful delivery system reforms that improve patient care for low-income populations.”¹ Each region’s anchor is responsible for leading the community needs assessment (CNA) process, RHP coordination, holding regional collaboratives to discuss lessons learned, and supporting providers participating in the program. Under the current 1115 Waiver, DSRIP anchors can submit Medicaid administrative cost claiming for the coordination and administrative services provided to their regions.

DSRIP Transition

The DSRIP program will end in September 2021. As part of the DSRIP Transition Plan, HHSC must submit eight milestone deliverables to CMS. This report is designed to meet the deliverable requirement to identify options for the RHP structure post-DSRIP to maintain regional stakeholder collaboration consistent with approaches for sustaining delivery system reform.

¹ <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/1115renewal-cmsletter.pdf>

2. RHPs and Anchors in DSRIP

To develop the milestone deliverable, HHSC requested feedback in February 2020 from DSRIP providers and anchors on the benefits of the RHP structure. Most respondents (92%) agreed that their organization benefitted from a formal RHP Structure and supported the continuation of the structure in future programs. Respondents cited community needs assessments (CNA), sharing of best practices, increased relationship building, and learning collaboratives as the greatest successes of DSRIP RHPs.

Benefits of the RHP Structure

Community Needs Assessments

The RHP structure was designed to respond to the needs and characteristics of the populations and communities of each region. Provider initiatives have been based on regional CNAs and supported by the RHP structure to foster provider collaboration at the local and regional level. Regions were required to develop CNAs in Demonstration Year (DY) 1 and DY 7 and used the assessments to guide the region's RHP Plan. In the initial DSRIP program, providers were required to include in the RHP Plan the reasons for selecting their specific projects and the selections' basis on local data, gaps, community needs and key challenges. The RHP Plan also described how the distinct projects in a region were related to each other and how they would support delivery system reform. This requirement also laid the groundwork for outcomes reporting in DY 7-10 as providers were required to tie their DSRIP measure bundle selections to their region's needs assessment.

Survey respondents stated the CNA process helped providers to better understand the scope of the health issues affecting their region and aided in identifying pressing needs in their community. RHP anchors took the lead in the development of each region's CNA and engaged providers to identify:

- A region's healthcare infrastructure and environment (e.g., number/types of providers, services, systems, and costs; Health Professional Shortage Area);
- Key health challenges specific to the region supported by data (e.g., high diabetes rates, access issues, high emergency department utilization, etc.); and
- Any initiatives in which providers in the RHP are participating that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives underway in the RHP region.

Relationship Building and Sharing of Best Practices

The RHP structure's positive impact on developing regional relationships and sharing of information and best practices were widely cited by survey respondents as successes of the program. Some providers mentioned that building these strong partnerships had strong impacts on serving the Medicaid and low-income uninsured population. Common reporting measures that were rooted in the region's CNA resulted in providers in the region implementing similar strategies to achieve the measures. Providers also increased their communication with and reliance on others in their region. For example, some providers who reported on follow-up measures had to rely on health information exchange (HIE) data and other providers' documentation across their regions to meet metric targets in their own reporting.

DSRIP anchors are required to coordinate a minimum of one learning collaborative per year to encourage collaboration, development of new relationships, and sharing of best practices. These activities are especially valuable to rural providers, some of which reported that they do not have the staff or financial resources to develop these connections independently.

Increased Stakeholder Engagement

Providers reported that RHPs enhanced engagement of stakeholders around the state. Anchors regularly engaged regional partners in the creation of the RHP Plans and through the learning collaboratives. Learning collaboratives provided an opportunity to share information across the participating providers, including smaller providers who were newer to state, and industry-level standards and best practices. Some of these providers reported that having a regional anchor gave them more of a voice at the state level, particularly for smaller providers.

Support to Participating Providers

In addition to the activities above, most providers surveyed agreed that the RHP structure with anchors has been beneficial because it provided them access to technical assistance for reporting and a single point of contact with HHSC. These providers stated their region benefitted from anchor-facilitated communication with HHSC regarding reporting requirements and compliance monitoring. In these situations, anchors provided training, troubleshooting, and guidance.

3. Essential Functions to Sustaining Healthcare Transformation

There are multiple essential functions of the RHP structure and anchors that should be considered in future programs in the state. Based on stakeholder feedback, these activities contributed to the success of DSRIP and improvements in healthcare for Medicaid beneficiaries and low-income uninsured individuals. Below is a list of activities that should be continued in region-focused programs:

- Regional-level communication on best practices for driving quality improvement and health outcomes.
- Technical assistance and training on reporting processes and requirements or HIE connectivity.
- Facilitating collaboration, relationship building, and data sharing channels
- Identifying local population needs and services
- Streamlining communication across broad stakeholders

Post-DSRIP

Considerable uncertainty has been added to the DSRIP Transition planning by CMS's purported rescission of the 1115 Waiver Extension approved on January 15, 2021, which was designed to partially offset the loss of the DSRIP funding and provide stability for state programs and planning.

As part of its DSRIP Transition Plan, HHSC proposed four new directed payment programs (DPPs)² to further healthcare improvements on a provider-level³:

- Comprehensive Hospital Increased Reimbursement Program (CHIRP)
- Directed Payment Program for Behavioral Health Services (DPP BHS)
- Rural Access to Primary and Preventive Services Program (RAPPS)
- Texas Incentives for Physicians and Professional Services (TIPPS)

² <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/dsrp-support-delivery-system-reform.pdf>

³ The 1115 Waiver Extension that was approved on January 15, 2021, also included a Public Health Provider Charity Care Pool (PHP-CCP) as part of the DSRIP Transition Plan. The PHP-CCP would support funding stability for certain DSRIP participating providers.

The four DPPs will be administered through managed care organizations (MCOs) that operate the state's Medicaid managed care programs in 13 service delivery areas (SDAs) across the state. The new DPPs are specific to a provider type and each provider class reports on different program measures. The new DPPs are designed to advance the goals of the Medicaid Managed Care Quality Strategy, which is focused on statewide priorities.

A critical difference between the DPPs and the DSRIP program is that the goals of the DPPs are not regionally-focused. They are not defined or developed based on the unique needs of a region. For these state-directed programs, the essential functions listed above naturally shift to HHSC rather than a regional entity.

HHSC has not yet identified sufficient functions for regional entities in proposed DY11 programs to support a post-DSRIP RHP structure. During DY11, the current RHP structure will continue to assist with the completion of DSRIP DY10 reporting. However, as HHSC continues system transformation, the role for a regional coordinating entity (RCE) may be more appropriate.

For DY12 and beyond HHSC is considering program concepts such as initiatives to improve regional population health outcomes, increase health information exchange (HIE), and strengthen community responses to social determinants of health (SDOH). These types of programs are groundbreaking initiatives that would benefit from coordination on a local level and across the state.

Potential Regional Coordinating Entity Structure

An RCE structure could be similar to the DSRIP RHP structure, featuring an anchor that serves as the central communication hub between HHSC and program providers, organizes regional learning collaboratives, and develops the CNAs. Or, the RCE structure could take the form of a governance board for participating entities to better coordinate care, designate accountability among participants, and facilitate data connectivity and referral channels. HHSC has not yet identified a permissible funding mechanism that could support the functions of a regional coordinating entity.

Potential structure and roles for the RCE could include:

- An organization aligned with Texas Medicaid managed care 13 SDAs to advance integration of DSRIP lessons learned into the broader Medicaid program.

- Primary facilitators on a regional level for conducting CNAs and determining specific regional goals. This role would be especially important for programs intended to address SDOH and population health outcomes.
 - ▶ Addressing SDOH requires coordination not only of healthcare providers, but also community-based organizations and resource referrals that may not already be connected to the healthcare system. An RCE could be responsible for assisting hospitals, public health authorities, local mental health authorities, community-based organizations, community providers, MCOs, and the community could identify needs and strategies.
 - ▶ Improving population health outcomes requires establishing clear population-specific goals, data collection and sharing processes, and reporting. An RCE could track the regional population-health metrics and report to key stakeholders, participating providers and community-based organizations, and HHSC.
- Assistance with implementation of the HHSC Health IT Strategic Plan Strategy 1: Medicaid Provider HIE Connectivity.
 - ▶ This strategy will further Medicaid providers' connections to local HIE organizations to facilitate electronic reporting and data exchange between providers and Texas Medicaid.
 - ▶ This could include outreach to providers who have not participated in HIEs by using provider and region-specific information.
- Coordination of regional learning collaboratives. RCEs could hold regional learning collaboratives to focus on provider needs, regional population health and services, and connect providers to share best practices.
 - ▶ Learning collaboratives enhance provider connection and merit continuation to drive improvements in system coordination.
 - ▶ Learning collaboratives provide opportunities to share best practices and build relationships within the regions.

4. Conclusion

The current RHP structure is recognized as an effective model for the regionally-focused DSRIP program but may not be the optimal structure for regional engagement after the DSRIP is wound down. For post-DSRIP programs, HHSC is exploring the use of RCEs in concepts currently in development.

Informed by the experience of DSRIP, RCEs could be instrumental in meeting the objectives of post-DSRIP programs to continue system transformation. The DSRIP Transition Plan requires HHSC to submit to CMS options for programs to begin in DY12. The milestone deliverable for DY12 programs is due to CMS on September 30, 2021.