# Overview of Six Texas Demonstrations

The chart below provides an overview of six Texas demonstrations. Where possible, the chart indicates the purpose of the demonstration, the types of quality measures and data sources used to evaluate the program, the frequency of reporting, and the state's assessment partners.

| Program | Federal Agency | Purpose | Authority | Measures/Indicators/Data Sources | Reporting schedule | Types of data sources | State Assessment Partners |
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| **DMIE –** Demonstration to Maintain Independence and Employment | CMS | To test whether a coordinated program of employment and health supports can prevent the loss of employment and independence for workers with potentially disabling health conditions (Per UT Austin School of Social Work) | Authorized under the Ticket to Work and Work Incentives Improvement Act of 1999 (per Mathemat-ica report) | HPQ: The World Health Organization's Work Performance Questionnaire (HPQ) (number of times visited dentist or optician; had treatment or surgery; visited a mental health professional; overall health status; mental health status). | baseline / 12, 18, 24, 32 months | Administrative databases, enrollment forms, case manager reports, surveys. | UT Austin School of Social Work, Addiction Research Institute |
| | | | | Activities of Daily Living and Instrumental Activities of Daily Living scales | baseline / 12, 18, 24, 32 months | | |
| | | | | SF12v2 (a self-report survey that measures perceived overall physical and mental functioning and health-related quality of life) | baseline / 12, 18, 24, 32 months | | |
| | | | | Basis-24 health status survey | baseline / 12, 18, 24, 32 months | | |
| | | | | HCHD administrative data (demographics, including education level, family income, marital status, and housing type) | annually | | |
| | | | | State unemployment data, including employment history, job change frequency, and NAICS industry code and job type.) | annually | | |
| **DMIE** (cont.) | | | | HCHD customer healthcare cost and utilization data | At least annually | | |

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| | | | | Focus Group and individual interview | At least annually | | |
| | | | | Sources: 5/18/2015 email from senior policy advisor, Texas Department of State Health Services; 11/8/2006 presentation by TX Dept. of State Health Services, Harris County Hospital District, & UT Austin | | | |
| **DSRIP -** Delivery System Reform Incentive Payment. DSRIP is only one component of the Texas 1115 waiver. | CMS | To provide incentive payments to hospitals and other providers for investments in delivery system reforms that increase access, improve quality, and enhance the health of patients and families. (Source: Regional Healthcare Partnership Planning Protocol) | • Section 1115 of the Social Security Act<br>• Special Terms and Conditions (STC) 45 of the Demonstra-tion | • Providers select pay-for-performance and/or pay-for-reporting measures from a menu of predetermined measures that correspond to their projects.<br>• Providers also report on population health measures, such as preventive health and patient experience, which are not directly tied to specific projects.<br>• There were 1,491 approved and active DSRIP projects as of Sept. 9, per 9/9/2014 presentation by Chief Deputy Medicaid/CHIP Director.<br>• There are over 300 approved measures<br>• Quality, access, and health improvement measures will be determined by the metrics included in the DSRIP projects submitted by each Regional Healthcare Partnership (RHP).<br>• A cost effectiveness analysis will be developed once RHP plans are compiled (per CMS-approved evaluation plan for entire TX 1115 waiver).<br>• The largest (55 TX DSRIP projects) relatively homogeneous set of projects focused on "reducing inappropriate ED use through care navigation" (per | Providers report twice a year on project metrics and milestones to earn DSRIP incentive payments.<br><br>(Source: 9/9/2014 presentation by Chief Deputy Medicaid/ CHIP director) | Interviews with care navigators and providers to whom they refer patients; interviews with patients; site visits; claims data, hospital discharge data, surveys. | |

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| **DSRIP** (cont.) | | | | 8.14.2013 Detailed Evaluation Plan, p. 23). Evaluators chose 10 projects for a case study.<br><br>Planned evaluation data sources and measures include:<br><br>• Potentially preventable ED use<br>• Access to preventive care (including CAHPS items)<br>• Patient experience of care navigation (including CAHPS items)<br>• Provider experience of care navigation<br>• Patient outcomes – RAND 8 item health survey; PROMIS psychosocial illness impact<br>• Cost of care measures<br>• Factors hypothesized to affect implementation effectiveness (such as distance to services, hospital size and staffing stability, work climate and role clarity for care navigators, etc.)<br><br>Source: Detailed Evaluation Plan, 8/14/2013 | | | |
| **Duals** – Financial Alignment Initiative | CMS | The Texas Health and Human Services Commission seeks to better coordinate the care of dual eligibles. As of April 1, 2015, dual eligible members in the six demonstration counties are passively enrolled | Section 2602 of the ACA, which created the Federal Coordinated Health Care Office. | Sample of quality measures, from Texas Dual Eligibles Integrated Care Demonstration Project MOU:<br><br>• All-cause readmission<br>• Antidepressant medication management<br>• Blood pressure control<br>• Breast cancer screening<br>• CAHPS (multiple settings) and | "Quarterly reports will provide rapid-cycle monitoring of enrollment, utilization of services, and costs (pending data availability)." | Site visits, qualitative analysis of program data, focus group and key informant interviews, data, cost, and quality measures (TX | CMS, NORC at the University of Chicago, EQRO |

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| **Duals** (cont.) | | into a Medicare-Medicaid plan, which will provide the member the full array of Medicaid and Medicare services, integrating acute care and long term services and supports.<br><br>Objectives:<br><br>1. Make it easier for members to get care.<br>2. Deliver person-centered care.<br>3. Promote independence in the community.<br>4. Improve the quality of services.<br>5. Eliminate cost shifting between Medicare and Medicaid.<br>6. Achieve cost savings for the state and federal government through improvements in care coordination. | | other beneficiary surveys<br>• Care transition record transmitted to health professional<br>• Colorectal cancer screening<br>• Depression screening and follow-up<br>• Diabetes care<br>• Fall prevention<br>• Follow-up after mental health hospitalization<br>• HEDIS measures<br>• Immunizations<br>• Initiation and Engagement of alcohol and substance use disorders<br>• Medication management reconciliation after discharge from inpatient facility<br>• Part D medication measures<br>• Pressure ulcers<br>• Quality of life, satisfaction, and access to care information<br><br>Source: Texas Dual Eligibles Integrated Care Demonstration Project MOU | (TX Duals MOU).<br><br>Plans will report state-specific measure data to the CMS contractor.<br><br>Medicare-Medicaid Plans (MMPs) submit a quality assessment and perfor-mance improvement program at least annually. | Duals MOU). | |

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| **Money Follows the Person** - TX Behavioral Health Pilot | CMS | Texas' MFP Behavioral Health Pilot integrates specialized behavioral health services into the state's long term services and supports system to help adults with mental health or substance use disorders who have been institutionalized in nursing facilities return to the community. | Section 6071, Deficit Reduction Act of 2005, Public Law 109-171; Section 2403, Affordable Care Act, Public Law 111-148. (Began as a TX state initiative in 2001). The pilot began in 2008. | Key evaluation questions include whether the pilot improves functioning and quality of life, and what percentage of participants returns to nursing facilities.<br>1. Enrollment, number of community transitions, and service utilization<br>2. The Quality of Life Scale (QLS) (21 items) was developed to evaluate deficit symptoms and impaired functioning in people with schizophrenia.<br>3. The Multnomah Community Ability Scale (MCAS) (17 items) measures the functioning of chronically mentally ill persons living in the community.<br>4. The Social and Occupational Functioning Assessment Scale (SOFAS) is a single item that measures an individual's level of social and occupational functioning resulting from mental and physical health problems. | These measures were tracked at baseline, 90, 180, 270, 365 days during intervention and 18 and 24 months after intervention. | • Transformed Medicaid Statistical Information System (TMSIS)<br>• Clinical Management for Behavioral Health Services (CMBHS) database<br>• Interviews with participants, partners, family members, providers<br>• Quantitative data on measureable outcomes<br>• Video about participants' return to the community | UT Austin School of Social Work – Addiction Research Institute |
| **MIPCD -** Medicaid Incentives for the Prevention of Chronic Diseases | CMS | Wellness Incentives and Navigation (WIN) is designed to help improve health self-management and reduce chronic disease among non-elderly adult Medicaid SSI | Authorized by Section 4108 of the Patient Protection and Affordable Care Act (Pub. L. 111-148) | CMS measures (per MIPCD Operational Protocol 9-12-14 and 4-15-2013):<br>• Health status as measured by the SF-12-V2,<br>• The MOS Cognitive Functioning Scale Revised (MOS COG–R)<br>• The Instrumental Activities of Daily Living (IADL) scale; | | • Participant experience narratives and videos<br>• Enrollment and claims/encounter data, and enrollment files<br>• Medical record | University of Florida Institute for Child Health Policy (ICHP) |

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| **MIPCD** (cont.) | | beneficiaries, especially those with behavioral health diagnoses. | | • Health use and care expenditures for all care and for potentially preventable events such as inpatient admissions, readmissions and ED use,<br>• HEDIS quality of care measures, and<br>• Participant reported experiences with care.<br>• Clinical Risk Groups health status category;<br>• Potentially preventable inpatient admissions, readmissions, and ED use;<br>• Outpatient use;<br>• Use of appropriate medications for people with asthma;<br>• Cholesterol management for patients with cardiovascular conditions;<br>• Comprehensive diabetes care;<br>• Antidepressant medication management;<br>• Follow-up after hospitalization or mental illness;<br>• Initiation and Engagement of Alcohol and Other Dependence Treatment;<br>• Adult Access to Preventive/Ambulatory Health Services<br><br>Tracked by TX:<br>• Member survey (CAHPS with additional questions);<br>• Race<br>• Gender<br>• Age | | review<br>• Member report via telephone survey (CAHPS with added items)<br>• Navigator activity reports<br>• Other survey data: behavioral discounting, memory testing, Patient Activation Measure (PAM) | |

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| | | | | • Neighborhood poverty<br>• Behavioral discounting and memory testing;<br>• Patient Activation Measure (PAM) | | | |
| **SIM* –** State Innovation Models<br><br>*Note: TX received a round one SIM model design award, but did not move ahead with implementa-tion of the proposed quality measures. | CMS/ CMMI | TX identified transformation "drivers" that impact Triple Aim outcomes: adopting healthy lifestyle behaviors;<br>· patient/family engagement and accountability;<br>· evidence-based screening and appropriate care; and<br>· coordinated and clinically integrated care. | Social Security Act, Section 1115A(b)(2)(B)(xi)], which authorizes the Center for Medicare and Medicaid Innovation. | Eight "dashboard" measures: potentially preventable hospitalizations, ED visits, and 30-day readmissions; pre-term deliveries; satisfaction with health care, personal doctor, and specialist; total cost of care; total cost of potentially preventable events.<br>Driver measures:<br>Weight:<br>• 1 Weight management/control process, plus one additional not currently calculated<br>• 2 Weight outcome measures<br>• 7 Weight process measures<br>Diabetes:<br>• 8 Diabetes outcome measures plus 2 not currently calculated<br>• 6 Diabetes process/evidence-based care measure, plus 2 not currently calculated<br>• 1 Diabetes/ prediabetes risk factor/outcome<br>• 1 Diabetes/pre diabetes process/evidence-based care; patient engagement measure<br>• 1 Diabetes Utilization/outcome measure<br>• 2 Diabetes Cost measures<br>Hypertension (HTN) management/control<br>• 2 HTN outcome measures<br>• 10 HTN process measures | • Dashboard measured reported quarterly or monthly.<br><br>• Driver measures reported quarterly. | Enrollment, Claims/encount-er data, Behavioral Risk Factor Surveillance System (BRFSS), HEDIS, CAHPS, Medicare data, Quality of Care External Quality Review. | |

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| **SIM** (cont.) | | | | • 1 HTN cost measure not currently calculated<br>Management of Behavioral Health (BH) Comorbidities:<br>• 1 outcome plus one outcome not currently calculated<br>• 1 access measure<br>• 1 process plus 3 process not currently calculated<br>Pregnancy management:<br>• 3 process measures<br>• 7 outcome measures, plus 4 not currently calculated<br>Also SIM Innovation Measures:<br>• EHR/HIE<br>• Clinical Care Transformation<br>• Spreading/sustaining innovations<br>• Community-based public health innovations<br>• Multi-payer engagement and alignment. | | | |