Evaluation of Four State Directed Payment Programs

State Fiscal Years

2022, 2023 and 2024

As Required by 42 CFR 438.6(c)

TEXAS
Health and Human Services

Texas Health and Human Services

Commission

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1. Summary

In state fiscal year (SFY) 2022, the Texas Health and Human Services Commission (HHSC) received approval for four new Medicaid directed payment programs (DPPs.)

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

The DPPs were designed to help advance the goals and objectives of the *Managed Care Quality Strategy*[1]**.** DPPs must be evaluated annually to test whether the payment arrangement advances the goals of the Texas Managed Care Quality Strategy.

The hospitals, physician groups, rural health clinics, and behavioral health centers that participate in these four programs have now completed their second year of quality reporting, and third year activities are underway.

Figure 1: DPP Quality Objective Dashboard October 2023 (see **Appendix D**)

This evaluation shows the following:

1. The state is making clear progress in meeting four of the five quality strategy goals of the Texas Managed Care Quality Strategy and is implementing program changes to ensure continued progress.
2. Many key measures are showing improvements in the second year of the program. Fifteen of the 24 provider-reported program-specific evaluation measures improved. Although there are notable areas of concern regarding immunization measures and birth-outcomes measures, these concerns align with national trends.
3. Many providers are now engaging in non-medical drivers of health (NMDOH) screening and follow-up planning for food, housing, and transportation needs. There were also increases in care coordination planning, health information exchange, and integrated physical and behavioral health.

[1] 2021 Texas Managed Care Quality Strategy: https://www.hhs.texas.gov/about-hhs/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/quality-strategy

2. Data Sources

The data for this evaluation comes from DPP participating providers and the Texas External Quality Review Organization (EQRO).

DPP participating providers track adoption of structure measures[2] like participating in a data exchange, as well as performance rates for process and outcome measures, such as the percentage of members seen during the year that have their diabetic HbA1c under control. Providers use their electronic health records (EHRs) and other administrative data files to collect data.

The EQRO tracks DPP program population rates for process and outcome measures like Emergency Room (ER) utilization for STAR members seen by a TIPPS provider, as well as state level rates for outcome measures that cannot be attributed to a DPP, such as the percentage of members that say they can always get care quickly. The EQRO uses Medicaid claims from validated encounters, Medicaid enrollment files, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys.

At the time of this evaluation, the following data are available:

- Adoption of structure measures over SFY 2022, SFY 2023 and SFY 2024 (as of August 31, 2021; August 31, 2022; and August 31, 2023)
- Final provider reported performance rates for SFY 2022 (January - December 2021) and SFY 2023 (January – December 2022)
- Final EQRO reported population rates for SFY 2022 (January – December 2021) and SFY 2023 (January – December 2022)

The EQRO data used in this evaluation is available as a Microsoft Excel file (**Attachment 1**). Provider-reported data from SFY 2023[3] are posted publicly. More information on the background and methodology can be found in the evaluation plans for SFY 2022[4], SFY 2023[5] and SFY 2024[6].

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[2] "Structure Measures" 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" indicate what a health care organization does to maintain or improve health, often reflecting generally accepted recommendations for clinical practice. "Outcome Measures" reflect the impact of the health care service or intervention on the health status of patients. AHRQ Talking Quality: https://www.ahrq.gov/talkingquality/measures/types.html

[3] Provider-reported data are on the quality requirements site

[4] SFY 2022 Evaluation Plan for Four State Directed Payment Programs: https://www.hhs.texas.gov/sites/default/files/documents/y1-dpp-evaluation-plan.pdf

[5] SFY 2023 Evaluation Plan for Four State Directed Payment Programs: https://www.hhs.texas.gov/sites/default/files/documents/y2-dpp-evaluation-plan.pdf

[6] SFY 2024 Evaluation Plan for Four State Directed Payment Programs: https://www.hhs.texas.gov/sites/default/files/documents/y3-dpp-evaluation-plan.pdf

3. Results

The evaluation can assess if the program is on track to meet its goals and provide a general overview of how providers' performance and participation have evolved. With 30 months of program data, there is now tangible evidence that supports the notion the directed payment programs are advancing the goals and objectives of the Texas Managed Care Quality Strategy. Participating providers are meeting the program requirements and starting to show improvements in key outcomes.

Conditions of Participation

As a condition of participation in each directed payment program, participating providers report data to HHSC. Participants submit responses to qualitative questions that summarize their progress towards implementing structure measures but are not required to implement those structure measures. Providers also submit numerator and denominator rates for performance measures and respond to qualitative questions about their data collection methodology. Performance rates for most measures must be stratified by payer-type[7] including by the Medicaid managed care programs that are a part of the payment arrangement, with some exceptions that are described in the next section.

In the first year of the program, DPP BHS participants had two reporting periods to submit the required data, and CHIRP, TIPPS, and RAPPS participants had one reporting period. Participants that did not submit the required data did not meet the conditions of participation, and either withdrew or were removed from the program. In subsequent years, there are two reporting periods for all four programs.

Table 1: Number of participants that enrolled in the program and percent of enrolled participants that met the conditions of participation

Year	CHIRP	TIPPS	RAPPS	DPP BHS
SFY 2022	418 / 98%	71 / 87%	181 / 94%	39 / 100%
SFY 2023	406 / 99%	61 / 91%	160 / 99%	40 / 100%

The number of participants enrolled in the program in SFY23 declined for CHIRP, TIPPS and RAPPS from SFY22.

[7] For adult and pediatric hospital safety outcome measures, hospitals will report a rate as specified for all-payer types.

The percent of enrolled participants that met the conditions of participation increased from SFY 2022 to SFY 2023 for CHIRP, RAPPS and TIPPS. The percent stayed the same at 100% for DPP BHS. HHSC staff regularly survey the people who submit DPP quality reporting about their experience and uses this feedback to improve technical assistance. Since staff incorporated feedback from users, program participants have been more likely to meet quality reporting deadlines, less likely to submit inaccurate data, and report having an increased understanding of the reporting requirements and their program's impact on the Texas Managed Care Quality Strategy.

Population Characteristics

Some measures are tracked at the DPP population level by using claims data to isolate the population of Medicaid clients that had at least one visit during the measurement year with any provider participating in the DPP. This data gives us a broader picture of the health of the population served by DPP participants.

Potentially Preventable Admissions

Potentially Preventable Admissions (PPAs) are hospital admissions that could potentially have been addressed in the outpatient setting. In many cases PPAs are for flare-ups of chronic conditions that could have been avoided with monitoring and follow-up, like medication management.[8] The EQRO tracks a PPA population rate for TIPPS, DPP BHS, and RAPPS. In Calendar Year (CY) 2022, Medicaid clients seen by TIPPS, DPP BHS, and RAPPS providers exhibited a higher number of actual admissions for preventable conditions, compared to CY 2021 data. The COVID-19 Public Health Emergency may have impacted Potentially Preventable Admissions, leading to atypical utilization which may have influenced these results. **Appendix B Figure 1** provides detailed rates.

- In CY 2022, DPP BHS exhibited higher PPAs in STAR and STAR Kids managed care programs compared to other DPPs. Both of these actual to expected ratios were higher than in other DPPs. However, CY 2022 rates have slightly improved compared to CY 2021 numbers.
- STAR+PLUS clients seen by DPP BHS providers were admitted to the hospital for preventable conditions less often compared to CY 2021.
- In CY 2022, RAPPS data shows decline in the actual number of admissions and the number of Medicaid clients with PPA admissions compared to CY 2021.

[8] 3M™ Population-focused Preventables (PFP) Classification System Methodology Overview: https://apps.3mhis.com/docs/Groupers/PFP/methodology_overview/grp305_pfp_v2.2_meth_overview.pdf

Potentially Preventable ED Visits

Potentially Preventable ED Visits (PPVs) are emergency department visits for conditions that could otherwise be treated by a care provider in a non-emergency setting. PPVs may also result from a lack of adequate care or inadequate ambulatory care coordination, such as lack of access to urgent care facilities or limited availability of primary care physicians. Like PPAs, PPVs include visits that adequate patient monitoring and treatment like medication management should be able to reduce or eliminate.

The EQRO tracks a PPV population rate for TIPPS, DPP BHS, and RAPPS.

- During CY 2022, Medicaid clients seen by TIPPS, DPP BHS, and RAPPS providers visited the ED for preventable conditions more often than expected when compared to other Medicaid clients. See **Appendix B Figure 2** for specific rates.
- In CY 2022, PPV rates improved across all managed care programs including STAR, STAR+PLUS, and STAR Kids in DPP BHS and RAPPS compared to CY 2021, however, even after improvement, PPV rates were higher than expected.
- In CY 2022, TIPPS experienced improvement in STAR and STAR Kids compared to CY 2021, with actual PPV rates remaining higher than expected.

Potentially Preventable Complications

The EQRO tracks a Potentially Preventable Complications (PPC) population rate for the CHIRP program, stratified by STAR and STAR+PLUS programs. PPCs measure complications that arise during an inpatient stay because of improper care or treatment and do not represent the progression of the underlying disease. CHIRP PPC rates based on total at-risk admissions with one or more PPC for the STAR and STAR+PLUS programs were relatively similar in CY2022 in comparison to CY2021. There were slight improvements in STAR+PLUS program in CY2022.

Potentially Preventable Readmissions

The EQRO also tracks Potentially Preventable Readmissions (PPR) population rate for the CHIRP program, stratified by STAR and STAR+PLUS programs. PPRs measure potentially avoidable readmissions to the hospital within 30 days that are clinically related to the initial hospital admission.

- CY 2022 PPR rates for STAR +PLUS have improved compared to a previous year. The rate decreased to 15.05 percent compare to 15.43 percent in CY 2021. Rates for the CHIRP STAR rates have remained unchanged.

Behavioral Health Measures

Program population rates were determined for the following measures for TIPPS, DPP BHS, and RAPPS, stratified by managed care program.

- Antidepressant Medication Management Age 18+ (AMM)
- Follow-Up After Emergency Department Visit for Mental Illness Age 6+ (FUM)
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment Age 13+ (IET)

The program population rates were **better than** the statewide rate for a given managed care program for **most** of the identified population measures. However, comparison of the rates between the years shows that the program population rates decreased for 40 percent of the tracked rates. STAR program rates for Engagement of Alcohol and Other Drug Abuse or Dependence Treatment Age 13+ have decreased in CY 2022 in all three DPPs compared to CY2021. However, Initiation of Alcohol and Other Drug Abuse or Dependence Treatment Age 13+ increased for all programs in CY 2022 compared to CY 2021. STAR +PLUS rates for Antidepressant Medication Management Age 18+ (acute phase only) have decreased between two years across three DPPs. For the Follow-Up After Emergency Department Visit for Mental Illness Age 6+ (30 day and 7 day) the rates increased in CY 2022 compared to 2021 for TIPPS, stayed about the same for DPP BHS, and decreased for RAPPS in all programs except for STAR.

The program population rates were worse than the statewide rate for some measures and populations, including IET measure (primarily Engagement portion of the measure) in TIPPS where performance is below the statewide rate in SFY 2022 and is lower than in SFY 2021.

Half of RAPPS population rates were lower than the statewide rates in CY 2022. The number of rates that were lower than the statewide rates increased compare against CY 2021. FUM rates for STAR Kids population had the highest decrease in comparison to the statewide rates since CY 2021, as shown in **Appendix B Figures 3 – 8.**

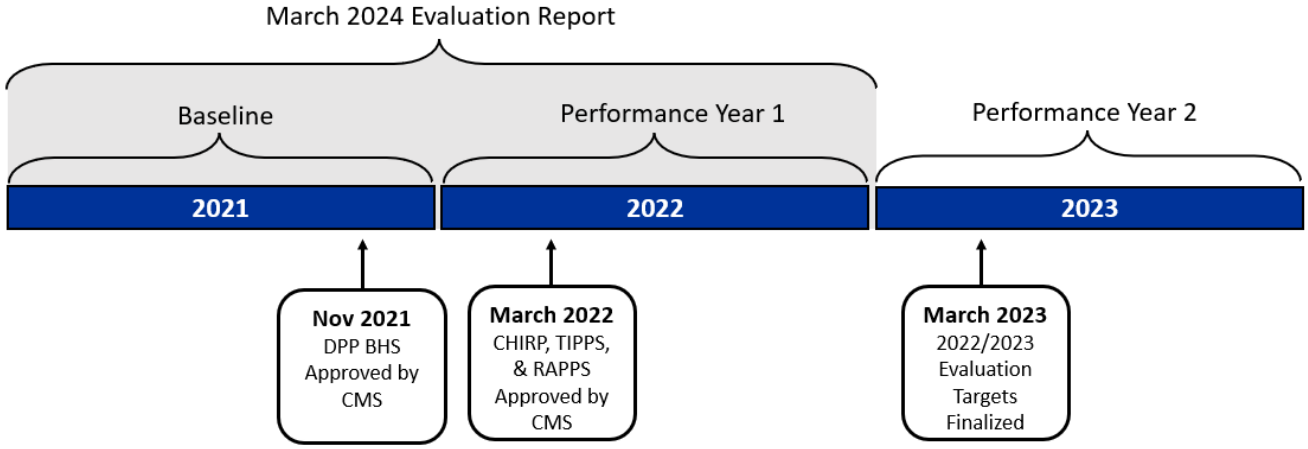
Provider Performance

This evaluation includes two full years of provider reported process and outcome measure data and three years of structure measure data. This data is a preliminary look at how well providers are or are not meeting the quality goals and objectives of the programs as well as changes in their capacity to deliver high value care.

The evaluation uses CY 2021 as the baseline year for process and outcome measures. DPP BHS was approved by CMS in November 2021 and CHIRP, TIPPS and RAPPS were approved by CMS in March of 2022, as shown in **Figure 2**. This evaluation does not reflect a full year of program implementation.

Additionally, evaluation targets for process and outcome measures were set in March 2023. Due to delays in program approvals and lags in claims data and reporting needed to establish baselines, these targets apply to both 2022 and 2023. This gives providers part of 2022 and all of 2023 to demonstrate improvement. This evaluation only includes data for 2022. Data for 2023 will be included in the SFY2024 evaluation.

Figure 2: Process and Outcome Measures Evaluation Data Timeline



Trends in process and outcome measures

Trends were identified by limiting data that are reported consistently across program years (i.e., for measures reporting Medicaid Managed Care, limiting year 1 data to reporting by Medicaid managed care). Measure-specific performance details for all provider-reported measures with evaluation targets are summarized in **Appendix C**.

Fifteen of the 24 provider-reported program-specific measures with evaluation targets showed an improvement in the median performance rate between 2021 and 2022, while one showed no change and eight showed a decline. Seven measures met the 2022 evaluation target, although the targets were set retroactively and do not reflect a full year of program implementation.

Figure 3: Provider Reported Evaluation Measure Trends 2021 - 2022

Three of the measures that saw declines in performance from 2021 to 2022 were immunization measures (these include the TIPPS Childhood Immunization Status measure and the TIPPS and RAPPS Influenza Immunization measures). The decline in immunization measures mirrors national trends. The national average for the Childhood Immunization Status measure, for example, was 35.94% in 2021 and 31.86% in 2022. Despite this decline, TIPPS did see an improvement in the Immunizations for Adolescents measure from 2021 to 2022.

HHSC currently has two strategies underway to improve performance on DPP measures: enhanced provider education and transitioning some programs to include pay-for-performance.

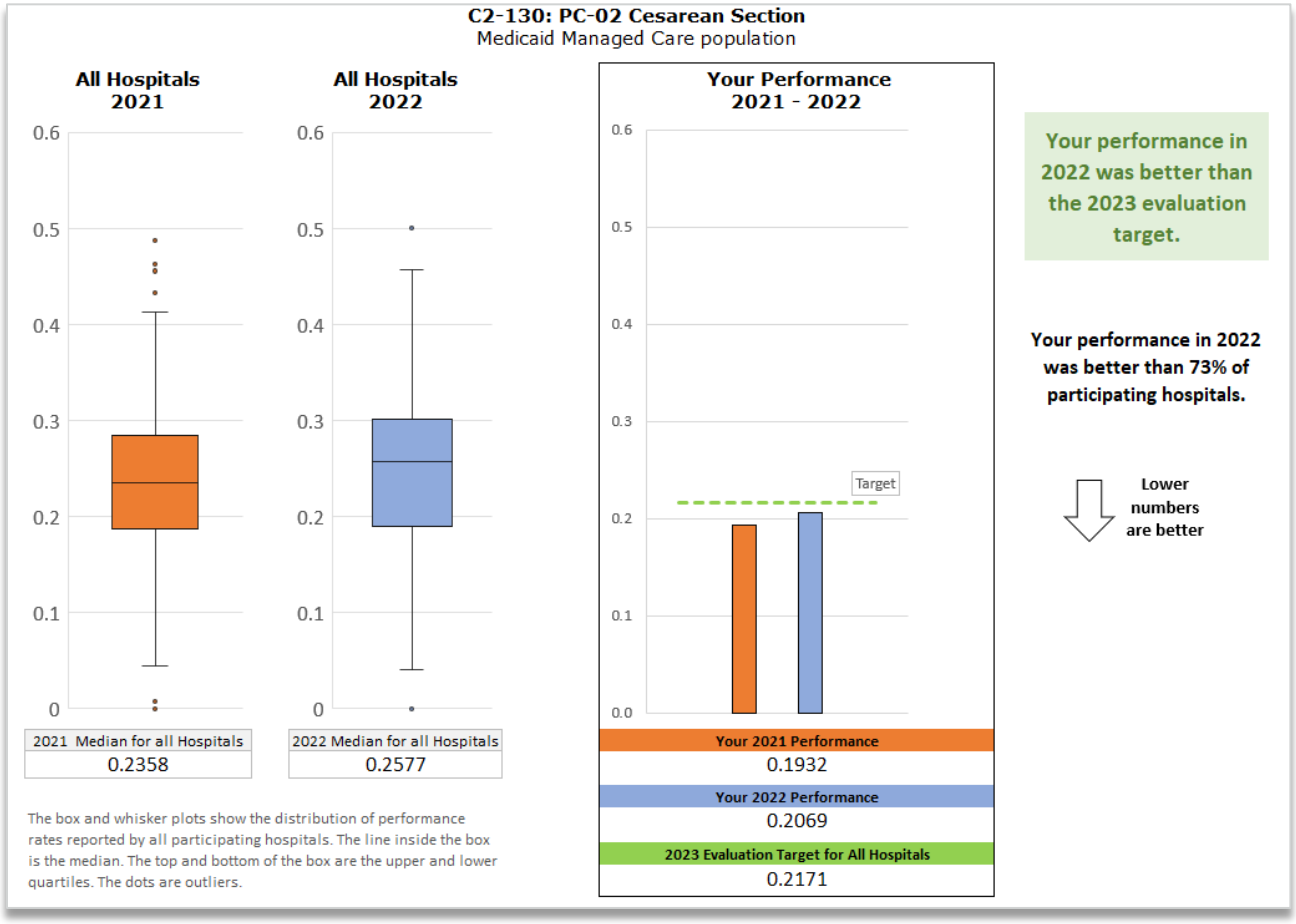
Strategy 1: Enhanced Provider Education

HHSC staff published a data visualization tool that compares each participating provider's performance to other participating providers and the evaluation target. This tool will help providers monitor their progress toward meeting the evaluation targets and help providers determine where to focus their performance improvement efforts, see **Figure 4.**

In July of 2023, HHSC staff launched a new training for participating providers, the Measure Spotlight Series. These virtual trainings provide an overview of specific measures, measure specifications, and performance to date. Providers can ask questions about the featured measures and discuss strategies for quality improvement. To date, staff has hosted nine trainings.

HHSC staff will continue to focus on additional opportunities for education and technical assistance to increase the adoption of best practices in SFY 2025.

Figure 4: Sample Data Visualization Scorecard for a CHIRP Hospital



Strategy 2: Pay-for-Performance

HHSC is proposing to shift a portion of program payment to pay-for-performance for CHIRP in SFY 2025. PC-02 Cesarean Section, one of the CHIRP measures that saw a decline in the median rate from 2021 to 2022, will become a pay-for-performance measure.

HHSC is also proposing to shift TIPPS towards pay-for-performance in SFY 2026, which would further incentivize improvements in quality performance. The TIPPS measures that will move to pay-for-performance are not yet determined. HHSC will review current performance trends and work with stakeholders in 2024 to identify measures for pay-for-performance.

Changes in structure measure adoption

Across the four DPPs, participating providers reported on the adoption of 14 structure measures in SFY 2024. The following structure measures showed the greatest improvement in the percent of providers implementing the measures:

- CHIRP: Written transition procedures that include formal MCO relationship or EDEN notification/ADT Feed for non-psychiatric patients: 19%
- DPP BHS: Provide integrated physical and behavioral health care services to children and adults with serious mental illness: 7%

Many participating providers reported that their decision to implement a structure measure was influenced by the DPP. In SFY 2024, 90 percent of DPP BHS providers report that structure measure implementation is being influenced by DPP, followed by 58 percent of TIPPS providers, 46 percent of RAPPS providers and 34 percent of CHIRP providers.

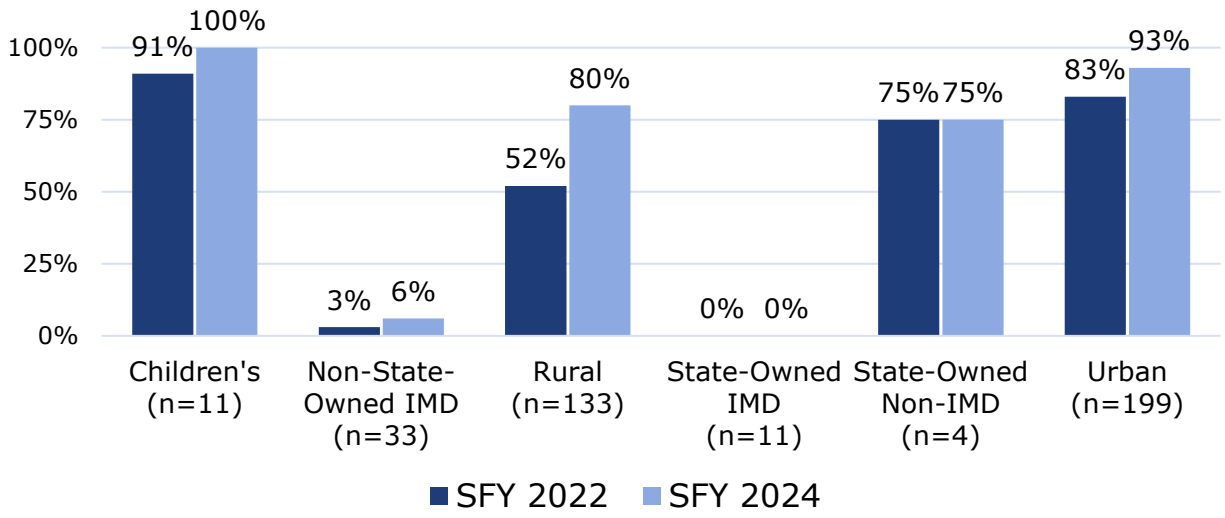
Updates on Health Information Exchange

HIE in CHIRP

There are 391 hospitals participating in CHIRP in SFY 2024. Of these 391 hospitals, 308 (79 percent) connect with an HIE or use an electronic health record (EHR) with HIE capabilities. This represents a 15-percentage point increase from SFY 2022.

Rural hospitals had the largest percentage increase in the use of HIEs or EHRs with HIE capabilities from SFY 2022 to SFY 2024 of all the classes, and children's hospitals achieved 100 percent adoption. IMDs and state-owned non-IMD hospitals did not substantially change their HIE participation.

Figure 5: Percentage of CHIRP Hospitals Participating in HIE by Class



Not all participants that connect to HIEs or use EHRs with HIE capabilities send data to HIETexas Emergency Department Encounter Notifications (EDEN) as referenced in the Texas *Health Information Technology Strategic Plan*.[9] For example, while 94 percent of urban hospitals connect to an HIE, only 34 percent sent data to HIETexas EDEN as of August 31, 2023.

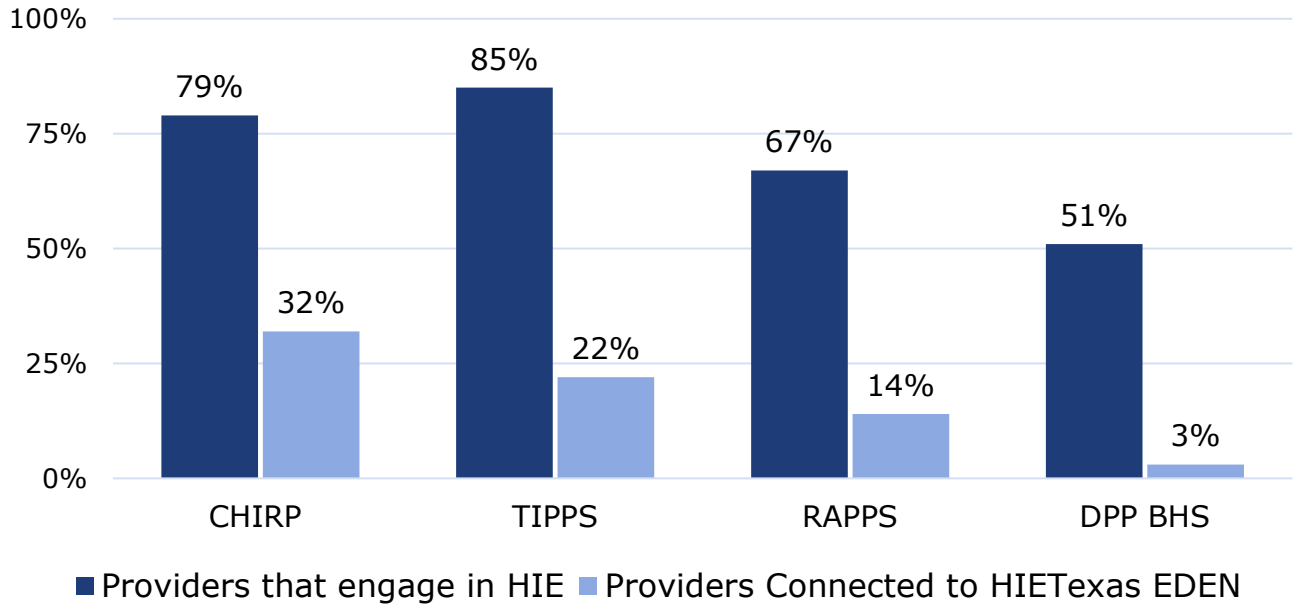
Still, the percentage of all CHIRP hospitals connected to HIEs or using EHRs with HIE capabilities that send data to HIETexas EDEN has been rising – it increased from 27 percent in SFY 2022 to 40 percent in SFY 2024. EDEN is the first step in Texas Medicaid's use of clinical data to facilitate care coordination by sending out notifications about patient's admission, discharge, and transfers from hospitals.

More hospitals indicated they had written protocols for notifying MCOs of patient transitions in SFY 2024 than they did in SFY 2022 for both psychiatric patients (10 more hospitals) and non-psychiatric patients (29 more hospitals).

HIE in TIPPS, RAPPS, & DPP BHS

Beginning in SFY 2024, all TIPPS, RAPPS and DPP BHS participants are required to report the HIE structure measure. The percentage of providers connected with an HIE or using an EHR with HIE capabilities continues to be lower in DPP BHS than the other three DPPs.

Figure 6: HIE and HIETexas EDEN in CHIRP, TIPPS, RAPPS, and DPP BHS



[9] Health IT Strategic Plan: https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/attachment-n-health-it-strategic-plan.pdfeco

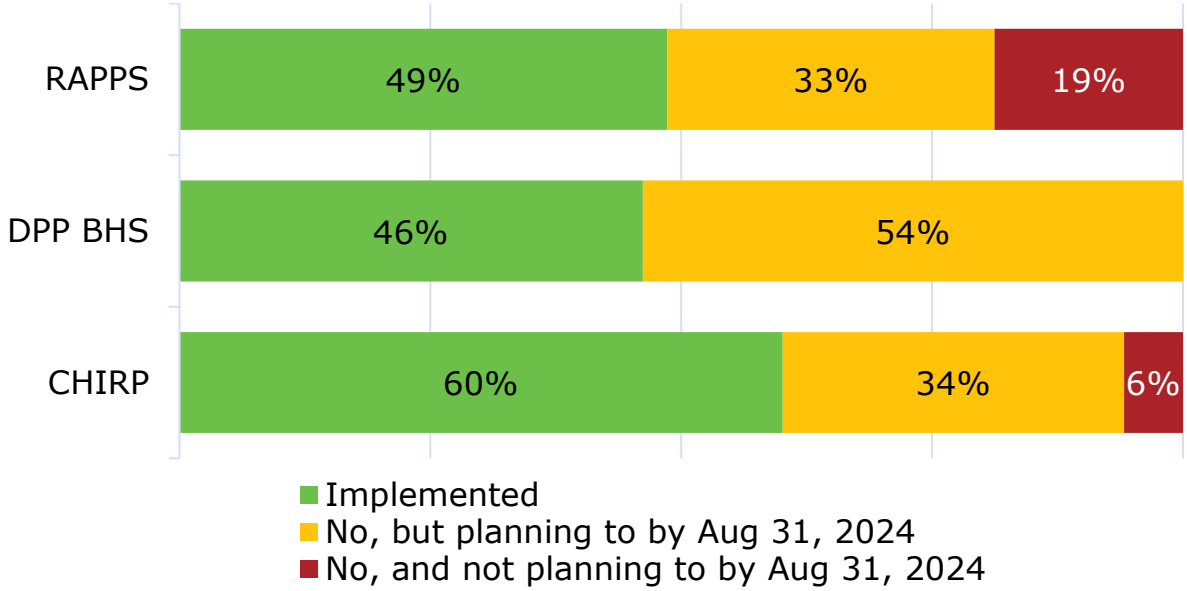
Deep dive on non-medical drivers of health (NMDOH) screening and follow-up plan best practices

Non-medical drivers of health (NMDOH) are the conditions in the place where people live, learn, work, and play that affect a wide range of health risks and outcomes.[10] In SFY 2024 CHIRP, RAPPS, and DPP BHS participating providers reported on their status of implementing any best practices related to screening and follow-up planning for non-medical needs including but not limited to food, housing, and transportation needs.

As shown in **Figure 7**, 60% (235/391) of CHIRP providers, 49% (88/181) of RAPPS providers, and 46% (18/39) of DPP BHS providers have already implemented a process in place for screening and documenting non-medical needs, and almost all DPP providers plan to have NMDOH screening practices implemented by August 31, 2024.

Even though many DPP providers have started to screen their patients for non-medical needs, there is a variation of screening and follow-up plan practices being used, such as which screening tools, types of non-medical needs, and follow-up plans and actions. Additionally, very few DPP providers stated they are sharing the NMDOH screening data with MCOs, suggesting there are opportunities for DPP providers, MCOs, and CBOs to share data and coordinate follow-up plans and delivery of services to shared clients.

Figure 7: Percentage of DPP Participating Providers that implemented NMDOH Screening Practices as of Aug 31, 2023



[10] https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/non-medical-drivers-health

Relationship Between Structure Measure Adoption and Performance

HHSC conducted a supplemental analysis of provider reporting from SFY 2023 to better understand the relationship between the implementation of structure measures and performance on process and outcome measures, using a tobit regression model as outlined in the SFY 2023 Evaluation Plan.

Across 29 tobit regression models, 11 statistically significant associations emerged between structure measures and DPP performance measures (see **Table 2**). The largest associations were found in the desired directionality for CHIRP, DPP BHS, and TIPPS providers. After controlling for provider characteristics, CHIRP providers who participated in a healthcare quality learning collaborative had lower hospital-onset Clostridium difficile infection (CDI) rates. DPP BHS providers who provided integrated physical and behavioral health care services to children and adults with serious mental illness were more likely to screen for unhealthy alcohol use and provide brief counseling, if necessary. TIPPS providers with a Patient-Centered Medical Home (PCMH) accreditation or recognition status were more likely to provide immunizations to children under two years of age and observe a response to treatment twelve months after a patient's depressive event.

In addition to the large effects reported above, medium-sized effects were found in the desired direction for all four DPPs. After controlling for provider characteristics, participation in a health information exchange integration of physical and behavioral health, having personnel in a care coordination role not requiring clinical licensure, and having a PCMH status were associated with moderate improvements in select DPP performance measures (see **Table 2**), compared to providers who did not implement these structure measures.

Lastly, one structure measure was associated with change in the non-desired direction: After controlling for provider characteristics, CHIRP providers who implemented written transition procedures had higher central line-associated bloodstream infection (CLABSI) rates. This may indicate differences in capacity or case complexity rather than a correlation between CLABSI rates and transition planning.

Notably, only one finding from Year 1 persisted into Year 2: TIPPS providers with a PCMH status were more likely to screen for depression and develop a follow-up plan, if necessary.

Collectively, these results suggest a slightly positive relationship between the structure measures and DPP performance measures. The relationship between the structure measures and DPP performance measures will continue to be explored as additional years of data become available.

Table 2: Year 2 Statistically Significant Tobit Regression Model Results

DPP	Performance Measure (Process/Outcome)	Structure Measure (Predictor)	Model Sample Size	Direction	Effect Size[1]
CHIRP	Unintentional Medical Discrepancies	HIE participation	192	Positive (negative directionality)	Medium
CHIRP	CLABSI	Written transition procedures	40	Negative (positive directionality)	Large
CHIRP	Hospital-onset CDI	Healthcare Quality Learning Collaborative Participation	112	Positive (negative directionality)	Large
DPP BHS	Unhealthy Alcohol Use: Screening & Brief Counseling	Integrated physical and behavioral health	40	Positive (positive directionality)	Large
DPP BHS	BMI screening	Integrated physical and behavioral health	40	Positive (positive directionality)	Medium
RAPPS	HbA1c Poor Control[2]	Personnel in care coordination role	102	Positive (negative directionality)	Medium
TIPPS	Childhood Immunization Status	PCMH Status	21	Positive (positive directionality)	Large[3]
TIPPS	Depression screening	PCMH Status	22	Positive (positive directionality)	Medium[3]
TIPPS	Tobacco Use and Help with Quitting Among Adolescents	PCMH Status	22	Positive (positive directionality)	Medium[3]
TIPPS	Food Insecurity Screening[4]	PCMH Status	22	Positive (positive directionality)	Medium[3]
TIPPS	Depression Response at Twelve Months[4]	PCMH Status	21	Positive (positive directionality)	Large[3]

Notes. [1] Effect sizes were calculated using Hedge's g, where $g < 0.5$ indicated a small effect, $g \geq 0.5$ and < 0.8 indicated a medium effect, and $g \geq 0.8$ indicated a large effect. [2] County type was excluded from RAPPS tobit regression models because all providers are located in rural counties. [3] Effect sizes may be unstable due to small sample sizes. [4] County type was excluded from these TIPPS tobit regression models due to low variance.

Table 2 shows only statistically significant findings from 29 tobit regressions models across the four DPPs. When feasible, models control for county type and Medicaid Managed Care volume. An upwards

arrow indicates providers who implemented the structure measure had higher rates on the respective DPP performance measure, whereas a downwards arrow indicates providers who implemented the structure measure had lower rates on the respective DPP performance measure. Green indicates the effect was in the desired direction, whereas red indicates the effect was in the non-desired direction.

Source. Year 2 Data Masters for CHIRP, DPP BHS, TIPPS, and RAPPS; Delivery System Quality and Innovation Team, Medicaid and CHIP Services, HHSC. Prepared by the Office of Data, Analytics, and Performance, HHSC.

4. Limitations

The results included in this evaluation report should be interpreted alongside the following limitations and considerations.

Delayed program approval

While the evaluation uses CY 2021 as the baseline year, DPP BHS was approved by CMS in November 2021 and CHIRP, TIPPS and RAPPS were approved by CMS in March of 2022. This evaluation only includes process and outcome measure data for 2022, which does not reflect a full year of program implementation. Program participants may not have engaged in quality improvement activities related to the payment arrangement until the program was approved.

Challenges with provider reported data

Because Medicaid clients may be seen by multiple providers and settings, and program participants are reporting data based on their own claims systems and electronic health records, provider reported rates reflect a limited picture of the health of clients.

Further, the complexity of measures specifications and administrative burden of reconciling documentation of processes and procedures with measure specifications is a challenge for many participants. As measures are reported over multiple years and participants refine their data systems, HHSC expects the accuracy of the data to improve. During the first year of reporting, participants without systems in place to stratify data by Medicaid-managed care were allowed to stratify instead by Medicaid (inclusive of Medicaid-managed care and Medicaid fee-for-service). Many participants had challenges isolating the Medicaid managed care population in their electronic health record. For measures with Medicaid managed care payer type reporting, all providers were required to report Medicaid managed care in year 2 (CY 2021). However, the lack of available Medicaid managed care data for some providers in Year 1 (CY 2022) meant that performance trends were limited to providers that were able to report Medicaid managed care in Year 1.

Additionally, HHSC staff review provider-reported measures to ensure compliance with program requirements and identify potential data quality concerns like outliers or missing values. However, provider-reported data are not audited and the accuracy of reported data cannot be verified by HHSC. Because of these limitations on provider reporting, improvements in provider-reported rates do not necessarily indicate improvements in health outcomes or the quality of care available to Medicaid clients; rather improvement could indicate advances in data collection and reporting, changes in case mix of a given provider, or other factors outside of a provider's control.

Alignment of measurement year and rating period

The DPP's program year and the evaluation measurement period operate on overlapping timeframes. For example, the first program implementation year of the DPPs is state fiscal year 2022 (September 1, 2021 - August 31, 2022), while the first evaluation measurement period is the calendar year 2021 (January 1, 2021 - December 31, 2021). Similarly, the second program implementation year of the DPPs is state fiscal year 2023 (September 1, 2022 - August 31, 2023), while the second evaluation measurement period is the calendar year 2022 (January 1, 2022 - December 31, 2022). In other words, while the programs operate on state fiscal years, the evaluations use a measurement period of January 1 through December 31, to align with measurement timeframes used by the participating providers and the EQRO, who are the data sources for the evaluation measures.

Impacts of the COVID-19 Public Health Emergency

The DPPs were implemented amidst the ongoing uncertainty of the COVID-19 federal public health emergency (PHE). Beginning in March 2020, the PHE 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. The PHE expired in May 2023, and the short and long-term effects of the PHE on the health care delivery systems are still unknown. Within the appropriate context of the PHE, this evaluation report presents as pertinent results as possible.

Changes in program enrollment and reporting requirements

The DPPs all have an annual approval, and the participating population is subject to change year over year. This impacts the evaluation's ability to track changes year over year.

Causal relationships

Lastly, the final baseline results included in this evaluation report do not determine any causal relationships between the DPPs and the evaluation measures, only associations between the impact of the DPPs and the evaluation measures.

Despite these limitations, this evaluation report presents an indication of provider performance during the first two and a half years of the DPPs.

5. Conclusion

This report satisfies the requirement that each DPP must be evaluated to measure the degree to which the payment arrangement advances the goals of the Texas Managed Care Quality Strategy. While trends in performance are preliminary, this evaluation shows that two-thirds of the process and outcome measures with evaluation targets showed improved performance in 2022 and the state is effectively furthering the goals and objectives of the quality strategy.

Appendix A: List of Acronyms

Acronym	Full Name
ACIA	Average Commercial Incentive Award
ADT	Admission, Discharge, Transfer
AIM	Alliance for Innovation on Mental Health
AMA-PCPI	American Medical Association Physician Consortium for Performance Improvement
AMB-CH	Ambulatory Care: Emergency Department Visits
AMM	Antidepressant Medication Management
BMI	Body Mass Index
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CAUTI	Catheter-Associated Urinary Tract Infection
CBP	Controlling High Blood Pressure
CCBHC	Certified Community Behavioral Health Clinic
CDC	Centers for Disease Control and Prevention
CDI	Clostridium Difficile Infection
CHIP	Children's Health Insurance Program
CHIRP	Comprehensive Hospital Increased Reimbursement Program
CHL	Chlamydia Screening in Women
CHSPS	Children's Hospitals' Solutions for Patient Safety
CIS	Childhood Immunization Status
CLASBI	Central Line Associated Bloodstream Infection
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
DPPs	Directed Payment Programs
DPP BHS	Directed Payment Program for Behavioral Health Services

DSRIP	Delivery System Reform Incentive Payment
DTA	Descriptive Trend Analysis
ED	Emergency Department
EDEN	Emergency Department Encounter Notification
EHR	Electronic Health Record
EQRO	External Quality Review Organization
FUM	Follow-up after Mental Illness
HbA1c	Hemoglobin A1c
HIE	Health Information Exchange
HEDIS	Healthcare Effectiveness Data and Information Set
HHSC	Texas Health and Human Services Commission
HRI	Health-Related Institution
IET	Initiation and Engagement of Alcohol and other Drug Abuse or Dependence Treatment
IMA	Immunizations for Adolescents
IMD	Institutions of Mental Disease
IME	Indirect Medical Education
MCO	Managed Care Organization
MDD	Major Depressive Disorder
MMC	Medicaid Managed Care
NA	Not Applicable
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
PCMH	Patient-Centered Medical Home
PCPI	Physician Consortium for Performance Improvement Foundation
PHE	Public Health Emergency
PPA	Potentially Preventable Admissions
PPC	Potentially Preventable Complications
PPR	Potentially Preventable Readmissions

PPV	Potentially Preventable Emergency Department Visits
RAPPS	Rural Access to Primary and Preventive Services Program
RHC	Rural Health Clinic
SDA	Service Delivery Area
SFY	State Fiscal Year
SMM	Severe Maternal Morbidity
SSI	Surgical Site Infection
STAR	State of Texas Access Reform
TIPPS	Texas Incentives for Physicians and Professional Services
UHRIP	Uniform Hospital Rate Increase Program

Appendix B: Population Data

Figure 1: How does the rate of potentially preventable admissions (PPAs) for a program population compare to the expected rate of PPAs in CY 2021 and 2022?

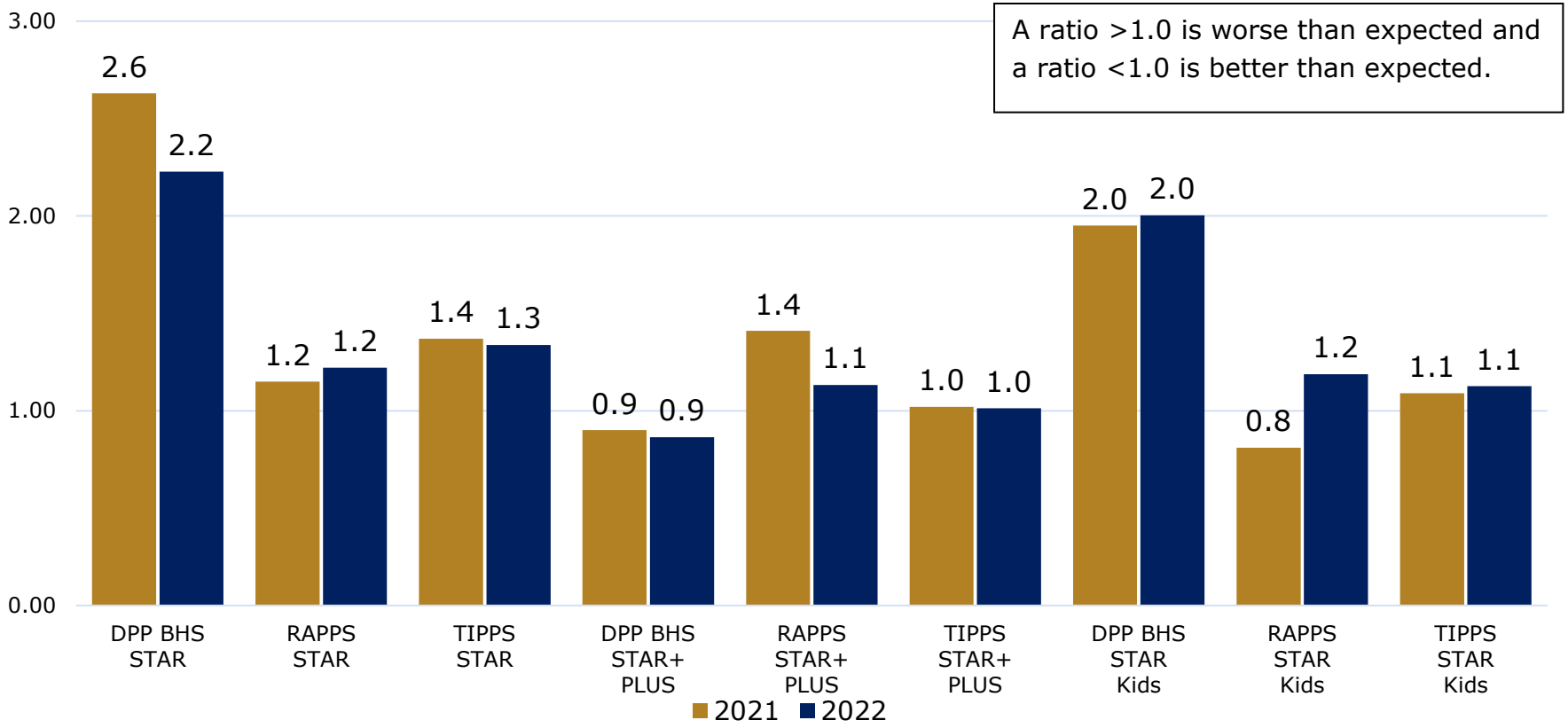


Figure 2: How does the actual rate of potentially preventable ED visits (PPVs) for a program population compare to the expected rate of PPVs in CY 2021 and 2022?

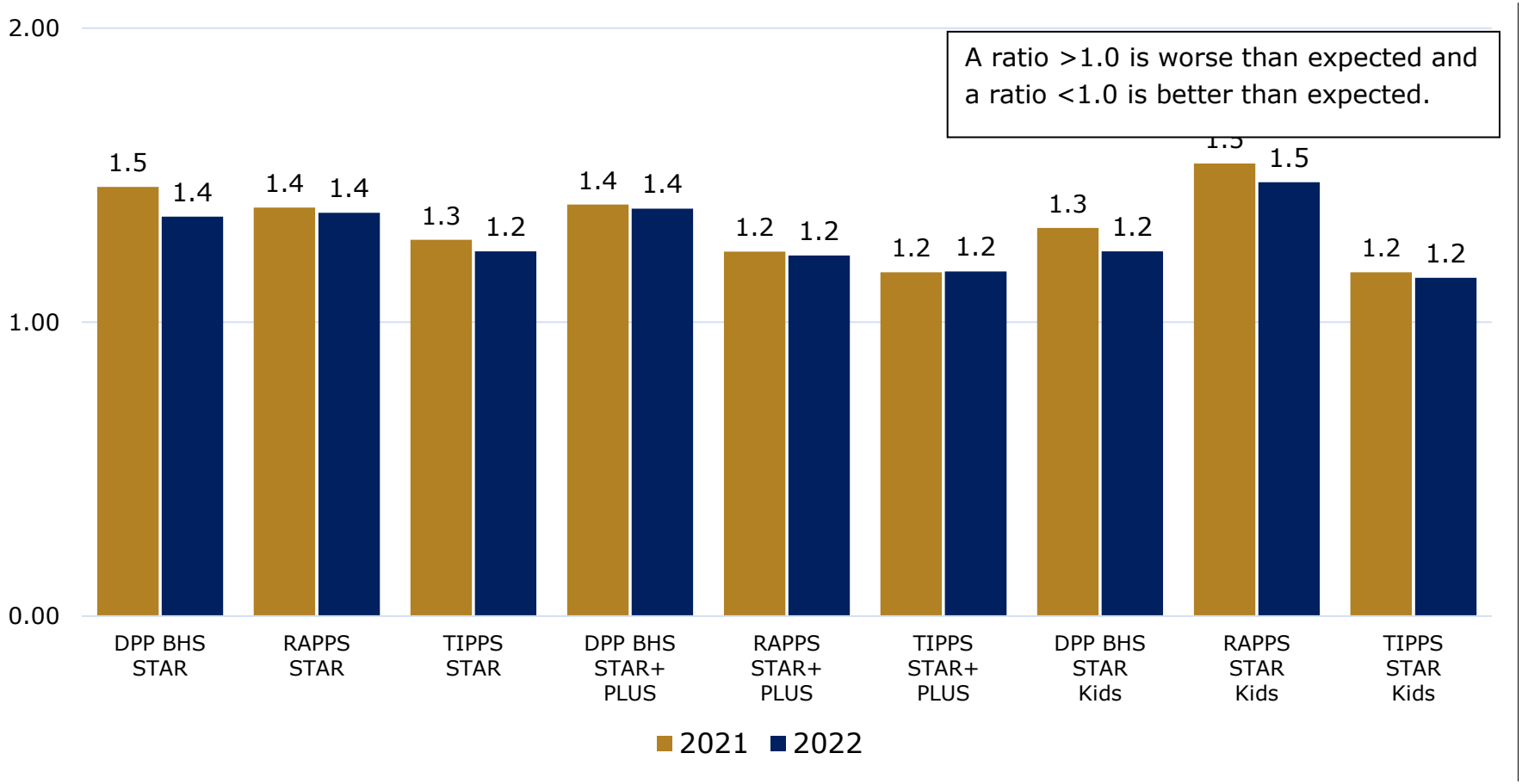


Figure 3: How do TIPPS program population rates compare to statewide Medicaid performance in CY 2021 and 2022?[11]

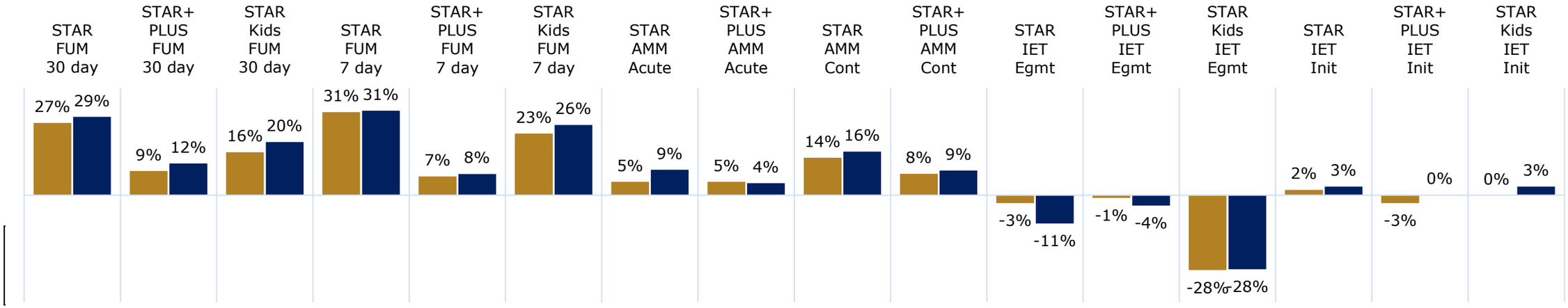
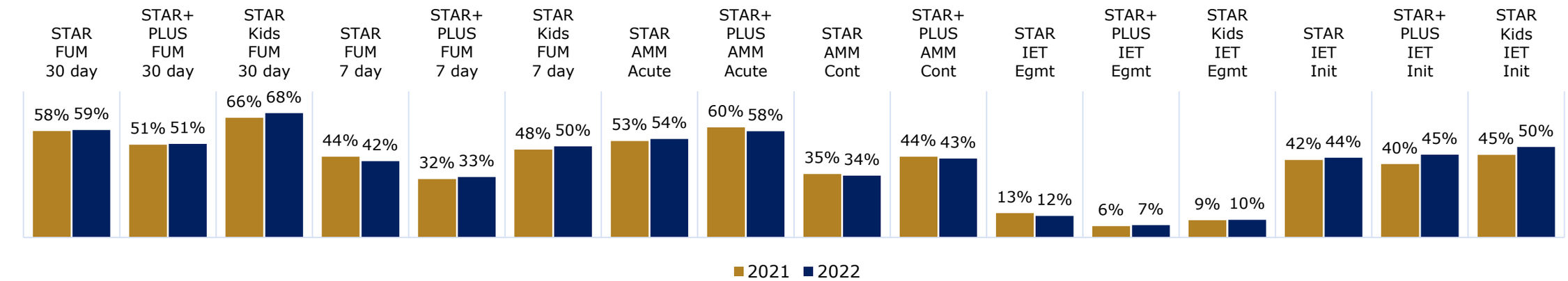


Figure 4: TIPPS program population rates CY2021 - 2022



[11]FUM: Follow-Up After Emergency Department Visit for Mental Illness Age 6+ (7 Day, 30 Day)
AMM: Antidepressant Medication Management Age 18+ (Acute Phase, Continuation Phase)
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment Age 13+ (Initiation, Engagement

Figure 5: How do DPP BHS program population rates compare to statewide Medicaid performance in CY 2021 and 2022?[12]

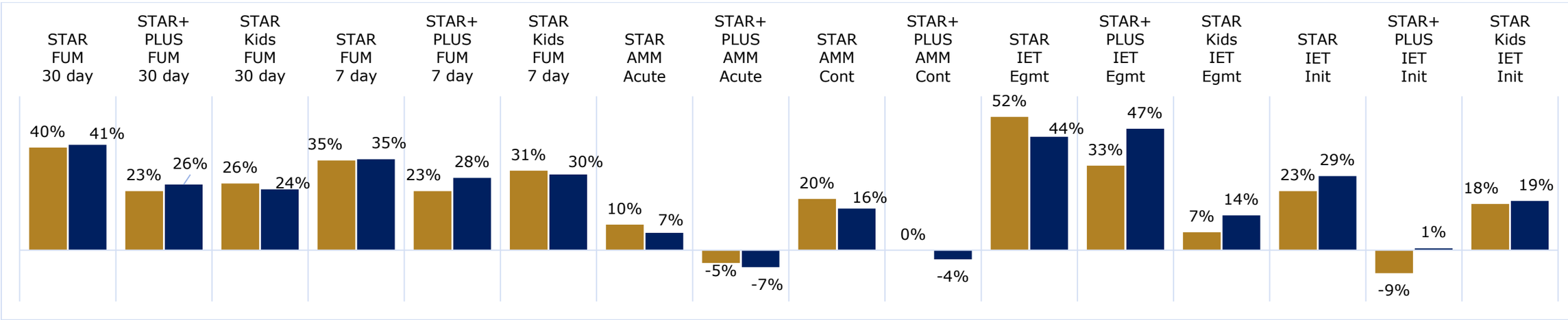
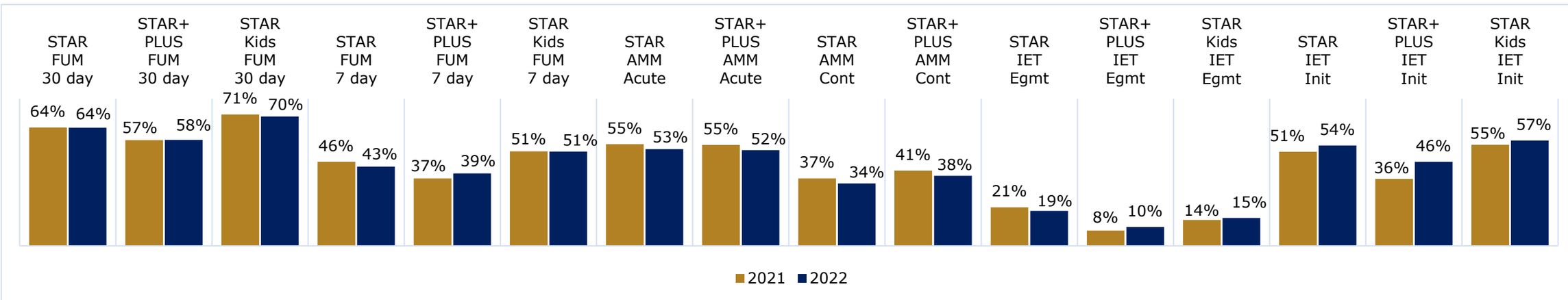


Figure 6: DPP BHS program population rates CY2021 - 2022



[12] FUM: Follow-Up After Emergency Department Visit for Mental Illness Age 6+ (7 Day, 30 Day)
AMM: Antidepressant Medication Management Age 18+ (Acute Phase, Continuation Phase)
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment Age 13+ (Initiation, Engagement

Figure 7: How do RAPPS program population rates compare to statewide Medicaid performance in CY 2021 and 2022?[13]

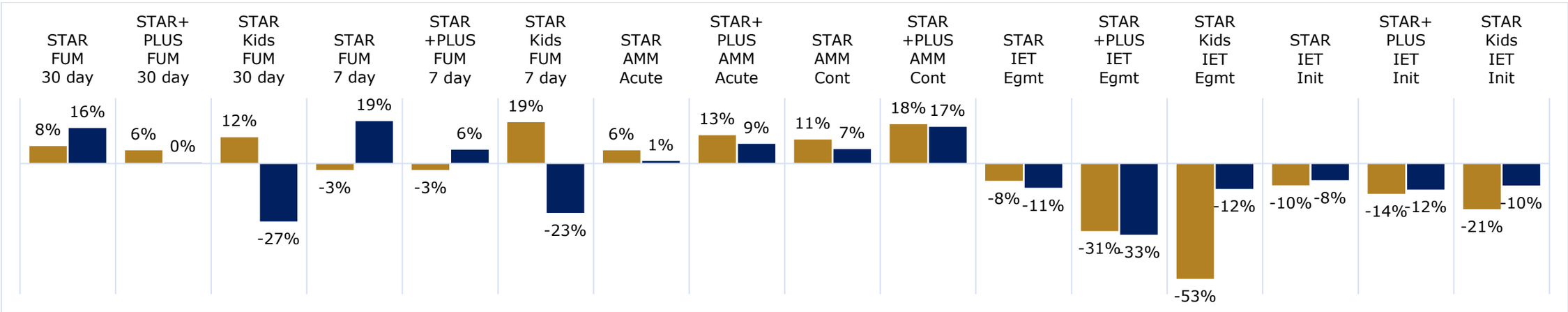
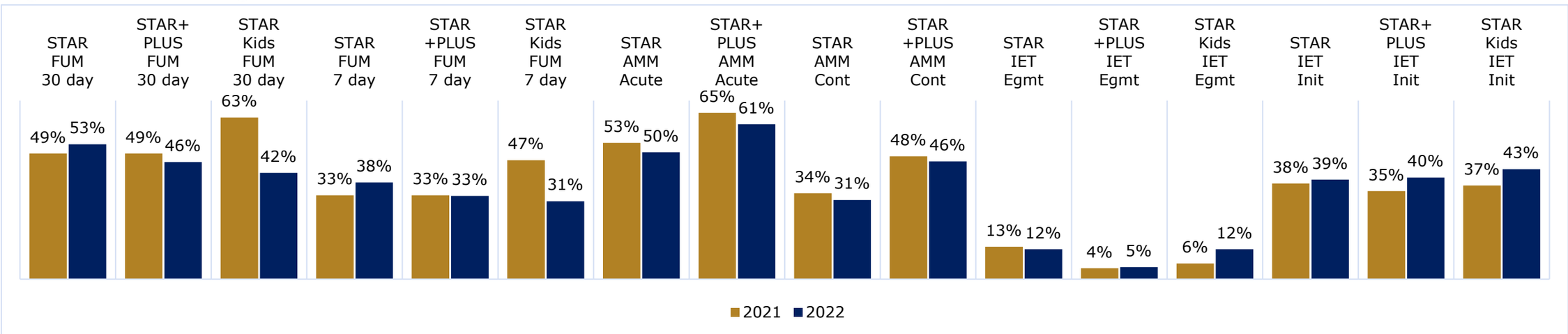


Figure 8: RAPPS program population rates CY2021 - 2022



[13] FUM: Follow-Up After Emergency Department Visit for Mental Illness Age 6+ (7 Day, 30 Day)
AMM: Antidepressant Medication Management Age 18+ (Acute Phase, Continuation Phase)
IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment Age 13+ (Initiation, Engagement)

Appendix C: Provider-Reported Performance Data by Quality Strategy Goal

Table 1: Optimal Health Quality Strategy Goal

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?

Measure Name	DPP	Median Rate CY2021[14]	Median Rate CY2022[15]	% of Providers that Improved [16]	CY2022 and CY2023 Evaluation Target[17] (green if met in CY2022)
Tobacco Screening & Cessation Intervention (Rural)	CHIRP	44.40%	64.47%	57%	34.55%
Tobacco Screening & Cessation Intervention	TIPPS	83.36%	84.96%	37%	89.11%
Tobacco Use and Help with Quitting Among Adolescents	TIPPS	74.15%	73.39%	31%	75.48%
Influenza Immunization	TIPPS	35.85%	31.14%	37%	40.81%
Influenza Immunization	RAPPS	19.25%	15.84%	43%	24.30%
Childhood Immunization Status	TIPPS	22.17%	15.13%	47%	28.95%
Immunizations for Adolescents	TIPPS	35.20%	39.02%	57%	41.12%
Food Insecurity Screening	TIPPS	0.00%	3.21%	82%	10.00%

[14] Providers with no Medicaid volume are excluded from the calculation of baseline rate.

[15] Median rates that got better are in green. Median rates that got worse are in red. Median rates for 2021 and 2022 may include a different mix of providers.

[16] The percent of providers that reported a measure with consistent payer-type that had better performance in 2022 compared to 2021.

[17] CY2022 and CY2023 evaluation targets are the same due to timing of available data for the SFY2023 and SFY2024 Evaluation Plans. These targets were based on CY2021 medians limited to providers who stratified by Medicaid Managed Care.

Table 2: Free from Harm Quality Strategy Goal

Did the DPPs keep patients free from harm by building a safer healthcare system that limits human error?

Measure Name	DPP	Median Rate 2021 (Baseline Year)[18]	Median Rate 2022[19]	% of Providers that Improved in 2022[20]	CY2022 and CY2023 Evaluation Target[21] (green if met in CY2022)
Unintentional Medication Discrepancies *	CHIRP	11.24%	10.07%	68%	10.67%
Severe Maternal Morbidity *	CHIRP	2.24%	2.42%	55%	1.88%
PC-02 Cesarean Section *	CHIRP	23.58%	25.77%	51%	21.71%
Catheter-Associated Urinary Tract Infection (CAUTI) *	CHIRP	0.5939	0.4276	73%	0.5642
Central Line Associated Bloodstream Infection (CLABSI)	CHIRP	0.8663	0.5898	77%	0.8230
Pediatric CLABSI per 1000 *	CHIRP	0.1300	0.1200	50%	0.1200
Pediatric CAUTI per 1000 *	CHIRP	0.0000	0.0500	70%	0.0000

[18] Providers with no Medicaid volume are excluded from the calculation of baseline rate.

[19] Median rates that got better are in green. Median rates that got worse are in red. Median rates for 2021 and 2022 may include a different mix of providers.

[20] The percent of providers that reported a measure with consistent payer-type that had better performance in 2022 compared to 2021.

[21] CY2022 and CY2023 evaluation targets are the same due to timing of available data for the SFY2023 and SFY2024 Evaluation Plans. These targets were based on CY2021 medians limited to providers who stratified by Medicaid Managed Care.

* Indicates that lower numbers are better.

Table 3: Effective Practices for Chronic Conditions Hypothesis Quality Strategy Goal

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?

Measure Name	DPP	Median Rate 2021 (Baseline Year)[22]	Median Rate 2022[23]	% of Providers that Improved in 2022[24]	CY2022 and CY2023 Evaluation Target[25] (green if met in CY2022)
Controlling High Blood Pressure	TIPPS	57.81%	66.03%	62%	58.90%
Hemoglobin A1c Poor Control >9% *	TIPPS	38.17%	36.66%	60%	39.90%
Depression Screening and Follow-Up Plan	TIPPS	40.62%	42.61%	62%	46.68%
Depression Response at Twelve Months	TIPPS	5.35%	10.56%	76%	10.59%
Unhealthy Alcohol Use: Screening and Brief Counseling	DPP BHS	75.00%	75.34%	59%	82.44%
Child and Adolescent Suicide Risk Assessment	DPP BHS	73.33%	63.76%	59%	79.82%
Adult Suicide Risk Assessment	DPP BHS	74.49%	86.63%	56%	87.14%
Follow-Up After Hospitalization for Mental Illness 7-Day	DPP BHS	75.00%	75.00%	55%	85.71%
Follow-Up After Hospitalization for Mental Illness 30-Day	DPP BHS	88.64%	94.12%	70%	96.97%

[22] Providers with no Medicaid Managed Care volume are excluded from the calculation of baseline rate.

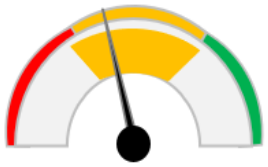
[23] Median rates that got better are in green. Median rates that got worse are in red. Median rates for 2021 and 2022 may include a different mix of providers.

[24] The percent of providers that reported a measure with consistent payer-type that had better performance in 2022 compared to 2021.

[25] CY2022 and CY2023 evaluation targets are the same due to timing of available data for the SFY2023 and SFY2024 Evaluation Plans. These targets were based on CY2021 medians limited to providers who stratified by Medicaid Managed Care.

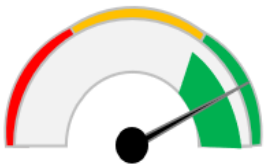
* Indicates that lower numbers are better.

Appendix D: DPP Quality Objective Scorecard – October 2023

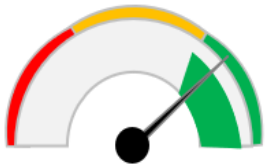


Optimal Health

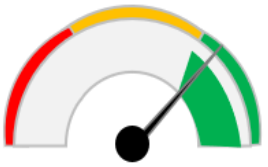
Right Care, Right Place, Right Time



Free From Harm



Chronic Conditions



Team-Based Collaborative, Coordinated Care

	Optimal Health	Right Care, Right Place, Right Time	Free From Harm	Chronic Conditions	Team-Based Collaborative, Coordinated Care
CHIRP	Tobacco Screening & Cessation	Transition Procedures Potentially Preventable Readmissions*	Unintentional Medical Discrepancies Severe Maternal Morbidity Potentially Preventable Complications* PC-02 Cesarean Birth CAUTI / CLABSI Ped. CAUTI / Ped. CLABSI AIM Collaborative Participation		HIE Participation
TIPPS	Tobacco Screening & Cessation Tobacco Use Among Adolescents Influenza Immunization Immunization for Adolescents Childhood Immunization	Potentially Preventable Admissions* Potentially Preventable ED Visits* Ambulatory Care: ED Visits*		HbA1c Poor Control (>9%) Controlling High Blood Pressure Screening for Depression & Follow-Up Depression Response at Twelve Months Antidepressant Med Management* Alcohol & Other Drug Treatment	HIE Participation
DPP BHS		Potentially Preventable Admissions* Potentially Preventable ED Visits* Ambulatory Care: ED Visits*		Mental Illness Hospitalization Follow-Up Adult Suicide Risk Assessment Child Suicide Risk Assessment Alcohol Screening & Counseling Antidepressant Med Management* Alcohol & Other Drug Treatment	HIE Participation CCBHC Certification Status
RAPPS	Influenza Immunization	Potentially Preventable Admissions* Potentially Preventable ED Visits* Ambulatory Care: ED Visits*		Antidepressant Med Management* Alcohol & Other Drug Treatment	

Structure Measures: are based on comparing implementation or planning to implement between SFY23 and SFY24.
Provider Reported and EQRO Process and Outcome Measures: are based on performance between CY2021 and CY2022.

EQRO Scoring: Scoring for EQRO reported measures is based on a combination of performance rates through STAR, STAR+PLUS and STAR kids. A scoring weight of *0.50* is applied to STAR Kids programs to account for a smaller representative size.

* indicates an EQRO Reported Measure
Green indicates the median and most providers improved
Orange indicates the median became worse, but most providers improved
Red indicates the median and most providers became worse
Gray indicates the measure is high-performing and the median rate maintained

Statewide
CAHPS Getting Care Quickly*
CAHPS Getting Needed Care*