# Section V. DSRIP Projects

## RHP Plan Development

**RHP 8 Requirements**

RHP 8 is a Tier 4 region, which carries a minimum requirement of four projects from Categories 1 and 2, with at least two from Category 2.

The RHP 8 Plan includes 19 Category 1 projects and 22 Category 2 projects for a total of 41 Category 1 and 2 projects (four of these projects are considered three-year projects). Of the original 17 Category 1 and 20 Category 2 projects, 23 were selected in Pass 1 and 14 in Pass 2.

Table 2-1 shows all the Category 1 and 2 projects (both original Waiver projects and three-year projects) included in this section of the Plan. Addendum 4 describes projects that were considered in earlier planning stages and were not included in the Plan. Projects were not included primarily because they did not have IGT and did not meet the final planning protocol requirements.

**Pass 1 / Pass 2**

As a smaller region, RHP 8 used a relatively simple process for Pass 1 and Pass 2 project selection. As mentioned in Section III, each IGT Entity was provided with the local and regional assessment data and asked to determine its priorities early in the process. These priorities were communicated in public meetings and were summarized and disseminated to eligible performing providers to inform them what IGT Entities would be willing to fund. Based on the then-current list of project areas and options, the Anchor Team created a form, and the performing providers were asked to submit a short, 2-page concept proposal for the IGT Entities to review. The Anchor Team compiled the concept proposals and facilitated meetings with the IGT Entities and performing providers to discuss their ideas. This allowed providers and IGT Entities to begin to negotiate. As the planning protocol evolved, so did the projects.

Once the final planning protocol was approved, most of the performing providers and IGT Entities had agreements in place as to what funds were available for which projects; the amount of DSRIP for the region did not approach the regional DSRIP cap. Based on this, RHP 8 proceeded through Pass 1 focused on meeting the Pass 1 requirements and ensuring that eligible Pass 1 providers were able to include projects that would enable them to participate in Pass 2.

RHP 8 has only one major safety net hospital and no public hospitals.

The process utilized the performing providers’ Pass 1 workbooks for information to ensure the following:

* **RHP 8 met the minimum number of projects from Categories 1 and 2;**
* **The major safety net hospital’s DSRIP projects were included in Pass 1;**
* **The private and non-profit hospital providers’ DSRIP projects met the 5% allocation guideline for broad participation;**
* **LMHAs were each represented in Pass 1 so that they could participate in Pass 2; and**
* **The local health departments were represented in Pass 1 so that they could participate in Pass 2.**

In this process, the region was able to include everything in Pass 1 except for what the IGT Entities with smaller percent allocations had in excess of those allocations—the LMHAs, local health departments, and academic health science center.

Since the academic health science center did not have direct care Providers in RHP 8 outside of other Participating Performing Providers, it elected to give away its allocation so that all of the LMHAs and local health departments could be represented in Pass 1 with meaningful size projects and be able to include all of their projects through Pass 2.

Pass 2 consisted of projects that would not fit under the Pass 1 allocations, as well as those from providers not eligible under Pass 1.

**Process for Project Evaluation and Selection**

The PFM established the requirements for project selection, requiring projects address a specific regional need identified in the community needs assessment that is supported by data. The PFM also identified criteria for RHP and provider participation, including RHP and provider allocations. In RHP 8, the initial allocations were outlined for the region as a whole, and then Pass 1 allocations were given by the HHSC for each hospital that had previously participated in the Disproportionate Share Hospital (DSH) or Upper Payment Limit (UPL) programs. The designated percentages of the regional allocation were also calculated for named categories of providers: academic health science centers, LMHAs, and public health departments. Given these allocations, RHP 8 went through the steps described above in the “Pass 1 / Pass 2” Section:

* **Prioritization of community need within each community and as a region;**
* **Solicitation of project concepts based on identified priorities and the then-current DSRIP menu;**
* **Presentation of project concepts by providers to IGT Entities;**
* **Revision of project concepts with the new and final DSRIP Planning Protocol;**
* **Review of proposed projects by Anchor entity to highlight any potential issues related to the fit with the Planning Protocol;**
* **Review of the proposed projects by IGT Entities to determine fit with local needs and priorities, as well as the scope and potential impact of each project;**
* **Selection of projects to support by IGT Entities; and**
* **Negotiation of project specifics and amount of IGT available to support each project.**

Once the IGT Entities committed support to the projects they selected, the Anchor Team conducted a cursory review to ensure that the requirements were met, which was subsequently verified through the Provider and Anchor workbooks. The final, initial RHP 8 Plan included all proposed projects that met HHSC requirements, addressed an appropriate community need, and had secured IGT. No project that met these requirements was excluded from the Plan.

**Category 4 Exemptions**

No performing providers in RHP 8 are exempt from Category 4 reporting.

**U.S. Department of Health and Human Services (DHHS) Funding**

RHP 8 Providers indicated DHHS funding they received in Table 3-8. In addition, each Provider addressed DHHS funding in their narratives in Section V of this Plan.

## Project Valuation

RHP 8 adopted a general five-step approach to guide project valuation across the RHP, with each Provider able to determine the ultimate valuation of each project with its related IGT Entity. Once each Provider had determined the content of the project, including tasks, timelines, milestones, and metrics, it was asked to consider the following steps:

1. **Determine how much the project will cost to implement, including the Category 1 or 2 portion, the Category 3 portion, and the Category 4 portion where applicable.**

It is critical each Provider understands the actual cost to their organization of implementing a project, to ensure feasibility of implementation, long-term sustainability, and that the valuation at least covers these costs. When determining the actual implementation costs, several factors influence variations in costs across seemingly similar projects, including:

* Size of the organization (existing infrastructure, resources, administrative costs);
* Complexity of the project and project implementation;
* Size and scope of the project;
* Size of the target area (geography) if the project is in multiple locations or including transportation as a supporting service;
* Size and characteristics of the target population; and
* Resource needs for implementation and long-term sustainability.

The initial estimated project costs were suggested to include all implementation costs, including personnel, equipment/supplies, travel, training, expert consultants, subcontracts, and any administrative support costs. This bottom line for the project gives Providers a starting point for valuing their project.

1. **Calculate any cost savings or costs avoided, both short- and long-term.**

Substantial variability arises from this step, as each project focuses on different target outcomes, where the cost-savings or costs avoided may be calculated in a variety of ways. For each project, Providers were encouraged to estimate additional value of the project in consideration of the following:

* Collaboration of resources or services with other providers reducing the costs of service delivery;
* Cost-savings for potentially preventable admissions, readmissions, and complications;
* Costs potentially avoided that had historically been incurred through:
  + Transportation of patients to services;
  + Inappropriate ED utilization;
  + Poor prevention or chronic care management that leads to the need for acute care;
  + Disability and long-term care needs resulting from lack of care;
  + Unnecessary criminal justice institutionalization; and
  + State mental health hospital utilization.

As a final step in estimating value, providers were asked to consider other sources of value to patients, to the healthcare system, and to the community—particularly those sources that are more difficult to put dollar amounts to but can be significantly impacted in the long-term. These include:

* + Overall patient and community quality of life;
  + Increased stability for patients and their families;
  + Reduced missed workdays and/or increased productivity;
  + Better overall health outcomes for patients and their families; and
  + Other community factors—better quality of life allows for stronger economic development, which contributes to having more resources for health and human services.

1. **Determine how much IGT is available for the project.**

Once the provider had an estimated amount for the entire project, including both cost and value, they were recommended to work with their IGT Entities to determine how much IGT would be available for the project by year. This was also influenced by each provider’s DSRIP allocation in Pass 1 and Pass 2 that determined maximum amounts for projects they could propose. There is variability among seemingly similar projects based on IGT availability, given IGT Entities’ available resources and their willingness to commit them to specific projects.

1. **Scale the project appropriately based on the support available.**

With an understanding of the IGT available and how much incentive that may generate for a provider, given that they are able to meet their metrics, Providers were encouraged to use their cost and value estimates to determine the feasible and sustainable scale of the project. In many cases, limited IGT forced Providers to reduce the scope of their projects and to select specific target areas or target populations, or limit the number of clients they could see each year. Thus, much variability is a result of limited IGT in this RHP.

1. **Divide the total project value between Category 1 or 2, Category 3, and Category 4 (if a hospital performing Provider).**

The final step in the process was for the Provider to take the entire project valuation and divide it appropriately among the project component categories (1 or 2, 3, and if a hospital, 4), at the minimum meeting the required percentages for each category but with discretion left to the Provider to determine what was appropriate for their project.

Within this valuation framework, each performing Provider has the flexibility to consider factors unique to its project. Thus, there is variability among seemingly similar projects based on aspects of the organizations, project complexity, investment needed to implement and sustain activities, target population, scope of the project, and available IGT.