Evaluation Plan for Year 2 (State Fiscal Year 2023) of Four State Directed Payments

As Required by 42 C.F.R. §438.6(c)

TEXAS
Health and Human Services

Texas Health and Human Services Commission

March 2022

Contents

Contents **2**

1. Background **3**
Directed Payment Program (DPP) for Behavioral Health Services (BHS) 3
Comprehensive Hospital Increase Reimbursement Program (CHIRP) 4
Texas Incentives for Physicians and Professional Services (TIPPS) 6
Rural Access to Primary and Preventive Services Program (RAPPS) 6

2. Methodology **8**
Evaluation Questions and Hypotheses 8
Table 1. DPP Evaluation Questions and Evaluation Hypotheses 8
Evaluation Design 9
Evaluation Data Measurement Periods and Anticipated Timing of Data Availability 11
Evaluation Population 11
Evaluation Data Sources 12
Analytic Methods 13
Year 2 Evaluation Performance Targets 13
Table 2. Proposed Preliminary Year 2 Evaluation Performance Targets for DPP BHS-Specific Evaluation Measures 14
DPP Evaluation Measures 15
Evaluation Measures isolating DPP-specific Impacts 15
Table 3. Overview of Evaluation Measures Isolating DPP-specific Impacts 15
Evaluation Measures investigating Statewide Impacts 17
Table 4. Overview of Evaluation Measures Investigating Statewide Impacts 18
Anticipated Limitations 19

3. Appendix **21**
Appendix I. DPP Evaluation Measures – Additional Information 21
Appendix II. Overview of Structure Measures 24

1. Background

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

This evaluation plan outlines how the Texas Health & Human Services Commission (HHSC) will evaluate Year 2, or state fiscal year (SFY) 2023, of the four state directed payment programs (DPPs):

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

However, as this Year 2 (SFY 2023) evaluation plan was written in January 2022, only DPP BHS has been approved by CMS for Year 1 (SFY 2022) program implementation.

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

DPP BHS is a program for Texas Medicaid community mental health centers (CMHCs) and local behavioral health authorities (LBHAs) serving adults and children enrolled in STAR, STAR+PLUS, and STAR Kids.[1] DPP BHS incentivizes the continuation of successful Delivery System Reform Incentive Payment (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.

[1] State of Texas Access Reform (STAR), STAR Kids, and STAR+PLUS are examples of Texas Medicaid medical managed care programs. 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. https://hhs.texas.gov/services/health/medicaid-chip/

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

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

There are two components in the DPP BHS program. 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. As a condition of participation, all DPP BHS-participating CMHCs and LBHAs are required to report on all measures in the components for which they are eligible.

The qualitative and numeric data reported by DPP BHS providers are an essential piece of the evaluation and will be used to monitor provider-level progress toward advancing the goals from the Texas Medicaid 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. 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.

CHIRP 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 CHIRP, hospitals opt into the ACIA Component. However, as a condition of participation, all CHIRP-participating hospitals must report on all required program measures in UHRIP and all measures in the modules for which they are eligible in the ACIA Component.

The qualitative and numeric data reported by CHIRP providers are an essential piece of the evaluation and will be used to monitor provider-level progress toward 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.

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. As a condition of participation, all TIPPS-participating physician practice groups are required to report on all measures in the components for which they are eligible.

The qualitative and numeric data reported by TIPPS providers are an essential piece of the evaluation and will be used to monitor provider-level progress toward 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. 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. As a condition of participation, all RAPPS-participating RHCs are required to report on all measures in all components.

The qualitative and numeric data reported by RAPPS providers are an essential piece of the evaluation and will be used to monitor provider-level progress toward advancing the goals from the Texas Medicaid Quality Strategy.

2. Methodology

Evaluation Questions and Hypotheses

The four DPPs were designed to help advance the following goals from the September 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

To evaluate the extent to which the DPPs helped advance these quality goals, **Table 1** outlines the related Evaluation Questions and corresponding Evaluation Hypotheses.

Table 1. DPP Evaluation Questions and Evaluation 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,	**1.a.** The DPPs supported the practice of healthy behaviors to yield reduced rates of tobacco use, obesity, and substance use **1.b.** The DPPs improved access to routine and timely preventive and primary care **1.c.** The DPPs addressed social drivers of health

[3] 2021 Texas Managed Care Quality Strategy

and the healthcare system to address root causes of poor health?	**1.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?	**2.a.** The DPPs supported reductions in the rate of avoidable hospital admissions and readmissions **2.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?	**3.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?	**4.a.** The DPPs slowed the progression of chronic disease and improved management of complex conditions **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 **4.c.** The DPPs promoted effective medication management **4.d.** The DPPs increased prevention, identification, treatment, and management of behavioral and mental health **4.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 based, collaborative, and coordinated care?	**5.a.** The DPPs increased the number of individuals, particularly individuals with complex medical needs, served in integrated and/or accountable care models **5.b.** The DPPs supported reductions in the proportion of population reporting difficulties accessing care, including through telehealth

Evaluation Design

The evaluation relies on a one-group post-test only design to analyze consecutive observations of evaluation measures that test each Evaluation Hypothesis and ultimately aims to answer each Evaluation Question outlined in **Table 1**. Pending CMS approval of all four DPPs, the final evaluation report will include DPP-specific evaluation measures to isolate DPP-specific impacts over time as well as statewide evaluation measures to investigate meaningful statewide impacts over time.

To isolate DPP-specific impacts over time, HHSC will conduct analyses of the DPP provider-reported evaluation measures with measure types known as "process" and "outcome" measures. Additionally, HHSC will investigate meaningful statewide impacts over time by analyzing a total of statewide evaluation measures reported by the Texas Medicaid External Quality Review Organization (EQRO). These statewide evaluation measures will not necessarily be attributable to the DPP participating providers only; however, these statewide data will offer HHSC further insight into the impact of the DPPs on key statewide indicators that cannot be evaluated using provider-reported evaluation data alone. For example, multiple delivery system-level factors and provider types beyond those provider types participating in the DPPs contribute to the successful prevention of avoidable hospital events and other adverse events. By analyzing statewide data, HHSC can explore whether the DPPs alongside other statewide initiatives were associated with reductions in the rate of avoidable hospital events (e.g., **Evaluation Hypotheses 2.a., 2.b., and 3.a.** 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*).

Furthermore, as possible, HHSC may conduct supplemental analyses of the DPP provider-reported evaluation measures with measure types known as "structure" measures (see **Appendix II**).[4] By conducting supplemental analyses, HHSC aims to investigate the extent to which associations exist between provider performance on process and outcome measures and those providers who implemented certain structure measures as part of DPP participation (i.e., exploring whether DPP participation influences provider implementation of certain structure measures and whether such implementation is associated with higher performance on evaluation measures).

In Year 1, the provider-reported data and EQRO-reported statewide data will be used to establish the baseline rates for each evaluation measure. In Year 2 and subsequent years of the evaluation, the performance rates on these evaluation measures will be compared against the baseline to test the Evaluation Questions

[4] "Structure Measure", "Process Measure", and "Outcome Measure" are measure type classifications used in health care quality measurement. "Structure Measures" are a type of measure that helps provide a sense of a health care organization's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. "Process Measures" are a type of measure that helps indicate what a health care organization does to maintain or improve health, often reflecting generally accepted recommendations for clinical practice. "Outcome Measures" are a type of measure that helps reflect the impact of the health care service or intervention on the health status of patients. https://www.ahrq.gov/talkingquality/measures/types.html

and Evaluation Hypotheses outlined in **Table 1**. The year-to-year evaluation performance targets will be to exceed the baseline and demonstrate improvement over the length of each DPP (see ***Year 2 Evaluation Performance Targets*** section for additional information).

Evaluation Data Measurement Periods and Anticipated Timing of Data Availability

For each evaluation measure, the following evaluation data measurement periods will be used:

- Year 1 Baseline (SFY 2022): January 1, 2021 – December 31, 2021
- Year 2 (SFY 2023): January 1, 2022 – December 31, 2022

For Year 2, the anticipated timing of data depends on the data source. For the Year 2 evaluation measures using DPP provider-reported data sources, the 12 months of CY 2022 data will tentatively be available by June 2023. For the evaluation measures using EQRO-reported data sources, the 12 months of CY 2022 data will tentatively be available by October 2023.[5]

Evaluation Population

In all four DPPs, providers will report data stratified by the Medicaid managed care payer type. For the DPP BHS, TIPPS, and RAPPS programs, the Medicaid managed care evaluation population includes adults and children in the STAR, STAR+PLUS, and STAR Kids Medicaid managed care programs. For CHIRP, the Medicaid managed care evaluation population includes adults and children in the STAR and STAR+PLUS Medicaid managed care programs.

For all four DPPs, in Year 1 only, HHSC allowed providers without systems in place to stratify required data by Medicaid managed care (inclusive of the respective Medicaid managed care programs as outlined above) instead to stratify required data by Medicaid. However, in Year 2, HHSC will require data stratification by the Medicaid managed care payer type as outlined above.

---

[5] If a Year 2 preliminary evaluation report is needed by the submission deadline for a subsequent year's pre-prints (for example, if Year 3 or SFY 2024 pre-prints are submitted in February 2023, then assuming at least one Year 2 reporting period for provider-reported data occurs by November 2023 with CMS approval, HHSC may provide preliminary provider-reported data for six months of CY 2022 (January 1, 2022 – June 30, 2022).

Evaluation Data Sources

The evaluation relies on two data sources: DPP provider-reported data and the EQRO data.

Examples of data sources for DPP provider-reported data include:

- **Electronic Health Record (EHR).** The DPP 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 files.** Any other administrative data files such as billing data or patient surveys with patient information documented by the provider.

Examples of data sources for EQRO data include:

- **Medicaid claims files.** Medicaid claims data contain encounter, procedure, diagnosis, and place of service codes and other member-level information necessary to calculate evaluation measures.
- **Medicaid enrollment files.** Medicaid enrollment data contain member-level demographic information, such as age, sex, ethnicity, race, preferred language, and county of residence, managed care program, and length of Medicaid enrollment.
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys.** CAHPS® survey data are collected through sampling (rather than collected on each member) and contain information about member experience receiving care through their health plan.

The data source determines the level of data analysis HHSC can perform. For evaluation measures relying on DPP 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 measurement period. Alternatively, for evaluation measures relying on the EQRO, the unit of analysis is the Medicaid member (rather than the participating DPP provider). Therefore, for EQRO measures, HHSC will perform analyses in which the evaluation population is 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.

Analytic Methods

The evaluation will mainly use descriptive trend analyses (DTAs) 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 and quantification of a trend using correlation coefficients or ordinary least squares regression, if feasible.

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

Furthermore, the evaluation may employ tobit regression analysis to investigate whether DPP providers who implemented certain structure measures have higher performance on the evaluation 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), so a series of tobit regression models may be used to examine the association between implementation of structure measures and DPP provider performance on process and outcome measures. Specifically, each evaluation measure (one per model) would 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: $Y = \beta_0 + \beta_1 control\ variables + \beta_2 structure1 + \cdots + \beta_n structureN + \varepsilon$.

Year 2 Evaluation Performance Targets

As required in the preprint, 44.b. Table 8, HHSC will establish final Year 2 evaluation performance targets for each DPP after the evaluation baseline data are known for the full 12 months of CY 2021 data. At the time of submitting this Year 2 evaluation plan, only DPP BHS has been approved by CMS for Year 1 and only preliminary DPP BHS baseline data are available (i.e., six months of CY 2021 data); therefore, final evaluation performance targets cannot yet be established.

However, based on the available preliminary DPP BHS baseline data, HHSC proposes preliminary evaluation performance targets only for the 6 total DPP BHS program-specific evaluation measures (see **Table 2**). These proposed preliminary DPP BHS evaluation performance targets reflect incremental, year-over-year

percentage improvements[6] over the baseline towards perfect performance, setting the DPP BHS process measures (4 total) at a 10% improvement target and the DPP BHS outcome measures (2 total) at a 5% improvement target.

After the baseline data for all four DPPs, pending CMS approval, are known for the full 12 months of CY 2021, HHSC will establish final evaluation performance targets.

Table 2. Preliminary Year 2 Evaluation Performance Targets for DPP BHS-Specific Evaluation Measures

DPP BHS Evaluation Measure	Measure Type	DPP BHS Prelim BL*	DPP BHS Prelim Performance Target for CY2022
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling	Process	0.65	**0.69** (BL + 0.10*(1 - BL))
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Process	0.64	**0.68** (BL + 0.10*(1 - BL))
Follow-Up After Hospitalization for Mental Illness 7-Day (discharges from state hospital)	Outcome (Interm)	0.60	**0.62** (BL + 0.05*(1 - BL))
Follow-Up After Hospitalization for Mental Illness 30-Day (discharges from state hospital)	Outcome (Interm)	0.67	**0.69** (BL + 0.05*(1 - BL))
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Process	0.84	**0.85** (BL + 0.10*(1 - BL))
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Process	0.73	**0.74** (BL + 0.10*(1 - BL))

*For a given evaluation measure, the DPP BHS Year 1 preliminary baseline (BL) is the median Medicaid managed care rate (includes STAR, STAR+PLUS, and STAR Kids) for the first six months of CY 2021.

[6] The percentage improvements use a gap closure methodology, meaning the Year 2 performance target in CY 2022 is to close the gap between the CY 2021 baseline and perfect performance by 10% for process measures and by 5% for outcome measures.

DPP Evaluation Measures

The evaluation intends to use a total of 44 evaluation measures collectively across the four DPPs to test each Evaluation Hypothesis and ultimately answer each Evaluation Question related to the 2021 Texas Medicaid Quality Strategy. Of the 44 total evaluation measures, 34 measures isolate DPP-specific impacts over time and 10 measures investigate meaningful statewide impacts over time.

Evaluation Measures isolating DPP-specific Impacts

To isolate DPP-specific impacts over time, **Table 3.** provides an overview of the 34 DPP-specific evaluation measures, including the evaluation questions, corresponding evaluation hypotheses, the evaluation measure names, and applicable DPP(s).

Table 3. Overview of Evaluation Measures Isolating DPP-specific Impacts

Evaluation Hypothesis	Evaluation Measure Name	DPPs Using Measure			
		DPP BHS	CHIRP	TIPPS	RAPPS
Evaluation Question 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. DPP BHS, TIPPS, and CHIRP supported the practice of healthy behaviors to yield reduced rates of tobacco use, obesity, and substance use	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling	X			
	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	X			
	Tobacco Use and Help with Quitting Among Adolescents			X	
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents			X	
	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention		X	X	
	Cervical Cancer Screening			X	
	Childhood Immunization Status (CIS)			X	
	Chlamydia Screening in Women (CHL)			X	

Evaluation Hypothesis	Evaluation Measure Name	DPPs Using Measure			
		DPP BHS	CHIRP	TIPPS	RAPPS
1.b. CHIRP, TIPPS and RAPPS improved access to routine and timely preventive and primary care	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	
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	
Evaluation Question 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		
Evaluation Question 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	Controlling High Blood Pressure (CBP)			X	
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing			X	

Evaluation Hypothesis	Evaluation Measure Name	DPPs Using Measure			
		DPP BHS	CHIRP	TIPPS	RAPPS
improved management of complex conditions	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, including with co-occurring behavioral health diagnoses	Follow-Up After Hospitalization for Mental Illness 7-Day (discharges from state hospital)	X			
	Follow-Up After Hospitalization for Mental Illness 30-Day (discharges from state hospital)	X			
4.c. CHIRP promoted effective medication management	Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient		X		
4.d. DPP BHS and TIPPS increased prevention, identification, treatment, and management of behavioral and mental health conditions	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	X			
	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	X			
	Depression Response at Twelve Months			X	
	Preventive Care and Screening: Screening for Depression and Follow-Up Plan			X	
Evaluation Question 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.a. 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

To investigate meaningful statewide impacts over time, **Table 4.** provides an overview of the 10 statewide evaluation measures, including the evaluation questions, corresponding evaluation hypotheses, and evaluation measure names.

Table 4. Overview of Evaluation Measures Investigating Statewide Impacts

Evaluation Hypothesis	Evaluation Measure Name
Evaluation Question 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)
Evaluation Question 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)
Evaluation Question 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)
Evaluation Question 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 Year 2 evaluation will need to be interpreted alongside the following anticipated limitations and considerations. First, at the time of submitting this Year 2 evaluation plan, only DPP BHS has been approved by CMS for Year 1 program implementation, while the remaining three DPPs are still pending CMS approval for Year 1. As described in the ***Background*** section, all information included in this Year 2 evaluation plan operates under the assumption that all four DPPs will be approved by CMS for Year 1 program implementation.

Additionally, as noted in the ***Evaluation Population*** section, in Year 1 only, HHSC allowed providers without systems in place to stratify data by Medicaid managed care instead to stratify by Medicaid (inclusive of Medicaid managed care and Medicaid fee-for-service). However, in Year 2, HHSC will require data stratification by Medicaid managed care. Although the final Year 1 evaluation may include results at the level of stratification of both Medicaid managed care and Medicaid payer types, the Year 2 evaluation will only include results at the level of stratification of the Medicaid managed care payer type. HHSC expects any effect on the Year 2 evaluation findings to be minimal, given the majority of Texas Medicaid beneficiaries are enrolled in Medicaid managed care.

Moreover, a consideration to note is how the program year of the DPPs and the evaluation measurement period 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, although Year 2 (SFY 2023) program implementation of the DPPs are proposed to begin September 1, 2022 through August 31, 2023, the Year 2 (SFY 2023) evaluation will use an evaluation measurement period of January 1, 2022 through December 31, 2022 to align with the measurement timeframes used by participating providers and the EQRO, who are the data sources for the evaluation measures.

Furthermore, the DPPs are being implemented amidst the ongoing 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. Within the appropriate context of the PHE, the evaluation will present pertinent results as possible.

Lastly, the results from the Year 2 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 Year 2 evaluation will provide initial insight into whether the DPPs are advancing 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
				Provider Reported				EQRO	
				DPP BHS	CHIRP	TIPPS	RAPPS		
Follow-up after Hospitalization for Mental Illness 7-Day (discharges from state hospital)	576	NCQA	Child/ Adult	X					Outcome - Intermediate
Follow-up after Hospitalization for Mental Illness 30-Day (discharges from state hospital)	576	NCQA	Child/ Adult	X					Outcome - Intermediate
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	104	Mathematica	NA	X					Process
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	1365	Mathematica	NA	X					Process
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling	2152	NCQA	NA	X					Process
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	421	CMS	NA	X					Process
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

Evaluation Measure Name	NQF #	Measure Steward	CMS 2021 Medicaid Core Set	Data Source					Measure Type
				Provider Reported				EQRO	
				DPP BHS	CHIRP	TIPPS	RAPPS		
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
Engagement in Integrated Behavioral Health	NA	Texas HHSC	NA		X				Process
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	28	NCQA	NA		X	X			Process
Preventive Care and Screening: Influenza Immunization	41	NCQA	NA		X	X	X		Process
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9%)	59	NCQA	Adult			X	X		Outcome - Intermediate
Depression Response at Twelve Months	1885	MN Community Measurement	NA			X			Outcome
Controlling High Blood Pressure (CBP)	18	NCQA	Adult			X			Outcome
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	Texas HHSC	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

Evaluation Measure Name	NQF #	Measure Steward	CMS 2021 Medicaid Core Set	Data Source					Measure Type
				Provider Reported				EQRO	
				DPP BHS	CHIRP	TIPPS	RAPPS		
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
Potentially Preventable Complications (PPC)	NA	3M	NA					X	Outcome
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	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; 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			
	DPP BHS	CHIRP	TIPPS	RAPPS
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			
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