FAQ: Category B - System Definition and PPP

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	System Definition: What can be included or excluded?	
1.	Providers have requested additional clarification about the inclusion of non-clinical settings in their system.	Non-clinical settings (such as school-based services) are optional, and inclusion in system may vary dependent upon access to data (that can be used to support any potential audit of reported information). HHSC does hope that those projects that have benefited clients in the non-clinical settings will continue, regardless of whether or not they are specifically being measured. Please note, however, that many of the activities in a non-clinical setting will not be part of any Category C measurement unless actual, documented services are delivered.
2.	2. Some providers requested to limit their system definition to only certain populations that are being served.	Providers may not limit the system definition by types of populations being served. The System should be as inclusive as possible to get the most accurate count of all of the patients who are served by the provider. Choosing a specific population (such as by zip code, diagnosis, services received, or certain high-risk behaviors) for purposes of the system definition may give unfair advantages to providers when calculating achievement of Category C outcome measures. The Category C measures will naturally limit the denominators of measures by the setting of the measurement and by measure specifications (which may target specific populations based on diagnosis, for example).

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3.	3. There have been many questions about a provider's TPI and its role in the system definition.	TPI is only used in DSRIP for the purpose of payment. If these are two separate TPIs that are used for DSRIP payments because they are two separate DSRIP providers, then the TPIs may not be combined (unless they are previously approved, or in the circumstance of a hospital and physician practice that work in the same space). However, outside of DSRIP participation, a single provider may have many TPIs. That is not a factor for the purposes of DSRIP system definition.
4.	A provider has consolidated their projects that were previously under multiple RHPs into one RHP. Does the system now include all components from the multiple RHPS/regions? And is there just one MLIU count and one system to which Category C applies?	Yes, the system now should include all components across the multiple regions. There will be one MLIU PPP count for the one system definition and the Category C measures will apply to that one system across multiple regions (as applicable per setting and measure specification).
5.	Providers asked if there are components of a system that are not currently listed on the required or optional list in the Measure Bundle Protocol, if they may be included.	Yes, these should be included under the Optional - Other Category. The RHP Plan Update template will have space for the provider to explain this other system component.
6.	Some providers intend to include activities of a partner organization in their Category A Core Activities reporting, but to exclude them from the Cat B System Definition. Is that allowed?	This is allowable, such as school-based interventions that will not be measured as part of Category C. The provider should clarify in the Category A Core Activities description that they are collaborating with this partner, but not counting them for purposes of Categories B or C.
7.	Providers asked if it is at the provider discretion, if they have multiple participating provider hospitals and many owned clinics, to determine which clinic belongs to which hospital's system.	Yes. Ideally the system relationship is based on collaboration between these clinics and hospital locations. But if there is not a clear delineation, the provider may determine based on proximity or other important factors. Please note, however, if a patient attending one clinic in System A attends the hospital in System B, both systems may count that individual for purposes of Category B PPP. We know this type of duplication across systems may not be avoided.
8.	Respondents requested the definition of Performing Provider.	According to the PFM, "'Performing Providers' are providers that are responsible for: 1) implementing Core Activities to achieve the Category C measure goals in an RHP Plan Update; and 2) measuring, reporting, and improving performance on the Category C measure goals in an RHP Plan Update, among other reporting requirements outlined in this protocol. All Performing Providers must have a current Medicaid provider identification number. Performing Providers that complete milestones and measures as specified in [the] "Measure Bundle Protocol" are the only entities that are eligible to receive DSRIP incentive payments in DY7-8. Performing Providers will

	Question/Feedback	HHSC Response
		primarily be hospitals, but CMHCs, LHDs, and physician practices may also receive DSRIP payments."
9.	Respondents asked if they are partnering with a separate entity and including them in the system definition (under optional) do they need to include all services they provide or just services provided on our behalf.	Providers may determine which arrangements make most sense for them, but providers must maintain consistency across all measurements periods and document their arrangement. For example, if a provider chooses to only include the services provided on their behalf with a contracted provider, they should document that in their system description and they should only include those contracted services (not all services) in each DY of the waiver.
10.	Many respondents were concerned about how to avoid duplication across provider systems.	There may be overlap in system definition between providers who share the same contracted entity, but Performing Providers should avoid system definitions that include required components of another DSRIP Performing Provider's system. For example, DSRIP Performing Provider hospital A should not include the specialty clinic that is operated by the DSRIP Performing Provider hospital B. Individuals may be in multiple systems, but should not be included in each system based on the same single service. If an individual is served by System A in DY7 and also served by System B in DY7, they may be counted in both systems in the providers' respective system PPP. For example, if one hospital Performing Provider system refers an individual patient to a separate Performing Provider CMHC for services, they would both count this individual as part of their Patient Population by Provider for Category B purposes. However, they are providing different services, and most likely, will be selecting different measures for Category C. In this hypothetical scenario, the hospital may not be measuring some mental health related outcome based on the referral to the CMHC, but the CMHC might.
11.	Hospital DSRIP Participating Providers in DY 2-6 asked about adding hospitals to their system definition in their region that are owned by the same hospital system.	For the purposes of DSRIP, ownership by the same parent company does not constitute a system. For example, if there are 6 hospitals owned by one company in a region, but only three of them participated as independent DSRIP participating providers during DY2-6 (each had their own projects and 3 separate valuations), they do not need to add the 3 other hospitals that are owned by the same company. The three hospitals that were each operating independently in DSRIP would instead add owned/operated clinics and other required or optional components with which they collaborate to their system definition. The DY2-6 providers would have the option of adding an additional hospital if there is significant collaboration between the hospitals, but it is not required.

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<tr><th></th><th>Question/Feedback</th><th>HHSC Response</th></tr>
<tr><td>12.</td><td>Respondents asked about the overlap between hospitals and physician groups.</td><td>HHSC will allow existing DSRIP Performing Provider physician practices and the hospitals where they practice to combine into one system since there is overlap between the individuals they serve and the collaboration for transformative purposes. These providers will have a combined total MPT, based on the original MPTs assigned, with the maximum MPT remaining at 75. These providers should have notified HHSC by August 31, 2017, if they would like to combine MPTs. This applies to the following providers. Please notify HHSC immediately if this applies to a DSRIP Performing Provider hospital and related physician practice that are not listed.

<table>
<tr><th>RHP</th><th>Hospital TPI</th><th>Hospital</th><th>PP TPI</th><th>Related Physician Practice</th></tr>
<tr><td>2</td><td>094092602</td><td>University of Texas Medical Branch - Galveston</td><td>109372601</td><td>University of Texas Medical Branch - Galveston</td></tr>
<tr><td>6</td><td>136141205</td><td>University Health System (Bexar County Hospital District)</td><td>092414401</td><td>Community Medicine Associates</td></tr>
<tr><td>9</td><td>175287501</td><td>University of Texas Southwestern St Paul University</td><td>126686802</td><td>UT Southwestern Medical Center at Dallas</td></tr>
<tr><td>10</td><td>126675104</td><td>Tarrant County Hospital District dba JPS Health Network</td><td>360106401</td><td>Acclaim Physician Group Inc</td></tr>
<tr><td>10</td><td>130606006</td><td>Decatur Community Hospital (Wise Reg Health System)</td><td>206106101</td><td>Wise Clinical Care Associates</td></tr>
<tr><td>12</td><td>137999206</td><td>Lubbock County Hospital District dba University Medical Center</td><td>079877902</td><td>UMC Physician Network Services</td></tr>
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</td></tr>
<tr><td colspan="3">Counting Patient Population by Provider (PPP)</td></tr>
<tr><td>13.</td><td>The PFM indicates that providers should include in the Patient Population by Provider (PPP) count even those clients that receive services that are funded exclusively by a federal grant or program.</td><td>That is correct. Providers may include in their PPP and system those clients that are served through federal grant or other-funded programs. PPP is no longer measuring the impact specific to DSRIP; it is looking at who the provider’s system is serving at large. Providers should check guidelines for any other federal grants to see if there are any conflicts therein.</td></tr>
<tr><td>14.</td><td>One provider asked if a Core Activity that was previously provided through a contracted entity for DY 2-6 DSRIP activities is discontinuing in DY 7, should the provider exclude those patient counts in the Total PPP and MLIU PPP baselines.</td><td>It depends on the location of the services. If the activity was occurring in one of the required components of the system, then patients must be included in the baseline. If the activity was in an optional component of the system, then the population may be excluded from the baseline.</td></tr>
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	Question/Feedback	HHSC Response
15.	A number of providers raised questions about active patient definitions.	For purposes of Cat. B System definition and the PPP, the patient must have received a service in the DY, as defined in the PFM. You do not need repeat clients within a DY to be able to count an individual toward the Category B PPP. Category C measure specifications may have different allowances/requirements for active patient definition.
16.	Some respondents stated there is a potential, based on outside factors, for certain grant-funded or other non-DSRIP services to be decreased in the future and impact the provider's ability to maintain their system population. Providers requested to amend their baseline for any anticipated/possible funding changes.	Baselines may not be amended based on possible future policy changes. There are allowances for normal fluctuation in the system makeup by the fact that (1) the baseline is set on the average of two years to account for natural fluctuations; (2) providers are granted an allowable variance from 100% achievement [the percentage variance is to be determined based on provider type and MLIU populations]; and (3) there are partial achievement levels in the Category B PPP. In addition, the PFM indicates that a provider may request to amend their baseline and goal in the event that a major change impacts the provider's system definition, such as a policy change that the provider has little control over.
17.	There remains some confusion about the change in Patient Population by Provider (PPP) from QPI -- system versus project-specific reporting -- and how to calculate the PPP baseline.	The baseline for PPP is a new number that is no longer tied to project-specific impact of DSRIP. The baseline is a new count of the total population and the MLIU population served by a provider system. The total population baseline is the average of the total population served by the system in DY5 and DY6. The MLIU baseline is the average of the MLIU population served by the system in DY5 and DY6.
18.	If we discontinue a project in DY7-8 that attracted many MLIU patients during DY5-6, can we exclude that project from our baseline calculation, knowing that we may see a decrease in the MLIU population served?	The intention of the Category B PPP is that providers **maintain at least** the same number of MLIU patients served under DSRIP DY2-6 projects into DY7-8. This is because the MLIU population is the target population of the waiver and DSRIP funding. So if discontinuing certain DSRIP projects means a provider will reduce the number of MLIU patients served, there are two options: (1) Maintain the number of MLIU patients served by expanding access to system services or recruiting those patients in another way. (2) Earn less than the full valuation of the Category B measures. A provider may earn 100%, 90%, 75% or 50% of the total valuation based on the equivalent attainment of the maintenance goal. While the new structure allows flexibility for providers to discontinue projects that they no longer deem meaningful or that are not working, the goal is still to serve at least the same number of MLIU patients. So removing those DY5-6 project populations from the baseline calculation is not allowable.

	Question/Feedback	HHSC Response
	Data Questions	
19.	Providers inquired about the role of data availability in determining system definition.	Data availability may be used in consideration of which optional system components to choose. But data availability (or simplicity of accessing data) is not a reason to exclude one of the required components of the system definition.
20.	Some providers raised concerns about capturing system-wide data across different EMR systems.	We understand this may take some additional work to get a unique patient count within one system but across different EMR systems. But in the efforts to prepare providers for more data-supported quality improvement and improved patient outcomes, and to prepare providers for sustainability through HIE partnerships or potential VBP arrangements, we think this is an important step.
21.	Can contracted clinics be limited by type of EMR they have accessible?	Contracted clinics are optional.
22.	With respect to data availability and providers' ability to capture their system of patients, it would be helpful to understand, from an audit perspective, which specific data fields will be used to validate system definition. This will allow providers to create a patient list that comports with all required elements of an audit and will reduce the need for reconciliation and re-work.	We will request some guidelines/parameters from the independent assessor, Myers & Stauffer. Most likely, you will need to be able to provide a unique patient ID and evidence of encounter date within the DY. Then, you will need supporting evidence for this, such as screen shots that validate the encounter and patient ID.
23.	One respondent stated that the social services aspect of the physician practices should be separate, and due to the sensitivity and confidentiality of each counseling session, it would be hard to get the patient's information in an electronic form since social workers don't electronically document their sessions.	A Performing Provider cannot be split into two systems. Providers will not be providing PHI to HHSC for reporting purposes. If the counseling session providers are billing for their services, they should have the information required for reporting purposes. Only auditors would be eligible to review that information, should the provider be subject to an audit.
24.	How should the data sharing happen, to what extent, and what infrastructure will be available to support the data sharing activities?	That is to be determined by the contracted/partnered entities. The participating provider is responsible for ensuring they have access to necessary data to support any achievement reporting.

	Question/Feedback	HHSC Response
	System Relationship to Category C	
25.	Respondents asked if they have to choose Measure Bundles or measures that address the entire system or if they are free to choose any bundles or measures as long as they meet the MPT.	You may choose any bundles for your provider type as long as you meet the MPT.
26.	Some providers seem still confused about the relationship of system definition to measure bundles and measures. Some want to have different system definitions for different bundles.	Each DY2-6 DSRIP performing provider will only have one system. The entire system population is not necessarily (and most likely is not) the denominator for any one measure. The system definition and PPP is larger than the denominator of any one measure. The denominator will be limited by the setting of any one measure and by the measure specifications. The system is the universe of patients that may or may not be measured in the Category C measures. But all people included in a Cat C measure should be included in the Category B System PPP. So if a provider wants to partner with other clinics in order to add more measures and reach their MPT, they need to include those partner clinics in their system (and be able to access data necessary for reporting measure outcomes and patient populations). Providers may not limit their system based on their Category C measure bundle selections. They should be counting all patients who they serve for the purposes of Category B Patient Population by Provider.
	Required and Optional Components of a System	
27.	Providers raised questions about required components and how to define their system if they do not have some of the required components.	The required components are only required to be included in the provider's system definition and PPP if the provider has that business component. For example, if a hospital does not perform births or have a maternal unit, it does not need to be required in the system definition.
28.	Providers thought the inclusion of required versus optional was in conflict with the statement that the system definition should incorporate all aspects of its organization that serve patients.	The required components were HHSC's efforts to get at a common set of services/settings/departments among provider types that should be included in the provider's system definition. The optional components (that are not contracted) should be included if the provider has them because the goal is to get the largest sense of who the provider serves, but the optional components are less common across a provider type. If providers believe there are more common components of a provider type that have been left off the required list, please provide suggestions. Flexibility is primarily afforded for system definition in the case of contracted/partner entities.
29.	Providers asked if Rural Health Clinics are included under required hospital components.	If they are owned or operated by the hospital, they should be included in the system definition.

	Question/Feedback	HHSC Response
30.	How would an LHD characterize public health/prevention/education services, such as teen pregnancy prevention or diabetes self-management education that is delivered in community locations for purposes of defining their system? Would these be considered optional components and fall under "Other"?	Yes.
	Systems and Contracted Entities	
31.	Respondents asked if providers can pick and choose which contractors they include in their system based on data sharing arrangements.	Yes. Contracted entities are optional, and a provider should have access to data to support any reported achievement in order to include contracted/partner entities.
32.	What is the process of adding contracted entities to a system's definition? Contract arrangements can take months, therefore a timeline of approval is necessary.	The system definition will be required as part of the RHP Plan Update due in January 2018. For purposes of Category B only, adding contractors is fine.
33.	Respondents requested definition of owned/operated versus "contracted."	If the provider has any partial ownership of the clinic, entity or service, it should be considered owned. The language also includes the use of operated -- so if the provider operates a clinic but the doctors are all private contractors, it would be considered owned or operated.
	MLIU	
34.	Category B MLIU PPP goals are based on the number of Medicaid, low income, and uninsured patients to which a hospital provides services. In the initial Waiver period, providers included low-income patients based on various methods, such as patient interviews regarding income or a proxy calculated by the hospital. In the comments to the PFM protocol, HHSC states that providers who do not have systems in place to evaluate income status do not need to include low-income patients in their MLIU count, and would only be authorized to count individuals with Medicaid and individuals without insurance. If providers are not allowed to include low-income individuals in the Category B PPP reporting based on a proxy or other reliable methodology, then Provider is concerned that this will negatively impact Provider's MLIU goals. Provider respectfully requests that HHSC consider allowing providers to continue to report MLIU patients based	HHSC has provided flexibility in setting the baseline and goal and measuring the achievement of PPP. At this point, we want providers to get the most accurate picture possible of the patients they serve. Self-attestation is acceptable, but providers must maintain paperwork documenting the self-attestation. A proxy will not be utilized for DY7-8 as this does not comport with the structure of the achievement at 90%, 75% and 50% thresholds, much less the allowable variance.

	Question/Feedback	HHSC Response
	on a proxy, patient interviews, or other reliable methodologies as they did in the prior Waiver periods.	
35.	Can we receive clarification on what should be included in the Medicaid part of the MLIU calculation? I.e., Medicaid, Medicaid managed care, CSHCN, CHIP, etc.	Medicaid includes Medicaid Fee-for-service, Medicaid managed care, and Medicaid dual-eligibles. Medicaid also includes Medicaid as a wrap-around or secondary coverage, too. CHIP may be included under Low-income and/or uninsured as the CHIP eligibility threshold is 200% (+/- for MAGI).
36.	In expanding the PPP from project to system level, the MLIU population may be more diluted. The other components of the system may have lower numbers of Medicaid and uninsured, which will make their overall ratio low. While providers are not being penalized for ratios, reporting on this broader population for Cat B and expanding interventions across these facilities (since patients will be reported in all-payer Cat C rates) could really dilute efforts intended to target the Medicaid and LIU populations. If the goal of DSRIP is to transform care for the MLIU, a provider should focus their efforts only on those facilities in their system where the larger proportion of this population is served.	This is a valid point. While we do want providers to maintain their MLIU focus, we also want to impact the healthcare delivery system at the system-level. The combination of Category B and the default reliance on MLIU denominators (with exceptions) in Cat C tries to balance out this approach.
	Other Feedback/Questions Received	
37.	Since we are moving to system-level reporting that is significantly larger than the project-specific reporting we did in DY2-6, can we request an increase in valuation? The activities that we undertake to improve outcomes at the system level may involve more resources than what was previously utilized in the specific projects.	There will not be an increase in any provider's valuation. All providers are moving to system-level activities to improve outcomes. Depending on the measures/bundles selected, the activities may still only apply to certain aspects of the provider's services. Providers should also consider only continuing those activities that improve outcomes and demonstrate value.