Evaluation of the Uniform Hospital Rate Increase Program (2018-2019)

As Required by 42 CFR 438.6(c)

TEXAS
Health and Human Services

Texas Health and Human Services Commission

February 2021

Table of Contents

1. Background

The Texas Health and Human Services Commission (HHSC) has approval from the Centers for Medicare and Medicaid Services (CMS) to implement the Uniform Hospital Rate Increase Program (UHRIP) for hospital services. UHRIP is a directed-payment program pursuant to 42 CFR 438.6(c), which allows HHSC to direct managed care organizations to pay increased reimbursement rates above their contracted rate with a hospital for certain services. Since inception, only STAR and STAR+PLUS Medicaid managed care organizations (MCOs) and their enrolled hospital providers participate in UHRIP.

HHSC began a pilot UHRIP program on December 1, 2017, in the El Paso and Bexar managed care service delivery areas (SDAs), and expanded the pilot to all other SDAs, other than Travis County, on March 1, 2018. HHSC launched the full statewide program on September 1, 2018 for state fiscal year 2019 and renewed the program for a second statewide program September 1, 2019 for state fiscal year 2020. The program is ongoing in state fiscal year 2021.

42 CFR 438.6(c) authorizes states to operate directed-payment programs (DPPs) to advance at least one goal or objective included in the state's managed care quality strategy. The state must also have a plan to evaluate the degree to which the program advances the quality goal(s) or objective(s). This evaluation examines the degree to which the first two years of the statewide UHRIP program advanced the quality goals or objectives identified.

2. Methodology

Evaluation Questions and Hypotheses

The UHRIP evaluation questions and hypotheses are derived from the Payment Arrangement Quality Strategy Goals outlined in the UHRIP preprint approved by CMS for state fiscal years 2018 through 2020. HHSC identified "Hospital quality performance measurement" and "Improve member satisfaction with care" as the quality strategy goals that UHRIP was expected to advance. Furthermore, HHSC described how these goals would be advanced by UHRIP with the following explanation:

> The state anticipates that increased hospital payment rates will act as an incentive which will encourage hospitals to continue participation in the Medicaid program while strengthening their ability to provide inpatient and outpatient services to Medicaid clients in the communities in which they are located and preserve the safety net. The UHRIP payment arrangement will also advance the goals of measuring and reducing hospital preventable events and improving member satisfaction with care. The State will employ evidence-based clinical and administrative practices to encourage the best care possible for Texans and improve the overall state performance for at-risk populations.

Texas developed one overarching evaluation question and four hypotheses to evaluate the impact of UHRIP on the intended quality outcomes.

Evaluation Question 1. Did UHRIP advance Texas's quality strategy?

Hypothesis 1.1. UHRIP will support members' satisfaction with their care.

Hypothesis 1.2. UHRIP will keep patients free from harm.

Hypothesis 1.3. UHRIP will provide the right care in the right place at the right time.

Hypothesis 1.4. UHRIP will support an adequate MCO provider network to ensure members' access to care.

Evaluation Design

The UHRIP evaluation relies on two quasi-experimental designs: a one-group pretest-posttest design and a one-group posttest only design. Most measures are evaluated using a one-group pretest-posttest design. One measure did not have pre-UHRIP data available and is evaluated using a one-group posttest only design.

- **One-Group Pretest-Posttest Design**: This evaluation design relies on repeated observations of UHRIP measures to monitor changes before and after UHRIP implementation. Due to the limited number of data points available for the UHRIP evaluation, measures evaluated through a one-group pretest-posttest design use descriptive statistics. To strengthen this design, the evaluation also leverages benchmarks where feasible to help substantiate and contextualize results.

- **One-Group Posttest Only Design:** This evaluation design relies on consecutive observations of UHRIP measures in the post-UHRIP implementation period only. This evaluation design is vulnerable to threats to validity and is only used in cases where pre-UHRIP implementation data were unavailable. Measures evaluated through a one-group posttest only design use descriptive statistics.

Subsequent sections provide additional information on the evaluation populations, evaluation periods, evaluation measures, and analytic methods for each design.

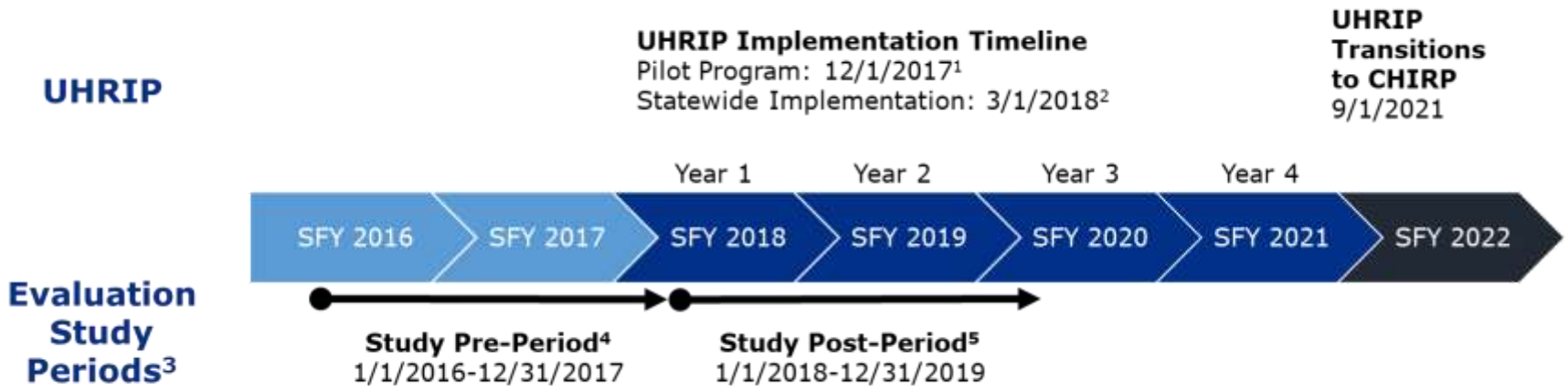
Evaluation Population

The UHRIP population includes all hospitals, except institutions for mental diseases, serving adults and children in the STAR and STAR+PLUS Medicaid managed care (MMC) programs. All eligible hospitals participate in UHRIP. However, UHRIP evaluation measures focus on Medicaid clients, rather than hospitals, as the unit of analysis. The UHRIP evaluation population consists of all STAR and STAR+PLUS members, including those who did not visit a hospital during the study timeframe.

Evaluation Period

The evaluation includes two years of pre-UHRIP implementation data (Calendar Year [CY] 2016 and 2017) and two years of post-UHRIP implementation data (CY 2018 and 2019). Figure 1 shows the timelines for UHRIP and the evaluation. Due to data lags, CY 2019 was the most recent calendar year with complete data available.

Figure 1. UHRIP and Evaluation Timelines



Notes. [1] UHRIP was only available in the El Paso and Bexar SDAs during the pilot program. [2] UHRIP was not available in the Travis SDA until 9/1/2018. [3] UHRIP operates on state fiscal years. The evaluation study periods operate on calendar years to align with reporting timelines of evaluation measures. [4] Pre-period data is not available for Hypothesis 1.4. [5] UHRIP began 12/1/2017, but the study post-period begins on 1/1/2018 to ensure consistent calculation of measures in pre- and post-periods. UHRIP = Uniform Hospital Rate Increase Program; CHIRP = Comprehensive Hospital Increased Reimbursement Program; SDA = Service Delivery Area.

Evaluation Measures

The UHRIP evaluation relies primarily on measures reported by Texas's External Quality Review Organization (ERQO). The Institute for Child Health Policy (ICHP) at the University of Florida has served as the EQRO for Texas HHSC since 2002. ICHP uses a comprehensive set of health care quality measures to evaluate performance in Texas Medicaid. These include measures from the Agency for Healthcare Research and Quality's (AHRQ) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey and measures of potentially preventable events developed by 3M™.

Error! Reference source not found. provides an overview of the measures, evaluation populations, and data sources for the four evaluation hypotheses. HHSC used descriptive statistics as the analytic method for each evaluation hypothesis.

Table 1. UHRIP Evaluation Measures

Evaluation Hypothesis	Measures	Evaluation Population	Data Sources or Data Collection Methods
Evaluation Question 1: Did UHRIP advance Texas's quality strategy?			
1.1. UHRIP will support members' satisfaction with their care.	1.1.1 Getting needed care 1.1.2 Getting care quickly	STAR and STAR+PLUS members	CAHPS® Surveys (calculated by Texas's EQRO)
1.2. UHRIP will keep patients free from harm.	1.2.1. Potentially preventable complications	STAR and STAR+PLUS members	Medicaid member-level data (calculated by Texas's EQRO)
1.3. UHRIP will provide the right care in the right place at the right time.	1.3.1. Potentially preventable admissions	STAR and STAR+PLUS members	Medicaid member-level data (calculated by Texas's EQRO)
1.4. UHRIP will support an adequate MCO provider network to ensure members' access to care.	1.4.1 Network adequacy	STAR and STAR+PLUS members	Network adequacy reports (calculated by HHSC)

Note: UHRIP = Uniform Hospital Rate Increase Program; EQRO = External Quality Review Organization; STAR = Texas Medicaid Managed Care program for children, newborns, and pregnant women; STAR+PLUS = Texas Medicaid Managed Care program for individuals age 21 and older with disabilities and individuals age 65 or older.

Data Sources

The UHRIP evaluation leverages administrative data sources used by Texas's EQRO and by HHSC.

- **CAHPS® surveys.** CAHPS® surveys assess members' experience getting care through their health plan. The Technical Appendix provides additional information about the CAHPS® composites selected for the UHRIP evaluation.
- **Medicaid member-level data**
  - **Fee-for-service claims and MMC encounter data.** Fee-for-service claims and MMC encounter data contain the procedure and diagnosis codes, place of service codes, and other information necessary to calculate evaluation measures.
  - **Member-level enrollment files.** The enrollment files contain information about the members' age, gender, race/ethnicity, county, MMC program, and length of enrollment.
- **HHSC network adequacy reports.** Network adequacy reports contain information on the percentage of members meeting prescribed Medicaid network standards for UHRIP participating hospitals.

Analytic Methods

UHRIP outcomes are evaluated using descriptive statistics based on summaries of annual estimates prior to and after UHRIP implementation. Given the limited number of time points for each method, advanced methods for identifying and analyzing trends (e.g., descriptive trend analysis or interrupted time series) are not feasible. However, analytic methods incorporate benchmarks, as available and applicable, to strengthen the validity of observed outcomes.

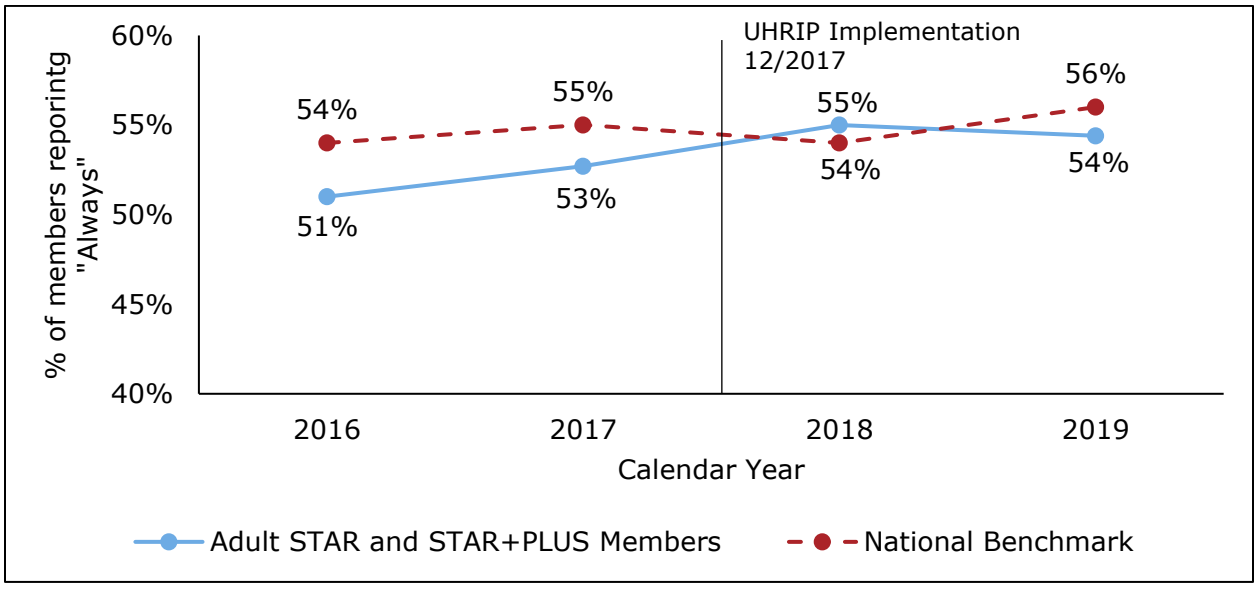
3. Results

CAHPS® Surveys (Hypothesis 1.1)

Getting Needed Care

Figure 2 presents annual estimates for the CAHPS® Getting Needed Care composite among adults in STAR and STAR+PLUS. The percentage of STAR and STAR+PLUS members who reported being able to get needed care increased between the pre- and post-period. For ease of comparison the pre-implementation results were averaged and compared to the post-implementation average. The percentage of members reporting "always" being able to get needed care increased from approximately 52 percent in 2016 and 2017 to 55 percent in 2018 and 2019, a 6 percent increase that brought state estimates into close alignment with national benchmarks during the post-period. These findings suggest adult members were more satisfied with their access to needed care after UHRIP implementation.

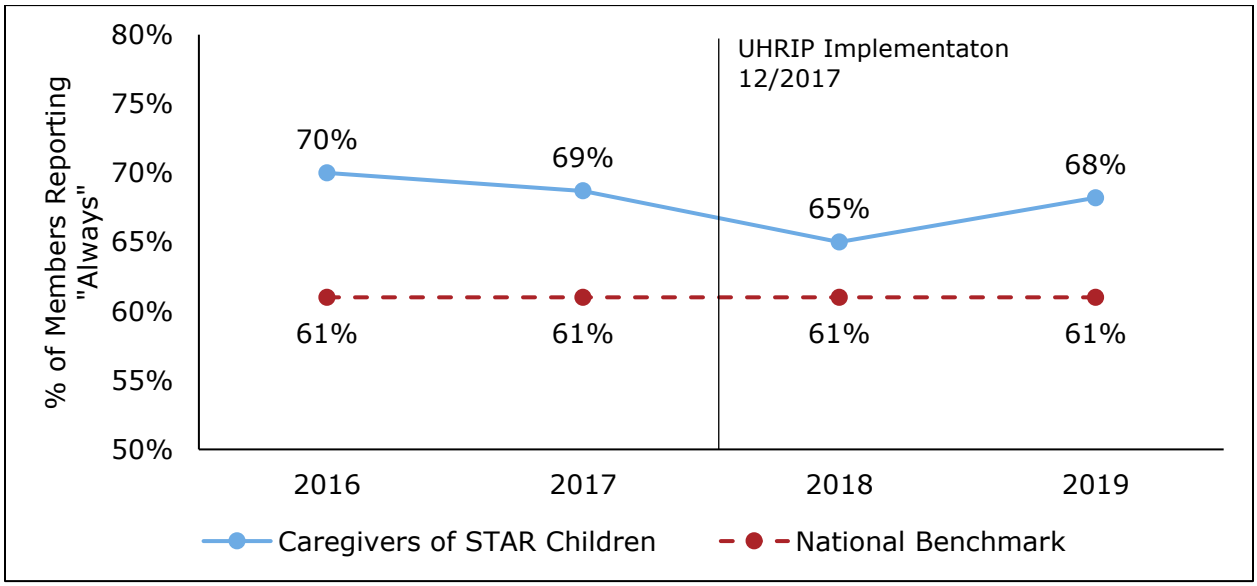
Figure 2. CAHPS® Getting Needed Care Composites, Adult Medicaid



Population: Adult Medicaid (18-64 years old) Statewide. Dual eligible members were excluded.
Texas CAHPS® Sources: 2016 Adult Core Measures Survey; 2016 STAR Member Survey; 2016 STAR+PLUS Member Survey; 2017 Adult Core Measures Survey; 2018 STAR Adult Biennial Survey; 2018 STAR+PLUS Biennial Survey; 2018 Adult Medicaid Core Measure Survey.
National CAHPS® Benchmark Source: https://cahpsdatabase.ahrq.gov/Summaryresults.aspx.
Prepared by: ICHP, The University of Florida; Center for Analytics and Decision Support, HHSC.

Figure 3 presents annual estimates for the CAHPS® Getting Needed Care composite among children in STAR. The percentage of caregivers reporting "always" being able to get their child needed care decreased from approximately 70 percent in 2016 and 2017 to 67 percent in 2018 and 2019, a 4 percent decrease. However, this difference was primarily due to a one-year deviation in the composite score in 2018. Texas estimates exceeded national benchmarks in all calendar years. These findings suggest caregivers were satisfied with their child's access to needed care before and after UHRIP implementation.

Figure 3. CAHPS® Getting Needed Care Composites, Child Medicaid

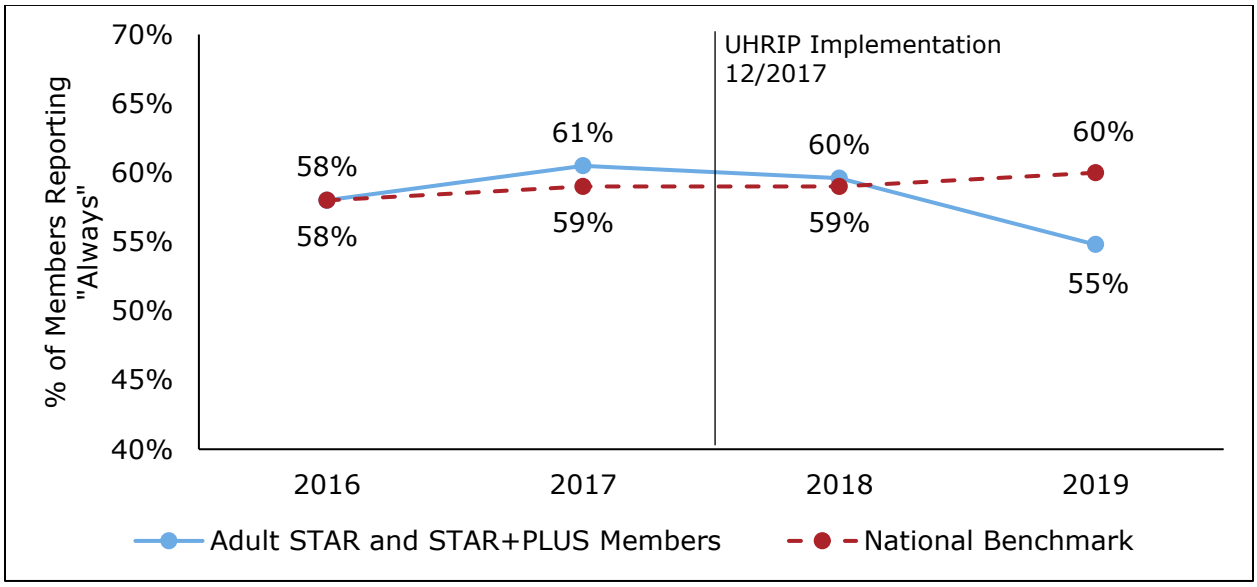


Population: Child Medicaid (<18 years old) Statewide.
Texas CAHPS® Sources: 2016 Medicaid Child Core Survey; 2017 Child Core Measures Survey; 2018 Medicaid Child Core Survey; 2018 STAR Kids Biennial survey; 2018 STAR Health Biennial Survey; 2019 Medicaid Child Core Survey.
National CAHPS® Benchmark Source: https://cahpsdatabase.ahrq.gov/Summaryresults.aspx.
Prepared by: ICHP, The University of Florida; Center for Analytics and Decision Support, HHSC.

Getting Care Quickly

Figure 4 presents annual estimates for the CAHPS® Getting Care Quickly composite among adults in STAR and STAR+PLUS. Between 2016 and 2018, the percentage of members indicating they were "always" able to get care quickly remained between 58 and 61 percent. In 2019, the rate fell to 55 percent. For most years, the Getting Care Quickly composite estimates for Texas adults met or exceeded national benchmarks, suggesting adult members were satisfied with timely access to care during most of the evaluation period.

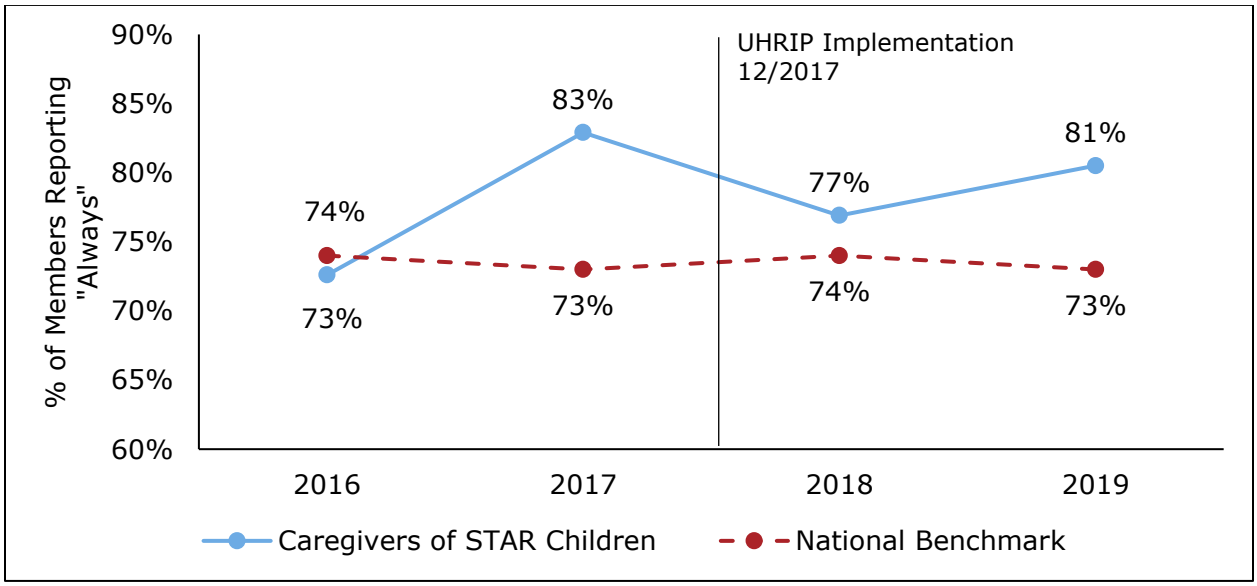
Figure 4. CAHPS® Getting Care Quickly Composites, Adult Medicaid



Population: Adult Medicaid (18-64 years old) Statewide. Dual eligible members were excluded.
Texas CAHPS® Sources: 2016 Adult Core Measures Survey; 2016 STAR Member Survey; 2016 STAR+PLUS Member Survey; 2017 Adult Core Measures Survey; 2018 STAR Adult Biennial Survey; 2018 STAR+PLUS Biennial Survey; 2018 Adult Medicaid Core Measure Survey.
National CAHPS® Benchmark Source: https://cahpsdatabase.ahrq.gov/Summaryresults.aspx.
Prepared by: ICHP, The University of Florida; Center for Analytics and Decision Support, HHSC.

Figure 5 presents annual estimates for the CAHPS® Getting Care Quickly composite among children in STAR. Texas estimates for the composite varied over time, but the percentage of caregivers indicating they were "always" able to get their child care quickly remained stable between the pre- and post-period. The percentage of caregivers reporting "always" being able to get their child care quickly was 78 percent in the pre-period and 79 percent in the post-period. Additionally, Texas estimates exceeded national benchmarks all years except 2016. These findings suggest caregivers were satisfied with their child's timely access to care before and after UHRIP implementation.

Figure 5. CAHPS® Getting Care Quickly Composites, Child Medicaid



Population: Child Medicaid (<18 years old) Statewide.
Texas CAHPS® Sources: 2016 Medicaid Child Core Survey; 2017 Child Core Measures Survey; 2018 Medicaid Child Core Survey; 2018 STAR Kids Biennial survey; 2018 STAR Health Biennial Survey; 2019 Medicaid Child Core Survey.
National CAHPS® Benchmark Source: https://cahpsdatabase.ahrq.gov/Summaryresults.aspx.
Prepared by: ICHP, The University of Florida; Center for Analytics and Decision Support, HHSC.

Potentially Preventable Events (Hypotheses 1.2 and 1.3)

The UHRIP evaluation includes two measures of potentially preventable events (PPEs): potentially preventable complications (PPCs) and potentially preventable admissions (PPAs). The PPEs are calculated by the EQRO using a risk-adjusted algorithm from 3M™.[1] A national benchmark is not available.

Texas's EQRO calculates rates of PPEs separately for the STAR and STAR+PLUS programs. STAR covers children, newborns, and pregnant women, whereas STAR+PLUS covers adults with disabilities and individuals 65 years of age or older. Because of the differing health needs of each population, emergency department and hospital utilization may be greater among STAR+PLUS members than STAR members. As a result, the PPE rates for STAR and STAR+PLUS should not be directly compared.

Potentially Preventable Complications

PPCs are in-hospital complications that were not present on admission but result from treatment during an inpatient stay. PPCs represent harmful events or negative outcomes that might result from processes of care and treatment rather than natural progression of an underlying disease. Lower PPC rates reflect better performance by hospitals.

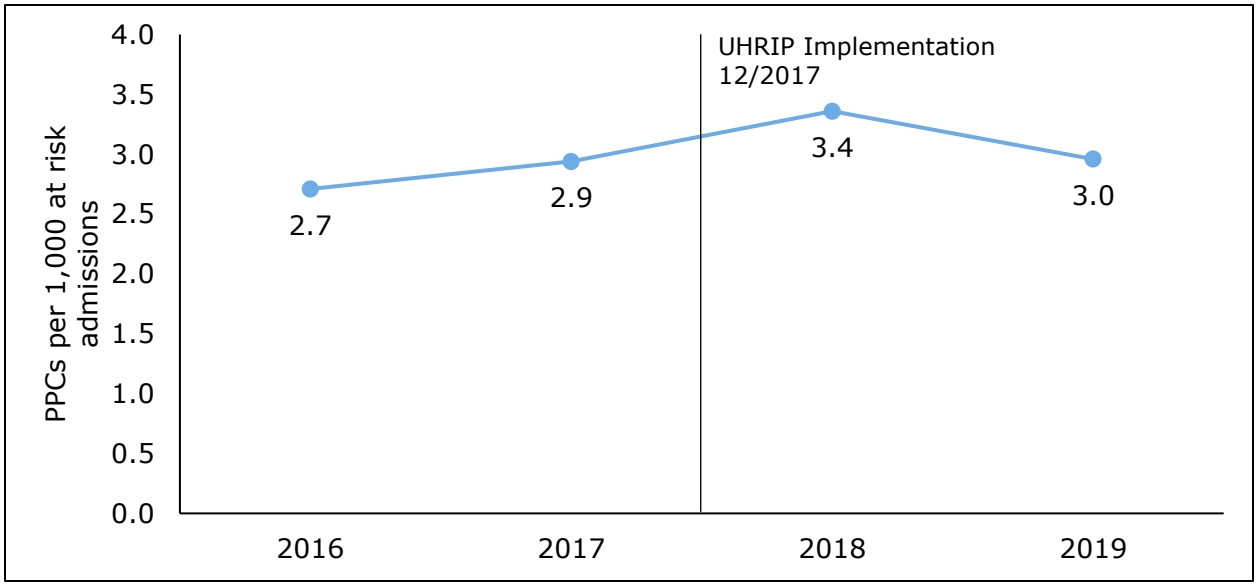
The 3M PPC methodology identifies PPCs based on risk at admission, using information from inpatient encounters, such as diagnosis codes, procedure codes, procedure dates, present on admission (POA) indicators, patient age, sex and discharge status. Accurate coding of the POA indicators are particularly important as they serve two primary purposes: (1) to create a method for identifying potentially preventable complications from among diagnoses not present on admission, and (2) to allow only those diagnoses designated as present on admission to be used for assessing the risk of incurring complications.

Error! Reference source not found. Figure 6 presents the rate of PPCs per 1,000 at risk admissions among STAR members. The rate of PPCs per 1,000 at risk admissions increased between the pre- and post-period from approximately 2.8 in

[1] Additional details on potentially preventable events can be accessed at: THLCportal.com

2016 and 2017 to 3.2 in 2018 and 2019, a 14 percent increase. However, this difference was primarily due to a one-year deviation in PPCs scores in 2018. These findings suggest STAR members may have experienced a slight shift in processes of care and treatment directly following UHRIP implementation.

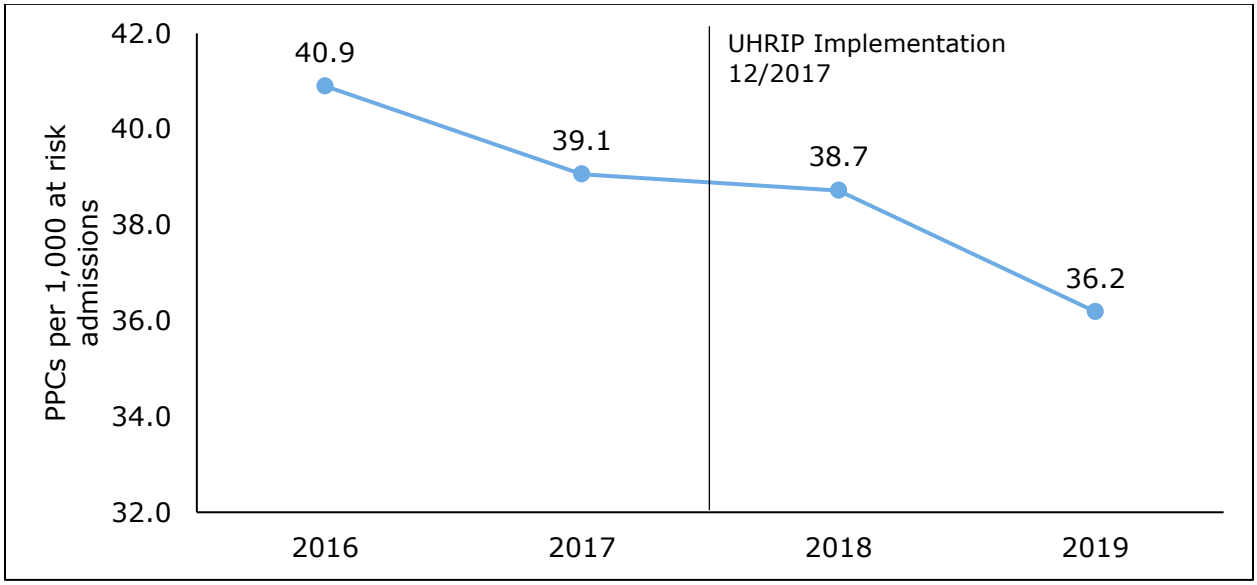
Figure 6. Potentially Preventable Complications Among STAR Members



Note: Estimates represent the potentially preventable complication weights per 1,000 at risk admissions.
Sources: Enrollment, claims, and encounters captured in Vision 21 data during calendars years 2016-2019. Dual eligible members were excluded. Admissions from hospitals that failed the POA data quality screening were excluded. Software: PPC version 36.0, All Patient Refined Diagnosis-Related Groups Grouper version 36.0.
Prepared by: ICHP, The University of Florida; Center for Analytics and Decision Support, HHSC.

Error! Reference source not found. presents the rate of PPCs per 1,000 at risk admissions among STAR+PLUS members. There was a steady decrease in the rate of PPCs between 2016 and 2019, from 40.9 to 36.2 PPCs per 1,000 at risk admissions. The rate of PPCs per 1,000 at risk admissions declined from approximately 40.0 PPCs in 2016 and 2017 to 37.5 in 2018 and 2019, a 6 percent decrease. These findings suggest STAR members received improved processes of care and treatment after UHRIP implementation.

Figure 7. Potentially Preventable Complications Among STAR+PLUS Members



Note: Estimates represent the potentially preventable complication weights per 1,000 at risk admissions.
Sources: Enrollment, claims, and encounters captured in Vision 21 data during calendars years 2016-2019. Dual eligible members were excluded. Admissions from hospitals that failed the POA data quality screening were excluded. Software: PPC version 36.0, All Patient Refined Diagnosis-Related Groups Grouper version 36.0.
Prepared by: ICHP, The University of Florida; Center for Analytics and Decision Support, HHSC.

Potentially Preventable Admissions

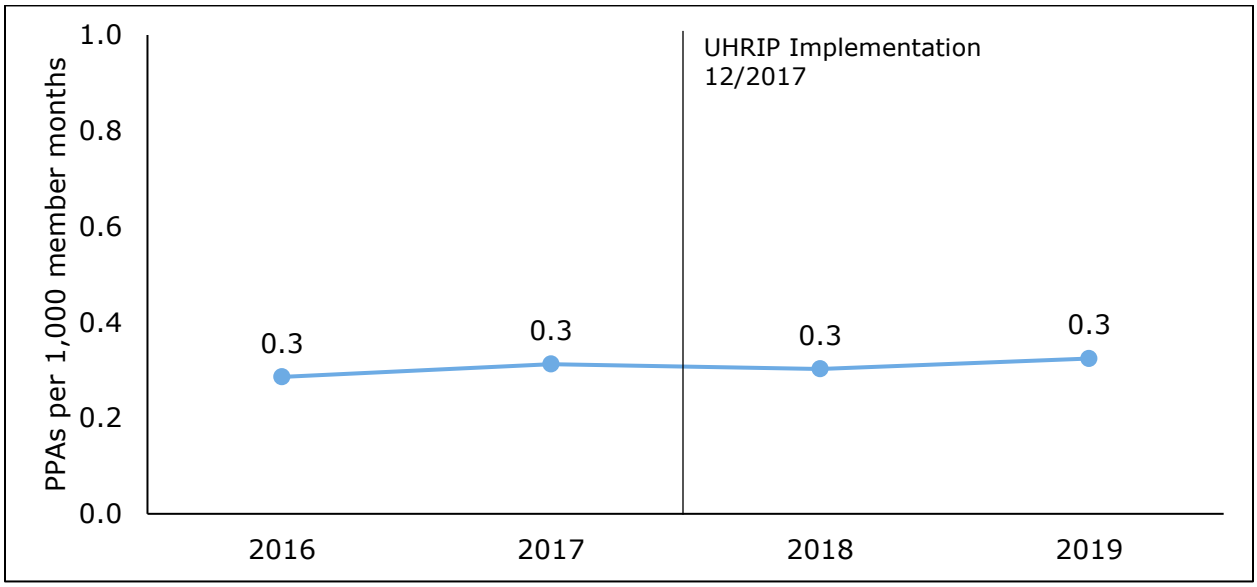
PPAs are hospital admissions that could have potentially been addressed in an outpatient setting. PPAs may have resulted from lack of adequate access to care or ambulatory care coordination. Circumstances associated with PPAs are ambulatory sensitive conditions (e.g., asthma) for which adequate patient monitoring and follow-up (e.g., medication management) can often avoid the need for admission. Lower PPA rates reflect better performance by MCOs.

In the Texas Medicaid program, minimizing PPAs is considered primarily an MCO responsibility to be accomplished through improved access and quality with regard to outpatient care and service coordination for their members. Therefore, the PPA rate measure serves only as a sentinel, not as an indication of participating hospitals' performance. It would be an unintended consequence if this program resulted in a sharp increase in the PPA rate.

Figure 8 presents the rate of PPAs per 1,000 member months among STAR members. The PPA rate remained table between 2016 and 2019 at 0.3 PPAs per

1,000 member months. These findings suggest STAR members received similar ambulatory care before and after UHRIP implementation.

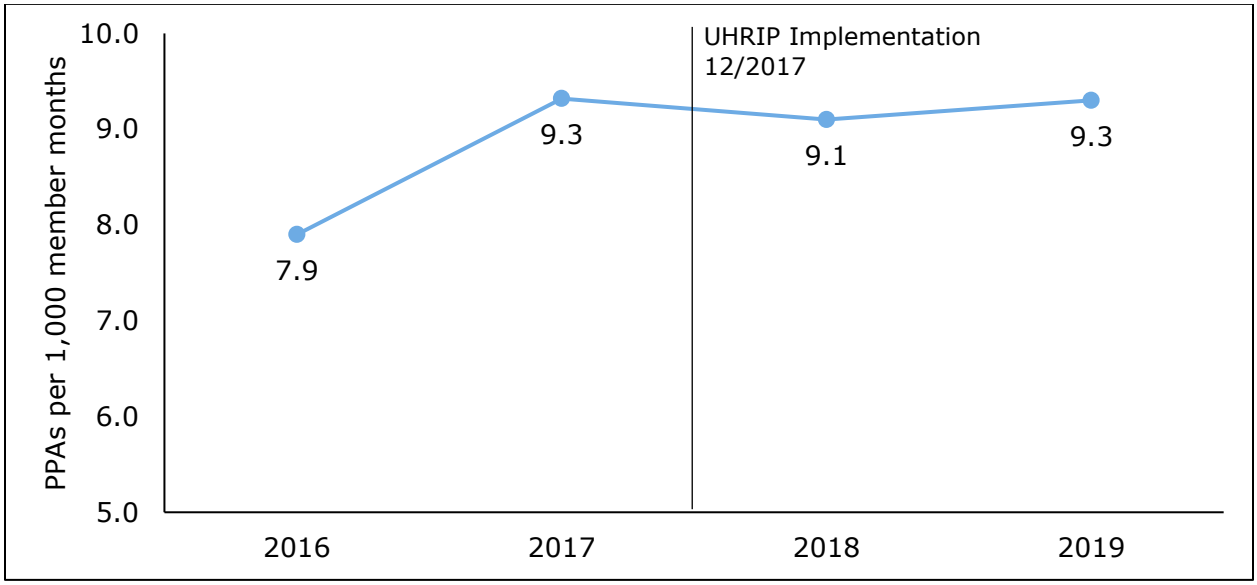
Figure 8. Potentially Preventable Admissions Among STAR Members



Note: Estimates represent the total weighted potentially preventable admissions per 1,000 member months.
Sources: Enrollment, claims, and encounters captured in Vision 21 data during calendars years 2016-2019. Dual eligible members were excluded. Members with less than 3 months of enrollment during the prior year were excluded for the measurement year. Software: 3M Population-focused Preventables Grouper version 2.1.0. PPA weights based on Texas All Patient Refined Diagnosis-Related Groups weights version 34.
Prepared by: ICHP, The University of Florida; Center for Analytics and Decision Support, HHSC.

Figure 9 presents the rate of PPAs per 1,000 member months among STAR+PLUS members. The rate of PPAs per 1,000 member months increased during the pre-period from 7.9 in 2016 to 9.3 in 2017. The rate remained relatively stable in the post-period at approximately 9.2 PPAs per 1,000 member months. These findings suggest STAR+PLUS members received similar ambulatory care before and after UHRIP implementation.

Figure 9. Potentially Preventable Admissions Among STAR+PLUS Members



Note: Estimates represent the total weighted potentially preventable admissions per 1,000 member months.
Sources: Enrollment, claims, and encounters captured in Vision 21 data during calendars years 2016-2019. Dual eligible members were excluded. Members with less than 3 months of enrollment during the prior year were excluded for the measurement year. Software: 3M Population-focused Preventables Grouper version 2.1.0. PPA weights based on Texas All Patient Refined Diagnosis-Related Groups weights version 34.
Prepared by: ICHP, The University of Florida; Center for Analytics and Decision Support, HHSC.

Network Adequacy (Hypothesis 1.4)

The HHSC contract with MCOs requires compliance with network adequacy standards for acute care hospital providers. For all acute care hospital types, members must have access to at least two network providers within 30 miles or reachable within 45 minutes. This contract requirement applies regardless of the population density of the county in which the member resides.

The current performance standard is 90 percent. MCOs whose performance falls below the standard are subject to remedies under the contract. Prior to SFY 2019, the performance standard was 75%.

Network adequacy results were only available during the post-period (SFYs 2018 and 2019). Table 2 presents the Managed Care Organization (MCO) hospital network adequacy among STAR and STAR+PLUS members. The compliance for STAR members was 98 percent in SFY 2018 and 99 percent in SFY 2019. The

average compliance for STAR+PLUS MCOs was 99 percent in both SFY 2018 and SFY 2019. MCO hospital network adequacy was above the relevant compliance threshold the first two years of UHRIP implementation.

Table 2. MCO Hospital Network Adequacy Among STAR and STAR+PLUS Members

State Fiscal Year	STAR	STAR+PLUS	Compliance Threshold
2018	98%	99%	75%
2019	99%	99%	90%

Note: Network adequacy estimates reflect average MCO compliance during Quarter 2 of each year. Members must have access to at least one hospital within the following number of miles or travel time of the member's residence: 30 miles/45 minutes for members residing in a metro county; 30 miles/45 minutes for members residing in a micro county; or 30 miles/45 minutes for members residing in a rural county.
Prepared by: Center for Analytics and Decision Support, HHSC.

4. Limitations

Results from the evaluation above should be interpreted alongside several limitations. The most salient threat to the internal validity of the evaluation is the possibility that external factors outside of UHRIP affected the evaluation measures. For example, the Delivery System Reform Incentive Payment (DSRIP)[2] pool was in effect during both the pre- and post-periods. HHSC also administers other payment incentive programs, such as the Medical Pay-for-Quality (P4Q) program and the Hospital Quality-Based Payment Program[3], that may influence outcome measures among UHRIP providers. As a result, it is not possible to determine the extent to which outcomes are due to UHRIP, DSRIP, P4Q, or other similar initiatives. This limitation is compounded by the lack of a comparison group; all eligible hospitals participate in UHRIP, and thus no effective comparison group exists. Without a comparison group it is not possible to attribute observed changes solely to UHRIP. Additionally, it is not possible to identify negative impacts that may have occurred in the absence of UHRIP, or to assess whether outcomes reflect the performance of MCOs or other providers, rather than hospital performance.

A second limitation involves the population included in the evaluation. The CAHPS® survey measures (Getting Needed Care and Getting Care Quickly composites) are reported for a representative sample of all STAR and STAR+PLUS members. It is not possible to isolate members with hospital encounters in the CAHPS® survey samples. Similarly, network adequacy standards are developed and monitored for entire MMC-programs; HHSC does not have network adequacy standards specifically for MMC members who interact with hospitals. As a result, the CAHPS® survey measures and network adequacy findings include individuals who did not interact with a hospital, and therefore were not exposed to any potential impacts of UHRIP during the reporting timeframe.

Third, most measures include only four data points—two in the pre-period and two in the post-period—which is not sufficient to establish a trend. Given the limited

---

[2] DSRIP provides incentive payments to providers who engage in reforms that improve access to care, quality of patient care, population health outcomes, and reduce per capita costs.

[3] See the *Annual Report on Quality Measures and Value-Based Payments 2020* for additional information about these programs.

number of data points, it was not possible to use moving averages or statistical smoothing methods to control for random variation. Accordingly, any observed annual variations may be due to statistical noise, rather than to true changes in UHRIP outcomes. Additionally, the evaluation only had access to annual estimates for survey measures, not estimates of dispersion or margins of error, further limiting the ability of the evaluation to determine true change amidst minimal movement in the point estimates.

UHRIP and the evaluation operate on different calendar cycles. UHRIP began as a pilot program on December 1, 2017, was implemented in all but one SDA on March 1, 2018, went statewide on September 1, 2018, and operates on a State Fiscal Year calendar (September to August). However, the evaluation post-period began on January 1, 2018 and most measures operate on calendar years to align with calculations by Texas's EQRO. Accordingly, the evaluation post-period includes two months in which UHRIP was not available in a majority of the state.

The CAHPS® survey questions specifically ask members to exclude experiences with overnight stays in hospitals. The CAHPS® findings may therefore be more indicative of members' experiences in hospital outpatient settings or with providers outside the hospital setting specifically, rather than a reflection of all services provided through UHRIP.

Finally, the CAHPS® survey measures make use of national data sources to identify suitable benchmarks. Benchmarks may represent different populations than STAR and STAR+PLUS members. Benchmarks are provided to contextualize measures, and changes in measures over time, but should not be used as a direct comparison to STAR and STAR+PLUS estimates.

Collectively, these limitations suggest the evaluation does not have a high degree of sensitivity to detect direct outcomes associated with UHRIP. Additional data collection efforts, such as provider-reported information or investigations into the cost-effectiveness of UHRIP payments, may provide greater opportunities to examine the direct impacts of UHRIP.

5. Conclusion

Despite the limitations above, this evaluation provides insight into the impact of UHRIP on Medicaid quality outcomes. Statewide surveys show the percentage of adult and child members able to get needed care remained above national benchmarks after UHRIP implementation. The percentage of adult members able to get care quickly dipped slightly in 2019, but the percentage of child members able to get care quickly remained above the national benchmark during this period. Taken together, these results indicate that members were sufficiently satisfied with their care during UHRIP implementation.

Trends in PPEs were also generally positive during the UHRIP evaluation period. PPC rates only measure hospital performance, so they are subject to fewer limitations than the CAHPS measures. STAR members generally experienced similar rates in PPCs before and after UHRIP implementation. However, the PPC rate improved (decreased) for STAR+PLUS members after UHRIP implementation, suggesting UHRIP may play a supportive role in keeping patients free from harm. The rate of PPAs during UHRIP implementation was consistent with the rate prior to UHRIP implementation for both STAR and STAR+PLUS members. This suggests that UHRIP supports provision of the right care in the right place at the right time.

Finally, MCO hospital network adequacy remained above compliance thresholds during UHRIP implementation. Although the evaluation did not have access to estimates of hospital network adequacy prior to UHRIP implementation, this finding suggests that UHRIP helps to support adequate access to MCO hospital networks.

Texas will continue to monitor these outcomes and will submit annual evaluations after UHRIP transitions to CHIRP in fiscal year 2022. The importance of UHRIP will be significantly elevated post-DSRIP for the many Texas hospitals that participated in the program. As Texas transitions beyond DSRIP, HHSC expects relevant DSRIP program achievements and the positive trends presented in this evaluation to continue. As UHRIP matures into CHIRP, the program will introduce new participation requirements for providers, including regular reporting on new quality metrics. This information will help HHSC monitor and evaluate its effectiveness. CHIRP is one of several new programs Texas will implement to advance the goals of the revised managed care quality strategy and to shape the ever-evolving Texas healthcare delivery system.

Technical Appendix

CAHPS® Surveys

The UHRIP evaluation relies on two CAHPS® composite scores for adult and child STAR and STAR+PLUS members. The two CAHPS® composites, and corresponding questions are presented in Table 3. Additional data notes provided by Texas's EQRO are provided below.

Table 3. CAHPS® Composite Measures

CAHPS® Composite	Adult Survey	Child Survey
Getting Needed Care	• In the last 6 months, how often was it easy to get the care, tests, or treatment you needed? • In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?	• In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed? • In the last 6 months, how often did you get an appointment for your child to see a specialist as soon as you needed?
Getting Care Quickly	• In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? • In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?	• In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed? • In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?

Adult Medicaid (18-64 years old) Data Notes

The data provided includes combined survey results for members more than 18 years of age in STAR and STAR+PLUS. Dual eligible members were excluded. Results include individual question summary rates and global composite scores for: (1) Getting Needed Care, and (2) Getting Care Quickly, as specified in the Adult Core Measures "Core Set of Adult Health Care Quality Measures for Medicaid: Technical Specifications and Resources Manual for Federal Fiscal Year 2017 Reporting - Measure CPA-AD: **CAHPS® Health Plan Survey 5.0H, Adult Version (Medicaid)**." This data represents member responses about their experience with the care provided by the health plan. These survey questions specifically ask respondents to **exclude** experiences with overnight stays in hospitals and dental care visits. Details regarding the measure years, data sources, and data time periods are shown in Table 4.

Table 4. CAHPS® Adult Medicaid Measurement Years, Data Sources, and Data Time Periods

Measurement Year	Data Sources	Data Time Period		
		Survey Fielding	Enrollment	Survey Recall
2016	• 2016 Medicaid Adult Core Survey • 2016 STAR Member Survey • 2016 STAR+PLUS Member Survey	05/2016- 08/2016	10/2015- 03/2016	11/2015- 08/2016
2017	• 2017 Adult Core Measures Survey	09/2017- 11/2017	02/2017- 07/2017	03/2017- 11/2017
2018	• 2018 STAR Adult Biennial Survey • 2018 STAR+PLUS Biennial Survey	05/2018- 09/2018	10/2017- 03/2018	11/2017- 09/2018
2019	• 2019 Adult Medicaid Core Measure Survey	09/2019- 11/2019	02/2019- 07/2019	03/2019- 11/2019

Child Medicaid (<18 years old) Data Notes

The data provided includes combined survey results from caregivers of members less than 18 years of age in STAR and Medicaid Fee for Service. Results include individual question summary rates and global composite scores for: (1) Getting Needed Care, and (2) Getting Care Quickly, as specified in the Child Core Measures - **CAHPS® reporting specifications A1 - CAHPS® Health Plan Survey 5.0H, Child Version**. This data represents caregiver responses about their child's experience with the care provided by the health plan. These survey questions specifically ask respondents to **exclude** experiences with overnight stays in hospitals and dental care visits. Details regarding the measure years, data sources, and data time periods are shown in Table 5.

Table 5. CAHPS® Child Medicaid Measurement Years, Data Sources, and Data Time Periods

Measurement Year	Data Sources	Data Time Period		
		Survey Fielding	Enrollment	Survey Recall
2016	• 2016 Medicaid Child Core Survey	07/2016-09/2016	12/2015-05/2016	01/2016-09/2016
2017	• 2017 Child Core Measures Survey	09/2017-11/2017	02/2017-07/2017	03/2017-11/2017
2018	• 2018 Medicaid Child Core Survey • 2018 STAR Kids Biennial Survey • 2018 STAR Health Biennial Survey	06/2018-11/2018	12/2017-07/2018	12/2017-11/2018
2019	• 2019 Medicaid Child Core Survey	09/2019-11/2019	02/2019-07/2019	03/2019-11/2019

List of Acronyms

Acronym	Full Name
AHRQ	Agency for Healthcare Research and Quality
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CHIRP	Comprehensive Hospital Increased Reimbursement Program
CY	Calendar Year
EQRO	External Quality Review Organization
HHSC	Texas Health and Human Services Commission
ICHP	Institute for Child Health Policy (Texas's EQRO)
MCO	Managed Care Organization
MMC	Medicaid Managed Care
PPA	Potentially Preventable Admissions
PPC	Potentially Preventable Complications
PPE	Potentially Preventable Events
SDA	Service Delivery Area
SFY	State Fiscal Year
UHRIP	Uniform Hospital Rate Increase Program