Evaluation Plan for Four State Directed Payment Programs

State Fiscal Year 2025

As Required by 42 C.F.R. §438.6(c)

Texas Health and Human Services Commission

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1. Background

This evaluation plan[1] outlines how the Texas Health & Human Services Commission (HHSC) will evaluate the fourth year, or state fiscal year (SFY) 2025, of 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).

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.[2] 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.

CMHCs and LBHAs must be certified CCBHCs to participate in DPP BHS (for program periods beginning on or after September 1, 2024). There is one component in the DPP BHS program. Component 1 is a uniform dollar increase paid as monthly payments. Component 1 includes structure, process, and outcome measures. It requires annual submission of status updates for the structure measures and data for the process and outcome measures. The structure measures promote

[1] Question 42 of the Section 438.6(c) Preprint requires states to confirm that they have "an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be specific to this payment arrangement."
[2] Texas Medicaid medical managed care programs include State of Texas Access Reform (STAR), STAR Kids, STAR+PLUS, and STAR Health. STAR covers low-income children, pregnant women and families. STAR Kids covers children and adults 20 and younger who have disabilities. STAR+PLUS covers people who have disabilities or are age 65 or older. STAR Health covers children and adolescents in foster care or state conservatorship. https://hhs.texas.gov/services/health/medicaid-chip/

maintenance of CCBHC status such as non-medical drivers of health (NMDOH) screening, integrated physical and behavioral health services, and health information exchange (HIE) participation. The process and outcome measures are 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.

Comprehensive Hospital Increase Reimbursement Program (CHIRP)

CHIRP is a program for Texas Medicaid hospitals serving adults and children enrolled in STAR and STAR+PLUS. CHIRP allows HHSC to monitor progress on focus areas identified in the DSRIP Transition Plan[3], which include maternal health, behavioral health, patient navigation, care coordination, and care transitions, especially for patients with high costs and high utilization.

There are now three components in the CHIRP program. Component 1, known as Uniform Hospital Rate Increase Program (UHRIP), provides a uniform rate enhancement to participating CHIRP hospitals. 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. Component 3, known as Alternate Participating Hospital Reimbursement for Improving Quality Award (APHRIQA), is a new pay-for-performance (P4P) component to be included as of SFY 2025. There are six new measures in Component 3, and some Component 3 measures are already included in Component 2.

Component 1 includes a mix of structure and outcome measures applicable to all participating CHIRP hospitals. It requires annual submission of status updates for the structure measures and data for the outcome measure as a condition of participation in the program.

Component 2 is organized into modules, which are groupings of measures based on hospital provider class. 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. Modules in the ACIA Component include a mix of structure, outcome, and process measures and require annual submission of status updates for the structure measures and data for the outcome and process measures.

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

Component 3 is a newly established P4P component that includes process and outcome measures. It will require yearly submission of data for these measures. For SFY 2025, HHSC anticipates that urban and children's hospitals will be eligible to participate in Component 3. Component 3 introduces six new process and outcome measures to the CHIRP program. Component 3 also utilizes five measures that have been part of CHIRP Component 2 on a Condition of Participation basis and will now exist as part of the P4P component.

The following six hospital provider classes are eligible to participate in Components 1 and 2 of CHIRP, and only urban hospitals and children's hospitals are expected to be eligible to participate in Component 3:

- 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.

Texas Incentives for Physicians and Professional Services (TIPPS)

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

- physician groups affiliated with a health-related institution (HRI)
- 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) but have a contract with a Managed Care Organization (MCO) for delivery of Medicaid-covered benefits to the MCO's enrollees.

There are three components in the TIPPS program, and HRI and IME physician groups are eligible for Components 1-3, while other physician groups are eligible for Component 3 only.

Component 1 requires annual submission of numeric data on process and outcome measures focused on primary care and chronic care. Component 2 measures for

SFY 2024 are moved to Component 1 for SFY 2025[4]. Component 3 requires annual submission of numeric data on process and outcome measures focused on maternal health, behavioral health, and non-medical drivers of health as well as reporting on structure measures related to Health Information Exchange. 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.

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 is one component in the RAPPS program. Component 1 is a uniform dollar increase paid as prospective, monthly payments. Component 1 includes structure, process, and outcome measures. It requires annual submission of status updates for the structure measures and data for the process and outcome measures. The structure measures promote improved access to primary care and preventive services. The process and outcome measures are 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.

[4] For SFY 2025, no payments will be made under Component 2 of the TIPPS program. To allow HHSC to maintain accurate data across program years, measures associated with Component Two were, therefore, moved to Component 1 for SFY 2025.

2. 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 aims to track progress on quality goals as outlined in **Tables 1 - 6**.

The final evaluation report will include DPP-specific evaluation measures as well as statewide evaluation measures to track the programs impact over time. To isolate DPP-specific impacts over time, HHSC will conduct analyses of the provider-reported measures. Additionally, HHSC will investigate population impacts over time by analyzing measures tracked by the Texas Medicaid External Quality Review Organization (EQRO).

HHSC may conduct supplemental analyses of the implementation of structure measures.[5] This analysis will investigate associations between a provider's performance on process and outcome measures and the implementation of certain structure measures (i.e., exploring if the implementation of a structure is associated with better performance on other measures).

In the first year, provider-reported data were used to establish the baseline rates for evaluation measures that will be reported through the fourth year of the program. The evaluation will compare performance rates for certain measures against the baseline performance to test the evaluation hypotheses outlined in **Tables 2 - 6**. The evaluation will look for improvement over the course of each DPP, as described in the *Evaluation Performance Targets* section.

[5] "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. https://www.ahrq.gov/talkingquality/measures/types.html

Evaluation Hypotheses and Measures

The four DPPs were designed to help advance goals from the 2021 *Texas Managed Care Quality Strategy*.[6] The evaluation hypotheses are tied to these goals:

Table 1: Quality Strategy Goals

Quality Strategy Goal	CHIRP	TIPPS	RAPPS	DPP BHS
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	X	X	X	X
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	X	X	X	X
3. Keeping patients free from harm by building a safer healthcare system that limits human error	X			
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	X	X	X	X
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	X	X	X	X

To evaluate the extent to which the DPPs helped advance these goals, **Tables 2-6** outline the evaluation hypotheses and associated measures. Each evaluation hypothesis reflects an objective of the Quality Strategy.

[6] 2021 Texas Managed Care Quality Strategy: https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/quality-strategy

Table 2. Optimal Health Hypotheses 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?

Evaluation Hypothesis	Provider Reported Measures	EQRO Reported Measures
a. The DPPs supported the practice of healthy behaviors to yield reduced rates of tobacco use	• Tobacco Use: Screening & Cessation Intervention (TIPPS, CHIRP) • Tobacco Use and Help with Quitting Among Adolescents (TIPPS)	None
b. The DPPs improved access to routine and timely preventive and primary care	• Influenza Immunization (TIPPS, RAPPS) • Childhood Immunization Status (TIPPS) • Immunization for Adolescents (TIPPS) • IMM-2 Influenza Immunization (CHIRP)	None
c. The DPPs addressed non-medical drivers of health	• Rate of Food Insecurity Screening and Follow-up Plan (TIPPS, CHIRP) • Non-medical Drivers of Health Screening and Follow-Up Practices (CHIRP, DPP BHS, RAPPS)	None
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	• Prenatal Depression Screening and Follow-up (TIPPS)	None

Table 3. Right Care Right Place Right Time Hypotheses 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?

Evaluation Hypothesis	Provider Reported Measures	EQRO Reported Measures
a. The DPPs supported reductions in the rate of avoidable hospital admissions and readmissions	• Transition Procedures (CHIRP) • Plan All-Cause Readmission (PCR-AD) (CHIRP) • Pediatric All-Condition Readmissions (CHIRP)	• Potentially Preventable Admissions (TIPPS, RAPPS, DPP BHS) • Potentially Preventable Readmissions (CHIRP)
b. The DPPs supported reductions in the rate of avoidable emergency department visits	None	• Potentially Preventable Emergency Department Visits (TIPPS, RAPPS, DPP BHS) • Ambulatory Care: Emergency Department (ED) Visits (TIPPS, RAPPS, DPP BHS)

Table 4. Free from Harm Hypotheses Did the DPPs keep patients free from harm by building a safer healthcare system that limits human error?

Evaluation Hypothesis	Provider Reported Measures	EQRO Reported Measures
a. The DPPs supported reductions in the rate of avoidable complications or adverse healthcare events in all care settings	• Number of Unintentional Medication Discrepancies per Medication per Patient (CHIRP) • Catheter-Associated Urinary Tract Infection (CAUTI) (CHIRP) • Pediatric CAUTI (CHIRP) • Central Line-Associated Bloodstream Infection (CLABSI) (CHIRP) • Pediatric CLABSI (CHIRP) • Postoperative Sepsis Rate (CHIRP) • AIM Collaborative Participation (CHIRP) • Severe Maternal Morbidity (CHIRP) • PC-02 Cesarean Birth (CHIRP)	• Potentially Preventable Complications (CHIRP) • PPC 59 Medical and Anesthesia Obstetric Complications (CHIRP)

Table 5. Effective Practices for Chronic Conditions Hypothesis 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?

Evaluation Hypothesis	Provider Reported Measures	EQRO Reported Measures
a. The DPPs slowed the progression of chronic disease and improved management of complex conditions	• Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (TIPPS) • Controlling High Blood Pressure (TIPPS, RAPPS)	None
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 Hospitalization for Mental Illness (DPP BHS)	• Follow Up after Hospitalization for Mental Illness (CHIRP) • Follow Up after ED Visit for Mental Illness (CHIRP) • Follow Up after ED Visit for People with High-Risk Multiple Chronic Conditions (CHIRP)
c. The DPPs promoted effective medication management	None	• Antidepressant Medication Management (TIPPS, RAPPS, DPP BHS)
d. The DPPs increased prevention, identification, treatment, and management of behavioral and mental health	• Screening for Depression and Follow-Up Plan (TIPPS, CHIRP) • Depression Response at Twelve Months (TIPPS) • Depression Remission at Six Months (DPP BHS) • Suicide Risk Assessment (DPP BHS) • Depression Screening and Follow-Up Best Practices (RAPPS)	None
e. The DPPs promoted earlier identification and successful treatment of substance use disorders including opioid use disorders	• Unhealthy Alcohol Use: Screening & Brief Counseling (DPP BHS) • Safe Use of Opioids – Concurrent Prescribing (CHIRP)	• Initiation and Engagement in Alcohol and Other Drug Use or Dependence Treatment (TIPPS, RAPPS, DPP BHS)

Table 6. High-Performing Medicaid Providers Hypotheses 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?

Evaluation Hypothesis	Measures	
a. The DPPs increased the number of individuals, particularly individuals with complex medical needs, served in integrated and/or accountable care models	• CCBHC Certification Status (DPP BHS) • Integrated physical and behavioral health care for people with serious mental illness (DPP BHS)	None
b. The DPPs supported reductions in the proportion of population reporting difficulties accessing care, including through telehealth	None	• CAHPS Getting Care Quickly (statewide) • CAHPS Getting Needed Care (statewide)
c. Providers actively monitor patient outcomes and perspectives to address their needs and improve healthcare delivery	• Trauma Informed Care Training (CHIRP)	None
d. Timely and efficient exchange of health information and increased interoperability	• HIE Participation (CHIRP, TIPPS, RAPPS, DPP BHS)	None

Measurement Periods and Data Availability

The following measurement periods will be used:

- Year 1 (SFY 2022): January 1, 2021 – December 31, 2021
- Year 2 (SFY 2023): January 1, 2022 – December 31, 2022
- Year 3 (SFY 2024): January 1, 2023 – December 31, 2023
- Year 4 (SFY 2025): January 1, 2024 – December 31, 2024

Provider reported data for CY 2024 data will be available in September 2025. EQRO-reported data for CY 2024 will tentatively be available in October 2025.

Data Sources

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

Evaluation Population

Providers will report data stratified by the Medicaid managed care payer type, except for hospital safety measures that are reported at facility level. 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 evaluation measures relying on DPP provider-reported data, the unit of analysis is the participating DPP provider. For evaluation measures relying on the EQRO, the unit of analysis is the Medicaid member (rather than the participating DPP provider).

Most measures tracked by the EQRO will be isolated to the DPP population (Medicaid managed care clients with one or more encounters with a DPP provider during the measurement year). Statewide survey-based measures tracked by the EQRO cannot be isolated to the DPP population and will include those members who may not have had an encounter with a participating DPP provider during the evaluation measurement period.

DPP population data and statewide data will offer HHSC further insight into the impact of the DPPs on key 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.

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:

$$Y = \beta_0 + \beta_1 control\ variables + \beta_2 structure1 + \cdots + \beta_n structureN + \varepsilon.$$

3. Evaluation Performance Targets

Evaluation targets have been set for years two, three and four to track incremental improvement in certain provider reported process and outcome measures. Targets are set for provider reported measures that are reported uniformly across the four years of the program.

The targets are set using a formula approved by CMS for the DSRIP program.[7] While several measures showed high performance or had other data issues during the first year and were removed in SFY 2024, stakeholders supported keeping three high-performing measures because they align with priority areas. Because these high-performing measures are not likely to show improvement in future years, the targets are equal to the previous performance.

[7] Process measure targets for year four/CY2024 were set as a 10% gap closure, using the formula (CY2022 + 0.10*(1 – CY2022)). Outcome measure targets for year four/CY2024 were set as a 5% gap closure, using the formula (CY2022 + 0.05*(1 – CY2022) or (CY2022 – (0.05*CY2022) depending on if higher rates indicate better or worse outcomes. Based on experience in the DSRIP program, process measures are easier to improve in a shorter period.

Table 6. CHIRP – SFY 2025 UHRIP Targets

CHIRP UHRIP Measure	Type of Measure	Hospitals Included in Evaluation Data / Eligible Hospitals[8]	Median Rate Reported by Hospitals for SFY2023 (CY2022)	Evaluation Target for SFY2025 (CY2024)	How was the target determined?
Number of Unintentional Medication Discrepancies per Patient	Outcome	126 / 401	0.1007	0.0957	5% Gap Closure ↓

Table 7. CHIRP – SFY 2025 ACIA Targets

CHIRP ACIA Measure	Type of Measure	Hospitals Included in Evaluation Data / Eligible Hospitals	Median Rate Reported by Hospitals for SFY2023 (CY2022)	Evaluation Target for SFY2025 (CY2024)	How was the target determined?
Catheter-Associated Urinary Tract Infection	Outcome	114 /155	0.4276	0.4062	5% Gap Closure ↓
Central Line Associated Bloodstream Infection	Outcome	120 /155	0.5898	0.5603	5% Gap Closure ↓
PC-02 Cesarean Section	Outcome	127 / 128	0.2577	0.2448	5% Gap Closure ↓
Severe Maternal Morbidity	Outcome	125 / 128	0.0242	0.023	5% Gap Closure ↓
Tobacco Use: Screening & Cessation Intervention (Rural)	Process	74 / 83	0.6447	0.6625	5% Gap Closure ↑
Pediatric Catheter-Associated Urinary Tract Infection	Outcome	5 / 10	0.0005	0.0000	Maintenance ↓
Pediatric Central Line Associated Bloodstream Infection	Outcome	9 / 10	0.0012	0.0011	5% Gap Closure ↓

[8] The median rate was determined using participants that had adequate volume in year one. Participants that reported no data are excluded from the calculation of the baseline rate, even though they are eligible to report a measure.

Table 8. TIPPS Targets

TIPPS Measure	Type of Measure	Physician Groups Included in Evaluation Data / Eligible Physician Groups[9]	Median Rate Reported by Physician Groups for SFY2023 (CY2022)	Evaluation Target for SFY2025 (CY2024)	How was the target determined?
Comprehensive Diabetes Care: Hemoglobin A1c Poor Control >9%	Outcome	51 / 56	0.3666	0.3483	5% Gap Closure ↓
Depression Response at Twelve Months	Outcome	42 / 56	0.1056	0.1503	5% Gap Closure ↑
Food Insecurity Screening	Process	43 / 56	0.0321	0.0805	5% Gap Closure ↑
Childhood Immunization Status	Outcome	20 / 22	0.1513	0.1937	5% Gap Closure ↑
Controlling High Blood Pressure	Outcome	22 / 22	0.6603	0.6773	5% Gap Closure ↑
Immunizations for Adolescents	Outcome	20 / 22	0.3902	0.4207	5% Gap Closure ↑
Influenza Immunization Screening	Process	22 / 22	0.3114	0.3458	5% Gap Closure ↑
Screening for Depression and Follow-Up Plan	Process	22 / 22	0.4261	0.4548	5% Gap Closure ↑
Tobacco Use: Screening & Cessation Intervention	Process	22 / 22	0.8496	0.8571	5% Gap Closure ↑
Tobacco Use and Help with Quitting Among Adolescents	Process	22 / 22	0.7339	0.7472	5% Gap Closure ↑

[9] The median rate was determined using participants that reported a rate specific to Medicaid Managed Care and had adequate volume in year one. Participants that did not stratify by Medicaid Managed care and those with no Medicaid Managed Care volume are excluded from the calculation of the baseline rate, even though they are eligible to report a measure.

Table 9. RAPPS Targets

RAPPS Measures	Type of Measure	RHCs Included in Evaluation Data / Eligible RHCs	Median Rate Reported by RHCs for SFY2023 (CY2022)	Evaluation Target for SFY2025 (CY2024)	How was the target determined?
Preventive Care and Screening: Influenza Immunization	Process	157 / 159	0.1584	0.2005	5% Gap Closure ↑

Table 10. DPP BHS Targets

DPP BHS Measures	Type of Measure	CCBHCs Included in Evaluation Data / Eligible CCBHCs	Median Rate Reported by CCBHCs for SFY2023 (CY2022)	Evaluation Target for SFY2025 (CY2024)	How was the target determined?
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling	Process	39 / 40	0.7534	0.7657	5% Gap Closure ↑
Follow-Up After Hospitalization for Mental Illness 7-Day (discharges from state hospital)	Outcome (Intermediate)	31 / 40	0.75	0.75	Maintenance ↑
Follow-Up After Hospitalization for Mental Illness 30-Day (discharges from state hospital)	Outcome (Intermediate)	33 / 40	0.9412	0.9412	Maintenance ↑
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Process	40 / 40	0.8663	0.873	5% Gap Closure ↑
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Process	40 / 40	0.6376	0.6557	5% Gap Closure ↑

4. Anticipated Limitations

Results from the SFY2025 evaluation will need to be interpreted alongside the following anticipated limitations and considerations.

Delayed program approval

While the evaluation uses CY2021 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, which is a quarter through the second year of evaluation data. Program participants may not have engaged in quality improvement activities related to the payment arrangement until the program was approved. As such, neither the first nor second year of program data may reflect a full program year of activity.

Challenges with provider reported data

Because Medicaid clients may be seen by multiple providers and in multiple settings, and providers 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, we expect the accuracy of the data to improve. During the first year of reporting, providers 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 providers had challenges isolating the Medicaid managed care population in their electronic health record.

Additionally, HHSC staff review provider reporting to ensure compliance with program requirements and identify potential data quality concerns like outliers or missing values. However, provider reported data is 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.

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 evaluation measurement period is the 2021 CY (January 1, 2021 -December 31, 2021). In other words, the evaluation uses a calendar year measurement period 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 being 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 pertinent results as possible.

Changes in program enrollment and reporting requirements

The DPPs have an annual approval and enrollment cycle, and the participating providers are subject to change year over year. This will impact the evaluation's ability to track changes year over year.

Causal relationships

Lastly, the results of this evaluation report will 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, the SFY2025 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.

Appendix A. DPP Evaluation Measures SFY2022 – SFY2025

Measure Name	Measure Type	NQF ID	Measure Steward	Programs	Data Source	Program Years[10]	CMS Core Set '23
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Process	0104	Mathematica	DPP BHS	Provider	1 – 4	
AIM Collaborative Participation	Structure	NA	NA	CHIRP	Provider	1 – 4	
Behavioral Health Risk Assessment for Pregnant Women	Process	NA	CMS (retired)	TIPPS	Provider	1 – 2	
Care team includes personnel in a care coordination role not requiring clinical licensure	Structure	NA	NA	TIPPS RAPPS	Provider	1 – 2	
Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Outcome	0138	CDC	CHIRP	Provider	1 – 4	
Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure	Outcome	0139	CDC	CHIRP	Provider	1 – 4	
Certified Community Behavioral Health Clinic (CCBHC) Certification Status	Structure	NA	NA	DPP BHS	Provider	1 – 4	
Cervical Cancer Screening	Process	0032	NCQA	TIPPS	Provider	1 – 2	Adult
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Process	1365	Mathematica	DPP BHS	Provider	1 – 4	

[10] Year 1 (SFY 2022): January 1, 2021 – December 31, 2021
Year 2 (SFY 2023): January 1, 2022 – December 31, 2022
Year 3 (SFY 2024): January 1, 2023 – December 31, 2023
Year 4 (SFY 2025): January 1, 2024 – December 31, 2024

Measure Name	Measure Type	NQF ID	Measure Steward	Programs	Data Source	Program Years[10]	CMS Core Set '23
Childhood Immunization Status	Process	0038	NCQA	TIPPS	Provider	1 – 4	Child
Chlamydia Screening in Women	Process	0033	NCQA	TIPPS	Provider	1 – 2	Child
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Outcome	0059	NCQA	TIPPS RAPPS	Provider	1 – 4	Adult
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	Process	0057	NCQA	TIPPS	Provider	1 – 2	
Controlling High Blood Pressure	Outcome	0018	NCQA	TIPPS RAPPS	Provider	TIPPS 1 – 4/ RAPPS 3 – 4	Adult
Depression Remission at Six Months	Outcome	NA	MN Community Measurement	DPP BHS	Provider	3 – 4	
Depression Response at Twelve Months	Outcome	1885	MN Community Measurement	TIPPS	Provider	1 – 4	
Depression Screening and Follow-up Best Practices	Structure	NA	NA	RAPPS	Provider	3 – 4	
Engagement in Integrated Behavioral Health	Process	NA	Texas HHSC	CHIRP	Provider	1 – 2	
Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Outcome	1717	CDC	CHIRP	Provider	1 – 2	
Follow-Up after Hospitalization for Mental Illness 30-Day (discharges from state hospital)	Outcome (Intermediate)	0576	NCQA	DPP BHS	Provider	1 – 4	Child Adult

Measure Name	Measure Type	NQF ID	Measure Steward	Programs	Data Source	Program Years[10]	CMS Core Set '23
Follow-Up After Hospitalization for Mental Illness 7-Day (discharges from state hospital)	Outcome (Intermediate)	0576	NCQA	DPP BHS	Provider	1 – 4	Child Adult
Food Insecurity Screening	Process	NA	Texas HHSC	TIPPS	Provider	1 – 2	
Food Insecurity Screening and Follow-up Plan	Process	NA	Texas HHSC	CHIRP TIPPS	Provider	TIPPS 3 – 4 CHIRP 4	
Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	Outcome	0753	CDC	CHIRP	Provider	1 – 2	
Health Information Exchange (HIE) Participation	Structure	NA	NA	CHIRP TIPPS RAPPS DPP BHS	Provider	CHIRP 1 – 4, Others: 3 – 4	
Hospital Safety Collaborative Participation	Structure	NA	NA	CHIRP	Provider	1 – 2	
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	Structure	NA	NA	TIPPS	Provider	1 – 2	
IMM-2 Influenza Immunization	Process		The Joint Commission	CHIRP	Provider	4	
Immunization for Adolescents	Process	1407	NCQA	TIPPS	Provider	1 – 4	Child
Maternity Care: Post-Partum Follow-Up and Care Coordination	Process	NA	CMS	TIPPS	Provider	1 – 2	

Measure Name	Measure Type	NQF ID	Measure Steward	Programs	Data Source	Program Years[10]	CMS Core Set '23
Medication Reconciliation: Number of Unintentional Medication Discrepancies per Medication per Patient	Outcome	2456	HHSC (Adapted from Brigham and Women's Hospital)	CHIRP	Provider	1 – 4	
Non-Medical Drivers of Health Screening and Follow-up Plan Best Practices	Structure	NA	NA	CHIRP RAPPS DPP BHS	Provider	3 – 4	
Participate in electronic exchange of clinical data with other healthcare providers/ entities	Structure	NA	NA	DPP BHS	Provider	1 – 2	
Patient education focused on disease self-management	Structure	NA	NA	TIPPS	Provider	1 – 2	
Patient-Centered Medical Home (PCMH) Accreditation or Recognition Status	Structure	NA	NA	TIPPS	Provider	1 – 2	
PC-02 Cesarean Birth	Outcome	0471	The Joint Commission	CHIRP	Provider	1 – 4	
Pediatric Adverse Drug Events	Outcome	NA	CHSPS	CHIRP	Provider	1 – 2	
Pediatric All-Condition Readmissions	Outcome	NA	Center of Excellence for Pediatric Quality Measurement	CHIRP	Provider	4	
Pediatric CAUTI	Outcome	NA	CHSPS	CHIRP	Provider	1 – 4	
Pediatric CLABSI	Outcome	NA	CHSPS	CHIRP	Provider	1 – 4	
Pediatric SSI	Outcome	NA	CHSPS	CHIRP	Provider	1 – 2	
Plan All-Cause Readmission	Outcome	1768	NCQA	CHIRP	Provider	4	Adult
Postoperative Sepsis Rate	Outcome	NA	CMS	CHIRP	Provider	3 – 4	

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Prenatal Depression Screening and Follow-up	Outcome (Intermediate)	NA	Texas HHSC	TIPPS	Provider	3 – 4	
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process	0028	PCPI	CHIRP TIPPS	Provider	1 – 4	
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Process	0421	CMS	DPP BHS	Provider	1 – 2	
Preventive Care and Screening: Influenza Immunization	Process	0041e	NCQA	CHIRP TIPPS RAPPS	Provider	1 – 4	
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Process	0418	CMS	CHIRP TIPPS	Provider	1 – 4	Child & Adult
Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention	Process	0028e	NCQA	CHIRP TIPPS	Provider	1 – 4	
Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Process	2152	NCQA	DPP BHS	Provider	1 – 4	
Pre-visit planning and/or standing order protocols	Structure	NA	NA	TIPPS	Provider	1 – 2	
Provide integrated physical and behavioral health care services to children and adults with serious mental illness	Structure	NA	NA	DPP BHS	Provider	1 – 4	
Provide patients with services by using remote technology including audio/video, client portals and apps for the provision	Structure	NA	NA	DPP BHS	Provider	1 – 2	

Measure Name	Measure Type	NQF ID	Measure Steward	Programs	Data Source	Program Years[10]	CMS Core Set '23
of services such as telehealth, assessment collection and remote health monitoring/ screening							
Safe Use of Opioids – Concurrent Prescribing	Process	3316 e	CMS	CHIRP	Provider	4	
Same-day, walk-in, or after-hours appointments in the outpatient setting	Structure	NA	NA	TIPPS	Provider	1 – 2	
Severe Maternal Morbidity	Outcome	NA	AIM	CHIRP	Provider	1 – 4	
Telehealth to provide virtual medical appointments and/or consultations for specialty services, including both physical health and behavioral health services	Structure	NA	NA	TIPPS	Provider	1 – 2	
Telehealth to provide virtual medical appointments with a primary care or specialty care provider	Structure	NA	NA	RAPPS	Provider	1 – 2	
Tobacco Use and Help with Quitting Among Adolescents	Process	2803	NCQA	TIPPS	Provider	1 – 4	
Trauma Informed Care Training	Structure	NA	NA	CHIRP	Provider	3 – 4	
Use of electronic health record (EHR)	Structure	NA	NA	RAPPS	Provider	1 – 2	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (Weight Assessment Only)	Process	0024	NCQA	TIPPS	Provider	1 – 2	

Measure Name	Measure Type	NQF ID	Measure Steward	Programs	Data Source	Program Years[10]	CMS Core Set '23
Written transition procedures that include formal MCO relationship or EDEN notification/ ADT Feed for non-psychiatric patients	Structure	NA	NA	CHIRP	Provider	1 – 4	
Written transition procedures that include formal MCO relationship or EDEN notification/ ADT Feed for psychiatric patients	Structure	NA	NA	CHIRP	Provider	1 – 4	
Potentially Preventable Admissions (PPA)	Outcome	NA	3M	TIPPS RAPPS DPP BHS	EQRO	1 – 4	
Potentially Preventable Complications (PPC)	Outcome	NA	3M	CHIRP	EQRO	1 – 4	
Potentially Preventable Readmissions (PPR)	Outcome	NA	3M	CHIRP	EQRO	1 – 4	
Potentially Preventable ED Visits (PPV)	Outcome	NA	3M	TIPPS RAPPS DPP BHS	EQRO	1 – 4	
Getting Care Quickly	Outcome	0006	NCQA/ CAHPS	Statewide	EQRO	1 – 4	
Getting Needed Care	Outcome	0006	NCQA/ CAHPS	Statewide	EQRO	1 – 4	
Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	Outcome	NA	NCQA	TIPPS RAPPS DPP BHS	EQRO	1 – 4	Child & Adult
Antidepressant Medication Management (AMM)	Outcome	105	NCQA	TIPPS RAPPS DPP BHS	EQRO	1 – 4	Child & Adult
Follow-up after ED Visits for Mental Illness (FUM)	Outcome (Intermediate)	3489	NCQA	CHIRP	EQRO	3 – 4	Child

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Follow-up after Hospitalization for Mental Illness	Outcome (Intermediate)	0576		CHIRP	EQRO	3 – 4	Child & Adult
Follow-up after ED Visit for People with High-Risk Multiple Chronic Conditions	Outcome (Intermediate)			CHIRP	EQRO	3 – 4	
PPC 59 Medical and Anesthesia Obstetric Complications	Outcome		3M	CHIRP	EQRO	3 – 4	
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Outcome	4	NCQA	TIPPS RAPPS DPP BHS	EQRO	1 – 4	Adult

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.