

December 7, 2015

To: Giuseppe N. Colasurdo, M.D.
President

Re: **Addendum to Report on Delivery System Reform Incentive Payment (DSRIP)
Audit #15-109**

In response to a request from the UTHealth Audit Committee during the meeting on November 19, 2015, Auditing and Advisory Services performed additional fieldwork related to the project accounting of DSRIP. We performed the additional work to verify whether a process had been developed and implemented to ensure all incentive payments due were received.

The report was issued on November 3, 2015 and contained the following information:

Project Accounting

We performed work to determine whether all DSRIP incentive payments due were received and recorded in the institution's financial system. We reviewed the process for recording DSRIP revenue and found there is an adequate process within DSRIP and Medical School Finance to assure all revenue received is recorded. However, we were unable to validate the revenue amounts at the project level, and are therefore unable to verify all incentive payments due were received.

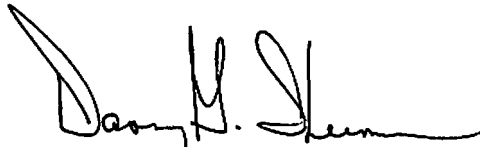
A&AS met with DSRIP management to review the process to reconcile incentive payments received to the completed metrics, and we were able to gain reasonable assurance there is a process in place to ensure all incentive payments are received in full.

During our original audit work, we identified a difference in the incentive payment approved by the Health and Human Services Commission (HHSC) in comparison to the incentive payment received for a specific project metric. We were able to obtain documentation issued by HHSC detailing a change in the incentive payment, which supported the amount actually received was correct.

Conclusion

Based on the additional fieldwork performed specific to project accounting, which included a review of the process and supporting documentation, we are including this amendment to the

report to indicate that we have gained reasonable assurance a process is in place to ensure all incentive payments are received in full.

A handwritten signature in black ink, appearing to read "Daniel G. Sherman". The signature is fluid and cursive, with a large initial "D" and "S".

Daniel G. Sherman, MBA, CPA, CIA
Assistant Vice President

cc: Audit Committee

Issued January 26, 2016

October 13, 2015

To: Giuseppe N. Colasurdo, M.D.
President

From: Daniel G. Sherman, MBA, CPA, CIA
Assistant Vice President



Report on Delivery System Reform Incentive Payment (DSRIP) Audit #15-109

We have completed our audit of the Delivery System Reform Incentive Payment (DSRIP) program. This audit was performed at the request of the UTHealth Audit Committee and was conducted in accordance with the *International Standards for the Professional Practice of Internal Auditing*.

BACKGROUND

In December 2011, the federal Centers for Medicare and Medicaid Services (CMS) approved a Waiver entitled "Texas Healthcare Transformation and Quality Improvement Program" in accordance with section 1115 of the Social Security Act. The waiver authorized Texas to establish the Delivery System Reform Incentive Payment (DSRIP) program.

Initiatives under the DSRIP program are designed to provide incentive payments to hospitals and other providers for investments in delivery system reforms that increase access to health care, improve the quality of care, and enhance the health of patients and families they serve. The program was approved through September 30, 2016.

As of July 2014, the state of Texas has 1,491 DSRIP projects. Over 300 providers participate in these projects across 20 Regional Healthcare Partnerships (RHPs). These providers consist of hospitals, physician practice groups (largely associated with academic health science centers like UTHealth), community mental health centers, and local health departments.

UTHealth is a part of RHP 3, which is the largest RHP in Texas. The RHP's plan is an ambitious, comprehensive effort to improve health care services for more than five million people within nine counties. Through a coordinated strategy, RHP partners and stakeholders have contributed thousands of hours to develop a communitywide strategic plan for transforming the region's health care delivery system. The DSRIP program is an opportunity to expand and transform the health care system to include the extensive health care needs of a highly populated community, with a special focus on Medicaid and uninsured patients.

Approximately 1,400 clinical providers certified in more than 80 medical specialties and subspecialties provide services in UT Physicians (UTP) clinics, with over 558,000 patient visits in 2014. In addition to their flagship location in the Texas Medical Center, UTP has neighborhood

locations throughout the Greater Houston area, and also offers specialty clinics at several hospital locations. UTP's recent expansion into neighborhood locations, as well as their partnerships with local hospitals, has made UTP uniquely able to develop the second largest number of DSRIP projects in the RHP.

OBJECTIVES

The objective of this audit is to review the processes and supporting documentation available to evaluate UTHealth's compliance with DSRIP reporting guidelines.

SCOPE AND METHODOLOGY

Through a review of UTP DSRIP reporting, Auditing and Advisory Services (A&AS) performed an audit of the UTP DSRIP program. The scope for our audit was the UTP DSRIP reporting for Demonstration Year 2 (DY) 2 and DY 3. A DY runs from October 1 through September 30. We selected a judgmental sample of four DSRIP projects based on management discussions and accumulated dollars.

AUDIT RESULTS

Compliance with Guidelines, Requirements, Policies and Procedures

Each RHP has one Anchoring Entity (Anchor), who has the responsibility of coordinating with the RHP participants. The Anchor's authority has been delegated by the Texas Health and Human Services Commission (HHSC), to which they have a reporting responsibility. The Anchor for RHP 3 is Harris County Hospital District (Harris Health System).

UTP created and submitted narratives to the Anchor that identified each project, their associated objectives, specific milestones, metrics, measures, and values for each. The Anchor compiled these narratives from each participating provider into an RHP Plan, and submitted the Plan for approval by both HHSC and CMS.

UTP has 22 approved DSRIP projects. Some objectives of these projects include:

- Establish and expand capacity at community clinics for primary, specialty, and behavioral health care.
- Train residents and faculty on primary care models, healthcare systems engineering and quality improvement.
- Implement a community health worker program.
- Implement a chronic disease registry and a chronic care model to coordinate care for those patients.
- Implement a 24-hour nurse triage line.
- Establish advanced medical homes to refer patients to doctors within the UTP network of specialty and primary care providers, and a navigation program to direct patients utilizing hospital services to an advanced medical home.
- Implement a care program to manage risk factors that lead to adverse pregnancy outcomes.

UTP is required to submit biannual reports to HHSC for each metric achieved in that period for every project. The Anchor must also submit an annual report to HHSC incorporating information provided in the interim reports, including data on the progress made for all metrics. DSRIP is then reported to CMS as a portion of the Texas' quarterly operational report.

We compared the DSRIP project requirements, guidance, documentation, and policies and procedures relating to the projects in our sample to UTP's implementation of the project. UTP policies, procedures and process documents have been developed when required and are generally in compliance with program guidelines.

HHSC Mid-Point Review

At the end of 2014, an independent assessor was hired by HHSC (as required by Texas Government Code 354.1624) to conduct a transparent midpoint assessment of all RHPs using criteria that was predetermined by CMS. The assessor reviewed certain projects identified by HHSC, CCMS, or the entity based on information provided in the semi-annual reports for elements specified by the DSRIP Funding and Mechanics Protocol. The purpose of this review is to provide the participants with an opportunity to modify projects and/or metrics based on lessons learned or new developments.

The midpoint assessment was a high-level review of DSRIP projects in all RHPs and included a desk review and selected site visits. Six of UTP's DSRIP projects were included in the sample for assessment. Based on criteria established by HHSC, one of six projects reviewed was considered a benchmark project. The project was designated as a benchmark project due to significant progress towards the achievement of the DY3 metrics, excellent lessons learned regarding the value of early commitment from stakeholders, and having well documented support for the achievement of their metrics. The remaining five projects were considered high risk. The designation of high risk is for projects that:

- May not be on track for meeting their project outcome goals;
- May not meet the DRSIP program's Triple Aim (to improve the health of the population, to enhance the experiences and outcomes of the patient, and to reduce the per capita cost of care for the benefit of communities);
- May have unclear metrics;
- May not have clear lessons learned; or
- May not have a clear baseline.

Demonstrating Completion of Metrics

The DSRIP DY 1 began October 1, 2011 and ended September 30, 2012. At the time of this report, UTP was working on the reporting for DY4, which is due October 31, 2015.

Each DSRIP project is made up of a number of metrics with completion dates in DY2 through DY5. Metrics are the quantitative or qualitative indicators of progress toward achieving an objective for DSRIP performance. In general, these metrics are developed to provide funding in the initial years for infrastructure, and funding in later years relating to more patient outcome based metrics. An early metric may be to develop policies and processes, expand existing clinics, create new clinics, or hire additional providers and support staff. In the later years, metrics are designated to maintain the infrastructure already created, increase the number of patient visits,

or increase the number of patients provided with different types of patient care related services. Many of the patient outcome related metrics have an accumulative component. For example, in the first DY the metric is to increase patient visits by a set number. In order to qualify for the incentive in the subsequent DY there would need to be an increase in patient visits over that amount.

Any metric not met in the initial DY can be extended for one additional DY. If the metric is still not met in the extended DY, the incentive payment will be lost. When requesting an extension, UTP must provide a narrative description on the status of the missed milestones and outline their plan to achieve the missed milestones by the end of the of the following demonstration year. It is the responsibility of the performing provider to identify whether a metric has been met and submit supporting documentation. HHSC performs a review of the documentation before authorizing the incentive payment.

The four projects in our sample contain a total of 39 metrics representing approximately \$47.7 million in incentive payments for DY2 through DY4. 22 of these metrics have already been reported as completed. Of the remaining 17 metrics, 13 are from DY4 which will be reported in October 2015. Based upon our discussions with DSRIP management and a review of documentation, as many as nine of the remaining metrics may not be met, representing \$11.7 million in incentive payments. Some significant factors in not being able to meet some metrics include a difficulty in recruiting qualified providers, permitting issues with the city, and unforeseen issues occurring during buildouts of the new clinics.

For each metric, the milestone contains a high-level reference to what will be used as the data source to support completion of a particular metric; however, what constitutes completion of a metric in many cases is subjective. There is a risk that what has been internally deemed as adequate documentation and subsequently accepted by the Anchor and HHSC could be disallowed when subjected to a subsequent audit. We identified some metrics that could be at risk if subjected to a retrospective audit.

Every DSRIP participant must also have one or more related Category 3 outcomes for each of their projects. These outcomes are meant to assess the results of the program's expanded care. The Category 3 outcomes measure patient experiences such as: patients' clinical events, patients' recovery and health status, patients' experiences in the health system, efficiency or cost. The estimated total value of all Category 3 outcomes for all DYs was \$30.5 million in addition to the \$280 million possible for meeting all project metrics over the life of the DSRIP program.

Project Accounting

We performed work to determine whether all DSRIP incentive payments due were received and recorded in the institution's financial system. We reviewed the process for recording DSRIP revenue and found there is an adequate process within DSRIP and Medical School Finance to assure all revenue received is recorded. However, we were unable to validate the revenue amounts at the project level, and are therefore unable to verify all incentive payments due were received.

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The payments from the DSRIP anchor are received as a lump sum. \$25.5 million was received in DY 2, \$37 million was received in DY 3 and \$16 million in DY 4, with an additional \$5 million accrued from the October reporting period.

Exit Strategies and Future Planning

Based on the understanding that DSRIP funding may not continue indefinitely, or a currently beneficial project may not remain beneficial, we attempted to determine whether adequate exit strategies exist should it become necessary to terminate a UTP DSRIP project.

Profitability and performance minimums are not set in advance for the future of the projects, and each project is handled in an individual manner. Oversight of the project areas are left up to the department management of the specialty.

UTP management stated that most contracts contain an escape clause so that if funding ends, we can terminate DSRIP-related leases (with proof funding ended). 10% percent of all DSRIP revenue is reserved for "wind-down" costs so that if funding abruptly ended, there would be some cushion for the exit.

CONCLUSION

The DSRIP program has brought forth many new projects which have created positive investments into the communities that the institution serves. It has also helped the growth and visibility of UTP; however, such growth and visibility is not without risk. To help mitigate these risks and lessen the likelihood that the institution will have to repay a portion of the revenues received as a part of the program, there are some opportunities for improvement.

We would like to thank the Executive Director of UTP Healthcare Transformation Initiatives, and the individuals throughout the institution who assisted us during our review.

DGS: cs

cc: Audit Committee
Andrew Casas
Dr. Sandra Tyson

Audit Manager: Dan Sherman, Chief Audit Executive
Auditor Assigned: Cara Saldivar, Senior Auditor

Issue Date: November 3, 2015