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

As Required by Centers for Medicare and Medicaid Services

TEXAS
Health and Human Services

Texas Health and Human Services Commission

March 2021

Table of Contents

1. Background

The Directed Payment Program (DPP) for Behavioral Health Services (BHS) is a program for the Community Mental Health Centers (CMHCs) in Texas that serve adults and children enrolled in STAR, STAR+PLUS, and STAR Kids.

DPP BHS was developed to align with the State's Quality Strategy and Delivery System Reform Incentive Payments (DSRIP) transition. DPP BHS is designed to: 1) continue successful DSRIP innovations by CMHCs to promote and improve access to behavioral health services, care coordination, and successful care transitions; and 2) incentivize continuation of services provided to Medicaid-enrolled individuals that are aligned with the Certified Community Behavioral Health Clinic (CCBHC) model of care.

All CMHCs are eligible to enroll in DPP BHS regardless of CCBHC certification status, however, the two classes of providers in the program: 1) CMHCs with CCBHC certification and 2) CMHCs without CCBHC certification.

DPP BHS includes two components:

- Component 1 is a uniform dollar increase issued in monthly payments to all CMHCs participating in the program for progress made toward CCBHC certification or maintenance of CCBHC status. CMHCs will track the implementation of activities foundational to quality improvement, such as telehealth services, collaborative care, integration of physical and behavioral health, and improved data exchange.
- Component 2 is a uniform percent increase on CCBHC services based on achievement of quality metrics that align with CCBHC measures and goals.

DPP BHS implementation begins September 1, 2021. CMS requires approved DPPs to be evaluated to test whether the payment arrangement advanced at least one of the goals of the State's quality strategy. This evaluation design outlines Texas's plan for conducting the evaluation of DPP BHS.

2. Methodology

Evaluation Questions and Hypotheses

DPP BHS was designed to help advance the following goals from the Texas Medicaid Quality Strategy: (1) promoting optimal health for Texans; (2) providing the right care in the right place at the right time; (3) promoting effective practices for people with chronic, complex, and serious conditions, and (4) 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. Texas developed evaluation questions and corresponding hypotheses to evaluate the extent to which DPP BHS helped advance these goals.

Evaluation Question 1. Does DPP BHS provide the right care in the right place at the right time?

> Hypothesis 1.1. DPP BHS will reduce the unnecessary hospital admissions and readmissions
>
> Hypothesis 1.2. DPP BHS will reduce rate of avoidable emergency department visits

Evaluation Question 2. Does DPP BHS promote effective practices for people with chronic, complex, and serious conditions?

> Hypothesis 2.1 DPP BHS will reduce the rate of avoidable hospital and ED visits for individuals with a behavioral health diagnosis
>
> Hypothesis 2.2. DPP BHS will improve effective medication management
>
> Hypothesis 2.3. DPP BHS will improve early identification and successful treatment of substance use disorders

Evaluation Question 3. Does DPP BHS attract and retain high performing behavioral health providers to participate in team-based, collaborative, and coordinated care?

> Hypothesis 3.1. DPP BHS will increase the number of individuals with complex medical needs serviced in integrated and/or accountable models
>
> Hypothesis 3.2. DPP BHS will reduce the proportion of the population reporting difficulties accessing care

Hypothesis 3.3. DPP BHS will increase the rate of active monitoring of patient outcomes and perspectives

Hypothesis 3.4 DPP BHS will improve the timely and efficient exchange of health information

Evaluation Design

Texas will use five structure measures and eight validated performance measures to evaluate the extent to which DPP BHS meets the intended quality outcomes. The DPP BHS evaluation will rely on a one-group post-test only design to assess the impact of DPP BHS over time. The performance target for all evaluation measures is to exceed baseline performance and demonstrate improvement from program implementation to program completion.

Subsequent sections provide additional information on the evaluation population, evaluation period, evaluation measures, data sources, and analytic methods.

Evaluation Population

The DPP BHS program population includes adults and children in the STAR, STAR+PLUS, and STAR Kids Medicaid managed care (MMC) programs that are served by CMHCs. However, the DPP BHS evaluation measures focus on both Medicaid clients and CMHC operations for analysis depending on the measure. For performance measures, the DPP BHS evaluation population consists of all STAR, STAR+PLUS, and STAR Kids members, including those who did not visit a CMHC during the study timeframe. Where feasible, the DPP BHS evaluation measures will also use provider-reported data for analysis at the CMHC level.

Evaluation Period

The evaluation includes three years of DPP BHS implementation data (calendar years 2021-2023). DPP BHS operates on state fiscal years (September 1 – August 31), whereas the evaluation periods operate on calendar years to align with reporting timelines of evaluation measures tracked by the Texas External Quality Review Organization (EQRO). The Texas EQRO provides data for the previous calendar year in the following November (e.g. CY2021 data will be available in November 2022). Texas will utilize calendar years 2019-2020 data for context as feasible. As DPP for BHS requires annual approval, evaluation measures for future years are subject to change pending approval for each program year.

Table 1. DPP BHS Evaluation Data Timing (Years 1-3)

Year 1 Interim Evaluation Data (Completed February 2022)

Data Type	Data Available	Measurement Periods Available	Able to Demonstrate a Trend in 2022
EQRO Reported Data	1 Year	CY2020	No
Provider Reported Data	6 Months	Jan – Jun 2021	No
Provider Reported Structures	1 Reporting Period	Oct 2021	No

Year 1 Final Evaluation Data, Year 2 Interim Evaluation Data (Completed Feb 2023)

Data Type	Data Available	Measurement Periods Available	Able to Demonstrate a Trend in 2023
EQRO Reported Data	2 Years	CY2020 - 2021	No
Provider Reported Data	1.5 Years	CY2021 Jan – Jun 2022	Preliminary
Provider Reported Structures	3 Reporting Periods	Oct 2021 – Oct 2022	Yes

Year 2 Final Evaluation Data, Year 3 Interim Evaluation Data (Completed Feb 2024)

Data Type	Data Available	Measurement Periods Available	Able to Demonstrate a Trend in 2024
EQRO Reported Data	3 Years	CY2020 - 2022	Yes
Provider Reported Data	2.5 Years	CY2021 CY2022 Jan – Jun 23	Yes
Provider Reported Structures	5 Reporting Periods	Oct 2021 – Oct 2023	Yes

Evaluation Measures

Table **2**2 provides an overview of the measures, study populations, data sources, and analytic methods by evaluation hypothesis. Table 3 includes the evaluation measures, baseline, and performance targets as required in the preprint, 44.a. Table 8.

Table 2. DPP BHS Evaluation Measures

Evaluation Hypothesis	Measures	Study Population	Data Sources	Analytic Methods
Evaluation Question 1. Does DPP BHS provide the right care in the right place at the right time?				
1.1. DPP BHS will reduce the unnecessary hospital admissions and readmissions	1.1.1 Potentially Preventable Admissions	• STAR, STAR+PLUS, STAR Kids members	• Medicaid member-level data	• Descriptive statistics • Descriptive trend analysis
1.2. DPP BHS will reduce rate of avoidable emergency department visits	1.2.1 Potentially Preventable Emergency Department Visits 1.2.2 Ambulatory Care: Emergency Department Visits	• STAR, STAR+PLUS, STAR Kids members	• Medicaid member-level data	• Descriptive statistics • Descriptive trend analysis
Evaluation Question 2 Does DPP BHS promote effective practices for people with chronic, complex, and serious conditions?				
2.1. DPP BHS will reduce the rate of avoidable hospital and ED visits for individuals with a behavioral health diagnosis	2.1.1 Follow-up After Hospitalization for Mental Illness	• STAR, STAR+PLUS, STAR Kids	• Medicaid member-level data	• Descriptive statistics • Descriptive trend analysis
2.2. DPP BHS will improve effective medication management	2.1.2 Antidepressant Medication Management	• STAR, STAR+PLUS members	• Medicaid member-level data	• Descriptive statistics • Descriptive trend analysis

Evaluation Hypothesis	Measures	Study Population	Data Sources	Analytic Methods
2.3. DPP BHS will improve early identification and successful treatment of substance use disorders	2.1.3 Initiation and Engagement of Alcohol and other Drug Abuse or Dependence Treatment	• STAR, STAR+PLUS, STAR Kids members	• Medicaid member-level data	• Descriptive statistics • Descriptive trend analysis
Evaluation Question 3. Does DPP BHS attract and retain high performing behavioral health providers to participate in team-based, collaborative, and coordinated care?				
3.1. DPP BHS will increase the number of individuals with complex medical needs serviced in integrated and/or accountable models	3.1.1 CCHBC Certification Status 3.1.2 Provision of integrated physical health screenings	• DPP BHS Participating CMHCs	• DPP BHS Provider Reporting	• Descriptive statistics • Descriptive trend analysis
3.2. DPP BHS will reduce the proportion of the population reporting difficulties accessing care	3.2.1 Getting Care Quickly 3.2.2 Getting Needed Care	• Medicaid members	• CAHPS® Surveys	• Descriptive statistics • Descriptive trend analysis
3.3. DPP BHS will increase the rate of active monitoring of patient outcomes and perspectives	3.3.1 Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment 3.3.2 Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	• Medicaid members receiving care at DPP BHS participating provides	• DPP BHS Provider Reporting	• Descriptive statistics • Descriptive trend analysis
3.4. DPP BHS will improve the timely and efficient exchange of health information	3.4.1 Electronic exchange of clinical data	• DPP BHS Participating CMHCs	• DPP BHS Provider Reporting	• Descriptive statistics • Descriptive trend analysis

Note. 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; STAR Kids = children and adults 20 and younger who have disabilities; CAHPS® = Consumer Assessment of Healthcare Providers and Systems.

Table 3. DPP BHS Evaluation Measures, Baseline, and Performance Targets

Measure Name	NQF#	Measure Steward	STAR Baseline	STAR+PLUS Baseline	STAR Kids Baseline	Performance Target	CMS Core Measure	CMHC Similar Measure
Potentially Preventable Admissions* *(rate per 1000 member months)*	NA	3M	2020: TBD 2021: TBD 2019: 0.32	2020: TBD 2021: TBD 2019: 9.30	2020: TBD 2021: TBD 2019: 2.09	• Maintain or decrease annually the rate of readmissions that may result from lack of adequate access to care or ambulatory care coordination • *A more specific performance target may be set after collecting performance data for CY 2021 and setting the baseline for DPP for BHS. The potential impact of COVID on this measure is not yet known.*	No	No
Potentially Preventable Emergency Department Visits* *(rate per 1000 member months)*	NA	3M	2020: TBD 2021: TBD 2019: 9.21	2020: TBD 2021: TBD 2019: 21.38	2020: TBD 2021: TBD 2019: 10.27	• Maintain or decrease annually the rate of ED visits that may result from lack of adequate access to care or ambulatory care coordination • *A more specific performance target may be set after collecting performance data for CY 2021 and setting the baseline for DPP for BHS. The potential impact of COVID on this measure is not yet known.*	No	No

Measure Name	NQF#	Measure Steward	STAR Baseline	STAR+PLUS Baseline	STAR Kids Baseline	Performance Target	CMS Core Measure	CMHC Similar Measure
Ambulatory Care: Emergency Department (ED) Visits* *(rate per 1000 member months)*	NA	NCQA	2020: TBD 2021: TBD 2019: 56.62	2020: TBD 2021: TBD 2019: 114.44	2020: TBD 2021: TBD 2019: 59.06	• Maintain or decrease annually the rate of ED visits that may result from lack of adequate access to care or ambulatory care coordination as compared to national trends • *A more specific performance target may be set after collecting performance data for CY 2021 and setting the baseline for DPP for BHS. The potential impact of COVID on this measure is not yet known.*	Yes	No

Measure Name	NQF#	Measure Steward	STAR Baseline	STAR+PLUS Baseline	STAR Kids Baseline	Performance Target	CMS Core Measure	CMHC Similar Measure
Getting Care Quickly*	NA	NCQA	2020: TBD 2021: TBD {2019: Adult - 54.8%; Child - 80.5%}			• Exceed the US Average every year. • Maintain or increase annually the percentage of Medicaid beneficiaries who reported getting care quickly relative to national trends *A more specific performance target may be set after collecting performance data for CY 2021 and setting the baseline for DPP for BHS. The potential impact of COVID on this measure is not yet known.*	Yes	No

Measure Name	NQF#	Measure Steward	STAR Baseline	STAR+PLUS Baseline	STAR Kids Baseline	Performance Target	CMS Core Measure	CMHC Similar Measure
Getting Needed Care*	NA	NCQA	2020: TBD 2021: TBD {2019: Adult - 54.4%; Child - 68.2%}			• Exceed the US Average every year. • Maintain or increase the percentage of Medicaid beneficiaries who reported getting needed care relative to national trends. • *A more specific performance target may be set after collecting performance data for CY 2021 and setting the baseline for DPP for BHS. The potential impact of COVID on this measure is not yet known.*	Yes	No
Antidepressant Medication Management (AMM)	0105	NCQA	Acute Phase 2020: TBD 2021: TBD {2019: 50.20%} Continuation 2020: TBD 2021: TBD {2019: 31.36%}	Acute Phase 2020: TBD 2021: TBD {2019: 53.16%} Continuation 2020: TBD 2021: TBD {2019: 38.22%}	NA	• Maintain or improve the AMM rate for both acute and continuation phases. • *A more specific performance target may be set after collecting performance data for CY 2021 and setting the baseline for DPP for BHS. The potential impact of COVID on this measure is not yet known.*	Yes	No

Measure Name	NQF#	Measure Steward	STAR Baseline	STAR+PLUS Baseline	STAR Kids Baseline	Performance Target	CMS Core Measure	CMHC Similar Measure
Follow-up after hospitalization for mental illness (FUH)	0576	NCQA	7 Day 2020: TBD 2021: TBD {2019: 29.97%} 30 Day 2020: TBD 2021: TBD {2019: 40.19%}	7 Day 2020: TBD 2021: TBD {2019: 22.83%} 30 Day 2020: TBD 2021: TBD {2019: 33.14%}	7 Day 2020: TBD 2021: TBD {2019: 32.89%} 30 Day 2020: TBD 2021: TBD {2019: 58.81%}	• Maintain or improve the follow-up after hospitalization for mental illness rate relative to national trends. • *A more specific performance target may be set after collecting performance data for CY 2021 and setting the baseline for DPP for BHS. The potential impact of COVID on this measure is not yet known.*	Yes	Yes
Initiation and Engagement of Alcohol and other Drug Abuse or Dependence Treatment (IET)	0004	NCQA	Initiation 2020: TBD 2021: TBD {2019: 41.16%} Engagement 2020: TBD 2021: TBD {2019: 14.85%}	Initiation 2020: TBD 2021: TBD {2019: 39.70%} Engagement 2020: TBD 2021: TBD {2019: 5.82%}	Initiation 2020: TBD 2021: TBD {2019: 45.37%} Engagement 2020: TBD 2021: TBD {2019: 13.48%}	• Improve initiation and engagement rates for alcohol and drug abuse dependence treatment relative to national trends. • *A more specific performance target may be set after collecting performance data for CY 2021 and setting the baseline for DPP for BHS. The potential impact of COVID on this measure is not yet known.*	Yes	No

Measure Name	NQF#	Measure Steward	STAR Baseline	STAR+PLUS Baseline	STAR Kids Baseline	Performance Target	CMS Core Measure	CMHC Similar Measure
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	0104	AMA-PCPI	2021: TBD			• Improve the median rate of child suicide risk assessment for participating CMHCs. • *A more specific performance target may be set after collecting performance data for CY 2021 and setting the baseline for DPP for BHS. The potential impact of COVID on this measure is not yet known.*	No	Yes
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	1365	AMA-PCPI	2021: TBD			• Improve the median rate of adult suicide risk assessment for participating CMHCs. • *A more specific performance target may be set after collecting performance data for CY 2021 and setting the baseline for DPP for BHS. The potential impact of COVID on this measure is not yet known.*	No	Yes

* Measure is a cross-cutting program measure that is included in the goals and evaluation of one or more complementary directed payment programs including Comprehensive Hospital Rate Increase Program (CHIRP), Rural Access to Primary and Preventive Services (RAPPS), and Texas Incentives for Physicians and Professional Services (TIPPS).

Data Sources

The DPP BHS evaluation measures leverage data sources used by the EQRO.

- **Medicaid claims data.** Medicaid fee-for-service and MMC claims data contain encounter, procedure, diagnosis, and place of service codes and other member-level information necessary to calculate evaluation measures.
- **Medicaid enrollment data.** Medicaid enrollment files contain member-level demographic information including age, gender, race/ethnicity, county, MMC 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.

Where feasible, the DPP BHS evaluation measures will use provider-reported data for analysis at the physician group level.

Analytic Methods

Advanced techniques for examining changes over time, such as interrupted time series analysis, are not appropriate due to the limited amount of data points available for the DPP BHS evaluation. Rather, the evaluation will use descriptive trend analysis (DTA) to determine improvements in DPP BHS performance measures over time. DTA plots and analyzes time-series data calculated at equally spaced intervals to explain patterns in selected measures over time. DTA typically focuses on identification 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 DTA and other descriptive statistics, the DPP BHS evaluation will also leverage benchmarks and subgroup analyses, where feasible, to help substantiate and contextualize observed trends.

Anticipated Limitations

Results from the DPP BHS evaluation will need to be interpreted alongside several limitations. The most salient threat to the internal validity of the evaluation is the possibility that factors external to the DPP BHS program will influence the evaluation measures. For example, several additional directed payment programs (e.g., the Comprehensive Hospital Increase Reimbursement Program, Texas

Incentive for Physicians and Professionals Services, and Rural Access to Primary and Preventive Services) will be implemented at the same time as DPP BHS. Accordingly, it is not possible to isolate the impact of DPP BHS through these evaluation measures. Additionally, the Delivery System Reform Incentive Program (DSRIP) began a gradual phase-out on October 1, 2019, and final payments will occur in January 2023. DSRIP incentivizes physician groups and other providers to meet access- and outcome-related goals. It is not possible to isolate the impact of DPP BHS from impacts associated with DSRIP ending.

It should also be noted that this evaluation design is being written amidst the COVID-19 pandemic. The outbreak has reordered priorities for both clients and providers in the state. HHSC anticipates the COVID-19 pandemic will have a direct or indirect impact on many of the measures used in this evaluation. At the time of writing, it is unknown how long the most severe effects of the pandemic will last. The DPP BHS evaluation will take care to present pertinent findings within the appropriate context.

Third, since the DPP BHS evaluation population will consist of all STAR, STAR+PLUS, and STAR Kids members, including those members who may not have had an encounter with a participating provider during the study timeframe, the evaluation measures may be analyzed at the Medicaid managed care (MMC) program-level but not necessarily at the CMHC level. Where feasible, the DPP BHS evaluation measures will use provider-reported data for analysis at the CMHC level. To mitigate this limitation in future years, HHSC is pursuing options to develop a member level attribution methodology for standard evaluation at the CMHC level.

A final limitation is that DPP BHS and the evaluation operate on different calendars. DPP BHS will begin on September 1, 2021 and, operate on state fiscal years, whereas the evaluation will operate on calendar years to align with the EQRO's reporting timelines of evaluation measures.

Despite these limitations, this evaluation will demonstrate how DPP BHS advances select goals identified in the Texas Managed Care Quality Strategy.