

# **Evaluation of Four State Directed Payment Programs**

**State Fiscal Years**

**2022 and 2023**

---

**As Required by 42 CFR 438.6(c)**



**TEXAS**  
Health and Human  
Services

**Texas Health and Human Services**

**Commission**

**March 2023**

# Table of Contents

<b>1. Summary</b> .....	<b>3</b>
<b>2. Data Sources</b> .....	<b>5</b>
<b>3. Results</b> .....	<b>6</b>
Conditions of Participation .....	6
Population Characteristics .....	7
Performance Trends .....	9
<b>4. Limitations</b> .....	<b>17</b>
<b>5. Conclusion</b> .....	<b>19</b>
<b>List of Acronyms</b> .....	<b>20</b>
<b>Appendix A: Population Data</b> .....	<b>23</b>
<b>Appendix B: Performance Data</b> .....	<b>26</b>

# 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*<sup>1</sup>. DPPs must be evaluated annually to test whether the payment arrangement advances the goals of the Managed Care Quality Strategy.<sup>2</sup>

The hospitals, physician groups, rural health clinics, and behavioral health centers that participate in these four programs have completed the first year of quality reporting and second year activities are underway. This report includes final data from the first year of the DPPs, and preliminary data from the second year including provider-reported data and population-based data that reflects the health of the Medicaid managed care (MMC) clients.

The evaluation shows the following:

1. Participants' ability to track and report data is improving, including the ability to isolate data for MMC clients. In the first year, participants were not able to report MMC data for approximately 30% of the measures that required it.
2. Providers participating in the DPPs serve Medicaid clients with higher rates of preventable hospital admissions and emergency department visits as compared to other Medicaid clients.
3. Some measures are not a good fit for the programs because performance rates are already high during the first year, or the measures have poor alignment with the Medicaid population.

---

<sup>1</sup> [2021 Texas Managed Care Quality Strategy](#)

<sup>2</sup> Preprint Question 44.c. states Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

4. Hospitals participating in CHIRP reported a 12% increase in the adoption of Health Information Exchange between the first and second year.
5. There continue to be challenges with evaluating the impact of the payment arrangement. The evaluation results are limited by initial delays in program approval, the accuracy of the data reported by participants, the impacts of the COVID-19 pandemic, and annual changes in program enrollment.

## 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<sup>3</sup> 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 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 is available:

- Adoption of structure measures over SFY2022 and SFY2023 (as of August 31, 2021, and August 31, 2022)
- Final provider reported performance rates for SFY2022 (January – December 2021)
- Preliminary provider reported performance rates for six months of SFY2023 (January – June 2022)
- Final EQRO reported population rates for SFY 2022 (January – December 2021)

The data used in this evaluation is available as Microsoft Excel file (Attachment 1). Provider-reported data from SFY2022<sup>4</sup> is posted publicly. More information on the background and methodology can be found in the evaluation plans for SFY2022<sup>5</sup> and SFY2023<sup>6</sup>.

---

<sup>3</sup> “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](#)

<sup>4</sup> Provider-reported data is on the quality requirements site: [CHIRP](#), [TIPPS](#), [RAPPS](#), [DPP BHS](#)

<sup>5</sup> [SFY2022 Evaluation Plan for Four State Directed Payment Programs](#)

<sup>6</sup> [SFY2023 Evaluation Plan for Four State Directed Payment Programs](#)

### 3. Results

With 18 months of program data, it is too soon to fully assess the degree to which the directed payment arrangements are meeting their goals and objectives. The evaluation at this time can assess if the program is on track to meet its goals. Early data provide a picture of the technical ability of participants to report the required data, a better understanding of the Medicaid population served by each program, and how well the measures align with the provider and population needs.

#### Conditions of Participation

As a condition of participation in the 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. They 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<sup>7</sup> 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 programs, 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.

**Table 1: Participants that met the conditions of participation SFY2022**

DPP	Number of participants that enrolled in the program for SFY2022	Percent of enrolled participants that met the conditions of participation
CHIRP	418	98%
TIPPS	71	87%
RAPPS	181	94%
DPP BHS	39	100%

---

<sup>7</sup> For adult and pediatric hospital safety outcome measures, hospitals will report a rate as specified for all-payer types.

## Challenges with Medicaid managed care stratification

In the first year of the programs, participating providers whose systems could not stratify data by MMC members were allowed to stratify data by Medicaid<sup>8</sup>. Participants used the exception to not stratify by MMC for approximately 30% of performance measures where MMC stratification was required. By the second year, almost 100% of participants were able to stratify data by MMC when required. This shows the increased technical ability of provider systems to meet the reporting requirements of the DPPs.

## 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 baseline health of the population served by DPP participants. The methodology to attribute Medicaid clients to a given DPP is explained in Attachment 1.

## Potentially Preventable Admissions

Potentially Preventable Admissions (PPAs) are hospital admissions that could potentially have been dealt with in the outpatient setting. In many cases PPAs are for flare-ups of chronic conditions could have been avoided with monitoring and follow-up like medication management.<sup>9</sup> The EQRO tracks a PPA population rate for TIPPS, DPP BHS, and RAPPS.

- During the baseline measurement year (2021), most Medicaid clients seen by TIPPS, DPP BHS, and RAPPS providers were admitted to the hospital for preventable conditions **more often** than expected when compared to other Medicaid clients, with a few exceptions.
- STAR+PLUS clients seen by DPP BHS providers and STAR Kids clients seen by RAPPS providers were admitted to the hospital for preventable conditions **less often** than expected. See **Appendix A Figure 1** for specific rates.

---

<sup>8</sup> The Medicaid grouping is a combination of all Medicaid managed care programs and Medicaid fee-for-service, instead of just the Medicaid managed care programs that are included in the DPP.

<sup>9</sup> [3M™ Population-focused Preventables \(PFP\) Classification System Methodology Overview](#)

## 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, limited availability of primary care physicians, etc. 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 the baseline measurement year (CY2021), 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 A Figure 2** for specific rates.

## Potentially Preventable Complications and Readmissions

The EQRO tracks a Potentially Preventable Complications (PPC) and Potentially Preventable Readmissions (PPR) 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. PPRs measure potentially avoidable readmissions to the hospital within 30 days that are clinically related to the initial hospital admission.

- The CHIRP population represents approximately 99% of all PPC admissions in STAR and 97% in the STAR+PLUS in CY2021. CHIRP hospitals had almost 3000 admissions with a PPC in both programs with PPC expenditures of approximately \$40 million
- Like PPCs, the CHIRP population represents approximately 98% of all PPR admissions in STAR and 95% in STAR+PLUS. CHIRP hospitals had 12,750 PPRs in both programs in CY2021 with PPR expenditures of approximately \$188 million.

## 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. The program population rates were worse than the statewide rate for some measures and populations, with the RAPPS population having the worst performance when compared to the state, as shown in **Appendix A Figures 3 – 5**.

## Performance Trends

### Baseline results for provider reported measures

The first full year of provider reported data gives insight into how well the selected process and outcome measures are targeting the Medicaid managed care population in the current program design and the potential of those measures to impact the quality goals and objectives of the program.

Some measures captured a low volume of Medicaid clients. In some cases, this is because the providers need additional time to implement the documentation processes needed to capture the target population. For other measures, it indicates a potential mismatch between the intent of the measure and the population typically seen by a participant. For example, Rural Health Clinics (RHCs) participating in RAPPS had low numbers of adults with diabetes enrolled in Medicaid-managed care. While diabetes care may be important to the full population seen by these clinics, the measure is not well targeted to the needs of Medicaid clients seen in RHCs and may prove difficult to improve over time.

Additionally, some measures showed a high baseline performance, including seven structure measures that had full adoption by participants. These measures may prove difficult to improve over time.

### Preliminary trends in process and outcome measures

Since the preliminary data for process and outcome measures in the second program year provides only six months of comparison, any observed trends are inconclusive. Still, some preliminary trends were observed among quality measures where the unit of denominator measurement was a healthcare encounter (rather than an individual).

Early trends were identified by isolating key measures that are reported consistently across program years (including limiting the analysis to measures that consistently stratify reporting by Medicaid managed care) as shown in **Appendix B Tables 1 - 2**. This analysis found mixed signals of performance improvement. For example, in

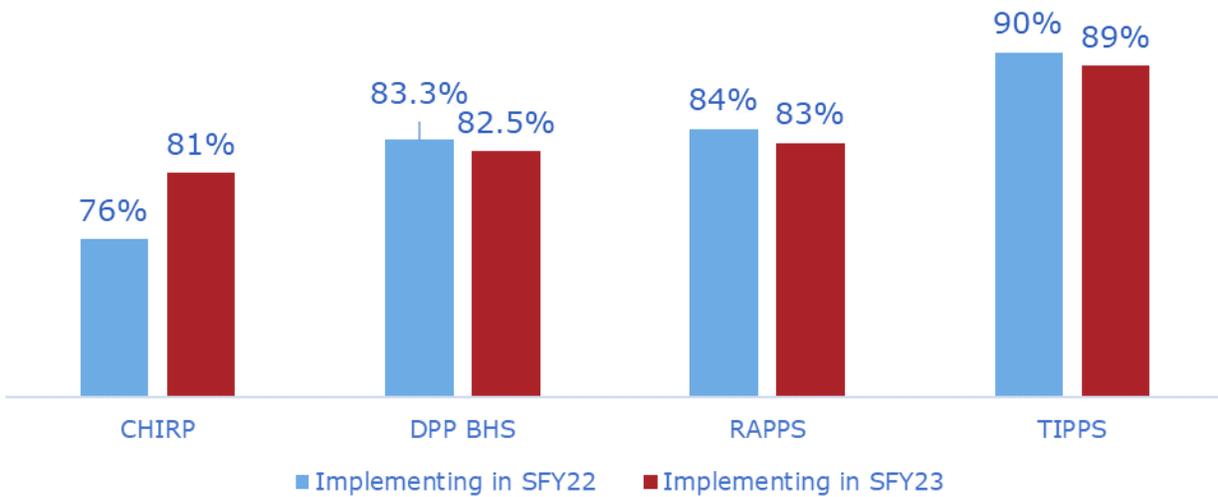
DPP BHS, preliminary trends show improved rates of adult, child, and adolescent suicide risk assessments and improved rates of 7-day follow-up after hospitalization for mental illness yet a slight decrease in rates for 30-day follow-up after hospitalization for mental illness. In CHIRP, preliminary trends show a slight decrease in the median rate of severe maternal morbidity during deliveries but an increased median rate of cesarean section deliveries. These trends should be viewed with caution as even measures tracking healthcare encounters may be subject to seasonal variation.

### **Changes in structure measure adoption**

Across the four DPPs, participating providers reported on the adoption of 22 structure measures in SFY2022 and SFY2023. Because providers are asked about their implementation status early in the program year, structure measures have two years of data for comparison at the time of this evaluation. Health Information Exchange (HIE) measures showed the highest increase in adoption and are analyzed in more detail in the subsequent section.

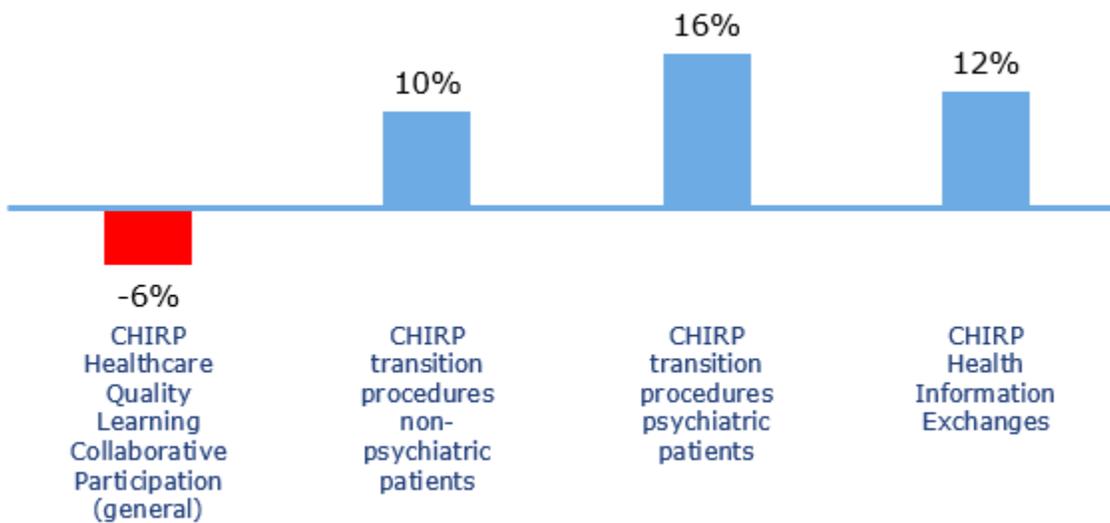
Overall, the percentage of structure measures implemented increased by 2 percent in the second year. However, this increase was largely driven by changes in CHIRP as DPP BHS, RAPPs, and TIPPS all had a slight decrease in rates of implementation due both decreased adoption and changes in enrollment. These three programs also had higher levels of implementation during their first year.

**Figure 2. Percent of Participants Implementing Structure Measures SFY22 - 23**



The following measures showed the greatest change in implementation between the first and second year.

**Figure 3. Change in the adoption rate of structure measures between SFY22 - 23**



## Impact of DPPs on structure measure implementation

Many participating providers reported that their decision to implement a structure measure was influenced by the DPP. The degree of that influence varies not only between measures but also between programs. For example, 95 percent of the behavioral health centers in DPP BHS reported being influenced by their participation in the DPP to receive a Certified Community Behavioral Health Clinic (CCBHC) certification status, with all centers reporting earning certification in the second year. In RAPPS, all Rural Health Clinics reported using an Electronic Health Record (EHR), but only 26 percent of them stated that the program had any influence on their decision.

Across all programs, the degree of influence increased slightly with participants reporting that their choice to implement structure measures was influenced by DPP participation, with the greatest degree of influence increase appearing in DPP BHS and TIPPS.

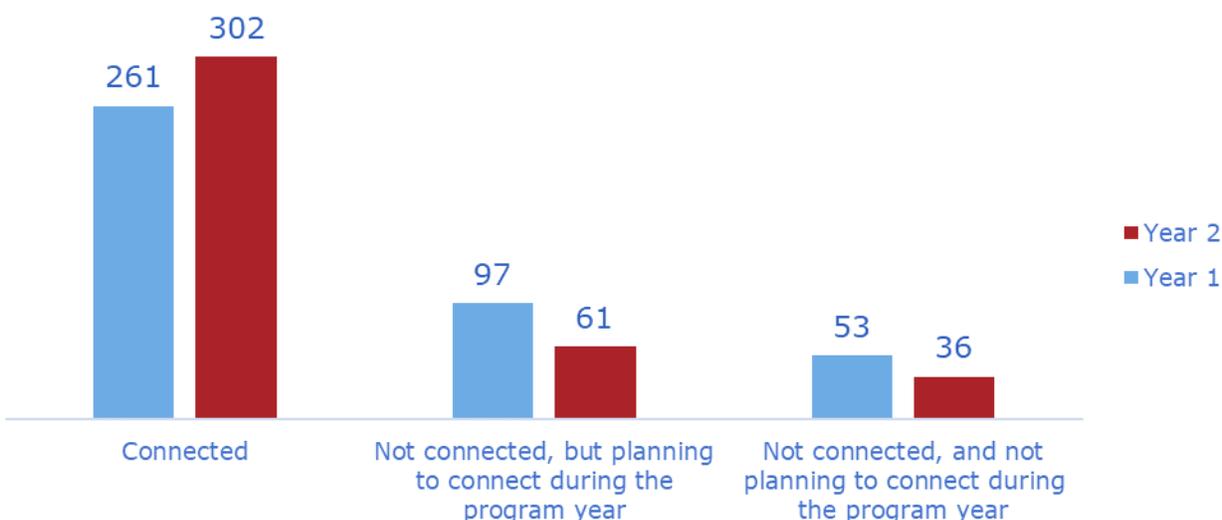
**Table 4: DPP Influence on Structure Measure Implementation SFY2023**

<b>DPP</b>	<b>Percent of Measures that are Influenced (Somewhat or Strongly) by DPPs</b>	<b>Change in degree of influence over SFY2022</b>
CHIRP	41%	2%
DPP BHS	89%	5%
RAPPS	28%	0%
TIPPS	38%	5%
Total	42%	3%

## Deep dive on Health Information Exchange and other clinical data exchange

The percentage of CHIRP hospitals connected with a public HIE or using an EHR with HIE capabilities increased 12 percentage points in the second year, from 64 percent to 76 percent. This represents an increase of 41 hospitals. Of those hospitals that progressed toward HIE adoption<sup>10</sup>, 60% (36 hospitals) said CHIRP somewhat influenced their decisions.

**Figure 5: Hospitals Connected to Public HIEs or EHRs with HIE Capabilities**



Rural hospitals had the largest percentage increase in the use of HIEs or EHRs with HIE capabilities 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.

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*.<sup>11</sup> For example, while 94 percent of urban hospitals connect to an HIE, only 37 percent sent data to HIETexas EDEN as of August 31, 2022. The percentage of all CHIRP hospitals reporting that their data is sent to HIETexas EDEN increased from 27 percent to 32 percent

<sup>10</sup> This includes those who previously said they were not planning to connect in SFY22 and indicated they were planning to connect in SFY23, and also those who said they were not connected but were planning to connect in SFY22 and changed to say they were connected in SFY23.

<sup>11</sup> [Health IT Strategic Plan](#)

between the first and second year. 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.

Of the hospitals that do not send data to HIETexas EDEN, about 60 percent say they send data via an HIE to other hospitals and non-hospital providers, but only about 20 percent say they share data with MCOs via HIEs. This indicates they either submit clinical data to MCOs via other mechanisms or do not share clinical data with MCOs. More hospitals indicated they had written transition procedures in place to notify MCOs of patient transitions in the second year for both psychiatric (12 more hospitals) and non-psychiatric patients (23 more hospitals).

HIE participation by TIPPS participants remained steady at about 90% of the physician groups that report on this measure (n=24 in SFY22 and n=22 in SFY23). Most of these participants used HIEs prior to the beginning of TIPPS and said TIPPS did not influence their decision to implement HIEs. Of those, more than two-thirds (n=17 in SFY23) do not send data to HIETexas EDEN. Almost all of these 17 physician groups do share data via an HIE with hospitals and non-hospital providers, but only 6 share data via an HIE with MCOs. Currently, only Health Related Institutions and Institutes of Medical Education reported on HIE participation. Other physicians will be asked to report on HIE participation beginning in SFY2024.

DPP BHS participants continued to have lower overall participation in electronic exchange of clinical data by any means, at roughly 50%. Some participants increased their data-sharing capabilities in the second year: four additional participants indicated they were sharing data via an HIE in a consolidated clinical document architecture (CCDA) format. Unlike CHIRP and TIPPS providers, almost all the participants that use HIEs indicated that they send data to MCOs via HIEs, more often than they send data via HIEs to hospitals and other non-hospital providers. The majority of DPP BHS participants say that the program is somewhat influencing their decisions to implement the electronic exchange of clinical data, as seen in Appendix B.

## **Relationship Between Structure Measure Adoption and Performance**

HHSC conducted a supplemental analysis of provider reporting from SFY2022 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 SFY2022 Evaluation Plan.

The model identified seven pairings of structure measure implementation and performance measures that had statistically significant associations with a medium or large effect. The largest associations between structure measures and DPP performance measures were for TIPPS. After controlling for provider characteristics, TIPPS providers with a Patient-Centered Medical Home (PCMH) accreditation or recognition status were more likely to screen for depression and develop a follow-up plan, if necessary, and more likely to provide post-partum follow-up care and coordination, as compared to providers without PCMH status.

In addition to the large effects reported above, medium-sized effects were found in the desired direction for CHIRP, DPP BHS, and TIPPS. After controlling for provider characteristics, implementation of written procedures, participation in electronic exchange of clinical data, and PCMH status were associated with moderate improvements in select DPP performance measures.

Lastly, some structure measures were associated with changes in the non-desired direction. After controlling for provider characteristics, CHIRP providers who participated in a health information exchange had higher *Clostridium difficile* infection (CDI) rates, and TIPPS providers with PCMH status were less likely to have patients whose blood pressure was adequately controlled. These non-desired relationships may further suggest that these DPP participants have more advanced resources and see more medically complex clients, rather than suggesting that the practices of HIE participation and medical homes produce worse outcomes.

**Table 6. Statistically Significant Tobit Regression Model Results**

<b>DPP</b>	<b>Performance Measure (Process/Outcome)</b>	<b>Structure Measure (Predictor)</b>	<b>Model Sample Size</b>	<b>Direction</b>	<b>Effect Size<sup>1</sup></b>
CHIRP	Hospital-onset CDI	HIE participation	101	↑	Medium
CHIRP	Procedure-specific SSI	Written transition procedures	25	↓	Medium <sup>2</sup>
DPP BHS	BMI screening	Electronic exchange of clinical data	39	↑	Medium
TIPPS	Tobacco use screening	PCMH Status	24	↑	Medium <sup>2</sup>
TIPPS	Depression screening	PCMH Status	24	↑	Large <sup>2</sup>
TIPPS	Controlling high blood pressure	PCMH Status	24	↓	Medium <sup>2</sup>
TIPPS	Post-partum follow-up	PCMH Status	20	↑	Large <sup>2</sup>

Notes. <sup>1</sup> Effect sizes were calculated using Cohen's *d*, where  $d < 0.5$  indicated a small effect,  $d \geq 0.5$  and  $< 0.8$  indicated a medium effect, and  $d \geq 0.8$  indicated a large effect. <sup>2</sup> Effect sizes may be unstable due to low sample sizes.

Table shows only statistically significant findings from 31 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. HIE=Health information exchange; CDI=Clostridium difficile infection; SSI=Surgical site infection; BMI=Body mass index; PCMH=Patient-centered medical home.

Source. Year 1 Data Master 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 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 midway 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 reflect a program year of activity.

### **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.

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 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; 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 through August 31, 2022), while the evaluation measurement period is the calendar year 2021 (January 1, 2021 through December 31, 2021). In other words, although CMS approved the DPPs for a retroactive program implementation beginning September 1, 2021 through August 31, 2022, the evaluation uses a measurement period of January 1, 2021 through December 31, 2021 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 are being implemented amidst the ongoing uncertainty of the COVID-19 federal public health emergency (PHE). Since March 2020, the PHE has shifted priorities and operations for Medicaid providers and managed care organizations in the state and impacted Medicaid managed care clients. HHSC anticipates the PHE will have significant direct and indirect impacts on the evaluation measures. The PHE expires 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 will impact 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 the DPP's provider performance during the first 18 months of the program.

## 5. Conclusion

This report satisfies the requirement that DPPs must be evaluated annually to test whether the payment arrangement advances the goals of the Quality Strategy. While it is still too early to assess trends in performance, the first full year of data shows that the programs are still on track to advance their identified goals, though there may be challenges with some of the initially selected measures.

Hospitals participating in the CHIRP program reported a 12% increase in participation in Health Information Exchanges, as well as increased adoption of procedures for care transitions. However, the adoption of other structure measures stayed largely unchanged. The results from the second year of reporting also provide insights into the level of influence DPP participation has on an organization's decision to implement structure measures.

As a result of some of the findings of this evaluation, HHSC proposed that measures be removed or replaced from all four programs in SFY2024 due to high baseline performance or lack of alignment with the Medicaid population served by a participating provider. Additionally, most structure measures have been removed or replaced with structure measures more likely to see a growth in implementation status. HHSC prioritized areas for program changes and worked with program participants and quality experts to propose replacement measures that align with key focus areas, including maternal health, behavioral health, non-medical drivers of health, and health information exchange, across all four programs.

## **List of Acronyms**

<b>Acronym</b>	<b>Full Name</b>
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 A: 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?

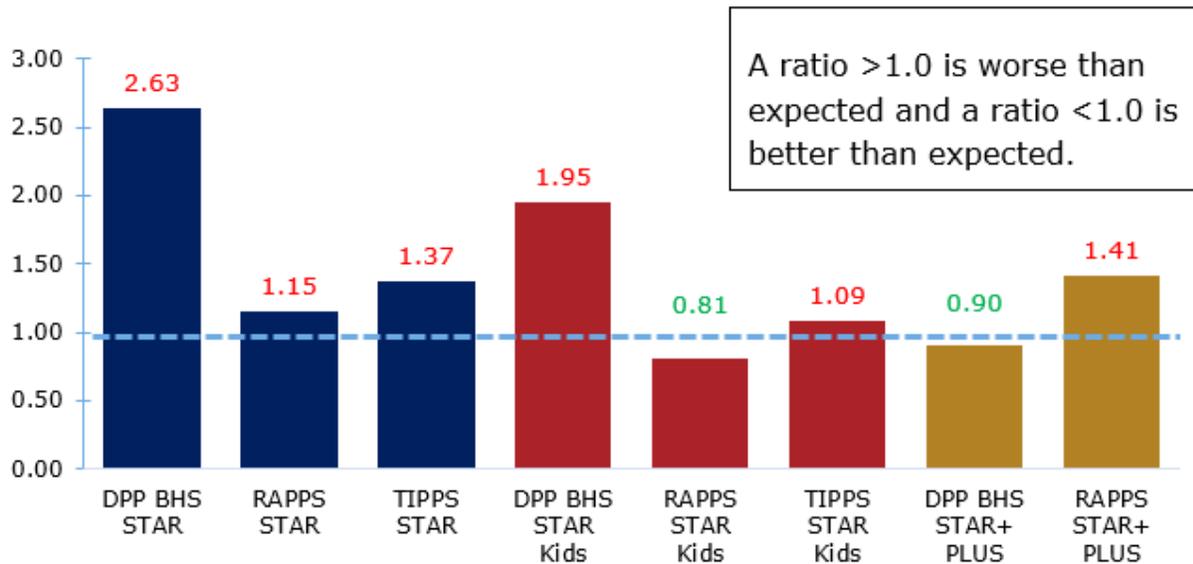


Figure 2. How does the actual rate of potentially preventable ED visits (PPVs) for a program population compare to the expected rate of PPVs in CY 2021?

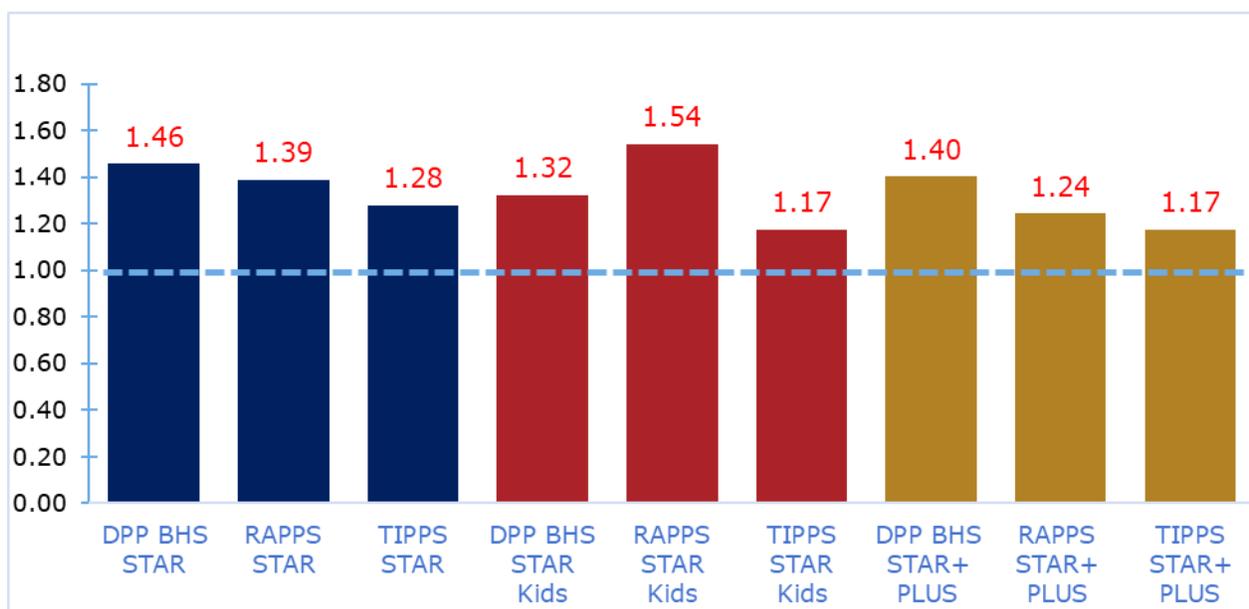


Figure 3. How much better or worse were TIPPS program population rates compared to statewide Medicaid performance in CY 2021?

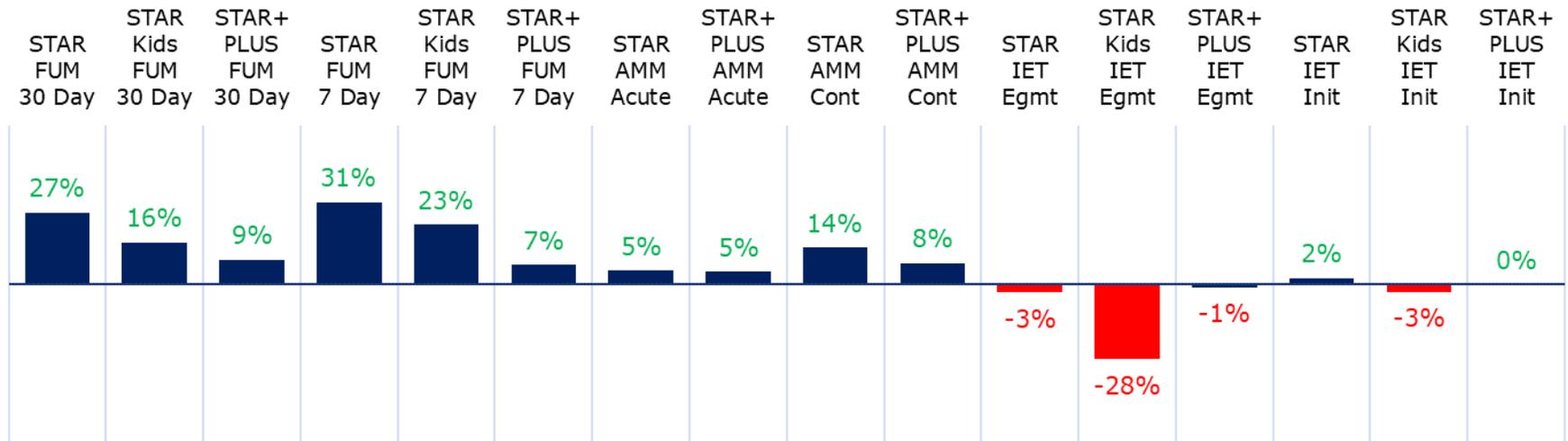


Figure 4. How much better or worse were DPP BHS program population rates compared to statewide Medicaid performance in CY 2021?

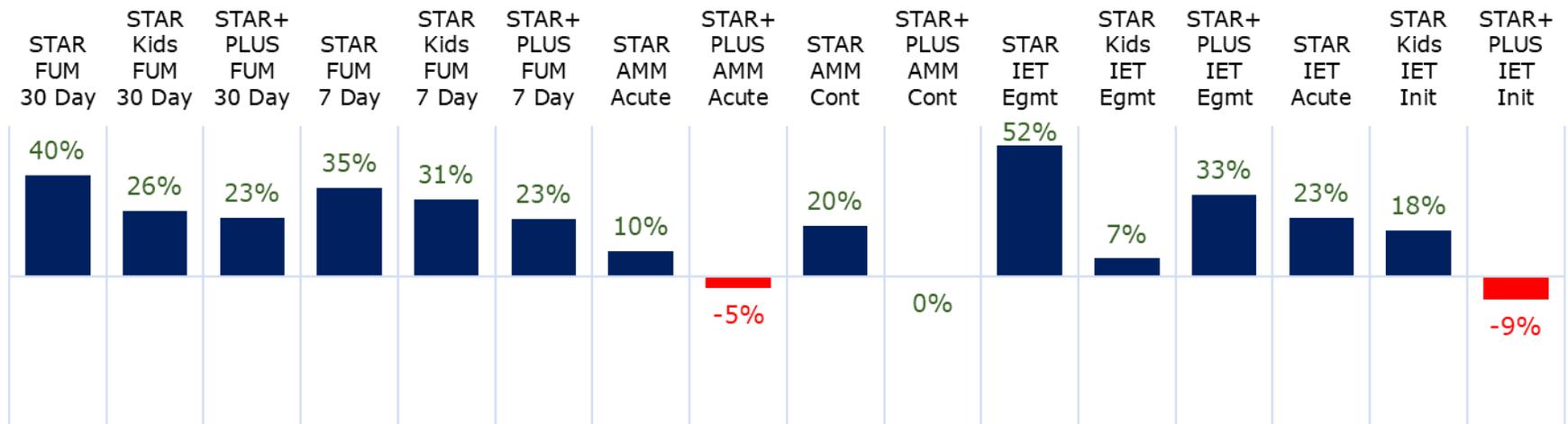
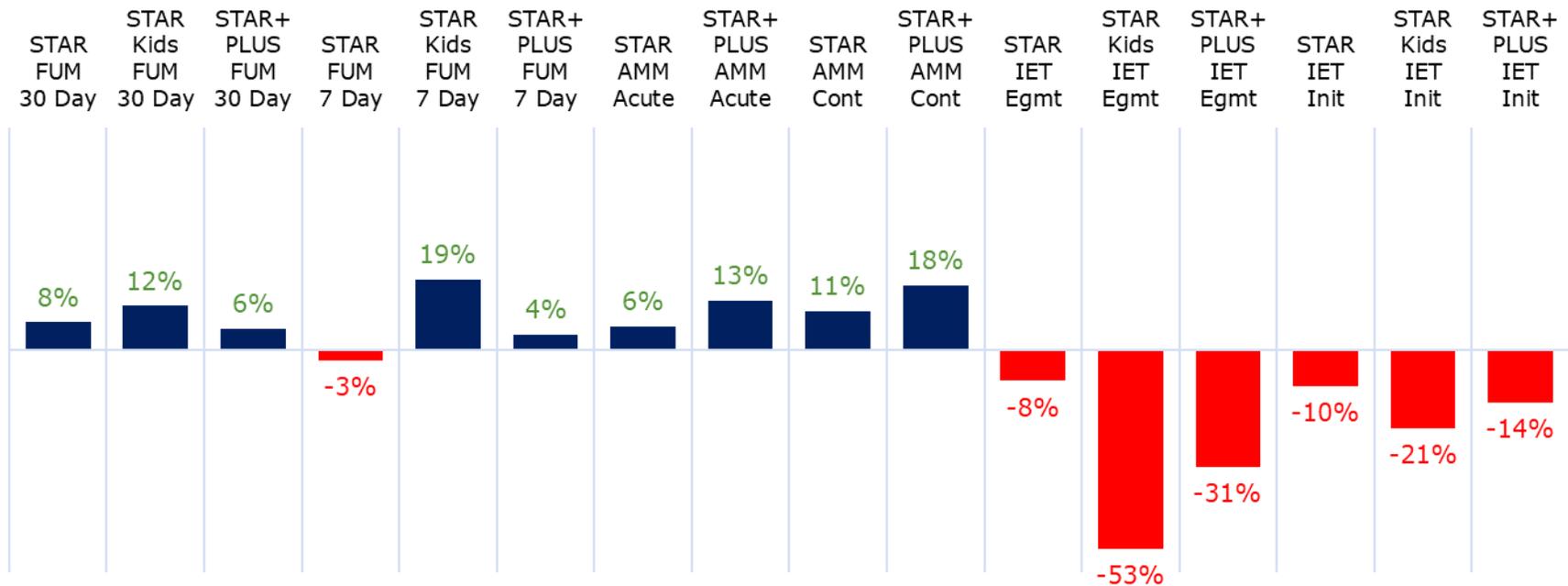


Figure 5. How much better or worse were RAPPS program population rates compared to statewide Medicaid performance in CY 2021?



- 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 B: Performance Data

**Table 1 CHIRP Preliminary Trends in Encounter Based Measures**

Measure Name	Participating Providers Reporting MMC in SFY22 & SFY23	Median SFY22 (Jan – Dec 21)	Median SFY23 (Jan – Jun 22)	Percent Change in Median <sup>12</sup>
Medication Reconciliation: Number of Unintentional Medication Discrepancies per Medication per Patient	391	0.1140	0.0777	32%
Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	132	0.5939	0.4446	25%
Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure	132	0.8692	0.5379	38%
Severe Maternal Morbidity	84	0.0198	0.0197	0%
PC-02 Cesarean Section	84	0.2286	0.2659	-16%
Pediatric CLABSI	10	0.0013	0.0008	40%
Pediatric CAUTI	10	0.0001	0.0003	-139%

<sup>12</sup> A positive result for the percent of change indicates the median rate is improving over the baseline year, and a negative result indicates the median rate worsened.

**Table 2 DPP BHS Preliminary Trends in Encounter Based Measures**

<b>Measure Name</b>	<b>Participating Providers Reporting MMC in SFY22 &amp; SFY23</b>	<b>Median SFY22 (Jan – Dec 21)</b>	<b>Median SFY23 (Jan – Jun 22)</b>	<b>Percent Change in Median</b>
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	27	0.7758	0.8667	12%
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	27	0.8571	0.9221	8%
Follow-Up After Hospitalization for Mental Illness 7-Day (discharges from state hospital)	27	0.8571	0.9167	7%
Follow-Up after Hospitalization for Mental Illness 30-Day (discharges from state hospital)	27	0.9697	0.9583	-1%

Figure 1 For hospitals that changed their HIE participation responses from SFY22 to SFY23, how much did CHIRP participation influence their decisions in SFY23?

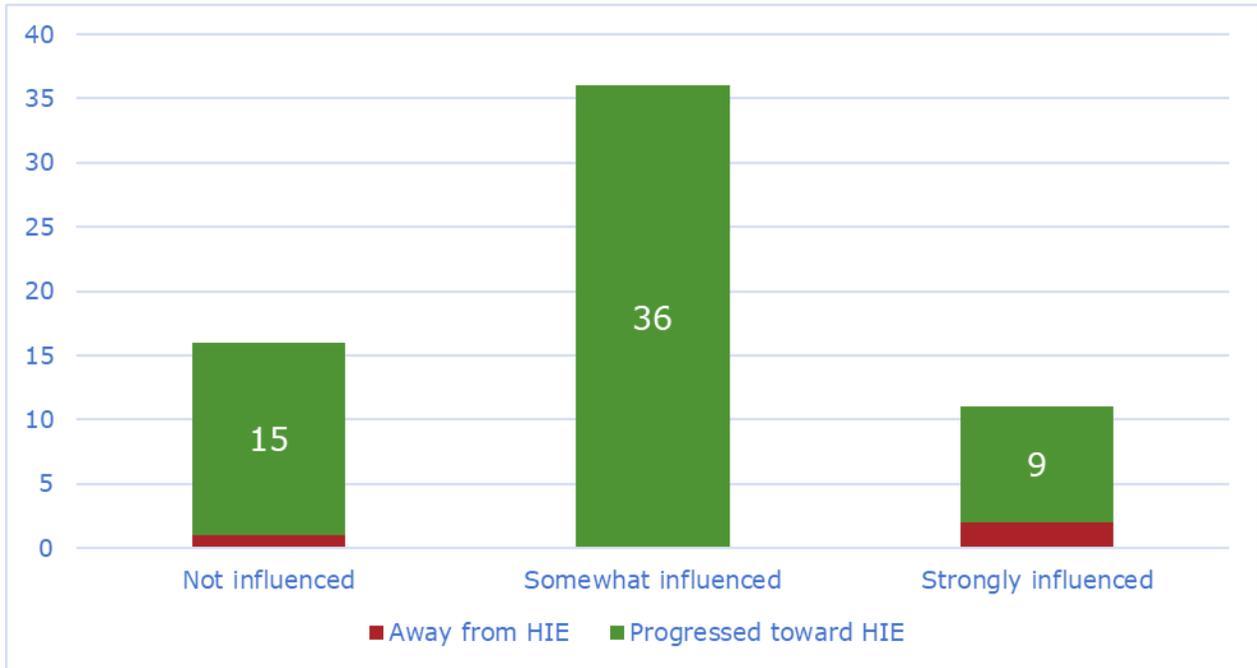


Figure 2 TIPPS: Does your organization connect with a public HIE or EHR with HIE capabilities?

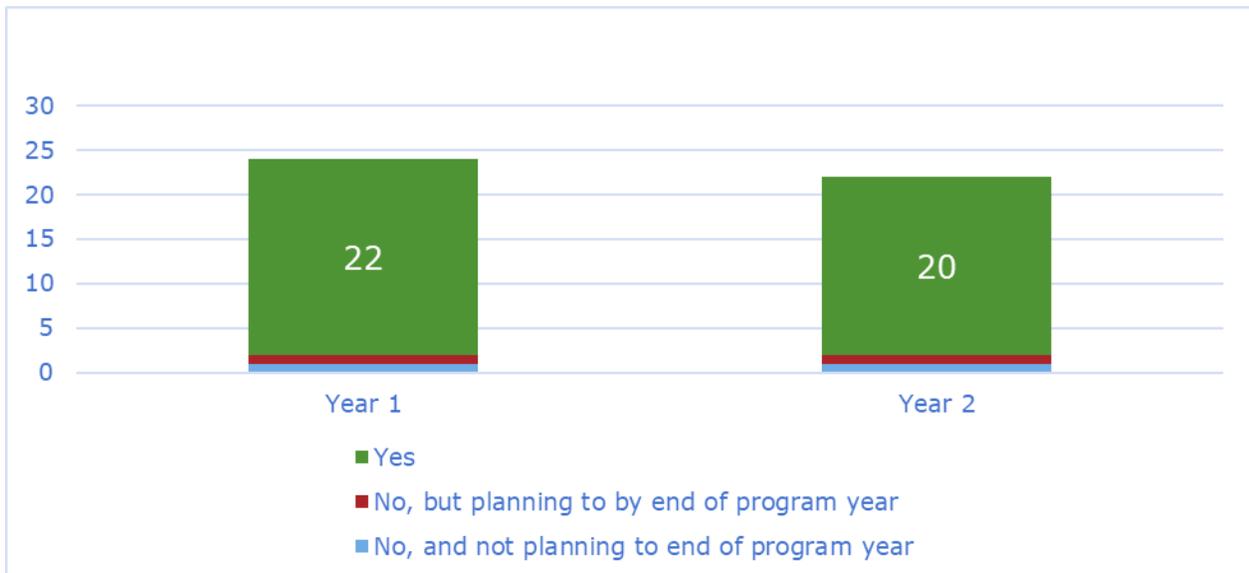


Figure 3 DPP BHS: CCBHCs sharing data via Consolidated clinical document architecture (C-CDA) format

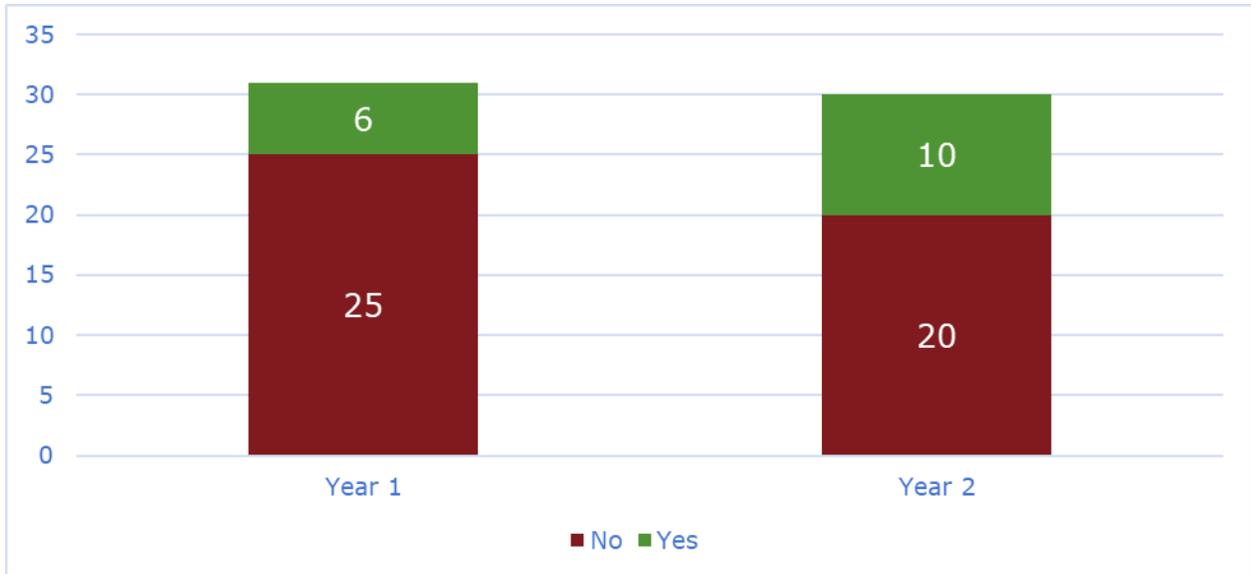


Figure 4 DPP BHS: To what extent are decisions to implement electronic exchange of clinical data influenced by DPP BHS participation?

