Evaluation Plan for Year 1 (SFY2022) of Four New State Directed Payments

As Required by Centers for Medicare and Medicaid Services

Texas Health and Human Services Commission

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1. Background

This evaluation plan outlines how the Texas Health & Human Services Commission (HHSC) will evaluate four state directed payment programs (DPPs):

- Comprehensive Hospital Increase Reimbursement Program (CHIRP),
- Texas Incentives for Physicians and Professional Services (TIPPS),
- Rural Access to Primary and Preventive Services Program (RAPPS), and
- Directed Payment Program (DPP) for Behavioral Health Services (BHS)

Per requirements by the Centers for Medicare and Medicaid Services (CMS), approved DPPs must be evaluated to test whether the payment arrangement advances goals of the State's Medicaid Managed Care Quality Strategy.

Comprehensive Hospital Increase Reimbursement Program (CHIRP)

CHIRP is a program for Texas Medicaid hospitals serving adults and children enrolled in STAR and STAR+PLUS[1]. The following six hospital provider classes are eligible to participate in CHIRP:

- children's hospitals,
- rural hospitals,
- state-owned non-Institutes of Mental Disease (IMD) hospitals,
- urban hospitals,
- non-state-owned IMD hospitals, and
- state-owned IMD hospitals

[1] Texas Medicaid medical managed care programs include State of Texas Access Reform (STAR), STAR Kids, STAR+PLUS, STAR Health, and Children's Health Insurance Program (CHIP). STAR covers low-income children, pregnant women and families. STAR Kids covers children and adults 20 and younger who have disabilities. STAR+PLUS covers people who have disabilities or are age 65 or older. STAR Health covers children and adolescents in foster care or state conservatorship. CHIP covers children in families that earn too much money to qualify for Medicaid but cannot afford to buy private insurance. https://hhs.texas.gov/services/health/medicaid-chip/

CHIRP is a new iteration of the Uniform Hospital Rate Increase Program (UHRIP). Redesigning the UHRIP program allows HHSC to monitor progress on focus areas identified in the DSRIP Transition Plan[2], which include:

- maternal health,
- behavioral health, and
- patient navigation, care coordination, and care transitions, especially for patients with high costs and high utilization.

There are two components in the CHIRP program. Component 1, known as UHRIP, provides a uniform rate enhancement to participating CHIRP hospitals, and Component 2, known as Average Commercial Incentive Award (ACIA), allows participating CHIRP hospitals to earn higher reimbursement rates based upon a percentage of the estimated average commercial reimbursement.

The UHRIP Component includes a mix of structure and outcome measures applicable to all participating CHIRP hospitals and requires semiannual reporting.

The ACIA Component is organized into six modules, which are groupings of measures based on hospital provider class; eligibility for each module is restricted to certain provider classes, as defined in program enrollment and historic volume and type of services provided. The six ACIA modules are: ACIA Maternal Care, ACIA Hospital Safety, ACIA Pediatric, ACIA Care Transitions, ACIA Psychiatric Care Transitions, and ACIA Rural Hospital Best Practices. For example, eligibility for the "ACIA Maternal Care" module is limited to hospital provider classes of children's hospitals, state-owned hospitals that are not IMDs, and urban hospitals. CHIRP hospitals opting into the ACIA Component must report on all ACIA modules for which their provider class type is eligible. Modules in the ACIA Component include a mix of structure, outcome, and process measures and require semiannual submission of status updates for the structure measures and numeric data for the outcome and process measures.

When hospitals apply to participate in the CHRIP program, hospitals opt into the ACIA Component. All participants are required to report on all measures for which they are eligible in the components for which they are eligible as a condition of participation.

The data reported by CHIRP hospitals will be used to evaluate the participating providers' progress advancing the goals from the Texas Medicaid Quality Strategy.

[2] hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/dsrip-transition-plan.pdf

Texas Incentives for Physicians and Professional Services (TIPPS)

TIPPS is a program for Texas Medicaid physician practice groups serving adults and children enrolled in STAR, STAR+PLUS, and STAR Kids. The following three physician practice group classes are eligible to participate in TIPPS:

- physician groups affiliated with a health-related institution (HRI) as defined by Section 63.002 of the Texas Education Code,
- physician groups affiliated with a hospital receiving the indirect medical education add-on (IME), and
- other physician groups that are not HRI or IME (Other).

There are three components in the TIPPS program, and HRI and IME physician practice groups are eligible for Components 1-3, while Other physician practice groups are eligible for Component 3 only. All participants are required to report on all measures in the components for which they are eligible as a condition of participation.

Component 1 is a rate enhancement and requires semiannual submission of status updates on structure measures.

Component 2 is a rate enhancement and requires semiannual submission of numeric data on process and outcome measures focused on primary care and chronic care.

Component 3 is a rate enhancement for certain outpatient services and requires semiannual submission of numeric data on process and outcome measures focused on maternal health, chronic care, behavioral health, and social drivers of health.

The data reported by TIPPS physician practice groups will be used to evaluate the participating providers' progress advancing the goals from the Texas Medicaid Quality Strategy.

Rural Access to Primary and Preventive Services Program (RAPPS)

RAPPS is a program for Texas Medicaid rural health clinics (RHCs) serving adults and children enrolled in STAR, STAR+PLUS, and STAR Kids. RAPPS incentivizes the provision of primary care, preventive services, and chronic condition management for Medicaid clients in rural communities of the state.

The following two RHC provider classes are eligible to participate in RAPPS:

- hospital-based RHCs, which include non-state government owned and private RHCs, and
- free-standing RHCs.

There are two components in the RAPPS program. All providers are required to report on all measures as a condition of participation. Component 1 is a uniform dollar increase paid as prospective, monthly payments and requires semiannual submission of status updates on structure measures that promote improved access to primary care and preventive services.

Component 2 is a uniform percent rate increase for certain services and requires semiannual submission of numeric data on process and outcome measures focused on preventive care and screening and management of chronic conditions.

The data reported by RAPPS RHCs will be used to evaluate participating providers' progress advancing the goals from the Texas Medicaid Quality Strategy.

Directed Payment Program (DPP) for Behavioral Health Services (BHS)

DPP BHS is a program for Texas Medicaid community mental health centers (CMHCs) serving adults and children enrolled in STAR, STAR+PLUS, and STAR Kids. DPP BHS incentivizes the continuation of successful DSRIP innovations that improve access to behavioral health services, care coordination, and care transitions and promotes the provision of services aligned with the Certified Community Behavioral Health Clinic (CCBHC) model of care to Medicaid clients.

Although all CMHCs are eligible to enroll in DPP BHS regardless of CCBHC certification status, the payment arrangements in DPP BHS are based on two CMHC provider classes in the program:

- CMHCs with CCBHC certification, and
- CMHCs without CCBHC certification.

There are two components in the DPP BHS program. All providers are required to report on all measures as a condition of participation. Component 1 is a uniform dollar increase paid as monthly payments and requires semiannual submission of status updates on structure measures that promote progress toward CCBHC certification or maintenance of CCBHC status such as implementation of telehealth services, collaborative care, integrated physical and behavioral health services, and improved data exchange.

Component 2 is a uniform percent increase for CCBHC services and requires semiannual submission of numeric data on process and outcome measures aligned with CCBHC measures and goals.

The data reported by DPP BHS CMHCs will be used to evaluate participating providers' progress advancing the goals from the Texas Medicaid Quality Strategy.

2. Methodology

Evaluation Questions and Hypotheses

The four DPPs, CHIRP, TIPPS, RAPPS, and DPP BHS, were designed to help advance the following goals from the July 2021 Texas Medicaid Quality Strategy[3]:

1. **Promoting optimal health for Texans** at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health
2. **Providing the right care in the right place at the right time** to ensure people can easily navigate the health system to receive timely services in the least intensive or restrictive setting appropriate
3. **Keeping patients free from harm** by building a safer healthcare system that limits human error
4. **Promoting effective practices for people with chronic, complex, and serious conditions** to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs
5. **Attracting and retaining high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers** to participate in team based, collaborative, and coordinated care

[3] 2021 Texas Managed Care Quality Strategy

To evaluate the extent to which the DPPs helped advance these quality goals, **Table 1** outlines the related evaluation questions and corresponding hypotheses.

Table 1. DPP Evaluation Questions and Hypotheses

Evaluation Question	Evaluation Hypothesis
1. Did the DPPs promote optimal health for Medicaid managed care clients at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health?	a) The DPPs supported the practice of healthy behaviors to yield reduced rates of tobacco use, obesity, and substance use b) The DPPs improved access to routine and timely preventive and primary care c) The DPPs addressed social drivers of health d) The DPPs increased the rate of preconception, early prenatal, and postpartum care and other preventive health utilization to reduce rates of infant and maternal morbidity and mortality
2. Did the DPPs provide the right care in the right place at the right time to ensure people can easily navigate the health system to receive timely services in the least intensive or restrictive setting appropriate?	a) The DPPs supported reductions in the rate of avoidable hospital admissions and readmissions b) The DPPs supported reduction in the rate of avoidable emergency department visits
3. Did the DPPs keep patients free from harm by building a safer healthcare system that limits human error?	a) The DPPs supported reductions in the rate of avoidable complications or adverse healthcare events in all care settings
4. Did the DPPs promote effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs?	a) The DPPs slowed the progression of chronic disease and improved management of complex conditions b) The DPPs supported reductions in the rate of avoidable hospital and emergency department visits for individuals with medical complexity, including with co-occurring behavioral health diagnoses c) The DPPs promoted effective medication management d) The DPPs increased prevention, identification, treatment, and management of behavioral and mental health e) The DPPs promoted earlier identification and successful treatment of substance use disorders including opioid use disorders
5. Did the DPPs attract and retain high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers to participate in team	a) The DPPs increased the number of individuals, particularly individuals with complex medical needs, served in integrated and/or accountable care models

based, collaborative, and coordinated care?	b) The DPPs supported reductions in the proportion of population reporting difficulties accessing care, including through telehealth

Evaluation Design

The evaluation of the four DPPs (CHIRP, TIPPS, RAPPS, and DPP BHS) relies on a one-group post-test only design. This design will use consecutive observations of DPP-specific measures and statewide rates after the DPPs are implemented. Collectively, the evaluation uses a total of 43 measures to test each evaluation hypothesis and ultimately answer each evaluation question related to the 2021 Texas Medicaid Quality Strategy.

HHSC will isolate DPP-specific impacts by analyzing evaluation measures reported by participating DPP providers over time.[4] Using the provider-reported evaluation data, HHSC will in future years also analyze the extent to which associations exist between structure measure[5] implementation and DPP provider performance on process and outcome measures (i.e., exploring whether providers who implemented structure measures have higher performance on evaluation measures). See **Appendix II** for the list of structure measures.

HHSC will investigate meaningful statewide impacts by analyzing evaluation measures reported at the Texas Medicaid managed care program level over time. Statewide evaluation data will not be attributed to the participating providers in each DPP yet will complement HHSC's insight into the impact of the DPPs on key statewide indicators that cannot be evaluated using provider-reported evaluation data alone. For example, since multiple provider types and system-level factors contribute to the successful prevention of avoidable hospital events and other adverse events, statewide data will be used to assess whether DPPs and other statewide initiatives supported reductions in the rate of avoidable hospital events (e.g. Evaluation Hypotheses 2a, 2b, and 3a related to Evaluation Question 2: Providing the right care in the right place at the right time to ensure people can easily navigate the health system to receive timely services in the least intensive or restrictive setting appropriate).

[4] In the first year of the DPPs, providers will stratify data by Medicaid managed care if their systems allow.

[5] "Structure Measures" are a type of measure (as opposed to "Process Measures" and "Clinical Outcome Measures") that help provide a sense of a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care.

In the first year of the evaluation, a baseline rate will be established for each evaluation measure, and then performance rates in subsequent years of the evaluation will be compared against the baseline evaluation rates to test the evaluation hypotheses. The performance targets for the evaluation will be to exceed baseline performance and demonstrate improvement over the length of the program. [6]

See the ***DPP Evaluation Measures*** section and **Appendix I** for more information regarding the evaluation measures.

Evaluation Data Measurement Periods

For the state fiscal year (SFY) 2022 implementation of CHIRP, TIPPS, RAPPS, and DPP BHS, the Year 1 evaluation would establish baseline rates for each evaluation measure using an evaluation measurement period of calendar year (CY) 2021 data (January 1, 2021 – December 31, 2021).

For a proposed SFY 2023 of CHIRP, TIPPS, RAPPS, and DPP BHS, the Year 2 evaluation would use an evaluation measurement period of CY2022 (January 1, 2022 – December 31, 2022) to compare against the baseline rates. Since CHIRP, TIPPS, RAPPS, and DPP BHS each require annual pre-print approvals, the overall DPP evaluation plan for future years including SFY 2023 is subject to change.

Evaluation Data Sources

The evaluation relies on two data sources: DPP provider-reported data and the Texas Medicaid External Quality Review Organization (EQRO) data. Of the 43 total evaluation measures, 33 measures rely on DPP provider-reported data, while 10 measures use EQRO data.

The data source determines the level of data analysis HHSC can perform. For measures relying on DDP provider-reported data, the unit of analysis is the participating DPP provider. Therefore, for DPP provider-reported measures, HHSC will perform analyses in which the evaluation population is the Texas Medicaid managed care clients served by the DPP providers during the evaluation

[6] The impacts of COVID-19 and the change in stratification requirements from year 1 to year 2 is unknown and may affect providers ability to demonstrate improvement in initial years.

measurement period.[7] The following are examples data sources used by DPP providers for evaluation measures:

- **Electronic health record (EHR) data.** The provider organization's system for electronically documenting the patient clinical record, including diagnosis, procedure or service, lab and test results, social history, and other qualitative clinician notes.
- **Other administrative data.** Any other administrative data files such as billing data or other patient surveys with patient information documented by the provider.

Alternatively, when using measures with EQRO data sources, the unit of analysis is the Medicaid member (rather than the participating DPP provider). Therefore, with EQRO-reported measures, HHSC will perform analysis in which the evaluation population consists of all Medicaid managed care members, including those members who may not have had an encounter with a participating DPP provider during the evaluation measurement period. The following are examples of EQRO data sources:

- **Medicaid managed care claims data.** Medicaid managed care claims data contain encounter, procedure, diagnosis, and place of service codes and other member-level information.
- **Medicaid enrollment data.** Medicaid enrollment files contain member-level demographic information including age, gender, race/ethnicity, county, managed care program, and length of enrollment.
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys.** CAHPS® survey data is sampled and contain information about member experience receiving care through their health plan

Anticipated Evaluation Data Availability

For the evaluation measures using DPP provider-reported data sources, CY 2021 data will be available by June 2022. For the evaluation measures using EQRO-reported data sources, CY 2021 data will be available by October 2022.

In the first year of the DPPs, providers will stratify data by Medicaid managed care if their systems allow. For providers without systems in place to stratify by Medicaid managed care in the first year of the program, HHSC will allow providers to report

[7] In the first year of the DPPs, providers will stratify data by Medicaid managed care if their systems allow.

measures stratified by Medicaid but will require stratification by Medicaid managed care in subsequent years. While this allowance may affect consistency in the level of stratification reported by providers between Year 1 and Year 2, the impact to the evaluation findings may be minimal given that approximately 95% of Texas Medicaid beneficiaries are enrolled in a Medicaid managed care program.

If an interim Year 1 evaluation is needed by February 2022 for submission with future pre-prints, then HHSC may provide six months of 2021 data (January 1, 2021 – June 30, 2021) using DPP provider-reported data sources, assuming at least one SFY 2022 reporting period occurs by November 2021. If additional context of prior performance years is needed, HHSC may also provide CY 2019 and CY 2020 data, as feasible but only with evaluation measures using EQRO-reported data sources.

Year 2 Evaluation Performance Targets

As required in the preprint, 44.a. Table 8, HHSC will establish evaluation performance targets. After the evaluation baseline data are known, HHSC will establish evaluation performance targets to demonstrate the requisite year-over-year improvement, and HHSC proposes the following approaches for setting the evaluation performance targets:

- A percentage improvement over baseline or statewide performance
- Meeting or exceeding an external benchmark (e.g., a national percentile)

Evaluation Population

For CHIRP, the evaluation population includes adults and children in the STAR and STAR+PLUS Medicaid managed care programs. For TIPPS, RAPPS, and DPP BHS programs, the evaluation population includes adults and children in the STAR, STAR+PLUS, and STAR Kids Medicaid managed care programs.[8]

Analytic Methods

The evaluation will use a descriptive trend analysis (DTA) to determine improvements in DPP evaluation measures over time. A DTA plots and analyzes time-series data calculated at equally spaced intervals to explain patterns in selected evaluation measures over time. A DTA typically focuses on identification

[8] In the first year of the DPPs, providers will stratify data by Medicaid managed care if their systems allow.

and quantification of a trend through the use of correlation coefficients or ordinary least squares regression, if feasible.

The evaluation may also make use of descriptive statistics, such as estimates of central tendency and dispersion, to describe performance on key measures during the evaluation period. To strengthen the DTA and other descriptive statistics, the overall DPP evaluation will also leverage benchmarks and subgroup analyses, where feasible, to help substantiate and contextualize observed trends.

Additionally, HHSC will employ tobit regression analysis to investigate whether providers who implemented structure measures have higher performance on DPP measures. A tobit regression is used when the dependent variable is limited in range (e.g., between 0 and 1 or between -1 and 0). A series of tobit regression models will examine the association between implementation of structure measures and DPP performance. Specifically, each DPP measure (one per model) will be regressed on a vector of control variables and a series of dummy variables representing structure measures implemented by the provider. The basic equation for these models is: $Y = \beta_0 + \beta_1 control\ variables + \beta_2 structure1 + \cdots + \beta_n structureN + \varepsilon$.

DPP Evaluation Measures

Evaluation Measures isolating DPP-specific Impacts

Of the total 43 measures in the evaluation, **Table 2** provides an overview of the 33 evaluation measures used to isolate DPP-specific impacts over time, including the evaluation question and corresponding hypothesis, evaluation measure name, and applicable DPP(s). As a reminder, the evaluation data measurement period for Year 1 of the evaluation is CY 2021, and the evaluation data measurement period for Year 2 of the evaluation is proposed to be CY 2022.

Table 2. Overview of Evaluation Measures Isolating DPP-specific Impacts

Evaluation Hypothesis	Evaluation Measure Name	DPPs Using Measure			
		CHIRP	TIPPS	RAPPS	DPP BHS
1. Did the DPPs promote optimal health for Medicaid managed care clients at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health?					
1.a. CHIRP, TIPPS, and DPP BHS supported the practice of healthy behaviors to yield reduced rates of tobacco use, obesity, and substance use	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	X	X		
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents		X		
	Tobacco Use and Help with Quitting Among Adolescents		X		
	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up				X
	Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling				X
1.b. CHIRP, TIPPS and RAPPS improved access to routine and timely preventive and primary care	Cervical Cancer Screening		X		
	Childhood Immunization Status (CIS)		X		
	Chlamydia Screening in Women (CHL)		X		
	Immunizations for Adolescents (IMA)		X		
	Preventive Care and Screening: Influenza Immunization	X	X	X	
1.c. TIPPS addressed social drivers of health	Food Insecurity Screening		X		

Evaluation Hypothesis	Evaluation Measure Name	DPPs Using Measure			
		CHIRP	TIPPS	RAPPS	DPP BHS
1.d. TIPPS increased the rate of preconception, early prenatal, and postpartum care and other preventive health utilization to reduce rates of infant and maternal morbidity and mortality	Behavioral Health Risk Assessment for Pregnant Women		X		
	Maternity Care: Post-Partum Follow-Up and Care Coordination		X		
3. Did the DPPs keep patients free from harm by building a safer healthcare system that limits human error?					
3.a. CHIRP supported reductions in the rate of avoidable complications or adverse healthcare events in all care settings	Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	X			
	Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure	X			
	Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	X			
	Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	X			
	PC-02 Cesarean Section	X			
	Pediatric Adverse Drug Events	X			
	Pediatric CAUTI	X			
	Pediatric CLABSI	X			
	Pediatric SSI	X			
	Pregnancy-Associated Outcome Measure: Severe Maternal Morbidity (SMM)	X			
4. Did the DPPs promote effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs?					
4.a. TIPPS and RAPPS slowed the progression of chronic disease and improved management of complex conditions	Controlling High Blood Pressure (CBP)		X		
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing		X		
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9%)		X	X	
4.b. DPP BHS supported reductions in the rate of avoidable hospital and emergency department visits for individuals with medical complexity,	Follow-up after Hospitalization for Mental Illness (FUH)				X

Evaluation Hypothesis	Evaluation Measure Name	DPPs Using Measure			
		CHIRP	TIPPS	RAPPS	DPP BHS
including with co-occurring behavioral health diagnoses					
4.c. CHIRP promoted effective medication management	Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	X			
4.d. TIPPS and DPP BHS increased prevention, identification, treatment, and management of behavioral and mental health conditions	Depression Response at Twelve Months		X		
	Preventive Care and Screening: Screening for Depression and Follow-Up Plan		X		
	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment				X
	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment				X
5. Did the DPPs attract and retain high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers to participate in team based, collaborative, and coordinated care?					
5a. CHIRP increased the number of individuals, particularly individuals with complex medical needs, served in integrated and/or accountable care models	Engagement in Integrated Behavioral Health	X			

Evaluation Measures investigating Statewide Impacts

Of the total 43 measures in the evaluation, **Table 3** provides an overview of the 10 evaluation measures used to investigate meaningful statewide impacts over time, including the evaluation question and corresponding hypothesis, evaluation measure name, and evaluation data source. As a reminder, the evaluation data measurement period for Year 1 of the evaluation is CY 2021, and the evaluation data measurement period for Year 2 of the evaluation is proposed to be CY 2022.

Table 3. Overview of Evaluation Measures Investigating Statewide Impacts

Evaluation Hypothesis	Evaluation Measure Name
2. Did the DPPs provide the right care in the right place at the right time to ensure people can easily navigate the health system to receive timely services in the least intensive or restrictive setting appropriate?	
2.a. The DPPs supported reductions in the rate of avoidable hospital admissions and readmissions	Potentially Preventable Admissions (PPA)
	Potentially Preventable Readmissions (PPR)
2.b. The DPPs supported reductions in the rate of avoidable emergency department visits	Potentially Preventable Emergency Department Visits (PPV)
	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)
3. Did the DPPs keep patients free from harm by building a safer healthcare system that limits human error?	
3.a. The DPPs supported reductions in the rate of avoidable complications or adverse healthcare events in all care settings	Potentially Preventable Complications (PPC)
4. Did the DPPs promote effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs?	
4.b. The DPPs supported reductions in the rate of avoidable hospital and emergency department visits for individuals with medical complexity, including with co-occurring behavioral health diagnoses	Follow-up After Emergency Department (ED) Visits for Mental Illness (FUM)
4.c. The DPPs promoted effective medication management	Antidepressant Medication Management (AMM)
4.e. The DPPs promoted earlier identification and successful treatment of substance use disorders including opioid use disorders	Initiation and Engagement of Alcohol and other Drug Abuse or Dependence Treatment (IET)
5. Did the DPPs attract and retain high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers to participate in team based, collaborative, and coordinated care?	
5.b. The DPPs supported reductions in the proportion of population reporting difficulties accessing care, including through telehealth	Getting Care Quickly
	Getting Needed Care

Anticipated Limitations

Results from the overall DPP evaluation will need to be interpreted alongside the following limitations and considerations. As noted in the "Data Sources" subsection, the evaluation measures consist of DPP provider and EQRO data sources, and the data source determines the level of data analysis HHSC can perform. For measures relying on DPP provider-reported data sources, HHSC can perform analyses that represent the Medicaid managed care clients served by the DPP providers during the evaluation measurement period.[9] However, for measures relying on EQRO data sources, HHSC can only perform analyses that represent all Medicaid members in a given Medicaid managed care program, including those members who may not have had an encounter with a participating DPP provider during the evaluation measurement period. Further, because HHSC cannot require providers who do not participate in DPPs to report on similar measures and EQRO data sources rely on the entire Medicaid managed care populations, creating a comparison group to determine the extent to which DPP outcomes differ from non-participating providers is not feasible.

Additionally, it should be noted the program year of the DPPs and the evaluation measurement year operate on different, yet overlapping, timeframes. For example, the program implementation year of each DPP is the state fiscal year (September 1st through August 31st of a given year), while the evaluation measurement period is the calendar year (January 1st through December 31st of a given year). In other words, while the DPPs are proposed to begin on September 1, 2021 through the state fiscal year until August 31, 2022, the evaluation will use a measurement period of CY 2021 to align with the measurement timeframes used by providers and the EQRO, who are the data source for the evaluation measures.

Furthermore, the DPPs are being implemented amidst the uncertainty of the COVID-19 public health emergency (PHE). Since March 2020, the PHE has shifted priorities and operations for Medicaid providers and managed care organizations in the state, and impacted Medicaid managed care clients. HHSC anticipates the PHE will have significant direct and indirect impacts on the evaluation measures. At the time of writing this evaluation plan, it is still unknown when the PHE will end and what the lasting effects of the PHE will be on health care delivery systems. The

[9] In the first year of the DPPs, providers will stratify data by Medicaid managed care if their systems allow.

overall DPP evaluation will present pertinent results as possible within the appropriate context of the PHE.

Lastly, the results from the evaluation will not determine any causal relationships regarding the DPPs and the evaluation measures, only associations between the impact of the DPPs and the evaluation measures. Despite these limitations, the overall DPP evaluation will provide insight into whether DPPs advance the goals of the Texas Managed Care Quality Strategy among DPP providers and across the Medicaid program as a whole.

3. Appendix

Appendix I. DPP Evaluation Measures – Additional Information

Evaluation Measure Name	NQF #	Measure Steward	CMS 2021 Medicaid Core Set	Data Source					Measure Type
				CHIRP	TIPPS	RAPPS	DPP BHS	EQRO	
Pregnancy-Associated Outcome Measure: Severe Maternal Morbidity (SMM)	NA	AIM	NA	X					Outcome
PC-02 Cesarean Section	471	The Joint Commission	NA	X					Outcome
Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	138	CDC	NA	X					Outcome
Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure	139	CDC	NA	X					Outcome
Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	1717	CDC	NA	X					Outcome
Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	753	CDC	NA	X					Outcome
Pediatric Adverse Drug Events	NA	CHSPS	NA	X					Outcome
Pediatric CAUTI	NA	CHSPS	NA	X					Outcome
Pediatric CLABSI	NA	CHSPS	NA	X					Outcome
Pediatric SSI	NA	CHSPS	NA	X					Outcome
Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	2456	Brigham and Women's Hospital	NA	X					Outcome
Depression Response at Twelve Months	1885	MN Community Measurement	NA		X				Outcome
Controlling High Blood Pressure (CBP)	18	NCQA	Adult		X				Outcome
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9%)	59	NCQA	Adult		X	X			Outcome

Evaluation Measure Name	NQF #	Measure Steward	CMS 2021 Medicaid Core Set	Data Source					Measure Type
				CHIRP	TIPPS	RAPPS	DPP BHS	EQRO	
Follow-up after Hospitalization for Mental Illness (FUH)	576	NCQA	Child/ Adult				X		Outcome
Engagement in Integrated Behavioral Health	NA	Texas HHSC	NA	X					Process
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	28	PCPI	NA	X	X				Process
Preventive Care and Screening: Influenza Immunization	41	NCQA	NA	X	X	X			Process
Food Insecurity Screening	NA	Texas HHSC	NA		X				Process
Maternity Care: Post-Partum Follow-Up and Care Coordination	NA	CMS	NA		X				Process
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	418	CMS	Child/ Adult		X				Process
Behavioral Health Risk Assessment for Pregnant Women	NA	CMS (retired)	NA		X				Process
Cervical Cancer Screening (CCS)	32	NCQA	Adult		X				Process
Childhood Immunization Status (CIS)	38	NCQA	Child		X				Process
Chlamydia Screening in Women (CHL)	33	NCQA	Child/ Adult		X				Process
Immunizations for Adolescents (IMA)	1407	NCQA	Child		X				Process
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	24	NCQA	Child		X				Process
Tobacco Use and Help with Quitting Among Adolescents	2803	NCQA	NA		X				Process
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	57	NCQA	NA		X				Process
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	104	AMA-PCPI	NA				X		Process
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	1365	AMA-PCPI	NA				X		Process
Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	2152	AMA-PCPI	NA				X		Process
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	421	CMS	NA				X		Process
Potentially Preventable Complications (PPC)	NA	3M	NA					X	Outcome

Evaluation Measure Name	NQF #	Measure Steward	CMS 2021 Medicaid Core Set	Data Source					Measure Type
				CHIRP	TIPPS	RAPPS	DPP BHS	EQRO	
Potentially Preventable Readmissions (PPR)	NA	3M	NA					X	Outcome
Potentially Preventable Admissions (PPA)	NA	3M	NA					X	Outcome
Potentially Preventable Emergency Department Visits (PPV)	NA	3M	NA					X	Outcome
Getting Care Quickly	NA	NCQA/ CAHPS	NA					X	Outcome
Getting Needed Care	6	NCQA/ CAHPS	NA					X	Outcome
Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	NA	NCQA	Child					X	Outcome
Antidepressant Medication Management (AMM)	105	NCQA	Adult					X	Process
Follow-up after ED Visits for Mental Illness (FUM)	3489	NCQA	Child/ Adult					X	Process
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	4	NCQA	Adult					X	Process

Note. NQF= National Quality Forum; AMA-PCPI=American Medical Association Physician Consortium for Performance Improvement; PCPI= Physician Consortium for Performance Improvement Foundation; CAHPS® = Consumer Assessment of Healthcare Providers and Systems, NCQA=National Committee for Quality Assurance; AIM=Alliance for Innovation on Maternal Health; CMS=Centers for Medicare & Medicaid Services; CDC=Centers for Disease Control and Prevention; HHSC=Health and Human Services Commission; CHSPS=Children's Hospitals' Solutions for Patient Safety; NA=Not Applicable.

Appendix II. Overview of Structure Measures

Structure Measure Name	Structure Measure Data Source			
	CHIRP	TIPPS	RAPPS	DPP BHS
Alliance for Innovation on Maternal Health (AIM) Collaborative Participation	X			
Hospital Safety Collaborative Participation	X			
Service Delivery Area (SDA) Learning Collaborative Participation	X			
Written transition procedures that include formal Managed Care Organization (MCO) relationship or Emergency Department Encounter Notification; (EDEN) notification/ Admission, Discharge, Transfer (ADT) Feed for non-psychiatric patients	X			
Written transition procedures that include formal MCO relationship or EDEN notification/ ADT Feed for psychiatric patients	X			
Health Information Exchange (HIE) Participation	X	X		
Pre-visit planning and/or standing order protocols		X		
Patient-Centered Medical Home (PCMH) Accreditation or Recognition Status		X		
Patient education focused on disease self-management		X		
Same-day, walk-in, or after-hours appointments in the outpatient setting		X		
Telehealth to provide virtual medical appointments and/or consultations for specialty services, including both physical health and behavioral health services		X		
Identification of pregnant women at-risk for Hypertension, Preeclampsia, or Eclampsia; treatment based on best practices; and follow-up with postpartum women diagnosed with Hypertension, Preeclampsia, or Eclampsia		X		
Care team includes personnel in a care coordination role not requiring clinical licensure		X	X	
Telehealth to provide virtual medical appointments with a primary care or specialty care provider			X	
Use of electronic health record (EHR)			X	
Participate in electronic exchange of clinical data with other healthcare providers/ entities				X
Provide integrated physical and behavioral health care services to children and adults with serious mental illness				X
Provide patients with services by using remote technology including audio/video, client portals and apps for the provision of services such as telehealth, assessment collection and remote health monitoring/ screening				X
Certified Community Behavioral Health Clinic (CCBHC) Certification Status				X