Will HHSC still pay supplemental payments for services provided by physician practice groups under the 1115 wavier?
Uncompensated care payments under the waiver may cover the unmet cost of providing physician services to Medicaid patients and uninsured patients. HHSC will seek clarification from CMS as to whether payments out of the pool may be made to qualifying physician practice groups where appropriate.

Will the payments still be calculated based on 145 percent of the Medicare rate?
Uncompensated care payments under the waiver will be limited to the cost of providing services, and therefore the current physician supplemental funding methodology using 145 percent of the Medicare rate will no longer be used. However, HHSC will compute transition payment caps for the first year based on historical Physician UPL payments.

Regional Healthcare Partnerships

What are Regional Healthcare Partnerships?
A Regional Healthcare Partnership is a collaboration of providers that work collectively to develop and submit to the state a regional plan for health care delivery system reform. The regional partnership will be led by the public hospital provider or providers in the region that agree to provide the intergovernmental transfer (IGT) of public funds as the state share for payments to providers in that region from the DSRIP program under the waiver. Regional Healthcare Partnerships will support coordinated, efficient delivery of quality care and a plan for investments in system transformation that is driven by the needs of local hospitals, communities, and populations, rather than a top-down, one-size-fits-all approach.

Who can participate in a Regional Healthcare Partnership?
Regional Healthcare Partnerships are created and led by public hospitals or local governmental entities responsible for funding the state match in partnership with regional health stakeholders. A provider may join a partnership if it obtains an affiliation with an entity that provides IGT, participates in the regional plan, and meets related objectives, reporting, metrics, and other criteria defined under the DSRIP program. The rules for developing and implementing a Regional Healthcare Partnership are being formulated in negotiation with CMS.

What is a Regional Healthcare Partnership plan and what is it for?
It's a five-year plan that outlines projects that support delivery system reforms tailored to the needs of the communities, the state and populations served by the regional partnership. The plans will include regional assessments, goals, rationale for projects, annual milestones, metrics, and expected results.

Who approves a Regional Healthcare Partnership plan?
CMS, the state, and hospital representatives will create a model, including required and flexible locally-driven categories and components, for Regional Healthcare Partnership plans. This will serve as the basis for ensuring compliance with the waiver. The state will have responsibility for review and approval of individual plans.

What are the boundaries of the Regional Healthcare Partnerships and who sets them?
HHSC proposes structuring Regional Healthcare Partnerships initially based on the managed care service areas for the 16 large transferring hospitals. The regions initially will be based on current public hospital counties and IGT-based affiliation agreements. For county transferring entities, regions will be based on current public entity governmental areas and IGT-based affiliation agreements. Plans would be updated annually to reflect expanded areas and stakeholders.

Does the waiver legally remove issues with provider related donations?
The federal restriction on provider related donations will remain unchanged. Documentation of uncompensated care costs that provides the basis for payments from the uncompensated care pool in the waiver will increase accountability and transparency for the use of these dollars.

In the development of Regional Healthcare Partnerships, will local stakeholders vote on counties' use of funds?
No, counties and other entities providing state share will control how their funds are used in the waiver.

Waiver Pool Funds

How are the waiver pool funds determined?
The amount of waiver pool funds will reflect the difference between the without-waiver baseline and the with-waiver baseline in the budget neutrality model. This includes hospital supplemental payments previously allocated through the UPL program for all populations, UPL equivalent payments for the current STAR population, supplemental payments allocated through the physician UPL program, and savings from managed care expansion. The waiver pool funds are calculated for the five years of the waiver.