# DSRIP Weekly Update
## May 23, 2017

Good afternoon RHP3 DSRIP stakeholders,

Weekly updates and follow up from questions raised during last the 5/17/17 Regionwide call are below.

# April Reporting

An email from HHSC about estimated April reporting IGT is below. If IGT changes described by HHSC are needed at your organization, complete the form linked below by June 1 @ 5pm:

IGT entities,

Please review the yellow highlighted columns in the attached file for DY6 Round 1 estimated DSRIP payments and DY6 Monitoring IGT due. The estimated payments are based on the assumption that all milestones/metrics reported as achieved in DY6 Round 1 will be approved by HHSC.

These estimates are provided to inform any needed IGT changes in entities or proportion due to HHSC by June 1, 2017, 5:00pm using the IGT Entity Change Form located at:

https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-docs/IGT-Entity-Change-Form-%28DY4-6%29.xlsx.

Do **not** use these estimates to submit IGT.

Rate Analysis will notify IGT Entities and Anchors of the actual IGT due

the week of June 19, 2017.

# DY7-8

- HHSC released the updated PFM, a summary document, and a feedback summary narrative last week.

  PFM Protocol DY7-8
  Summary of DRAFT Texas DSRIP DY7-8 Requirements
  Summary of Stakeholder Feedback and HHSC Responses

- The Round 4 hospital Bundle Advisory Team feedback document was released today.

  Bundle Advisory Team Feedback document

- The 5/23/17 TA BAT call included the following details:

  - TA representatives noted that there are mixed messages from HHSC about continuing current projects and newly defining system, which can seem at odds if the populations don't match. The state has taken note that the system definition may have unintended consequences for inter-organizational collaboration.

  - HHSC said some exceptions to the system definition will be allowed. During and after the mid-June HHSC PFM/Measure Bundle webinar is the appropriate time for applicable Providers to begin discussing this with HHSC.

  - HHSC intends to arrive at a unique definition of base unit for hospitals. An idea from the state was that base unit could be a hospital's inpatient and ER services, with add-ons allowed from there to outpatient services, etc.

  - The measure bundle protocol will be released in mid-June with a survey for Provider feedback. HHSC intends for the survey to be the only round of feedback sought.

# 5/17/17 Regionwide call follow up

**1. How do the populations of Category B and Category C relate?**

a. As is explained in the PFM feedback summary (page 13, Section F, question 28), "...Category C should not be measuring a population that is not included in the Category B system Total Patient Population by Provider..." however "Category C measures will not necessarily apply to the entire system; measure denominators may be naturally limited by setting or measure specification."

**2. What will the DY7 and DY8 values be based on?**

a. Per the updated PFM (page 11, Section 14.a), "A Performing Providers total valuation for each demonstration year of DY7 and DY8 is equal to its total valuation for DY6A with the following exceptions":

i. "If HHSC determined that a DSRIP project was ineligible to continue in DY6A, the Performing Provider affected by such a determination may use the funds associated with the DSRIP project beginning in DY7; or

ii. If a Performing Provider withdrew a DSRIP project between June 30, 2014, and June 30, 2016, the Performing Provider may use the funds associated with the DSRIP project beginning in DY7.

iii. Performing Providers beginning DSRIP participation in DY7 with a total valuation less than $250,000 for DY7 may increase their total valuation to up to $250,000 per each subsequent DY beginning in DY7. Performing Providers eligible for this option must make this choice in the RHP Plan Update"

**3. Is there any chance a Performing Provider's value would decline?**

a. Yes. Providers that do not select enough measures to reach their Minimum Point Threshold will have their valuations reduced.

i. Page 14, Section 17.f.i: "If a hospital or physician practice does not select Measure Bundles worth enough points to meet its MPT, its total DY7 valuation will be reduced

proportionately across its RHP Plan Update funds and Categories B-D based on the number of Measure Bundle points selected, and its total DY8 valuation will be reduced proportionately across its Categories B-D based on the number of Measure Bundle points selected."

ii. Page 17, Section 18.d.i: "If a CMHC or an LHD does not select measures worth enough points to meet its MPT, its total DY7 valuation will be reduced proportionately across its RHP Plan Update funds and Categories B-D based on the number of measure points selected, and its total DY8 valuation will be reduced proportionately across its Categories B-D based on the number of measure points selected."

**4. Can HHSC provide a clearer explanation of the patient count duplication they're seeking to avoid?**

a. Greater clarity is TBD, however, HHSC stated via email on 5/19/17: "When we're talking about duplication, we are talking about two providers reporting in Category B or Category C for the same clinic or facility. For example, a primary care clinic owned by another DSRIP performing provider or a psychiatric inpatient facility owned by another DSRIP performing provider." The issue seems to be between academic health science centers and hospitals, NOT an issue around serving patients in community-based clinics.

Please contact me at Giovanni.Rueda-Anguiano@harrishealth.org if you are having trouble downloading any of the linked files.

This weekly update is also located on our website here.

Regards,
Giovanni Rueda-Anguiano